

Implementation Manual

**An HIV/AIDS and STD Group-Level Intervention for
At-Risk Youth**

NONPROFIT CONSULTING SERVICES
A Division of Public Health Solutions



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Introduction and Overview



Section 1

Introduction To Implementation Manual

Intended Audience

This manual is a comprehensive guide for organizations, program managers, facilitators, and relevant staff preparing to implement Street Smart. It is the primary tool for community-based organizations (CBOs) to develop an organized strategic plan to implement this evidence-based HIV prevention intervention.

This manual provides details on all the processes needed to implement Street Smart. In particular, it provides explanatory material to help your agency understand the underlying goals and principles of the curriculum, accompanying logistics to support these goals, guidance on appropriately adapting and facilitating the intervention, and tips to ensure funding and efficacy in the longer-term.

Format of the Manual

This manual is divided into five sections followed by appendices. The following is a brief overview of the sections of the manual and how to use them.

Section 1: Introduction and Overview

This section provides an orientation to the Street Smart intervention, introducing the foundational issues necessary to familiarize yourself with the intervention. This section includes:

- An introduction to the manual;
- A Street Smart fact sheet;
- A brief overview;
- An explanation of how Street Smart works;
- A description of the underlying social and behavioral science theory;
- A review of the original research upon which Street Smart was based;
- A review and explanation of the core elements and key characteristics of the intervention; and
- A sample Street Smart behavior change logic model.

Section 2: Pre-implementation

This section addresses many of the pre-implementation logistical issues and covers the “nuts and bolts” of the intervention. This includes:

- A summary of the capacity and resource needs;
- A description of the desired experience and expertise of staff;
- A checklist to determine whether your agency is ready to implement Street Smart;
- A sample cost sheet to provide guidance on budgeting;
- A set of policies that should be in place prior to implementing Street Smart;
- A description of optimal locations and venues for delivery strategies on how to elicit community support for Street Smart;
- A comprehensive client recruitment, triage, and retention plan;
- Guidelines for the adaptation process;
- Checklists and timelines providing a step-by-step implementation plan; and
- An implementation summary.

Section 3: Implementation

The implementation section provides an outline of each of the 10 sessions of Street Smart. In-depth information is provided on the primary tools and techniques of Street Smart to assist facilitators in its implementation. This section also includes the Facilitator Guide, which addresses the practical/logistical side of implementation, including:

- An outline of the sessions of Street Smart;
- A description of the tools and techniques used;
- Tips on facilitating Street Smart; and
- A description of exercises and activities, scripts, facilitation hints, key points and activities.

Section 4: Maintenance

The maintenance section provides you with tools to ensure the effective and sustained delivery of Street Smart in your agency. This section includes:

- Information on how to institutionalize Street Smart within your agency;
- A guide on quality assurance, which includes strategies to monitor fidelity to core elements; and
- A monitoring and evaluation guide.

Section 5: Instruments

The instruments provided in Section Five are designed to assist implementing agencies track, rate and evaluate various aspects of the intervention. This section includes the:

- Participant Enrollment Form;
- Participant Guidelines;
- Pre- and Post-Test;
- Attendance Form;
- Fidelity Checklist;
- Supervisor Rating Form;
- Satisfaction Survey; and
- Community Resource Center Event Log.

Section 6: Appendices

The appendices contain a number of helpful resources including:

- A Glossary of Street Smart Terms;
- Original Research Articles for Street Smart;
- Program Review Panel Guideline for Content of AIDS-Related Written Materials;
- CDC: The ABC's of Smart Behavior;
- CDC: Statement on Nonoxynol-9 Spermicide Contraception Use;
- CDC Statement on Study Results of Product Containing Nonoxynol-9;
- Fact Sheet on Condoms;
- Fact Sheet on Testing;
- Resources for Pre-Implementation and Implementation; and
- References.

Section 1

Street Smart Fact Sheet

Program Overview

Street Smart is an HIV/AIDS and STD prevention program originally designed for runaway and homeless youth. Your staff may use this skills-building program to help high-risk youth reduce their unprotected sex acts, number of sex partners, and substance use. It is based on the social learning theory, which links feelings, attitudes, and thoughts to behavior change. Street Smart is conducted over a six- to eight-week period with 10-12 youth. The program consists of eight 1 ½- to 2-hour group sessions, one individual session, and one visit to a community-based organization resource. Each session has specific goals on HIV/AIDS, STDs, pregnancy prevention, coping and negotiation skills, personalized risk behaviors and reducing drug and alcohol use. Group members participate in scripted and non-scripted role plays, activities, and video production.

Core Elements

The core elements of the Street Smart program are:

- Enhancing affective and cognitive awareness, expression, and control;
- Teaching HIV/AIDS risk hierarchy and its personal application;
- Identifying personal triggers, using peer support and small group skills-building sessions; and
- Building participants' skills in problem solving, personal assertiveness, and HIV/AIDS risk reduction.

Target Population

The Street Smart program targets runaway and homeless youth, ages 11 to 18.

Program Materials

- Facilitator implementation manual (for program staff);
- Orientation video (for program staff);
- Workbook for participants;
- Sample social marketing and recruitment tools (or templates);
- Handouts for participants.

Research Results

After Street Smart was implemented, it yielded these results:

- Participants reported lower rates of substance use and unprotected sex acts;
- Young women self-reported greater reductions in substance abuse and unprotected sex acts than young men; and
- African-American youth self-reported less substance use than youth of other ethnic groups.

For More Information on Street Smart

To obtain additional information about the technical assistance system and/or to register for a future training, please visit **www.effectiveinterventions.org**. If you do not have access to the web, you may also call (800) 462-9521, or email **interventions@aed.org**.

Section 1

Street Smart Overview

Street Smart is an intensive program designed to prevent HIV/AIDS and other sexually transmitted infections (STDs) among homeless and runaway youth (11–18 years of age), outside of school settings, whose behaviors place them at high risk of becoming infected. It is a multi-session, manual-guided, small-group intervention that teaches problem-solving skills and strategies to support effective behavior change and reduce risk of HIV transmission.

Life circumstances define risk for some youth: being gay, a sex worker, runaway or homeless may increase the potential for risky behavior. Although Street Smart is designed for runaway and homeless youth, it has been effectively adapted for youth at high risk in other settings (e.g., incarcerated youth, injection drug users, and LGBTQ populations).

Street Smart has been demonstrated to be effective at achieving behavior change, in addition to influencing knowledge acquisition and attitude change. Modeled on previously successful programs targeting other risk behaviors (e.g., adolescent smoking), Street Smart incorporates skills training, behavioral self-management, and group and social support from peers into its programming to support behavioral change.

Street Smart has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project. Information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

The main goal of Street Smart is to reduce unprotected sex acts, number of sex partners, and substance use prior to sexual activity among high-risk youth. This is accomplished through a number of means including increasing self-efficacy, learning and practicing negotiation skills, identifying triggers to unsafe behavior, and problem solving.

Section 1

How It Works

Group Sessions

- Session 1: Getting the Language of HIV and STDs
- Session 2: Personalized Risk
- Session 3: How to Use Condoms
- Session 4: Drugs and Alcohol
- Session 5: Recognizing and Coping with Feelings
- Session 6: Negotiating Effectively
- Session 7: Self-Talk
- Session 8: Safer Sex

Street Smart has been demonstrated to be effective at achieving behavior change, in addition to influencing knowledge acquisition and attitude change. Modeled on previously successful programs targeting other risk behaviors (e.g., adolescent smoking), Street Smart incorporates skills training, behavioral self-management, and group and social support from peers into its programming to support behavioral change.

The Street Smart intervention incorporates three different learning formats to promote behavioral change. These formats include group sessions, an individual session, and a community resource center visit.

The eight group sessions (90- to 120-minutes each) aim to improve youths' social skills, assertiveness, and coping through exercises on problem solving, emotional management, identifying triggers, and reducing harmful behaviors. These sessions also enable youth to more accurately assess their personal risk and increase their perception of vulnerability to HIV. They provide an opportunity for youth to practice negotiation and social skills and develop a supportive environment and social networks to foster, encourage, and sustain behavior change.

To make these sessions youth-appropriate, they are structured to be engaging and fast-paced, incorporating interactive activities such as video production, role-plays, and quiz games.

Although it is preferable that youth attend every session, the program is designed so that each session can stand on its own. Ideally, six to ten youth attend the group sessions, which are facilitated by two trained facilitators. This small group structure provides a supportive environment for behavior change.

Individual Session

In an individual session youth are given the opportunity to meet one-on-one with a facilitator. This private session enables each youth to identify personal risks for HIV transmission; discuss the respective triggers, thoughts, and feelings related to those risks; and determine ways to overcome his or her barriers to safer sex. It offers youth an opportunity to discuss barriers and issues that they may not be comfortable discussing in a group setting.

This one-on-one session provides the youth with the opportunity to use and integrate all the skills and strategies learned during the group sessions to develop an HIV risk-reduction plan, tailored to their specific needs. During this session youth can be referred for additional services (e.g., medical care, mental health services, and housing), as needed.

Community Resource Center Visit

To promote awareness and utilization of available community resources and services, the youth visit a relevant community resource center. Examples include an STD clinic, family planning center, or any health-related resource that best serves their needs. This visit assists youth in making connections with local service agencies and providers. Such connections are vital as these community resource agencies can be invaluable in supporting and sustaining the desired behavior of practicing safer sex. Furthermore, it encourages youth to become informed consumers of health and other social service resources.

Section 1

Theory Behind The Intervention

Street Smart draws on the Social Learning Theory, which describes the relationship between behavior change and an individual's environment. Social Learning Theory focuses on the learning that occurs within a social context. It considers that people learn from one another via observational learning, imitation, and modeling. A key piece of the Social Learning Theory is that an individual's self-efficacy and his/her beliefs about the consequences of changing his/her behavior are determinants of effective behavioral change. It links thoughts, feelings, and attitudes to behavior change.¹²

General principles of Social Learning Theory:

1. Most behavior is learned not from individual experience, but by observation of the experiences of others and the outcomes of those experiences.
2. Observation alone does not necessarily result in behavior change. Behavior change is most likely to occur if the behavior is observed and rehearsed before being put into practice.
3. Cognition (including attention, perception, memory, reasoning, and judgment) is involved in learning. Individuals are more likely to adopt a behavior if they are aware of the potential outcomes and associate these outcomes with things they value. Moreover, behavior change is more likely to occur if individuals expect that the outcomes will be positive.

1 Bandura, A. (1977). *Social Learning Theory*. General Learning Press.

2 Rotter, J. B. (1954). *Social Learning and Clinical Psychology*. Prentice-Hall.

Research Findings

Street Smart was based on an intervention in the late 1980s in New York City in shelters for runaway adolescents. The study participants were young males and females aged 11-18 and were largely African-American and Hispanic.³ Further research was conducted in the early 2000's among a larger sample of New York City runaway youth with a quasi-experimental design.⁴

In research field trials, participants who completed the Street Smart group sessions reported decreases in HIV transmission risk. Following the completion of the intervention, participants reported lower rates of both IV drug use (a direct route of HIV transmission), as well as lower rates of other substance use, such as alcohol and marijuana (substances that can encourage risk-taking behavior and impair safer sex decision-making). Participants also reported improvements in safer sex behaviors, including a significant increase in condom use and a significant decrease in patterns of high-risk sexual behavior. Young women in the intervention demonstrated greater reductions in unprotected sexual acts and substance abuse than did young men.

To read the original articles, please see Appendix B.
For a complete reference list, please see Appendix J.

3 Rotheram-Borus, M. J., Koopman, C., Haignere, C., & Davies, M. (1991). Reducing HIV sexual risk behaviors among runaway adolescents. *JAMA: The Journal of the American Medical Association*, 266(9), 1237-1241.

4 Rotheram-Borus, M. J., Song, J., Gwadz, M., Lee, M., Van Rossem, R., & Koopman, C. (2003). Reductions in HIV risk among runaway youth. *Prevention Science: The Official Journal of the Society for Prevention Research*, 4(3), 173-187.

Section 1

Core Elements

Core elements are the parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Street Smart's core elements are:

- 1) Enhancing affective and cognitive awareness, expression, and control.
- 2) Teaching HIV/AIDS risk hierarchy and its application to oneself.
- 3) Using peer support to train youth in recognizing triggers for personal risk.
- 4) Building skills in problem solving, personal assertiveness and HIV/AIDS risk reduction.

Section 1

Key Characteristics

Key characteristics are crucial activities and delivery methods for conducting an intervention that may be adapted to meet the needs of the agency or target population and to ensure cultural appropriateness of the strategy. ***None of the key characteristics can be eliminated, but they can be adapted to fit different types of youth and agency needs.***

The key characteristics of Street Smart fall into two main categories:

1. Structure and Logistics of the Intervention:

- Convening groups of six to ten adolescents comprised of both sexes. (See Section 2: Pre-Implementation for further guidance on adapting for same-sex groups.)
- Delivering the intervention in eight, 90 to 120 minute group sessions, one individual session, and one trip to a community resource center.
- Conducting the intervention group sessions in a large, comfortable room protected from interruptions.

2. Techniques and Tools:

- Reinforcing positive behavior through frequent use of tokens and verbal appreciation.
- Building group cohesion through participant sharing and showing appreciation to others for their contributions.
- Eliciting participants' assessment of their feelings by using the "Feeling Thermometer" to gauge the intensity of the feelings they are experiencing.

- Building skills in expression and management of feelings through the use of the Feeling Thermometer, relaxation, and utilizing coping skills.
- Using role-playing as an opportunity for participants to practice and observe the skills that are learned during the session (e.g. ways of coping, condom negotiation, problem solving) by playing out typical circumstances where risk behaviors may occur in an instructive and supportive environment.
- Videotaping role-plays so participants can see themselves as others see them.
- Applying problem-solving steps to realistic circumstances.
- Creating concern over unsafe sexual behaviors and involvement in risky situations and/or with risky partners.

Section 1

Logic Model

A logic model is an essential element in planning for interventions. It provides a roadmap of the program and its rationale. When done correctly, logic models provide an easily understood, user-friendly graphic that demonstrates the relationships between the identified risk behaviors or problems, the activities of the intervention, and its intended outcomes. Logic models provide an organization with a common language and reference point to guide implementation efforts.

To best understand the goals and development of a logic model, it is helpful to have a basic understanding of the main components.

Behavioral Determinants describe the main issues that the intervention seeks to remedy and identify the underlying causes that the intervention will address.

Activities describe the programming that will be undertaken to address the behavioral determinants and achieve the goal(s) of the intervention.

Outcomes are the specific effects (e.g., changes in knowledge, attitudes, or behavior) that you expect the program to have on your target population. These are often divided into two or three sub-groups: immediate outcomes (expected changes which can be measured within 2 weeks), intermediate outcomes (results identified within 2 weeks to 6 months following intervention), and long-term outcomes (results persisting beyond 6 months, hopefully leading to permanent behavioral changes or other improvements).

The logic model below provides a sample behavior change logic model that reflects Street Smart activities and the behaviors and attitudes of members of targeted communities those activities are designed to affect. Organizations should tailor this logic model to reflect their specific implementation of Street Smart. This logic model should be used in conjunction with the Implementation Summary, which can be found in Section 2: Pre-Implementation.

Street Smart Behavior Change Logic Model

<p>Problem Statement: Runaway and homeless youth participate in high-risk sexual and drug-use behaviors due to a variety of developmental and contextual factors.</p>	
<p>Behavioral Determinants Corresponds to risk or contextual factors</p>	<p>Activities To address behavioral determinants</p>
<p>Knowledge Limited knowledge of HIV/STD transmission, symptoms, treatment, and testing</p> <p>Limited knowledge of relative safety of sexual acts</p> <p>Limited knowledge of protective barriers</p> <p>Limited knowledge of impact of substance use on HIV/STD risk behaviors</p>	<p>Discuss HIV/STD transmission, symptoms, treatment, and testing (“What Are the Facts About HIV?”)</p> <p>Discuss hierarchy of risk behaviors (“How Safe Am I?”)</p> <p>Discuss proper condom use (“The Steps for Putting on Male and Female Condoms”)</p> <p>Discuss effects of substance use (“How Do Drugs and Alcohol Affect Me Personally?”)</p>
<p>Attitudes/Perceptions Low perceived susceptibility/vulnerability to HIV/STDs</p> <p>Limited motivation to change attitude/perceptions regarding condom use</p> <p>Limited motivation to change attitudes/perception regarding substance use</p> <p>Limited motivation to change attitudes/perception regarding HIV/STD testing</p> <p>Limited motivation to change attitudes/perceptions regarding communicating with partners</p> <p>Low self-efficacy regarding condom use</p> <p>Low self-efficacy regarding access to resources</p>	<p>Self-assessment of risks and triggers (Triggers Questionnaire, Individual Session)</p> <p>Discuss partner’s risks (“How Safe Is My Partner?”)</p> <p>Explore the look and feel of condoms (“Getting the Feel of Condoms”)</p> <p>Decisional balancing around drug use (“What Are the Pros and Cons of Substance Use”)</p> <p>Decisional balancing around testing (“Advantages and Disadvantages of Getting Tested”)</p> <p>Role-plays on partner communication</p> <p>Use of tokens to reinforce positive attitudes and behaviors</p> <p>Putting condoms on models with partners (“Practicing Putting on Male and Female Condoms”)</p> <p>Trip to community resource center (Session 10)</p> <p>Development of personal risk-reduction plan (Individual Session)</p>

Outcomes

Expected changes as a result of activities targeting behavioral determinants

Immediate Outcomes

Increased knowledge of HIV/STD transmission, symptoms, and testing

Increased knowledge of relative safety of risk behaviors

Increased knowledge of how to use condoms properly

Increased knowledge of the effects of substance use

Intermediate Outcomes

Increased consistent and correct condom use

Decreased number of sexual partners

Decreased substance use

Increased awareness of triggers

Increased awareness of personal risk behaviors

Increased awareness of partner's risk behaviors

Increased perceived susceptibility to HIV/STDs

Increased positive attitudes toward condom use, testing, and communicating with partners

Increased critical attitude toward substance use

Increased self-efficacy to change behaviors

Increased self-efficacy to use condoms

Increased self-efficacy to access resources

Increased consistent and correct condom use

Decreased number of sexual partners

Decreased substance use

<p>Resources</p> <p>Limited social support for HIV/STD risk-reduction behaviors and positive reinforcement</p> <p>Limited access to supportive services</p> <p>Limited use of health resource services</p>	<p>Use of tokens to express appreciation, encourage group cohesion, and reinforce positive attitudes and behaviors</p> <p>Encourage participants to give feedback on role plays</p> <p>Create media message for safer sex</p> <p>Participate in 8 group sessions</p> <p>Trip to community resource center (Session 10)</p>
<p>Skills</p> <p>Limited communication skills related to assertiveness, communication of sexual/interpersonal boundaries, and negotiation (particularly around condom use)</p> <p>Limited ability to assess partner's risks</p> <p>Limited coping skills, including problem-solving skills</p> <p>Limited management of thoughts, feelings and actions</p> <p>Limited ability to identify boundaries</p> <p>Limited ability to recognize triggers for HIV/STD risk behaviors</p>	

<p>Increased social support for protective behaviors</p>	<p>Increased consistent and correct condom use</p> <p>Decreased number of sexual partners</p> <p>Decreased substance use</p>
<p>Improved ability to communicate assertively</p> <p>Improved ability to negotiate condom use</p> <p>Improved ability to talk to a partner about risk</p> <p>Improved ability to recognize self-defeating thoughts (as they relate to using drugs and practicing safer sex) and to switch these thoughts to helpful ones</p> <p>Improved ability to recognize triggers for HIV/STD risk behaviors</p> <p>Increased ability to use effective coping mechanisms and problem solving when faced with challenging situations (e.g. sexual)</p> <p>Increased ability to define one's own sexual values and align behaviors with these values</p> <p>Improved ability to recognize and control one's level of discomfort in a given situation and ability to link this to sexual decision-making</p>	<p>Increased consistent and correct condom use</p> <p>Decreased number of sexual partners</p> <p>Decreased substance use</p>

Section 1

Note On CDC Interventions

The Abstinence, Be Faithful, [use] Condoms (ABC) approach is an important component of HIV prevention for youth. Although abstinence-only interventions have been proven to be ineffective at reducing risk for HIV, integration of the ABC message into evidence-based interventions, such as Street Smart, may enhance safe-behavior education for youth by offering abstinence from sex or drugs as a part of more comprehensive risk-reduction strategies. To learn more about the ABC method, see Appendix D.



Pre-

Implementation

2



Section 2

Introduction

Prior to implementing Street Smart you will need to consider both your agency's capacity and strategy.

You should consider what you will need to fully implement the program including:

- Appropriate personnel;
- Equipment;
- Space;
- Services; and
- Policies.

You will also need to consider how you will implement the intervention. How will you:

- Choose a location?
- Recruit and retain participants?
- Elicit necessary support?
- Adapt Street Smart to your needs?

Lastly, a detailed workplan must be created so that responsibility can be assigned and a reasonable timeline can be established.

This section on pre-implementation will assist you in understanding what goes into implementing a Street Smart program, provide you with tools for assessing your capacity, and explain how to get your team ready.

Section 2

Capacity and Resources Summary

Before beginning Street Smart sessions your organization must have:

Two adult facilitators who...

- Have completed the Street Smart intervention training (4 full days)
- Will both attend each Street Smart session
- Can implement the entire program
- Can maintain fidelity to core elements if adaptation is necessary

An appropriate venue

- Safe
- Accessible
- Private

Adequate supplies (e.g., nametags, tissues, paper, pens and pencils, handouts) for all youth participants

A **system to refer youth** to additional services (e.g., counseling) if required

Adequate funds or creative community resources

Strong **relationships with various social service agencies** at both the leadership and staff levels

Access to at-risk youth

- Your organization must serve at-risk youth or have established relationships with organizations serving at-risk youth (e.g., juvenile detention centers, homeless shelters, drop-in youth centers, youth outreach centers).
- CDC does not endorse Street Smart for in-school programs

These elements will be discussed in more detail in the following sections.

Section 2

Capacity and Resources Summary

Facilitators

Personnel are an essential aspect of agency capacity. It is imperative that facilitators are well prepared to implement Street Smart. This manual will provide a list of the skills necessary to properly facilitate Street Smart, a list of the skills that will be taught to facilitators as they train to implement Street Smart, and a list of skills that facilitators might have in a good, better, and best case scenario.

Members of the street smart facilitation team should:

- Have experience working with youth, especially at-risk youth
- Have at least one facilitator with experience in youth group facilitation
- Be able to bridge theory and practice
- Be aware that some participating youth may already have been adversely affected by the HIV/AIDS epidemic
- Be trained in how to talk to youth about HIV/AIDS
- Understand the underlying principles of Street Smart
- Understand the behavioral theories that underlie the intervention
- Understand adolescent development and its impact on HIV risk behaviors

Each facilitator must attend a Training of Facilitators (TOF) conducted by a qualified capacity building assistance provider to learn the basic skills necessary to implement Street Smart. The TOF focuses on teaching facilitators how to:

- Reinforce positive behaviors
- Label feelings
- Encourage active participation
- Teach effective coping strategies
- Create concern over unsafe behaviors
- Encourage group cohesion of appropriate norms for behavior
- Facilitate role-playing activities
- Manage group dynamics

- Relate the intervention content to the lives of the youth
- Use supportive and nonjudgmental language

It is recognized that agencies have personnel with varying levels of expertise. For that reason, the following provides a set of “Good, Better, Best” skills that are additionally recommended for facilitators in their implementation of Street Smart.

What we mean by “good,” “better,” and “best.”

Good:

The basic set of knowledge, experience, and skills recommended for staff implementing behavioral interventions.

Better:

Supplements the basic criteria to demonstrate a higher level of knowledge and skills recommended for staff implementing behavioral interventions.

Best:

The skills set that can help an agency achieve excellence and expertise in the implementation of behavioral HIV/STD interventions. Facilitators meeting this standard demonstrate an exceptional understanding of behavioral science theory and its application to effective behavioral interventions.

Good:

Basic HIV and STD knowledge
Experience working with adolescents

Better:

Intermediate HIV and STD knowledge
Experience working with high-risk adolescents
Recruitment and retention experience

Best:

Expert HIV and STD knowledge
Experience working with high-risk adolescents, using a client-centered approach
Recruitment and retention experience
Experience using a structured curriculum-based intervention
Training in adolescent development
Program evaluation experience

Section 2

Program Managers

Program Managers

In Street Smart, Program Managers play an important role in ensuring the smooth functioning of the intervention. They will be responsible for:

- Organizing logistics
- Supervising facilitators
- Conducting monitoring and evaluation activities
- Developing and maintaining stakeholder relationships

It is suggested that Program Managers attend the Training of Facilitators to become familiar with the intervention and the skills required for the facilitators they will supervise. It is also preferable that Program Managers possess a Masters in Public Health or extensive experience in Public Health or a related field so that they are familiar with the behavioral science upon which this intervention is based.

Essential skills for Program Managers include:

Logistics

Program Managers should have strong organizational and logistical skills. They will play a role in selecting an appropriate venue and scheduling the sessions, arranging for appropriate referrals, and participating in the marketing of Street Smart.

Supervision

Program Managers are integral to ensuring the high quality and consistent delivery of the intervention. They will need strong supervisory skills as they will be meeting after each session with facilitators to debrief. They will discuss areas where facilitators can strengthen skills, help them troubleshoot problems, and provide general guidance.

Monitoring and Evaluation

Program Managers must have experience with quality assurance processes and program monitoring and evaluation. They should be comfortable adapting the data collection instruments provided in Section Five to the needs of their organization, as well as creating a data collection plan. They should be comfortable working with process and outcomes data to inform adaptations of the intervention.

Relationship Building

Program Managers should also possess or be adept at creating strong relationships with stakeholders. They should be able to accurately describe and advocate for Street Smart in the community and among other agencies. More information on the agency interfacing with sources of community support can be found in the “Community Support” portion of this section.

There are several practical considerations necessary before Street Smart can be implemented. Appropriate space, equipment, and services are essential for the smooth implementation of this intervention

Section 2

Resources Section

Meeting Space

Street Smart requires two different types of spaces. First, a private room that is inviting, comfortable, safe, and large enough for groups. Ideally, the same room should be used for all eight group sessions. Second, you will need a private, closed (e.g. not a cubicle), smaller, safe space for the individual session. Both spaces need to ensure confidentiality and be accessible to the youth who will be participating in your program.

Equipment and Supplies

Street Smart requires use of a DVD player or VCR, TV, and video camera. Facilitators should be familiar with how the equipment operates.

Facilitators should also have the following tools on hand:

- Nametags
- Markers
- Easel
- Newsprint
- Pencils
- Session-specific handouts
- Activity books
- Street Smart posters (including Feeling Thermometer)
- Tokens

In addition, organizations may find it helpful to have a shredder available to destroy any confidential forms filled out by youth (e.g., Trigger Questionnaire, etc.) following each session.

Services and Support for Youth

Agencies should ensure that youth participating in Street Smart have access to the following:

- Community resources to support the desired behavior including:
 - o HIV counseling, testing, and referral
 - o Health care
 - o Alcohol and drug treatment
 - o Legal aid
 - o General equivalency diploma (GED) examination programs
 - o Athletic programs
 - o Housing
- Transportation to community agencies and centers where they can personally meet the staff and learn about what they offer
- Session scheduling well in advance in order to make time to attend
- A telephone number they can call with questions about the program

Section 2

Agency Readiness Self- Assessment

After gaining an initial understanding of the requirements for implementing Street Smart, your agency can use the follow checklist to conduct a brief self-assessment to determine your current capacity and areas that you may need to develop. Read each item; place a check mark (✓) in only one response option.

Capacities and Resources Needed for Street Smart	Yes, we have this capacity	We do not presently have this capacity, but can build it	No, we do not have this capacity
1. Access to the target population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Two skilled group facilitators with experience in HIV/STD prevention and working with youth. Both will need to attend each Street Smart session.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. One Program Manager with experience managing direct-service staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Completion of four full days of Street Smart Training of Facilitators (TOF) by two agency facilitators and a Program Manager.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Meeting space that is private, comfortable and large enough to accommodate up to 10 youth to conduct Street Smart group sessions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Private room to conduct individual sessions that is large enough to accommodate two people comfortably.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ability to provide a variety of support materials (such as condoms, pelvic models, penile models, male and female condoms) for demonstration and skill-building.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Access to a video camera and TV/VCR/DVD player for use during the Street Smart sessions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Established referral agreements with appropriate youth serving agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Agency commitment to implement the entire Street Smart program (all 10 sessions) and to sustain the program over time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If all of your responses were in column 1 (“Yes, we have this capacity”) or column 2 (“We do not presently have this capacity, but we can build the capacity”), your agency is likely ready for Street Smart.

Section 2

Provider Cost Sheet To Implement Street Smart

Filling out this form will give you a sense of the total cost of implementing Street Smart.

Instructions

The cost sheet is broken down into five categories: personnel, facility, equipment, supplies, recruitment, travel, and consultancy. Next to each category is an approximate percentage of the total budget that should be allotted.

As the start-up and delivery budgets are likely to differ, there are two different columns for estimating these costs.

Personnel costs are estimated by the percent of the salary covered by this project. These costs will vary greatly by agency but should account for approximately 30% of the total budget.

Facility costs must be calculated. The methodology used by organizations may differ from the one shown below; agencies should consult with their fiscal staff and funder to determine which methodology should be used. To calculate values, insert the cost/rate next to the \$ and insert the appropriate percentage next to the % and multiply to arrive at a total cost.

For example, if the small group meeting room costs \$400 a month and you will be using it 6 days each month (20% of the time) then the calculation should be reflected as follows:

	Pre-Implementation	Implementation
Rent (small group meeting space)	\$400 x 10% =\$40	\$400 x 20% =\$80

Revealing a total cost for pre-implementation of \$40 and a total cost of \$80 for implementation per month.

Equipment costs are calculated based on the percentage of time used at a depreciated value using the same formula as the facility costs. They should account for approximately 10% of the total budget.

Supplies will account for approximately 15% of the total budget. Guidance relevant to quantities listed in this section can be found in the footnotes. Supply costs are calculated by estimating the quantity needed and multiplying by the price per unit.

Recruitment, travel, and consultancy costs will vary greatly by agency but together account for 20% of the total budget. Notice that for travel the number of staff members is included in the calculation.

Section 2

Budget Worksheet

Categories	Pre-Implementation (Start-up)		Implementation (Intervention Delivery)	
	# staff	% time, # hrs/wk	# staff	% time, # hrs/wk
Personnel (30%)				
Salaried:				
Executive Director	1	5%	0	0
Program Director	1	5%	0	0
Program Manager	1	15%	1	10%
Facilitator	2	5%	2	50%
Administrative Assistant	1	10%	1	10%
Accountant	1	5%	1	5%
Fringe Benefits		25%		25%
Facility (25%) (% of time used for the intervention)		Cost Methodology		Cost Methodology
Rent (office)		\$ x % = \$		\$ x % = \$
Rent (small group meeting space)		\$ x % = \$		\$ x % = \$
Utilities		\$ x % = \$		\$ x % = \$
Telephone/Fax		\$ x % = \$		\$ x % = \$
Maintenance (office)		\$ x % = \$		\$ x % = \$
Insurance (property, liability, etc.)		\$ x % = \$		\$ x % = \$
Equipment (10%) (% of time used for intervention at depreciated value)				

Television		\$ x % = \$		\$ x % = \$
Playback Device (VCR, DVD, Projector) ⁵		\$ x % = \$		\$ x % = \$
Video Camera		\$ x % = \$		\$ x % = \$
Supplies (15%)				
Postage and Mailing		\$		\$
Copying and Printing		\$		\$
Office Supplies:				
Paper (color and white)		# x \$ /ream = \$		# x\$ /ream = \$
Pens		# x \$ /box = \$		# x\$ /box = \$
Easel Paper		# x \$ /set = \$		# x\$ /set = \$
Markers		# x \$ /box = \$		# x\$ /box = \$
Certificate Paper ⁶		# x \$ /set = \$		# x\$ /set = \$
Masking Tape		# x \$ /roll = \$		# x\$ /roll = \$
Easel		# x \$ /easel=\$		# x \$ /easel=\$
Program Supplies:				
Anatomical Models ⁷				
Male		# x\$ /each = \$		# x\$ /each = \$
Female		# x\$ /each = \$		# x\$ /each = \$
Condoms ⁸				
Male		# x\$ /gross = \$		# x\$ /gross = \$
Female		# x\$ /gross = \$		# x\$ /gross = \$
Lube		# x\$ /box = \$		# x\$ /box = \$
Printed Materials/Promotional Giveaways				
Flyers/Brochures		\$		\$
Posters		\$		\$
Incentives ⁹		\$		\$

⁵ The cost of the playback device will depend on the type of video camera used. Some may plug directly into a television eliminating the need for a DVD player or VCR.

⁶ One per participant

⁷ Minimum of two male and two female needed

⁸ Minimum of 20 male condoms, female condoms, and lube packets for Session 3. Additional condoms and lube for distribution.

⁹ Ten required, one per session

Refreshments ¹⁰		\$		\$
Recruitment (10%)¹¹				
Advertising:				
Staff		\$		\$
Clients		\$		\$
Travel (5%)¹²				
Local: (Attend meetings or deliver intervention off-site)				
Vehicle miles		# of staff x\$ /mile = \$		# of staff x\$ /mile = \$
Public Transportation fares		# of staff x\$ /fare = \$		# of staff x\$ /fare = \$
Out-of-Town: (training, conferences)				
Airfare		# of staff x \$ /fare = \$		# of staff x \$ /fare = \$
Hotel		# of staff x \$ /night x # of nights = \$		# of staff x \$ /night x # of nights = \$
Per Diem		# of staff x \$ /day x # of days = \$		# of staff x \$ /day x # of days = \$
Consultancy (5%)¹³				
Evaluation Consultant		# of hours x\$ /hour = \$		# of hours x\$ /hour = \$

¹⁰ While recommended for retention, this item is optional

¹¹ This category is discretionary

¹² TOF attendance for all Facilitators plus possible conference attendance

¹³ As necessary

Section 2

Policies And Standards

Before you attempt to implement Street Smart, the following policies and standards should be in place to protect your organization and its clients:

Confidentiality and Informed Consent

A system must be in place to ensure that confidentiality is maintained for all participants in the program. A signed informed consent from the client or his or her legal guardian must be obtained before sharing any information with another agency to which a client is referred. This consent form should carefully and clearly explain (in appropriate language) the responsibility of your organization and the rights of the client. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Please refer to your agency policies for further clarification on what constitutes an appropriate signer. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Protocols should exist to ensure that not only is participant information protected from external sources, but also that internal confidentiality is maintained. Records should be stored in a locked file cabinet and other agency staff should be briefed on the confidentiality needs of Street Smart.

Cultural Competency

Your organization must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of your communities. You should hire, promote, and train all staff to be representative of and sensitive to these different cultures. If possible, you should offer materials and services in the preferred language of youth participants, or make translation available, if appropriate.

You should facilitate community and participant involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the National Standards for Culturally and Linguistically Appropriate Services in Health Care, which should be used as a guide for ensuring cultural competence in programs and services. You can access this by going to: (<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>).

Data Security

To ensure data security and client confidentiality, data must be collected, stored, and reported according to CDC requirements. Information on CDC guidance on security and policy considerations can be found at http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/guidance/attachment_b.htm

Legal and Ethical Policies

Your agency must know the state laws regarding disclosure of HIV status to sex partners and needle-sharing partners. You are obligated to inform clients of the agency's responsibilities if a client receives a positive HIV test. Your agency also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

You should be prepared to refer participants to other supportive services as needed. You must know appropriate, youth-friendly referral sources for additional prevention services and clinical needs, such as partner counseling and referral services, STD clinics, and other health department and CBO prevention programs.

Volunteers

If your organization uses volunteers to assist with or conduct this intervention, then you must know and disclose to volunteers how your liability insurance and worker's compensation applies prior to their involvement.

You must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. Your organization must also ensure that volunteers sign and adhere to a confidentiality statement that reflects your agency's policies surrounding confidentiality. Finally, you should take care to ensure that all background checks for volunteers are up-to-date.

Section 2

Location/Venues

The selection of an appropriate venue is key to the smooth implementation of Street Smart.

Street Smart should take place in an enclosed space that is conducive to confidentiality, but appropriate for the activities of the session. For the individual sessions, you want a space that is enclosed and private. For the group sessions, you want a space that is large enough to allow participants to move around.

Program Managers and facilitators should also be aware of the surroundings and location of the spaces and the potential impact these might have on participants, such as areas where drugs are used or exchanged or where sex work takes place. This is not only important for the physical safety of participants, but to prevent emotionally difficult situations. The following are some suggestions for location selection and room logistics:

- Central location - as close as possible to all major transit routes so it is easy for participants to access
- Flexible days/hours - the program should be conducted during days and hours that are most convenient to youth
- Flexible seating arrangements
 - o Room needs to be large enough to seat 12 persons (6-10 participants; 2 facilitators) comfortably in a circle
 - o Chairs should be easy to move around. Sofas are not recommended since they are not easy to move into a circle and may encourage youth to sleep during the session
- Tables for food and beverages

A number of factors need to be considered when choosing the days, times, and location for your sessions. Conducting a community assessment prior to implementation will help determine the most appropriate times and locations for holding the group sessions. Some issues to consider include childcare responsibilities/accessibility, and job and/or school commitments. Your agency and staff may be able to identify additional factors that could potentially affect participation by your target population.

Section 2

Community Support

While personnel, supplies, and money are important, their use cannot be optimized without broad support. Securing buy-in from your agency, other agencies, and other individuals is crucial to ensure the success of your program. Where your agency itself lacks certain capacities, the broader community may be able to assist. Furthermore, the strategies you select for implementing Street Smart can benefit from the input of community sources.

There are three main steps to securing support:

- Getting buy-in from key stakeholders
- Building a network of agencies
- Establishing a Community Advisory Board (CAB)

Remember that many agencies and individuals will be part of more than one of these categories above.

Stakeholders

Stakeholders include individuals or groups that have an interest in the successful implementation of an intervention. Fostering these relationships can mobilize support for implementing Street Smart.

Agency Networks

Although most agencies already have established agency networks it important to continue to establish and build upon these relationships. Agencies in your network can help with client recruitment and referrals.

Community Advisory Board

An effective CAB is essential for the adequate planning and implementation of Street Smart. CABs are generally made up of a maximum of twenty individuals who serve as the primary liaisons between the community and the implementing agency. Membership is composed of community leaders, health care professionals, program administrators, and policy makers committed to the reduction of HIV transmission in at-risk youth populations.

Examples of the assistance CABs can provide include:

- Performing general community outreach and education;
- Identifying the needs of the community and defining the target population to be reached by the intervention;
- Supporting recruitment efforts through active promotion of the intervention within their respective organizations and throughout the community;
- Providing implementing organizations with insight as to the potential perspectives, attitudes, or needs of the target population;
- Identifying potential venues for the facilitation of Street Smart;
- Monitoring programming to ensure it accords with the needs, concerns, and priorities of the community; and
- Connecting the implementing organization to broader efforts, such as representation at regional, national, and international meetings and conferences.

Section 2

Securing Support Checklist

Follow the steps in this checklist to enlist the support of stakeholders, network agencies and potential CAB members.

Step #1: Identify your stakeholders, network agencies, and potential CAB members.

You should have at least one agency or individual from each of the following categories:

Your agency's Board of Directors/Executive Board

Staff members from your agency who will have a role in the operation of the intervention:

- Administrators who will obtain support
- Supervisors who will monitor the intervention
- Staff who will interact with participants throughout the intervention

Local agencies from which you can recruit participants, facilities, or both:

- Agencies offering support or services to your target population of youth
- Health care providers and mental health professionals serving youth who are part of the target population
- Community and social service organizations (e.g., day care centers, clinic waiting room, work or income assistance programs)
- Social and entertainment focused venues that members of your target population frequent

Organizations which can provide assistance or other resources:

- Merchants for incentives, such as refreshments, cosmetics and toiletries, movie passes, clothes, etc.
- Agencies, newspapers and newsletters, merchants, social venues, printers, publishers, broadcasters, and others that can advertise the intervention
- Clinics, community centers, churches and other agencies that can provide a venue for the intervention
- Agencies that can provide childcare
- Agencies that can provide transportation
- Advisory board to help adapt the intervention
- Agencies for referring members of the target population for additional service needs

Agencies with whom you need to maintain good community or professional relations:

- Local health department
- Local medical and mental health associations
- Community and social service organizations
- Your funding source(s)
- Political or community leaders

Step #2: Decide what specific roles you would like each individual/ agency to play.

Find the right people to:

- Provide financial support
- Refer relevant youth to the intervention
- Serve as an intervention facilitator
- Be a resource to which you can refer participants
- Join your community advisory board
- Help adapt the intervention for your specific target population
- Assist in advertising the intervention
- Provide space in which the intervention sessions can take place
- Supply refreshments for participants
- Donate small incentives or lottery prizes for participants
- Spread the word about Street Smart by speaking supportively about it in conversations with people to whom they are connected

Step #3: Send informational letters to the selected individuals/agencies.

- Describe Street Smart
- Explain why Street Smart is important to your agency
- Outline the specific role(s) you believe they can play in ensuring the success of the intervention
- Offer an opportunity for them to learn more

Step #4: Make follow-up calls after two weeks to assess interest.

If they are interested, schedule a time to meet

- Lunch-and-Learn at your agency with a group of other stakeholders
- Presentation at their agency for several of their staff or association members)

Step #5: Hold a meeting or speak with each person/agency individually to enlist their support.

- Show Street Smart marketing materials if the setting and time allow
- Describe several specific roles they could play and what these would entail
- Highlight the benefits of involvement to their agency, the community, and the population of interest
- Answer any questions they may have
- Invite them to commit to supporting Street Smart by taking on one or several roles
- Keep track of commitments

Step #6: Get them involved.

Soon after meeting, send a thank you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest. Ask them to contact you if they would like to get involved or if they have any questions. Keep the letter on file in case they reconsider later.

If an individual or agency committed to a role that is important to pre-implementation, get them involved as quickly as possible.

If an individual or agency committed to a role that involves them later in the process, send brief progress updates and be sure they are clear on when you will be calling on them for support.

Step #7: Maintain stakeholders' interest and commitment to Street Smart.

Hold periodic celebratory meetings for supporters to demonstrate your appreciation for and the value of their contributions, keep them updated on the intervention's progress, and keep them engaged in the process.

Section 2

Recruitment

The target population for Street Smart is typically high-risk youth, which adds to the already challenging task of recruiting participants. Whatever the approach, it is essential that you involve every member of the implementation team.

Developing a Recruitment Plan

The first step in recruitment is to develop a clear plan detailing how and where you will recruit participants, what kinds of marketing/recruitment materials will be used, the number of participants you intend to recruit, and who will be responsible for each of the associated tasks.

One of the most valuable resources to your agency in developing a plan for participant recruitment will be your Community Advisory Board (CAB). Members of the CAB can provide guidance on:

- Appropriate locations and times to conduct recruitment;
- Targeted recruitment strategies for your specific population;
- Factors that might motivate potential participants to attend Street Smart sessions;
- Factors that might discourage potential participants from attending Street Smart sessions; and
- Free or low-cost space.

Designating Recruiters

Anyone familiar with the goals of the program or connected to your target population can be useful for client recruitment. You may designate staff such as facilitators and outreach workers to be recruiters. You may also look to specific members of the community such as case managers, staff at youth drop-in centers, and other youth providers. Also, members of your CAB and previous clients of the agency or intervention can either serve as recruiters themselves or connect you to other individuals interested in and able to recruit. Using peers of your target population to recruit can be particularly beneficial for recruiting hard-to-reach populations or for ensuring large responses in a relatively short time frame.

Methods

Recruitment into Street Smart can occur through word of mouth, flyers, newsletters, special events, and the Internet.

Your agency can mobilize staff members to conduct a variety of recruiting activities. Your agency personnel may consider recruiting by:

- Posting flyers in areas where your target population spends time;
- Placing advertisements in community newsletters;
- Placing advertisements or creating events on Facebook, MySpace or other youth-oriented websites;
- Making announcements at relevant events;
- Conducting street outreach; and
- Conducting agency in-reach (looking to youth you are already serving within your agency).

When recruiting, remember to tap into your existing social networks. This is a low-cost and often effective strategy for reaching large numbers of potential participants. This might include:

- Asking colleagues to send out e-mails;
- Asking sister agencies to post flyers;
- Asking youth participants to text-blast other youth; and
- Asking youth participants to advertise on their personal Facebook or MySpace pages.

Locations

The organizations, agencies, and social venues where members of your target population receive services or spend time are ideal for recruitment. These can include:

- Other programs at your own agency;
- Clinics or social and youth service agencies such as Planned Parenthood or Women, Infant, and Children (WIC) Centers;
- Youth and drop-in shelters; and
- Entertainment-focused venues such as dance clubs, community centers, and neighborhood hang-out spots.

Incentives

Incentives are useful for motivating participants to attend Street Smart for the first time. Incentives can be both practical (e.g., transportation vouchers and food coupons), or more fun (e.g., lottery prizes, make-up, clothing, or movie passes). It is important to set aside time and resources for appropriate incentives. If your agency does not have the capacity to purchase incentives, you may be able to solicit local businesses for donations such as gift cards or certificates. Your agency should research what the most cost-effective incentives are, using, if necessary, the guidance of both the CAB and selected members of the target population.

Section 2

Triage

Once participants are recruited, it is important that thought go into how participants should be grouped together. There are three main considerations for triaging participants:

- Age
- Risk Profile
- Demographics

Age

Your agency may want to consider creating groups of participants of similar ages. It may not be appropriate for eleven-year-olds and eighteen-year-olds to be in the same group as this will affect group cohesion and dynamics. Grouping similarly aged participants together helps to more effectively form social networks and support and may increase the likelihood of shared experience.

Risk Profile

When enrolled, participants will be asked a series of questions about their risk behaviors, such as sexual and drug use behaviors (see Participant Enrollment Form in Section Five). It may be wise to group participants with similar experiences together. For instance, you may choose to group all the crystal meth users or sex workers together. While it is certainly not possible to match participants on all risk behaviors, consider those most relevant to your population. There may be clear subgroups of participants that would benefit from a group composed of similar youth.

Be sure to group youth who speak the same language together. Also, consider grouping together youth with the same sexual orientation, ethnicity, or serostatus. While diversity in a group may lead to more fruitful discussion, groups composed of individuals who are uncomfortable with each other will stifle the goals of the intervention.

Section 2

Participant Retention

While each target population presents retention difficulties and all multi-session interventions face retention challenges, there are several strategies you can use to ensure that participants attend as many sessions as possible.

Session Atmosphere

The pace, flow, and interest level of the sessions can have a great impact on the willingness of participants to return to later sessions. Thus, facilitators have a large responsibility for supporting participant retention. Sessions should be exciting and presented in an innovative and fun way to encourage participants to return.

Participants who feel alienated or disconnected are less likely to return to future sessions than those who feel welcomed, safe, and supported. Facilitators should ensure participants contribute to discussions, participate in role-plays, and feel supported to express themselves. Positive reinforcement (e.g., through the use of tokens) can be helpful to promote retention. Personal thanks for attendance from facilitators after the session is completed can serve as an additional positive reinforcement tool—particularly if coupled with appreciation for specific contributions made by the participant during the session.

Location

The location of Street Smart can greatly influence retention rates. A location that your target population can access easily (and access in safety and comfort) can encourage regular attendance.

Administration

Administrative actions such as regular session reminders can improve participant retention. Keeping in touch with participants can help to support their commitment to the program and reinforce group support and cohesion. Obtain contact information that is as extensive as possible, including information on peers or parents who may be able to assist you in contacting the youth (the nature and availability of contact information will depend on your specific target population). Session reminders should be culturally relevant (e.g., use text messaging, if appropriate and feasible). Youth can be encouraged to assist in retention efforts to promote group cohesion and support for one another by texting reminders or using other reminder systems.

Incentives

Just as incentives can be powerful in recruitment, they can also encourage timely and consistent attendance. Your organization may decide to conduct a lottery at the beginning of each session, providing a small prize to those who arrive on time. Offering an introductory open house breakfast, snacks, and graduation ceremonies can motivate youth to attend consistently. Furthermore, your organization may decide to use a special incentive to reward those with the highest attendance rates at the end of the Street Smart program. These might include “larger-ticket” items such as theme park tickets or other culturally relevant prizes.

Section 2

Adaptation

As with any DEBI, you must consider how to adapt Street Smart to make it more relevant to your agency and youth participants. With a solid understanding of adaptation guidelines, your agency will find that this intervention is easily adaptable to many diverse populations. The following section provides an overview on how to adapt Street Smart while maintaining fidelity to the core elements and key characteristics. Before making adaptations to the curriculum you must contact a capacity-building assistance (CBA) provider through your local health department or the CDC. Additionally, an adaptation guide is available.

Adaptation, Core Elements, and Key Characteristics

Core elements are the critical features of an intervention's intent and design. These features are thought to be responsible for the intervention's effectiveness and must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which the intervention is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed.

Key characteristics are crucial activities and delivery methods for conducting an intervention. While they should not be eliminated, they may be adapted for different agencies and at-risk populations in order to meet the specific needs of the target population and ensure cultural appropriateness of the strategy.

For example, every implementation of Street Smart must include all the major tools (e.g., tokens, group brainstorm, role-plays, individual goal-setting). However, aspects of each of these tools and techniques can be altered, modified or re-named to make them more relevant to the target population.

Fundamentals of Adaptation

Adaptation of an intervention or strategy is the process of modifying the key characteristics of an intervention to best suit the needs of the target population and the implementing agency without competing with or contradicting the intervention's core elements.

While adaptation of the intervention is encouraged, the CDC requires that all DEBIs be adapted and implemented with fidelity. Fidelity is the practice of staying within the parameters of the approved adaptation process; it is keeping the heart of the intervention unchanged so as to reproduce its effectiveness with another population or in a different setting.

There is a process to making adaptations to a science-based intervention:

- First, one must understand the theoretical basis of the intervention to ensure adaptations are consistent with the goals of the intervention.
- Second, agencies need to take into account culturally relevant factors for the group being served, including thorough knowledge of the behaviors and determinants that place the population at risk for HIV infection.

There are two different ways to adapt an intervention:

The first involves the intervention being delivered to a different population or in a different venue than the one in which efficacy was originally demonstrated – in other words, the who or where of the intervention (e.g., Street Smart was originally tested in an urban setting, but has since been adapted to be used in a rural setting).

The second type of adaptation occurs when an intervention or strategy is changed to deliver a new message (e.g., addressing condom use versus limiting the number of sexual partners), at a different frequency (only having one session per week as opposed to two or three), or in a different manner (using more non-scripted role-plays) than was originally described – in other words what is addressed, when it is delivered, and how the message is conveyed.

FORMATIVE EVALUATION

A formative evaluation is a series of activities undertaken to garner information that will guide the program's adaptation and development process.

Steps of a formative evaluation include:

1. **Interviews** with community gatekeepers and stakeholders. These interviews can be used to determine the viability of delivering an intervention by weighing community support and concerns.
2. **Focus groups** with members of the target population. This can help an agency gain an understanding of the issues that are most important to them and impact most strongly upon the community. Focus groups can also provide information about the feasibility and appropriateness of the intervention in a particular community.
3. **Logic model development.** The logic model is often displayed in a flow chart or table to portray the sequence of steps leading to expected intervention outcomes. The logic modeling process should consider carefully the behavioral outcomes that were obtained in the original research of the evidence-based intervention and take into account the intensity and dosage of intervention activities that must be delivered. The goal is to ensure that the adapted program can attain or surpass the behavioral outcomes that were obtained in the original evidence-based intervention research.
4. **Pre-testing** of the original intervention with a small subgroup of the target population. This can help determine what is culturally relevant and responsive to the needs of the target population and what might be taken into consideration for adaptation.
5. **Pilot testing** the revised intervention with a small subgroup of the population. This will give an indication of the effectiveness of the adapted intervention.

Examples of Possible Adaptations to Street Smart

A. Role-play

Role-plays are one of the cornerstones of the Street Smart program and one of the best places to adapt the intervention. The scripted role-plays in the Street Smart curriculum were purposefully written without slang, since the terms and slang youth use in conversation changes rapidly and is often geographically and culturally bound.

- The names of the characters may be changed (e.g., change name from John to Juan).
- The language may be adapted to fit with local norms and slang.
- The names of drugs may be adapted or changed to those relevant to the target population.
- Places where the action is happening may be adapted (e.g., some Latino-serving agencies have changed role-plays so that they take place at a quinceanera - a young woman's celebration of her fifteenth birthday).

B. Problem-solving language (similar to the role-plays)

- The names of the characters may be adapted.
- The language may be adapted to fit with local norms and slang.
- The names of drugs may be adapted.
- Places where the action is happening may be adapted.

C. Relaxations

Relaxation exercises can be adapted in a similar way as role-plays and problem-solving situations. For example, if the relaxation is set on a beach and the program is being implemented among a community without close access to a beach (as in the Midwest), it can be adapted to a lake setting or a mountain top.

D. Other

- Agencies can imprint a logo on the tokens (e.g., the logo of the agency or a name that the group has made up).
- Tokens can be made using different shapes (e.g., stars, etc.).
- Tokens can be called by a different name (e.g., “thanks,” “love”).
- Facilitators may use fruit instead of penile models for the condom demonstration with younger adolescents.
- Facilitators may change the name of the program (e.g., on a Native American reservation that does not have “streets,” the name may be changed to Res Wisdom).
- Facilitators need to update facts on HIV/AIDS, STIs, and other medical information.
- Language on some of the activity cards may need to be simplified for some groups of youth (e.g., younger, low literacy, or ESL).

E. Setting

The original intervention was designed to be delivered in runaway shelters. However, the program may be delivered in other settings such as a drop-in shelter or a community-based organization that serves youth.

F. Group composition

Some agencies may want to form single-sex groups rather than mixed-sex groups. This is acceptable, but it is not recommended because one of the benefits of mixed-sex groups is that they allow youth to practice relational skills in a safe environment.

Additionally, agencies may want to alter the size of the group. For example, instead of groups of 6-10 youth, groups may consist of slightly larger numbers (up to 15). As group size increases, facilitators need to pay particular attention to group management. Larger groups are not recommended for younger youth (ages 11-13).

G. Length of sessions

Some agencies may believe that a session of 90-120 minutes is too long. Adapting the length of sessions is discouraged. Even youth as young as 11 years old can successfully complete a 90-120 minute session if the group is interactive and fast-paced. Trainers should discuss different ways to keep the pace lively and get youth moving. For example:

1. When youth are completing individual worksheets, encourage them to spread out in the room, sit on the floor, use chairs as writing surfaces, etc.
2. For role-plays, facilitators should instruct youth who are the observers to move around to see the action (e.g., move chairs around, sit on the floor, etc.).
3. The use of tokens is another ideal way for youth to get out of their seats in a controlled manner during the session.

Some agencies have created Street Smart weekend retreats and instituted other variations on the traditional, weekly 90- to 120-minute sessions. Street Smart implementers should consult with their funding source and/or their capacity building assistance (CBA) providers prior to making such structural changes.

H. Worksheets and Handouts

Worksheets and handouts may be adapted in order to better suit your population and community. For example:

- The STD/AIDS fact cards in Session 1 should be updated and may be revised to be made more age appropriate or relevant.
- The “Order of Sex Acts According to Safety” handout in Session 2 may be adapted to include any particular sex acts that are not listed but might be common among your population (e.g. rimming).
- The “Trigger Questionnaire” handout in Session 4 may be adapted to include triggers (e.g., house/ball event) that might be particular to your population.

For further assistance with adaptation and maintaining fidelity, contact your funding source for information on how to request assistance from a CBA provider.

Section 2

Pre- Implementation Workplan

Below is a suggested timeline for planning the specific activities, person(s) responsible, and trajectory for ensuring a comprehensive and smooth implementation of your intervention. Because time allocations, staffing, funding cycles, etc. are different for each agency, the implementation plan will also vary. Note: The timeline for implementation of the intervention begins upon notification that the organization has been awarded a grant to implement the intervention.

Timeline Pre-Implementation and Implementation

TASKS	Staff Responsible	Weeks												
		1	2	3	4	5	6	7	8	9	10	11	12	13
Organizational Structure & Capacity														
Assess agency capacity for implementing Street Smart (convene meetings with senior management staff including the Executive Director, Program Director, Accountant, and other relevant staff).	Executive Director Program Director	X	X	X	X									
Staffing														
Update or create job descriptions for the Program Manager and two facilitator positions.	Executive Director Program Director			X	X									
Identify additional staff to support coordination and delivery of the intervention (e.g., administrative staff)	Program Director Program Manager			X	X									
Advertise position vacancies in local newspapers, employment sites on the Internet, among agencies' network of affiliates and collaborating partners, etc.	Program Director				X	X								

TASKS	Staff Responsible	Weeks												
		1	2	3	4	5	6	7	8	9	10	11	12	13
Interview and hire candidates who satisfactorily meet the requirements of the positions. <i>(Refer to the Capacities and Resources Needed for Implementation section of this manual for the type of skills, education, experience and roles and responsibilities for the Program Manager and facilitator positions.)</i>	Executive Director Program Director					X	X	X	X					
Staff Capacity Development														
Arrange training for facilitators. Training also recommended for the Program Manager.	Program Manager					X	X	X						
Staff participates in training of facilitators (TOF).	Facilitators						X	X	X	X				
Schedule regular meetings to practice facilitation of intervention.	Program Manager Facilitators							X	X	X	X	X		
Client Recruitment														
Identify key stakeholders and Street Smart promoters.	Executive Director Program Director Program Manager Facilitators		X	X	X	X								
Conduct needs assessment to identify target population, potential venues to conduct intervention if in-house space is not suitable, etc.	Program Director Program Manager Community Advisory Board		X	X	X									

TASKS	Staff Responsible	Weeks												
		1	2	3	4	5	6	7	8	9	10	11	12	13
Begin to formulate a community advisory board (CAB) consisting of members from the community who represent the target population, Representatives from stakeholders may include staff from local or state health departments, CBA provider, etc. Staff should be experienced and knowledgeable about program planning and service delivery in order to inform development of the program.	Executive Director Program Director			X	X	X								
Develop a "Roles & Responsibilities" document that delineates the role of the CAB, key stakeholders and promoters.	Program Director Program Manager Facilitators		X	X	X	X	X							
Orient CAB members as to their roles and responsibilities and to the intervention.						X	X	X						
Secure stakeholders' and promoters' buy-in (Representatives from these organizations should sign a memorandum of understanding (MOU) which reflects their commitment to support the program).	Executive Director Program Manager					X	X	X						
Identify venues where the target population congregates, receives services, etc.	Program Manager Facilitators Community Advisory Board							X	X	X	X			
Select venue for intervention (ensure requirements stated in the manual are met).	Program Manager Facilitators Outreach Workers								X	X	X			

TASKS	Staff Responsible	Weeks												
		1	2	3	4	5	6	7	8	9	10	11	12	13
Develop and/or tailor marketing materials including brochures and flyers.	Program Manager Facilitators Community Advisory Board								X	X	X	X	X	
Research and assemble resource and referral lists.	Program Manager Facilitators Community Advisory Board											X	X	
Begin marketing the program and advertising availability of Street Smart services in the community.	Program Manager Facilitators Outreach Workers Community Advisory Board											X	X	X
Develop an Evaluation Plan and data collection instruments to gauge the effectiveness of the intervention with the target population.	Program Manager Facilitators Community Advisory Board									X	X	X	X	X
Fiscal														
Develop a budget that reflects approved cost categories based on the grant award.	Executive Director Program Director		X	X	X									

IMPLEMENTATION	Staff Responsible	Weeks													
		14	15	16	17	18	19	20	21	22	23	24	25	26	
Develop monitoring and evaluation framework.	Program Manager Evaluation Consultant	X	X	X											
Develop quality assurance (QA) plan.	Program Manager	X	X	X											
Screen lists/files of potential participants based on agency's criteria.	Program Manager Facilitators	X	X												
Administer pre-assessment questionnaire to capture basic demographic data and risk factors of potential participants.	Program Manager Facilitators	X	X	X											
Confirm venue.	Program Manager Facilitators		X	X											
Select participants.	Program Manager Facilitators	X	X												
Schedule interviews and complete baseline assessments of participants.	Program Manager Facilitators		X	X	X										
Confirm participants.	Facilitators		X	X	X										
Schedule sessions.	Program Manager Facilitators		X	X											
Inform participants of session venue and time.	Facilitators		X	X											
Prepare intervention materials.	Facilitators				X	X	X								
Practice and prepare Session 1 materials.	Program Manager Facilitators				X	X	X								
Obtain incentives.	Program Manager				X	X									
Arrange snacks/food.	Program Manager				X	X									

IMPLEMENTATION	Staff Responsible	Weeks													
		14	15	16	17	18	19	20	21	22	23	24	25	26	
Conduct Session 1.	Facilitators						X	X							
Schedule group supervision.	Program Manager						X	X							
Debrief Session 1.	Program Manager Facilitators						X	X							
Practice and prepare Session Two materials.	Program Manager Facilitators						X	X							
Conduct Session 2.	Facilitators							X	X						
Schedule group supervision.	Program Manager							X	X						
Debrief Session 2.	Program Manager Facilitators							X	X						
Practice and prepare Session 3 materials.	Program Manager Facilitators								X	X					
Conduct Session 3.	Facilitators								X	X					
Schedule group supervision.	Program Manager								X	X					
Debrief Session 3.	Program Manager Facilitators								X	X					
Practice and prepare Session 4 materials.	Program Manager Facilitators									X	X				
Conduct Session 4.	Facilitators									X	X				
Schedule group supervision.	Program Manager									X	X				

IMPLEMENTATION	Staff Responsible	Weeks													
		14	15	16	17	18	19	20	21	22	23	24	25	26	
Debrief Session 4.	Program Manager Facilitators									X	X				
Practice and prepare Session 5 materials.	Program Manager Facilitators										X	X			
Conduct Session 5.	Facilitators										X	X			
Schedule group supervision.	Program Manager										X	X			
Debrief Session 5.	Program Manager Facilitators										X	X			
Practice and prepare Session 6 materials.	Program Manager Facilitators											X	X		
Conduct Session 6.	Facilitators											X	X		
Schedule group supervision.	Program Manager											X	X		
Debrief Session 6.	Program Manager Facilitators											X	X		
Practice and prepare Session 7 materials.	Program Manager Facilitators												X	X	
Follow quality assurance plan.	Program Manager Facilitators						X		X	X	X	X	X	X	
Continue marketing and promoting the program throughout each cycle.	Program Manager Facilitators Outreach Workers Community Advisory Board							X	X	X	X	X	X	X	

IMPLEMENTATION	Staff Responsible	Weeks													
		14	15	16	17	18	19	20	21	22	23	24	25	26	
Develop adaptation methodology.	Program Manager Facilitators Community Advisory Board													X	X

Section 2

Implementation Summary

This implementation summary graphically depicts the inputs, activities, and outputs of Street Smart. It is a logical organization of what needs to occur to properly implement Street Smart.

IMPLEMENTATION SUMMARY OF THE STREET SMART INTERVENTION

Inputs →	Activities →	Outputs →
<ul style="list-style-type: none"> • Agency capacity to conduct the intervention (e.g., time and resources) • Staff who are qualified, culturally competent, and interested in implementing the intervention • Organizational policies and procedures • Private space and equipment to conduct the intervention • Materials to conduct the intervention 	<p>Pre-Implementation</p> <ul style="list-style-type: none"> • Closely review the intervention and training materials and understand the theory and science behind Street Smart • Assess capacity to conduct the intervention and solicit technical assistance for areas of need • Develop relevant community relationships • Develop implementation plan, monitoring and evaluation plan, and agency policies and procedures • Identify qualified, culturally competent, and interested staff to coordinate, facilitate, and recruit for the intervention • Train and build skills of agency staff 	<p>Pre-Implementation</p> <ul style="list-style-type: none"> • Implementation plan, tailored to target population, including measurable goals and process and outcome objectives • Written participant recruitment procedures • Written evaluation plan • All recruited facilitators complete training <p>Implementation</p> <ul style="list-style-type: none"> • Materials (e.g., printed materials, videos, logos) are developed for the intervention • Eight group-level sessions are conducted with youth

IMPLEMENTATION SUMMARY OF THE STREET SMART INTERVENTION

Inputs →	Activities →	Outputs →
<ul style="list-style-type: none"> • Agency and staff who support the intervention • Baseline data/information about target population's HIV & STD risk behaviors and influencing factors • Community support for implementation of the intervention • External technical assistance (as needed) • Access to youth population and to venues frequented by them 	<ul style="list-style-type: none"> • Identify logistics for implementation of the intervention (e.g., times, days, space) • Identify available youth and select which will be targeted <p>Implementation</p> <ul style="list-style-type: none"> • Identify and recruit youth participants • Adjust and update materials as needed • Plan and schedule sessions <p>Maintenance</p> <ul style="list-style-type: none"> • Document implementation of program • Solicit feedback from youth regarding the implemented program. Adjust the program as needed 	<ul style="list-style-type: none"> • One individual counseling session is conducted with youth • One trip to a community resource is conducted with youth <p>Maintenance</p> <ul style="list-style-type: none"> • Evaluation data and summary reports with interpretation • Documentation of regular program monitoring and program improvement in accordance with monitoring plan

Implementation

3

Section 3

Introduction

Section Three will assist you with conducting the actual implementation of Street Smart.

Included in this section are outlines detailing the format and session objectives for each of the eight Street Smart group-level sessions as well as explanations of the individual session and the community resource center visit.

Detailed explanations are provided for the primary tools and techniques of the intervention, as well as in-depth tips for successful facilitation.

This section also includes the Facilitator Guide, which provides the curriculum for all ten of the Street Smart Sessions.

Section 3

Session Outline

Objectives

Objectives for the eight group-level sessions, the individual session, and the community resource center visit of Street Smart are as follows:

Session 1: Getting the Language of HIV and Other Sexually Transmitted Diseases (STDs)

The main point of this session is to convey that knowing the facts about HIV/AIDS and STDs is essential because this knowledge enables an individual to better manage and implement HIV prevention strategies, thereby protecting themselves and others. In this session, youth will:

- Become familiar with the primary tools and techniques used in the intervention (e.g., tokens, “Feeling Thermometer”);
- Learn basic facts (including routes of transmission) about HIV and other STDs;
- Increase their perception of personal vulnerability to HIV and STD risks; and
- Explore their personal risk factors.

Session 2: Assessing Personalized Risk

The main point of this session is to help youth determine which of their behaviors put them at risk and which triggers lead to unsafe behaviors. In this session, youth will:

- Understand safer sex;
- Recognize personal risk behaviors;
- Increase their perception of personal vulnerability to HIV/STDs risks;
- Learn which triggers increase their personal risk; and
- Learn to set personal limits.

Session 3: Learning How to Use Condoms

The main point of this session is for youth to become less anxious and more comfortable talking about and using condoms. In this session, youth will:

- Learn and practice the correct use of male and female condoms
- Increase their comfort level with condoms

Session 4: Learning about the Effects of Drugs and Alcohol

The main point of this session is for youth to understand how drugs and alcohol affect their thinking and choices. In this session, youth will:

- Learn how alcohol and drugs affect their ability to practice safer sex;
- Explore the pros and cons of substance use;
- Learn how drugs and alcohol can affect a person;
- Learn about addiction and triggers for substance use; and
- Learn and practice skills for breaking the cycle of addiction.

Session 5: Recognizing and Coping with Feelings

The main point of this session is to help youth learn various coping styles and problem-solving techniques for tough situations. In this session, youth will:

- Learn skills for coping with stressful feelings;
- Understand that different coping styles are appropriate for different situations;
- Become familiar with the SMART method for coping and problem-solving; and
- Learn relaxation techniques.

Session 6: Negotiating Effectively

The main point of this session is for youth to assess their own values regarding sex and substance use and then to learn a method to communicate these values effectively. In this session, youth will:

- Explore personal sexual values;
- Learn how to stand up for their personal values;
- Learn coping skills to deal with peer pressure;
- Practice applying the SMART problem solving skills; and
- Learn and practice communicating effectively using “I” statements.

Session 7: Doing Self-Talk

The main point of this session is for youth to learn how to use their thoughts and self-talk to help them make safer decisions. In this session, youth will:

- Review the primary tools and techniques used in the intervention;
- Learn how to think through positive and negative events to facilitate protective actions;
- Learn to break the cycle of negative thoughts;
- Practice thinking positive thoughts about themselves; and
- Learn how to use self-talk as a coping mechanism during difficult situations.

Session 8: Practicing Safer Sex

The main point of this session is to provide an opportunity for youth to review the themes of the Street Smart intervention in order to explore why they engage in risky behaviors and to learn how to argue against their rationalizations. In this session, youth will:

- Assess personal risk in unclear sexual situations;
- Learn to combat rationalizations;
- Strategize how to deal with slip-ups; and
- Apply what they have learned to the media message they create.

Session 9: Individual Session

The main point of this session is to provide each youth with the opportunity to identify their own personal risk factors for HIV transmission and to use this information and what they have learned in the group sessions to develop an individualized strategy to reduce their risk for HIV transmission. In this session, youth will:

- Identify personal risk factors for HIV acquisition;
- Identify personal triggers that may lead to unsafe sex;
- Determine barriers to practicing safe sex;
- Develop a plan to cope with their triggers; and
- Create an individualized strategy to overcome barriers to practicing safe sex.

Session 10: Community Resource Visit

The main point of this session is to link youth to a variety of resources necessary for them to facilitate the desired behavior—practicing safer sex. In this session, youth will:

- Identify local resources and the services they provide;
- Visit a community resource center;
- Share an informal meal with community resource center staff members; and
- Make specific arrangements with staff to return to the center.

Section 3

Primary Tools And Techniques

This section introduces several of the primary tools and techniques of Street Smart. In-depth information is provided for each concept to assist facilitators in the proper implementation of Street Smart.



Tokens

The use of tokens is based on the theory of positive reinforcement. The theory of positive reinforcement states that behaviors that are noticed and encouraged by others will increase in frequency. Those that are not noticed or are punished usually decrease. This process generally occurs without awareness, and encouragement can be as simple as a smile.

Tokens are pieces of 2" X 2" multicolored construction paper that anyone can make. Facilitators give each participant a roughly equal stack of the tokens at the beginning of each session. Participants sit in a close circle as a discussion or activity is underway. When anyone says or does anything someone else likes or agrees with, finds encouraging, or causes him/her to think, he or she hands the person a token. The tokens are not "turned in" at the end of the session for something of value. Simply receiving a large number of tokens from their peers and being supportive of each other leaves most participants at the end of the session with positive feelings about themselves.

Because it is a new behavior, facilitators should model how to use tokens by frequently distributing tokens to each other as well as the youth throughout the sessions. In the beginning, facilitators are encouraged to give out tokens liberally in order to model encouragement, support, and positive affirmation. In the original research and in the piloting of the Street Smart intervention, we found that the use of tokens became a group norm after only a few sessions. Once the youth start using tokens on a regular basis, facilitators may choose to taper off their delivery of the tokens and use them more as a means to encourage and develop positive behaviors. This is further discussed in the section below.

There are several benefits to using tokens:

1. Adolescents learn how to give positive support to each other in a non-threatening manner.

For many at-risk adolescents, giving positive feedback and/or compliments to each other is rare. It is more likely that adolescents trade insults and criticism than positive feedback and support. Thus, giving positive feedback may seem unnatural and difficult for them at first. Street Smart allows them to have the experience of giving positive support in a safe, acceptable way.

2. Facilitators can use tokens to reinforce (and therefore increase) positive behavior.

Positive behaviors like participating in discussions or role-plays, getting to group on time, standing up and delivering tokens to other group members, and making eye contact when delivering a token can all be reinforced by the facilitator giving a token to a participant. Furthermore, facilitators can use tokens to reinforce positive behavior that is not the norm for participants. In these cases, it is best for the facilitator to explain why the token is being given. For example, if a youth who is normally unable to focus is sitting still and paying attention, the facilitator can hand him/her a token and state, “I like the way you are listening.”

3. Tokens help members show support without interrupting the group.

All group members are able to show their approval, agreement, support, and encouragement without verbally interrupting or disrupting the group.

4. Tokens help keep the pace and energy of the group.

First, because adolescents do not normally sit for two hours, using tokens allows them to move about in a non-disruptive manner. Secondly, if the group seems to be at a lull, the facilitator can increase the energy and participation by handing out more tokens. One way to hold attentiveness is for the facilitators to hand a youth a token and say, “Thanks so much for staying with us, we are almost done with the session.”

5. Tokens can be used to include shy or quiet adolescents.

In many groups, these participants feel left out. Here they can “say” something by just handing out the token and find support when they receive the tokens.

6. Tokens can be used to help assess the level of involvement of group members.

Facilitators will be able to gauge how involved the group is at any given time by the number of tokens that are being exchanged and who is doing the exchanging.

Remember, everyone’s use of tokens rests with the facilitators’ level of comfort. If the facilitators take tokens seriously and use them at every opportunity to offer positive encouragement, the youth will also respect their value and will actively use them. Note that tokens are used in every session. Facilitators can change the name of the tokens to “thanks” or another name.

Token Guidelines

- No “air deliveries.” Sometimes, participants toss the token or pass it down the line to the intended recipient. Participants should get up and give the token directly to the intended recipient.
- Give one or two tokens at a time. Sometimes, participants attempt to give all their tokens to just one person. While it is okay to give more than one (for emphasis, participants may give 4 or 5), the facilitator should instruct youth to only give out 1 or 2 tokens at a time.

- It's OK for youth to write on the tokens. We have found that youth are still listening and engaged during this time and doodling just allows them to release some energy. At the end of the sessions, facilitators may want to review the tokens just to assure that none of them have anything inappropriate written on them. If they do, they should be removed and replaced with blank tokens. There is no need to address the inappropriate writings with the youth.



Feeling Thermometer

One of the goals of Street Smart is to help adolescents become aware of the link between feelings, thoughts, and actions. As they begin to understand this link and become more aware of their feelings, youth often need help in learning to recognize, name, discuss, appropriately express, and manage feelings. Managing emotions is important because intense feelings can interfere with youths' ability to make good decisions and act safely.

The Feeling Thermometer is a tool that allows adolescents to better assess and discuss their feelings. The Feeling Thermometer ranges from 0 to 100. One hundred represents the most discomfort (associated with high intensity of an emotion), such as extreme anger, anxiety, excitement, nervousness, arousal, depression, etc. Zero represents a total lack of discomfort (associated with emotional intensity), such as feeling no anxiety or nervousness at all. As the Feeling Thermometer is used, youth learn that a high number on the Feeling Thermometer may affect an individual's thoughts and actions. A person at or near zero is better able to think and make decisions than the person at or near one hundred, regardless of the particular emotion. When youth begin to understand the correlation between feelings, thoughts and actions, they learn to manage their feelings better.

While the Street Smart curriculum designates specific instances for facilitators to use the Feeling Thermometer, this tool can be used at any time that it seems important to assess feelings. Some examples of times to use the Feeling Thermometer are:

- When the group seems to be having a strong emotional reaction (either positive or negative).
- When there is a lull of energy in the group.
- When the group seems to have too much energy.
- When facilitators sense a disconnect between themselves and the group in reaction to something that's been said or done during a session (e.g., if all of a sudden the group gets quiet, the facilitator might ask, "Where is everyone on their Feeling Thermometer?").

Introducing Youth to the Feeling Thermometer

Youth often become confused and associate lower numbers on the Feeling Thermometer (e.g., 10, 20) with “positive” feelings (e.g., contentment, happiness) and the higher numbers with “negative” feelings (e.g., anger, fear). The numbers are meant to refer to the intensity of a feeling; for example, an individual who rates herself at 85 of happiness feels happier than someone at 15 of happiness. The objective is to teach youth that regardless of the feeling, a high intensity of feeling affects an individual’s sense of control and effectiveness when making decisions. A person who is intensely happy versus someone who is intensely angry is equally at risk of not thinking clearly and making an unsound decision. In essence, high intensity inhibits rational thinking.

This tool becomes particularly helpful when discussing the issue of sexual behavior. Often, when you discuss risky sexual behaviors with youth, they will tell you “It just happened.” This tool teaches them that when someone is in a state of high sexual arousal (which is normally perceived as a positive feeling), their Feeling Thermometer is at a high number (perhaps 80 or 90). Through the use of the Feeling Thermometer, youth develop a better understanding of risky sexual situations. They recognize that their decision-making abilities may be impaired during certain sexual situations, and this tool helps them recognize the triggers for risky sexual behaviors. The Feeling Thermometer helps them learn to identify, attribute a value to, cope with, and reduce risky sexual behaviors.

For many youth, the Feeling Thermometer may represent one of the first opportunities to stop, consider their feelings, and recognize their intensity; often the very act of paying attention to one’s feelings can assist in their management. Additionally, the Feeling Thermometer provides an interim method for labeling feelings until the language of feelings is learned. Street Smart provides participants with a “Feelings and Emotions Word List” after introducing the Feeling Thermometer.

In the beginning, facilitators may ask the youth to give a number:

“Where are you on the Feeling Thermometer?”

As the session progresses and youth become more familiar with the Feeling Thermometer tool, facilitators should ask youth for a feeling word to associate with the number:

“So you’re at 80 on the Feeling Thermometer, what is the feeling associated with that number?”

It is important that facilitators remember not to over-process. Often a go-around where each youth states one word is sufficient. However, the facilitator may want to check if there is something they need to address at the moment. For example, if the majority of the group says they're at 40 but one youth says he is at 90, the facilitator may choose to ask that youth for an emotion word:

“What is that about?” or “What’s up?”

“Is there something you would like to share?”

If a participant’s Feeling Thermometer is high, facilitators may ask the youth to identify ways to lower their Feeling Thermometer and encourage them to consider using techniques learned in the groups. This teaches the youth how to apply the techniques they learn during the Street Smart program to other areas of their lives.

Facilitators should be careful not to make any participant feel singled out through use of the Feeling Thermometer. If the youth seems reluctant to give an emotion word or seems uncomfortable sharing, the facilitator should just continue on with the session. When necessary, facilitators may meet separately with a youth after the session to discuss private matters or concerns.

Relaxation

Relaxation is a useful tool to help manage feelings in combination with the Feeling Thermometer. Relaxation techniques typically bring youths’ (and facilitators’) Feeling Thermometers down. The facilitator who is leading the relaxation technique should be mindful to:

- Read relaxation in a calm, quiet voice.
- Read slowly.
- Make sure that they speak in a quiet voice, but loud enough for the group to hear.

If facilitators are not used to reading out loud in this manner, it is advised that they practice with some colleagues. The way in which the relaxation is read will create the proper mood and in turn the youth will be able to “buy into” the relaxation and benefit from this coping strategy. The co-facilitator should model the relaxation instructions (e.g., getting into a comfortable position, closing eyes, etc.).

Relaxation may be new to many of the youth and some youth may giggle or seem restless during the first few relaxations. Similar to the other new techniques, it is vital that facilitators model the skill and roll with the resistance. For example, when the instructions call for youth to close their eyes, many youth may be resistant to do so, especially at first. If some youth don't close their eyes, continue on with reading the relaxation. Facilitators conducting this technique with a variety of youth have found that youth typically get into the relaxation when it is modeled and read properly.

While there are specific points during the curriculum that call for relaxation techniques, it is often useful to use relaxations at other times as it is needed. For example, facilitators can do a "quickie relaxation" (e.g., <5 minutes) to calm the group down (such as when the group becomes upset about an issue that was brought up), or to re-focus the group. Once youth learn the quickie relaxation in Session 5, facilitators should encourage youth to use these quickie relaxations outside the sessions.



Role-playing

Role-playing allows youth to act out typical situations in an instructive and supportive environment. The Street Smart manual contains several different types of role-plays:

Quickie role-plays are short and scripted and are mainly used to introduce a session or topic. Quickie role-plays are usually found at the start of a session or exercise.

Longer role-plays may or may not be scripted. They use feedback from other participants and videotaping to give participants a more in-depth opportunity to explore new ways of dealing with high-risk situations.

Longer role-plays are divided between three different types:

- Scripted role-plays (youth read verbatim dialogue from a written script).
- Semi-scripted role-plays (start off scripted and then the actors make up the rest of their lines).
- Unscripted role-plays (youth are provided with a scenario and situation and i improvise).

Instructions for role-plays

Basic instructions for ***scripted role-playing*** are as follows:

- Ask for volunteers and give them a copy of the scripted role-play. Allow the actors to read the script. While one facilitator ensures that the actors understand their roles, the co-facilitator should assign other jobs to remaining youth (see below).
- If videotaping, assign someone to be the cameraperson.
- If there are enough participants, assign a director.
- Assign other participants to monitor the interaction, watch eye contact, and observe body language.
- Just before the role-play starts, check each actor's Feeling Thermometer.

Basic instructions for ***semi-structured role-plays*** are as follows:

- Tell the youth that this role-play starts scripted and then they will "make up" the end. Ask for volunteers and give them a copy of the scripted role-play. Allow the actors to review the script. While one facilitator does a "check-in" with the actors, the other facilitator should assign other jobs to remaining youth.
- Assign coaches: one is assigned to each of the principal actors to offer suggestions on what to say during the role-play. These coaches are vital in the unscripted role-plays.
- If videotaping, assign someone to be the cameraperson.
- If there are enough participants, assign a director.
- Assign other participants to monitor the interaction: a person to watch eye contact, a person to watch body language, etc.
- Just before the role-play starts, check each actor's Feeling Thermometer.

Basic instructions for *unscripted role-plays* are as follows:

- Provide the description of a risk situation. For example, “You are at a party and someone wants to make out in an empty bedroom.”
- Assign two persons as the principal actors (e.g., two persons who are newly dating each other). One wants to make out in an empty bedroom and the other does not. For unscripted role-plays, the actors should discuss what the scene should be like. One facilitator should “check-in” with the actors to address any questions, while the other facilitator should assign other jobs to the remaining participants.
- Assign coaches: One is assigned to each of the principal actors to offer suggestions on what to say during the role-play. These coaches are vital in the unscripted role-plays.
- If videotaping, assign someone to be the cameraperson.
- If there are enough participants, assign a director.
- Assign other participants to monitor the interaction: a person to watch eye contact, a person to watch body language, etc.
- Just before the role-play starts, check each actor’s Feeling Thermometer.
- Facilitators may stop the role-play before the conflict is resolved. At the point when the tension seems the highest, facilitators may stop the action by saying, “freeze.”

Debriefing all role-plays

Once the role-play has finished, there is a recommended sequence for delivering feedback. Facilitators should follow this format after every role play. However, by Session 3, most youth are familiar with the process and little review of the proper feedback process may be necessary by then. Play it by ear, but be sure to let the youth demonstrate that they understand what to do after a role play – if facilitators attempt to review information the youth already possess, they may get frustrated, bored or feel under-acknowledged.

1. Ask the principal actors, “Where are you on the Feeling Thermometer?”
2. Ask the actors to “Tell me one thing that you liked about what you did.”
3. Ask the actors to “Tell me one thing you would do differently.”
4. Ask the participants observing (e.g., body language, face, voice, etc.) what they observed.
5. Ask the coaches (if coaches were assigned) what they think the principal actors may have been thinking, but not saying, to the other person.
6. Do a quick go-round and ask the coaches and other participants, “Where are you on the Feeling Thermometer?”
7. If time allows, ask participants to suggest to the principal actors or coaches ways to resolve the issue elicited by the role-play.
8. If time allows, youth may continue filming while this discussion is going on. Some of the most interesting and useful comments come out during this exchange of ideas.
9. If time allows, ask the actors to choose one of the suggested ways for resolving the conflict, and conduct a second taping. After the scene is acted out a second time, play it back and ask participants to react.

Facilitators often wonder if they are asking participants what they liked about their performance as an actor or what they liked about the things their character did or said. While the goal is to discuss the actions of the characters, the instruction -- “tell me one thing you liked about what you did” -- is intentionally open-ended to encourage youth to identify with the character they are portraying. Facilitators should allow youth to answer the question either way (i.e., based on their performance or the action of their character).

If youth ask, “As the actor or as the character?” clarify by restating, “Either one. Just tell me one thing you liked about your behavior or what you did.” When youth respond to this question regarding their performance, they typically provide a response that lets you know that they are identifying with their character, for example, “I liked that I raised my voice with her when she said that she did not use protection.” During the post role-play discussion, when other participants talk about their observations, facilitators should steer the conversation to focus on the main point of the role-play and encourage actors who only discussed their performance to share their thoughts about their characters’ feelings, thoughts and actions.

Additional Tips for Role-plays

Re-write scripted role-plays to fit in with local norms and slang. Facilitators may find the language used in some of the role plays outdated or not relevant to their target population (due to regional or cultural variation in populations). Facilitators are highly encouraged to adapt the role-play language as necessary, provided the intention of the role-play is maintained.

Encourage youth to participate. Facilitators should encourage youth to take part in role-plays without ever forcing a youth to participate. In most groups, the same youth repeatedly volunteer to act in the role-plays; it is important that facilitators encourage youth who do not normally volunteer to participate. Quiet youth can be encouraged to participate in the quickie role-plays that often begin a session, as there are only a few lines for each youth to say.

Changing the role-plays. Facilitators should pay attention to participants' ability to read. If some youth appear uncomfortable or defensive about reading aloud, they may be weak readers. (In most cases the assessment conducted with each potential participant BEFORE the start of the intervention will assist facilitators in knowing which participants have reading difficulties.) Always tell the youth if the role-play is scripted or unscripted prior to asking for volunteers (a shy youth may not wish to volunteer if the role-play is unscripted). Furthermore, facilitators may vary the role-plays between unscripted and scripted role-plays or may choose to adapt the role-plays by altering a scripted role-play to a non-scripted one while maintaining the storyline and intended objective of the scripted role-play.

Use coaches for unscripted role-plays. Assigning coaches to assist the actors is a useful technique for role-plays where youth need to make up lines as they go along. The facilitators should assign one coach to each actor. Prior to the start of the role-play, facilitators should instruct coaches to offer suggestions to the actor about what to say if the actor gets stuck or strays too far from the main point of the role-play. Coaches should whisper their suggestions into the actors' ears. Facilitators may coach the coaches if their suggestions are not on track, if the role-play is going on too long, or if the coaches need help.

Gender and sexuality issues in role-plays

Facilitators should make every effort to avoid stereotyped role-playing. Many of the activities involve role-plays between persons with specific characteristics. Be sure that these exercises do not stereotype individuals by gender, sexual orientation, age, and/or race. Reverse gender roles whenever possible. For example: “Let’s have the girl this time be the one who doesn’t want to use a condom.” Also have girls role-play boys and boys role-play girls as early and as often as possible.

Role-playing sexual or romantic interactions between same-sex couples may be received with strong resistance by youth. Some facilitators may believe that these role-plays are not relevant for their youth population and that their youth are predominantly heterosexual. Therefore, facilitators often opt to change the same-sex role-plays to role-plays between opposite-sex couples or not have youth play different genders. This is highly discouraged. The incorporation of gender and sexuality issues into role-plays is highly necessary to the intervention and its success for several reasons:

- **Actual proportions of youth engaging in or experimenting with same-sex sexual activity may be higher than generally perceived.** A 1999 Safe Schools Coalition of Washington report found that approximately 5% of teens ages 14-18 self-identify as lesbian, gay, or bisexual; have engaged in same-sex sexual activity; or have experienced same-sex attraction.¹ This estimate may be conservative. Given that many youth may engage in same-sex sexual behaviors (or at least experience same-sex attraction), it’s highly unlikely that these role-plays are irrelevant for any youth population.
- **Youth who engage in same-sex behavior often experience a high degree of stigmatization and violence as compared with their heterosexual peers.** A study of Massachusetts youth published in 1998 found that youth engaging in same-sex behavior were four times as likely as other youth to be threatened or injured with a weapon at school and four times as likely to miss school as a result of perceived or actual threats. As a result of such violence and related feelings of isolation, rejection, confusion, and shame due to the stigmatization of homosexuality, same-sex youth were similarly found to have a far higher rate of substance abuse and suicide ideation (five times greater than youth who do not

14 Reis, Beth and Elizabeth Saewyc. Eighty-Three Thousand Youth: Selected Findings of Eight Population-Based Studies As They Pertain to Anti-Gay Harrassment and the Safety and Well-Being of Sexual Minority Students.” Safe Schools Coalition of Washington, May 1999. <<http://www.safe-schoolscoalition.org/83000youth.pdf>>

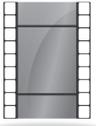
engage in same-sex behavior).² Role-playing sexual situations between same-sex partners helps de-stigmatize homosexuality and “normalize” issues of gender and sexuality, thereby allowing those youth who have engaged in same-sex behaviors (whether they self-identify as homosexual, bisexual, or heterosexual) to explore and discuss areas of risk without discussing their particular behavior. These youth may then feel free to have discussions with the facilitator without fear of judgment.

- **Adolescence is a time of experimentation and there is a wide range of risk behaviors and situations youth may experience, including same-sex sexual behaviors and drug use.** While it is not uncommon for youth to engage in risk behaviors that they do not disclose to peers or facilitators, they may be especially reluctant to disclose same-sex interactions. One of the ways the Street Smart program addresses this reluctance to disclose risk behaviors is by offering youth the opportunity to practice negotiating safer sex and situations involving substance use with peers through role-plays. Just as facilitators would not hesitate to talk about specific drugs, even though they don’t know if any of the youth in the group have used them, it is similarly important to have participants role-play same-sex sexual situations. These role-plays allow youth to learn skills for dealing with these sexual situations in safe, non-threatening ways without requiring self-disclosure. By eliminating these role-plays, facilitators run the risk of not addressing all the potential needs or risk situations of youth in their groups.

Facilitators often have found that their initial concern over whether their youth would have problems or discomfort with a same sex role-play was really about their (facilitators’) own discomfort. Street Smart facilitators should inspect their own feelings about same-sex issues and try to be aware of the biases they unknowingly display to or project onto youth.

If it is clear that youth refuse to do the same-sex role-plays, same-sex role-plays may be adapted so that instead of youth playing the part of someone who has engaged in same-sex behavior, the actors could talk about other youth engaging in same-sex behavior with the same issues that come up in the original role-play. For example, role-play #2 in Session 2 could be adapted so that Actor 1 plays the older sister/brother or friend of José, and asks advice of his/her friend (Actor 2) about how to advise José to be safe for his first sexual encounter with another male.

15 Faulkner, Ann H. and Kevin Cranston. (1998). Correlates of Same-Sex Sexual Behavior in a Random Sample of Massachusetts High School Students. *American Journal of Public Health*, 88 (2): 262-6.



Videotaping Role-Plays

Videotaping exercises such as role-plays fosters effective decision-making, problem-solving skills, and behavior change. The strength of videotaping is that it allows individuals to actually see themselves as others see them. It is important, therefore, that youth first see themselves in realistic circumstances, acting out scenes as they think most people would act. Afterwards, the youth can act out alternative ways of handling the situation. Being able to see themselves and their reactions to difficult situations can affect the way they perceive their own behaviors (e.g., they may realize they are coming off more aggressive or passive than they expected) and, accordingly, may result in their modifying their decisions and behaviors.

Facilitators must be thoroughly familiar with the videotaping and playback equipment. The smooth transition from videotaping to playing the videotaped role-plays is vital to the pacing of the session and maintaining the youth's attention. Video cameras that connect directly to monitors are typically the easiest to use.

The Facilitator leading the role-play should begin the discussion of the role-play while the tape is being rewound by/or under the guidance of the other facilitator. This keeps the pace moving and allows for immediate reactions from actors and observers.

Facilitators are strongly encouraged to provide guidance to the youth as they film and playback the role-plays. Be sure to give every youth a chance to work the equipment, if they are interested. Youth and/or facilitators familiar with the equipment can demonstrate the use of the video camera prior to or after sessions to allow this smooth transition.

Problem-solving

The SMART problem-solving model provides youth with a simplified, step-by-step method to problem-solving. The purpose of the SMART problem-solving method is to teach participants how to approach a problem in a systematic, logical way.

The steps are as follows:

State the problem.

Often, when people think of problems, they tend to lump several problems together. This first step in SMART encourages them to look at one problem at a time. Have participants identify one problem. The stated problem must be a behavior (not a person) and one that is within their control. Facilitators may have to help them by exploring what is not going right, what happened, where it happened, and when it happened. For example, “My boyfriend does not want to use a condom” is not sufficient as a problem. This statement emphasizes the boyfriend, not the youth (who has no control over him). “I do not want to have sex without a condom and my boyfriend won’t wear one” is more appropriate.

Make the goal.

Participants must clearly state what the desirable future behavior is. Again, the goal should be stated in a way that places it within their control. Continuing the example above, “To make my boyfriend use a condom” is not appropriate; “To only have sex with the use of a condom” is a goal within the youth’s control.

Actions – make a list of all the possible actions you could take.

Often, when people attempt to think of a solution, they will think of only one or two, and then tend to overlook other possibilities. This step encourages participants to explore all possible actions and discover alternative solutions that they might not have considered before. Participants should brainstorm all of the possible actions they could take to reach their goal. It is important that participants understand that they are to list all possibilities without judging them (they will do that in the next step). If the participants begin to judge their answers, stop them, and remind them that in this step they are to list a variety of possible actions and will have the chance to critique them later.

Reach a decision of which action you try.

In this step, participants look at their choices using consequential thinking. They are to look at each choice, consider its potential positive and negative outcomes, and write down the pros and cons. It is this weighing of pros and cons which assists youth in determining their best course of action, so these should be generated by the group or the individual with the problem, not the facilitator. It is also important to make participants aware that sometimes the solution is a combination of several actions.

Try and review it.

Participants should try the action they chose and review it. If the action did not work to their satisfaction, they can go back to their choices and try another one. When appropriate, redo the SMART problem-solving method.

Because SMART is a process with several steps, it is helpful to present it to the participants in a clear, logical manner. We suggest using the following format:

Problem Statement: _____

Goal: _____

Possible Actions:	Pros:	Cons:

I will do the following action(s): _____

The SMART Problem-solving technique is first introduced in Session Five. Once it is introduced, participants should be encouraged to apply problem-solving to any appropriate situation. If the need arises, it may be appropriate to introduce and teach this tool prior to Session Five. For example, if during the first three sessions, there are two youth who consistently engage in side conversations, the facilitator may address this in various ways such as referring to ground rules, asking them to stop, and using tokens to reward those that are actively listening. If, after these efforts, the problem still occurs, the facilitator may introduce the SMART problem-solving technique as a way to address the issue. In such a case, the facilitator should lead the group through an abbreviated version of it (Session 5 has a very in-depth explanation) and explain that this is a tool that will be covered and practiced more in Session Five. The early introduction of the tool will not deter from the intervention. As stated in the beginning of this chapter, the goal of Street Smart is to provide youth with skills to help reduce risky behaviors. Hence, facilitators should provide youth with every opportunity to generalize all the Street Smart tools to real life situations.

Here are some other examples of times when facilitators could use problem-solving when it is not specifically indicated in the curriculum:

Youth bring up personal problems in the group. For example, if a participant states that her boyfriend does not want to use a condom, the facilitator should focus the discussion away from the individual participant and use the SMART model to resolve the problem in general terms, such as, “That is true. Sometimes a person wants to use a condom and their partner may not. In such a case, what would be the problem? Remember, the problem is something you have control over.” Then, the facilitator can lead the group in creating a chart with all the possible actions: use female condoms, invite the partner to attend Street Smart, take a pamphlet home, break up with her/him, etc.

Group management issues. For example, if the group always starts late or two youths are having an issue within the group, the facilitator can lead the group to use problem-solving to address the issue.

Individual session. The SMART problem-solving model can be used to facilitate the one-on-one personal session with youth.

Section 3

Facilitation Tips

In addition to the techniques previously discussed, there are a number of group facilitation strategies that will help facilitators deliver the Street Smart intervention. These strategies are discussed at length below to support the ability of facilitators to implement the curriculum effectively.

Session Pacing and Group Management

The key to completing all the exercises in each session is to move at a steady pace; the exercises should flow seamlessly from one to the other. There are several strategies that will help accomplish this:

- Know the goals and structure of each exercise and each session (“knowing the session cold”)
Prior to conducting a session, facilitators should know and fully understand the objectives of the session and of the exercises within it. This does not mean that facilitators must memorize each sentence in the curriculum. They should know and understand the order and the structure of the exercises (e.g., “get into pairs, read the cards to each other, and then we will come back as a big group after 5 minutes to discuss the activity”) and the objective of each exercise (the message that each youth should take away).

- Jump right into the activities
Educators are typically taught to explain what is going to happen prior to doing any activity. This is appropriate for an educational setting; however, as a psycho-educational intervention, Street Smart is different. The curriculum provides excellent guidance as to how a facilitator should move from one exercise to the other. Typically, there is limited explanation given to the youth prior to conducting activities. This is intentional as it helps keep the fast pace and interactive nature of the sessions. Furthermore, during the pilot of Street Smart it was noted that this method of moving from one exercise to the next helped overcome potential resistance to exercises or the topics covered. Facilitators should answer questions/ clear up any confusion youth may have. However, experienced facilitators have often found it helpful to tell youth, “Let’s just try it and you’ll see what we’re doing.”
- Stimulate pointed discussions
Stimulating pointed discussion means focusing discussions on the exercises’ key points. It is common that participants will move discussions to another topic (perhaps related, but not exactly in the direction that is intended) or a discussion becomes prolonged. When this occurs, facilitators should guide the group back to the key points of the discussion.

One way a facilitator may effectively guide the discussion back to the main point is to take time to acknowledge the youths’ statements before moving the group to the next topic (e.g., “That’s true and it’s a very important point, now we want to focus on X”).

Another helpful technique is to paraphrase or connect participants’ comments to future discussions when participants bring up issues that are relevant to a later part of the session or program (e.g., “That is a really important point and leads us to the next exercise” or “That is a good point that we will be talking about next week, so I want the group to remember this”). This technique requires that the facilitators master the content of the curriculum.

Still another technique is to place the discussion within the larger goal of the intervention (e.g., “Thanks for sharing that; we are here to learn how to help each other keep ourselves safe” or “Thanks for sharing that; a lot of people have that experience”) and then continue the session. This is a helpful technique, particularly when youth bring up risky behavior, subjects that are unrelated to the current discussion or the intervention, or when youth are testing the boundaries of the facilitators.

- Acknowledge unrelated issues and move on

Youth may bring up issues during a session that are unrelated to the topic or Street Smart program. For example, a youth shares that he's going to visit his father over the weekend during a session on how to use a female condom. The facilitator might say, "Thanks for sharing. If you want to talk more about that after the session, we can do that. But right now, we're going to talk about how to use a female condom." Facilitators should encourage youth to share; however, it is important to keep the session moving. Also, it is helpful for facilitators to refer to time limits recommended for each exercise in the Street Smart curriculum when deciding how to address participants' comments.

- Work as a team

It is important that co-facilitators work as a team. Working as a team serves several functions:

- o Helps keep the pace moving;
- o Helps with group management issues;
- o Helps facilitators support one another; and
- o Models for youth how to work together cooperatively.

When co-facilitators are a male-female team, they also model for youth how men and women can work together, communicate effectively, and support one another.

Prior to the session, facilitators should decide each person's responsibilities. An easy way to do this is to trade off leading each exercise (e.g., facilitator 1 leads Exercise 3, facilitator 2 leads Exercise 4). After Session 1, the introductions typically should take less than 5 minutes; hence, it is recommended that the facilitator who starts the session leads both the introductions (Exercise 1) as well as Exercise 2. It is important for facilitators to keep in mind that although exercises are traded off, they should flow seamlessly from one to the other.

A facilitator who is not the "lead" person can assist his/her co-facilitator in the following ways:

He/she can take care of the technical issues (e.g., giving out tokens, passing out handouts or cards, writing on newsprint, setting up the videotaping and playback). This enables the “lead” facilitator to concentrate on the session and the group. It also keeps the group lively. For example, as one facilitator is giving out tokens at the end of an exercise, the co-facilitator could start explaining the next exercise. He/she can help keep time while the co-facilitator is running the exercise, and can attend to group management issues without disrupting the flow of the group.

Know your own and your co-Facilitators strengths and weaknesses

This is a vital aspect of working as a team. Facilitators often refer to this as “watching each others’ back.” For example, one facilitator may have a personal style that is relaxed, and tends to talk slowly, which results in the exercises he/she leads typically going over the allotted time. The co-facilitators job is to help move the session along, anticipating and having the materials to conduct the exercise at the ready, and using non-verbal cues to communicate that time is almost up, things need to move along, etc.

Limit self-disclosure

It is important that Facilitators are careful about what they disclose to youth about their personal lives. In the go-round at the start of each session, facilitators should participate but limit their responses to neutral topics. Disclosure of facilitators’ personal historical or current sexual or drug use patterns is particularly discouraged because one of the goals of the Street Smart program is for facilitators to create an atmosphere where positive social norms are articulated by the youth.

Maintenance

4



Section 4

Introduction

There are three functions of maintenance:

- institutionalizing Street Smart within an organization;
- facilitating quality assurance; and
- guiding the monitoring and evaluation process.

Institutionalization of Street Smart means moving beyond the initial launch and incorporating Street Smart into the regular activities of your agency. Making Street Smart a sustainable intervention requires thinking through strategies to ensure its continuation beyond the initially funded cycles.

Quality assurance is an ongoing process that is intended to ensure that facilitators deliver Street Smart as it was delivered in the original research project and described in this intervention package. This guide contains suggestions and information on implementing and ensuring quality assurance by organizations that conduct Street Smart. It is included to assist these organizations with implementing this evidence-based intervention in a consistent manner.

Monitoring and evaluation seek to identify areas for program improvement and ensure accountability to the community, to youth, and to the funding source. There are three types of monitoring and evaluation that can be conducted by an implementing agency:

- formative evaluation;
- process monitoring and evaluation; and
- outcome monitoring.

Funding sources are increasingly requiring agencies to demonstrate and quantify the quality and effectiveness of programming in reaching the target population as a contingency for the receipt of funds. As a result, it is becoming more and more necessary for agencies to develop an effective and sustained quality assurance and monitoring plan. An effective plan can assist your agency in determining whether Street Smart is actually reducing substance use and instances of unprotected sex among your target population. The plan can make you better equipped to understand the outcomes of your program and address whatever disparities may continue to exist following implementation.

The materials included in this manual are offered as suggestions to assist you in assessing and strengthening your implementation of Street Smart. The relevance and necessity of these forms to your agency will depend on your specific agency experience, needs, and available resources, as well as upon the evaluation and monitoring stipulations set by your funding sources. Accordingly, your agency should develop a quality assurance and evaluation plan based on these criteria. Your agency can do this on its own or in conjunction with a capacity building assistance provider that will help you identify your particular strengths and weaknesses and strategize a customized plan that will both improve your programming and satisfy your funding sources.

Section 4

Institutionalization

Once you have made an investment in Street Smart, including both time and money, you may want to consider how to sustain the program beyond the initial launch. You can use the strategies below to increase the likelihood that Street Smart is institutionalized at your agency.

- Conduct an In-Service Meeting
- Create contingency plans

In-Service Meeting

An in-service meeting that includes all the staff of your agency, including those with jobs unrelated to the implementation of Street Smart, can be a first step to institutionalizing the intervention. At this meeting, you can provide an overview of the intervention, the expected outcomes, what resources are required, and the timeline.

This meeting is meant to help garner agency-wide support for the program and to assess places where other programs can assist. It is possible that some of the resources required for Street Smart can be shared with another program. This meeting also helps to avoid future conflict resulting from poor communication between programs (sharing of equipment, space, time, etc.)

Contingency Plans

When gathering the necessary resources for Street Smart you may rely heavily on outside organizations for space, materials, and general support. It is important to think through how you will continue to implement the intervention should you lose one of these sources of support. Questions to consider include:

- Do I have back-up space?
- Could I purchase previously donated materials if necessary?

Also, there are internal issues that may arise that necessitate a contingency plan. Staff turnover, loss of funding, and space constraints are just a few of the issues that could disrupt implementation of Street Smart if they are not anticipated. Ask yourself:

- Do I have a back-up facilitator trained in Street Smart?
- Have I identified alternative sources of funding?
- How will I resolve a conflict over space with another program?

Section 4

Quality Assurance

Introduction

For the purposes of the Street Smart Implementation Manual, the focus of quality assurance is on delivery of the intervention itself and does not include quality assurance recommendations for other aspects of services, such as participant assessments.

Quality assurance involves assessment, feedback, and strategic planning. These tasks can be carried out through a variety of activities, including:

- Training and continuing education (for both facilitators and program managers);
- Review of fidelity checklists to ensure appropriate, accurate, and consistent documentation;
- Regular observation of Street Smart sessions, with follow-up feedback of facilitators delivering Street Smart sessions;
- Regular group supervision meetings to discuss specific Street Smart sessions. Group supervision meetings also serve as a means of developing staff skills and maintaining consistency in the intervention's delivery;
- Obtaining youth feedback; and
- Working with a capacity building assistance (CBA) provider to develop sound programming and infrastructure necessary for conducting all relevant activities.

Training and Continuing Education

All Facilitators are required to attend a four-day Training of Facilitators (TOF). The TOF focuses on the knowledge, attitudes, skills and supports needed to be an effective facilitator of the Street Smart intervention.

The training covers Street Smart’s goals, the role of the facilitators, core elements and key characteristics, group process skills, cognitive-behavioral techniques employed in the intervention, implementation tips, overview of intervention adaptation, a review of how exercises meet session objectives, and the behavioral change model used as the basis of the intervention. Each session will be reviewed in depth, allowing participants to practice and teach-back intervention sessions. Training for Street Smart also provides a setting in which facilitators can practice the skills they will need to successfully implement the intervention. This training ensures that all facilitators and supervisors conducting Street Smart receive standardized information and understand the basics of HIV prevention and group facilitation with youth.

Prior to taking the Street Smart training, facilitators and supervisors ideally should be trained in facilitation skills and concepts, HIV basics such as information on transmission routes and prevention, stages of adolescent development, and cultural competency (i.e., ethnicity, sexual orientation, age, class, gender, mental status, literacy, language). Additionally, facilitators should be familiar with the target population they plan to serve, including awareness of pertinent risk-related issues.

Once facilitators have completed the TOF, ongoing training and education is recommended in order to refresh and improve their facilitation skills as well as enhance their knowledge and understanding of the intervention.

Review of Fidelity Checklists

After each Street Smart session, the facilitators should complete the “Street Smart Fidelity/Process Form” which helps them assess whether they conducted each activity with fidelity. During this process the facilitators review the core elements of each session and rate the degree to which they covered the material. The “Fidelity/Process Form” includes ratings of: “Facilitated as suggested,” “Facilitated with changes,” and “Did not conduct.” Any deviations from the curriculum should be noted and explained. Additionally, the facilitators should note any problems with the exercises and/or group members, anything that occurred within the group that they felt was challenging, and any unusual disturbances that affected their ability to cover the material. Your organization may also choose to rate other important aspects of the session including participant interest and degree of participation. These fidelity forms serve as reinforcement of the core elements of Street Smart and document areas that facilitators may need to review. They may also help staff members identify potential facilitator training and curriculum adaptation needs. (See Fidelity Checklist in Section Five.)

The forms should be completed immediately following the session by facilitators and submitted to the supervisor as soon as possible. Facilitators should go over the form with their supervisor and can use it as a guide to debriefing with one another. Because immediate feedback is most useful, it is recommended that supervisors meet with the facilitators as soon as possible following the session.

These forms will give the supervisor and facilitator the opportunity to discuss and address any challenges faced in facilitating the session and will help facilitators improve their facilitation skills in regards to the program. In addition, it can help inform both facilitator and supervisor if there are any particular activities or exercises in the curriculum that are ongoing challenges. If supervisors find that their facilitators are having difficulty with any particular segment of the curriculum, they should seek assistance from an appropriate CBA provider. CBA providers can help clarify if the difficulty is due to a staff training need, issue of facilitation, or adaptation.

Your agency may already include a review of program documents as part of its ongoing quality assurance procedures. Program documentation includes facilitator fidelity forms, signed consent forms, client demographic information, outcome monitoring pre- and post-tests, and required funder reporting forms. The purpose of reviewing records for Street Smart is to ensure consistent documentation of sessions. As part of your agency's overall quality assurance and evaluation activities, you may want to schedule a regular review of program documentation such as on a weekly or bimonthly basis and give immediate feedback. For regular record reviews, follow your agency's policies and procedures. If no relevant policies exist, consider the experience level of your facilitators. For example, if your facilitators have less experience implementing Street Smart, you may want to review their completed records more frequently than for facilitators who have been facilitating for several years.

Observation of Street Smart Sessions

Observation of Street Smart sessions is the process in which a supervisor or senior facilitator directly observes a session or reviews one by watching a videotape of a session. By observing facilitators, a supervisor or senior facilitator can assess whether the facilitators are following the curriculum and demonstrating fidelity to the intervention. Observation may also help in assessing the facilitators' style of delivery of the content, level of facilitation skills (including group management), and appropriate and effective use of key facilitation tools and techniques (e.g., use of tokens, modeling skills for participants to practice, facilitation of role-plays, non-judgmental facilitation, etc.)

Session observation can help to ensure quality delivery, adherence to the curriculum, and consistency in delivery of the intervention by all facilitators. Observation and feedback by supervisors or other senior facilitators can be very useful in ensuring that facilitators understand how to conduct each session and uphold the integrity of the curriculum. The appropriate number of observations must be assessed by your organization based upon such considerations as the experience of the facilitator and the group dynamic and comfort of youth during observation.

Facilitators can be observed by their supervisor in person or the session can be taped for later review. Either way, it is important that participants are aware of and agree to the observation or recording of the session through a formalized consent form. Also, the consent form must state that the participants can refuse to have the observer in the room, refuse to be videotaped and can ask the observer to leave at any time. If the facilitators will be observed directly, the facilitators should explain to the participants that the observer will focus on the facilitators' work during the session and not on the issues presented by the participants.

To decrease anxiety and help prepare the facilitators and participants for observation, it is recommended that the observer schedule the observation ahead of time and discuss any concerns the facilitators and participants may have about the observation process.

If the observation is in person, they should be limited to one observation per cohort so as not to create too much disruption in the group. It is also recommended that the observer monitor the facilitators without interfering with the group interactions. The observer should avoid sitting in the participants' direct line of sight and should not speak during the session.

Videotaping of sessions can be advantageous because it is less intrusive; oftentimes the participants and facilitators will forget about its presence. Taping also allows the facilitators and the observer to review the tape together, which permits them to view and identify any issues revealed in the session.

If the session is to be taped for later review, the facilitators should explain to the participants that:

- The recording will be used for later review of the facilitators, not the participants;
- The tape will be viewed by a supervisor or other lead facilitator;
- The tape will be erased or destroyed once the staff member has used it for supervisory purposes; and
- The participants have a right to refuse to be recorded.

Whether the sessions are directly observed or taped, the same assessment should be completed. The sessions are evaluated for compliance to the protocol using the Supervisor's Rating Form (see Section 5). The following areas are assessed:

1. Ability to meet the goals of the exercises
2. Facilitators style
3. Managing group behaviors/process
4. Modeling behavior

The supervisor rates each of the four competency areas on a scale of 5 (Excellent) to 1 (Poor). After training, periodic observation of intervention sessions is usually helpful to ensure high-quality work. Based on the number of cycles of the intervention your agency delivers in a year or your agency's requirements, your organization may choose to vary the frequency at which facilitators are observed. It is within the purview of each agency and their respective funding source(s) to decide the extent of observation—for example, some agencies may feel it is necessary to observe every session for the first cycle, while others may choose to observe less frequently. If the agency feels that they want to observe sessions frequently, it must be done through videotaping as direct observation can affect the group cohesion and trust. The amount of time, resources, and the experience levels of your facilitators will all factor into your decisions around how often and how many cycles to observe.

If possible, it is recommended that facilitators implementing Street Smart for the first time be observed during most of the sessions in the first cycle. During the next cycle of implementation, observations can be made less frequently (e.g., observing only four of the eight group-level sessions). Once facilitators are sufficiently experienced in implementing the intervention, the frequency of observations can be reduced to once per cycle.

In addition to the Supervisor Rating Form, the supervisor should also complete the Fidelity Checklist specific to the session being reviewed. As stated earlier, these forms are tailored to the specific protocol and content of each session, with a special emphasis on assessing whether the exercises were taught as suggested. The forms are designed for the observer to note whether the counselor has or has not met the expectations for each exercise.

Regular Group Supervision Meetings

At the end of the observed session, it is recommended that the observer carefully review the forms' (Supervisor Rating Form and Fidelity Checklist) content to ensure completion. Because immediate feedback will be most useful, it is recommended that observers provide feedback to the facilitators as soon as possible following the observed session so that facilitators will be able to incorporate suggestions into later sessions. This feedback may take the form of formalized supervision meetings wherein the assessment of the facilitators' work is a joint activity by the supervisor or senior facilitator and the facilitators. These meetings should be conducted in a supportive manner. If kept as a record, it is recommended that the observation forms are filed in a manner that ensures confidentiality and security.

The following tips are provided to help the observing supervisor or senior facilitator provide feedback:

- Ask each facilitator to provide feedback on what they thought went well and what they would have done differently. This brings the facilitator into the process, clarifies what the facilitator perceives were the difficulties as well as the strengths of their observed session, facilitates agreement to the process, and expedites strategizing for staff development.
- Be specific. Specifically identify content and intervention delivery issues by exercise. The more specific feedback is, the more helpful it will be for the facilitator's development (e.g., "You seem to be uncertain about how to teach youth about rationalizations. Try to find a way to define 'rationalizations' in your own words and in a way that resonates with your youth, as opposed to reading from the script.")
- Identify aspects that need modification after discussing quality work. In a supportive manner, discuss the "Not Achieved" aspects with minimal judgment or inference. This will help the facilitator explore the observation and issues that impacted the session as well as explore alternative approaches to the exercise.

Feedback should be specific, constructive, and provide assistance as to how to modify the facilitators approach.

- Focus on main areas that need strengthening. This is especially important if the issue has come up before with the facilitator. Focus on areas to be strengthened rather than on problems since it is easier to understand and use such information. If a facilitator has difficulty conducting the sessions effectively, he/she may benefit from additional one-on-one coaching or capacity building assistance from a CBA provider. A facilitator overwhelmed with corrective feedback may be unable to make any changes. If a facilitator can improve in a number of areas, prioritize key issues rather than address all of them at once. This discussion should be done thoughtfully to ensure that it is collaborative and useful. Utilize techniques from Street Smart such as role playing and goal setting to improve facilitator skills. Supervisors also should feel free to utilize appropriate CBA providers to help explore how to increase their staff's ability to implement Street Smart effectively.

Youth Feedback

Youth can provide another excellent source of feedback. At the completion of sessions, youth are asked to fill out a Satisfaction Survey which can be found in Section 5 of this manual. Program supervisors should look at these data in conjunction with their own observation forms to develop a clear picture of how the facilitation of the intervention is working for youth.

To monitor and improve the quality of the community resource visits, agencies should collect feedback from the youth on their experience in Session 10, including successes and challenges of the visit to the community resource.

If your agency is not currently experienced in conducting these activities, you may contact a CBA provider for guidance on developing instruments and protocols that will enable you to conduct them in a meaningful way.

Section 4

Monitoring and Evaluation

As mentioned in the introduction to this section, there are three types of evaluation that can be conducted by an agency implementing Street Smart: formative evaluation, process monitoring and evaluation, and outcome monitoring. Each of these offers an opportunity to ensure accountability (to clients, funding sources, or the community) and to identify areas for program improvement.

To effectively conduct intervention monitoring and evaluation, your organization should develop an evaluation plan before implementing Street Smart (see the timeline in the “Pre-Implementation” section for guidance on the appropriate timing of the plan development).

This section will provide a template for a Street Smart evaluation plan to guide your organization in conducting effective monitoring and evaluation. Additionally, this section contains sample forms that your agency can adapt and use to conduct most of your monitoring and evaluation activities. For further guidance on adapting and using these forms, you may contact your Capacity Building Assistance (CBA) provider.

Formative Evaluation

The first type of evaluation that should be conducted is a formative evaluation. A formative evaluation can guide you in gathering data that describes the needs of the target population and the specific factors which put the target population at risk. The information collected for the formative evaluation is instrumental in ensuring that you can adapt the intervention to be appropriate for the target population. Additionally, this data collection can assist your organization in developing the “problem statement” for your logic model to guide your implementation of Street Smart—a key first step to linking the design of your program to its evaluation.

Process Monitoring and Evaluation

Process monitoring and evaluation focus on the implementation of the intervention. Information is collected throughout the intervention and can be used to improve program functioning.

Process monitoring describes efforts to routinely collect and record basic data to describe the implementation of Street Smart.

Process monitoring examines questions such as:

- How many youth were enrolled in Street Smart?
- How many youth completed all 10 sessions of Street Smart?
- What was the attendance at each of the sessions?
- What was the risk profile of the youth who completed all 10 sessions?
- What were the demographic characteristics of youth who had the highest attendance rates?

The data collected by an organization to answer these questions can help identify factors that influence attendance and participation in sessions. Such data may prove helpful not only for identifying factors that can strengthen later attendance at Street Smart, but may also inform other HIV prevention strategies. These data also can help to track whether the target population is being reached effectively through your implementation of Street Smart or whether it may be necessary to modify the recruitment strategy or make further adaptations to the intervention.

Process evaluation involves collecting data to compare what was planned and what actually occurred during implementation. Given the nature of the data needed for this comparison, the questions asked in process evaluation will be more detailed than those of process monitoring.

Process evaluation examines questions such as:

- Was each core element implemented as described in the Implementation Manual?
- How and why were Street Smart activities modified?
- What percentage of the youth enrolled actually match the demographic profile of the target population?
- What were the barriers to implementation?

Outcome Monitoring and Evaluation

Outcome monitoring is the process of collecting data about client outcomes (such as knowledge, attitude, skills, or behavior) to determine the extent to which the program goals and intervention objectives are being met. This process of outcomes monitoring is particularly important, as continued funding of interventions often depends on the ability of an agency to demonstrate whether or not changes in sexual behaviors or sexual risk-taking actually occurred as a result of the intervention.

Outcome monitoring examines questions such as:

- What proportion of participants demonstrated increased knowledge of HIV/STD transmission and risks?
- What proportion of youth demonstrated awareness of personal risk for HIV?
- What proportion of youth reported increased condom use?

Outcome evaluation is the process of collecting data about client outcomes to prove that the changes seen are caused by the intervention. One of the benefits of the Street Smart program is that it has already been demonstrated to be effective in multiple, peer-reviewed studies. As Street Smart has been previously tested with a control group, **organizations generally will not need to be concerned with conducting an outcome evaluation.** However, some organizations receiving outside funding--particularly those that have made more extensive adaptations to the curriculum-- may need to undertake outcome evaluation as a condition for continued receipt of funds. Such organizations should consult with an evaluation specialist or seek assistance from a CBA provider to analyze outcome results.

The following section includes evaluation questions and data collection forms to assist your organization in conducting intervention monitoring and evaluation. These forms can be modified to meet your agency's particular needs. It is important to ensure that any modifications to the instruments maintain the basic integrity of the original forms in order to fulfill reporting requirements of the funding agency. Your agency may have additional reporting requirements or you may have information needs within your organization that are not reflected in these materials (especially if you are receiving outside funds to conduct the intervention).

Instruments

5

Section 5

Participant Enrollment Form

Description: This form can be used to determine whether potential participants are eligible for Street Smart. It also gathers demographic information on your participants and provides a snapshot of their risk behavior at intake.

You are also welcome to use the questions/format on the following pages to create your own form if you have significantly tailored or modified the sessions to meet your target population's needs.

When to Use: This form should be completed when enrolling a client into Street Smart.

Completed by: The questions on this form should be read to the participant by a facilitator. The facilitator can record the client's answers directly on the form. DO NOT distribute it to Street Smart participants.

Instructions: Because Street Smart is designed for youth between the ages of 11 and 18, it is critical that you are familiar with local laws regarding soliciting information from minors.

Please instruct the facilitator to read the questionnaire instructions to the respondent and ask them to answer the questions as truthfully as possible. Be sure to ask the facilitator to remind the respondent to listen carefully to each question and the corresponding answer choices provided. It is important that the facilitator inform each prospective participant that all answers will remain confidential to the extent allowed by law.

Section 5

Participant Enrollment Form

Staff Name:		Staff ID:	
Today's Date:	(Month)	(Day)	(Year)
Start Time:		End Time:	
Client Name: (optional)		Client ID Code:	
Is client currently receiving services from this agency?	<input type="checkbox"/> Yes (please specify) <input type="checkbox"/> No		
Phone: (optional)	Home:		Cell/Mobile:
Email: (optional)			

1. How did you hear about this program?
- Agency (please specify: _____)
 - Billboard, flyer, brochure, newspaper, etc. (please specify: _____)
 - Your partner
 - A family member or friend
 - Other (please specify: _____)

2. In what year were you born? _____

3. In which state do you live? _____

4. Were you born as a male or a female?

- Male
- Female
- Refused to Answer
- Did Not Ask

5. How do you view yourself now (i.e., what is your current gender)?

- Male (Skip to 7)
- Female
- Transgender – Male to Female (Skip to 7)
- Transgender – Female to Male
- Don't Know
- Refused to Answer
- Did Not Ask

6. (If female) Are you pregnant?

- Yes (Ask 6a)
- No (Skip to 7)
- Don't Know (Skip to 7)
- Refused to Answer (Skip to 7)
- Did Not Ask (Skip to 7)

6a. (If pregnant) Are you receiving prenatal care?

- Yes
- No

7. What best describes your ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino
- Don't Know
- Refused to Answer
- Did Not Ask

8. What best describes your race? (check all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Don't Know
- Refused to Answer
- Did Not Ask

9. Do you speak English?

- Yes
- No
- Don't Know
- Refused to Answer
- Did Not Ask

10. What language do you speak most often?

- English
- Spanish
- Other (Specify: _____)
- Don't Know
- Refused to Answer
- Did Not Ask

11. How far did you go in school?

- No schooling completed
- 8th grade or less
- Some high school
- High school graduate, GED, or equivalent
- Some college
- Other (e.g., technical school, Associates Degree)
Please Specify _____
- Don't Know
- Refused to Answer
- Did Not Ask

12. In the past three months, where have you been living most of the time? (check all that apply)

- Shelter (temporary day or evening facility)
- Street/Outdoors (sidewalk, doorway, park, public or abandoned building)
- Institution (hospital, jail or prison)
- Foster home
- Home of parent(s)
- Home of caregiver (not parent(s))
- Apartment, room, or house s(he) rents or owns
- Other (please specify: _____)
- Don't Know
- Refused to Answer
- Did Not Ask

13. Are you currently working in a job for pay?

- Yes, full-time
- Yes, part-time
- No, unemployed
- No, other reason (please specify: _____)
- Don't Know
- Refused to Answer
- Did Not Ask

14. Are you currently a student?

- Yes, full-time
- Yes, part-time
- No
- Don't Know
- Refused to Answer
- Did Not Ask

15. In the past three months, have you been in jail or prison?

- Yes
- No
- Refused to Answer
- Did Not Ask

16. In the past three months, have you had sex for money?

- Yes (Ask 16 a)
- No (Skip to 17)
- Refused to Answer (Skip to 17)
- Did Not Ask (Skip to 17)

16a. Is this the main way you earned money?

- Yes
- No
- Don't Know
- Refused to Answer
- Did Not Ask

17. Have you ever had an HIV test?

- Yes (Ask 17a)
- No (Skip to 18)
- Don't Know (Skip to 18)
- Refused to Answer (Skip to 18)
- Did Not Ask (Skip to 18)

17a. (If tested) What is your HIV status?

- Positive (Ask 17b)
- Negative (Skip to 17d)
- Don't Know (Skip to 18)
- Refused to Answer (Skip to 18)
- Did Not Ask (Skip to 18)

17b. (If tested positive) What was the date of your first positive test for HIV?

____/____ (month/year)

- Don't Know (Ask 17c)
- Refused to Answer (Ask 17c)
- Did Not Ask (Ask 17c)

17c. (If tested positive) Are you currently receiving medical care or treatment for HIV?

- Yes (Skip to 18)
- No (Skip to 18)
- Did Not Ask (Skip to 18)
- Refused to Answer (Skip to 18)

17d. (If tested negative) When did you last test negative for HIV?

____/____ (month/year)

- Don't Know (Ask 18)
- Refused to Answer (Ask 18)
- Did Not Ask (Ask 18)

18. In the past three months, have you been diagnosed with an STD (not including HIV)?

- Yes (Ask 18a)
- No (Skip to 19)
- Don't Know (Skip to 19)
- Refused to Answer (Skip to 19)
- Did Not Ask (Skip to 19)

18a. (If diagnosed with STD) with which STD were you diagnosed?

- Syphilis
- Chlamydia
- Gonorrhea
- Other (please specify: _____)

19. Have you injected drugs in the past 3 months?

- Yes (Ask 19a)
- No (Skip to 20)
- Don't Know (Skip to 20)
- Refused to Answer (Skip to question 20)
- Did Not Ask (Skip to question 20)

19a. What substances did you inject? (check all that apply)

- Heroin alone
- Cocaine alone
- Heroin and Cocaine together
- Crack
- Amphetamines, speed, crystal, meth, ice
- Other narcotic drugs
- Hormones
- Steroids
- Silicone
- Botox
- Other medical substance

- Other (specify: _____)
- Don't Know
- Refused to Answer
- Did Not Ask

20. In the past three months, please indicate if you have engaged in the following behaviors:

	Yes	No	Don't Know	Refused to Answer	Did Not Ask
a) Vaginal or anal sex with male	<input type="checkbox"/>				
b) Vaginal or anal sex with female	<input type="checkbox"/>				
c) Vaginal or anal sex with transgender	<input type="checkbox"/>				
d) Oral sex with any partner	<input type="checkbox"/>				
e) Vaginal or anal sex in exchange for drugs or money	<input type="checkbox"/>				
f) Vaginal or anal sex while high	<input type="checkbox"/>				
g) Vaginal or anal sex with an injection drug user	<input type="checkbox"/>				
h) Vaginal or anal sex with someone who is HIV+	<input type="checkbox"/>				
i) Vaginal or anal sex with a person whose HIV status you did not know	<input type="checkbox"/>				
j) Vaginal or anal sex with a person who exchanges sex for drugs or money	<input type="checkbox"/>				
k) Vaginal or anal sex with someone you didn't know	<input type="checkbox"/>				
l) Vaginal or anal sex with someone you met via Internet	<input type="checkbox"/>				

****Note: If the client answered no to all the sex questions, skip to question 27.**

Instructions: I am now going to ask you a few more specific questions. Please answer truthfully as there is no right or wrong answer. If you do not know the answer to the question, please give your best guess. Now we are going to switch to things you have done just in the last 30 days.

21. How many sexual partners (total) have you had in the past 30 days? _____

None (Skip to 27)

22. Have you had vaginal or anal sex with a boy or man in the past 30 days?

Yes

No

Refused to Answer

Did Not Ask

23. Have you had vaginal or anal sex with a girl or woman in the past 30 days?

Yes

No

Refused to Answer

Did Not Ask

24. Have you had vaginal or anal sex with a transgendered person in the past 30 days?

Yes

No

Refused to Answer

Did Not Ask

25. How many times have you had vaginal or anal sex in the past 30 days? _____

Don't know

Refused to Answer

Did Not Ask

26. How many times have you had unprotected vaginal or anal sex (i.e., sex without a condom) in the past 30 days? _____ (if >0, ask 26a)

Don't know (Skip to 27)

Refused to Answer (Skip to 27)

Did Not Ask (Skip to 27)

26a. (If had unprotected sex) How many times were you intoxicated or high?

_____ (if >0, ask 26b)

Don't know (Skip to 27)

Refused to Answer (Skip to 27)

Did Not Ask (Skip to 27)

26b. (If had sex while high) What drug(s) were you using?

- Amphetamines, meth, speed, crystal, or crank
- Crack
- Cocaine
- Downers (including Valium, Ativan, Xanax)
- Pain Killers (including Oxycotin, Percocet)
- Hallucinogens (including LCD)
- Ecstasy
- GHB or ketamine
- Heroin
- Marijuana
- Poppers (amyl nitrite)
- Alcohol
- Other (specify: _____)
- Don't Know
- Refused to Answer
- Did Not Ask

27. Have you shared injection equipment in the past 30 days?

- Yes (Ask 27a)
- No (Skip to end)
- Don't Know (Skip to end)
- Refused to Answer (Skip to end)
- Did Not Ask (Skip to end)

27a. How many times did you share needles? _____

- Never (Skip to end)
- Don't know (Skip to end)
- Refused to Answer (Skip to end)
- Did Not Ask (Skip to end)

27b. How many times did you share needles with someone who was HIV positive?

- _____
- Never
 - Don't know
 - Refused to Answer
 - Did Not Ask

27c. How many times did you share needles with someone whose HIV status you

did not know? _____

Never

Don't know

Refused to Answer

Did Not Ask

Those are all of the questions that I have for you today.

Thank you for your participation!

Section 5

Participant Guidelines

When to Use: Intake

Administered by: Facilitator

Completed by: Participants

Instructions:

This is a sample of a form agencies may choose to use but is not a required part of the intervention. Agencies should ensure that the requirements are in accordance with local laws and agency-specific guidelines.

The facilitator should distribute two copies of the Street Smart Participant Guidelines to each participant at enrollment. The facilitator should read aloud, or ask the participant to read aloud, the form in its entirety. The facilitator should solicit and respond to any questions and ask if participants would like to add any additional ground rules that were not discussed or included on the form. Participants should then be instructed to sign and date both copies of the form if they agree with its contents and return one copy to the facilitator. Participants should be instructed to retain the second copy for their records and to refer to the ground rules throughout the duration of the Street Smart session. The facilitator shall serve as witness and sign on the appropriate line.

Section 5

Informed Consent & Ground Rules

Street Smart is a program for youth who are interested in reducing their risks for HIV/AIDS and STIs. You will have the opportunity to learn more about yourself, learn skills to take care of yourself and have fun while learning how to reduce your risks. It consists of 8 group sessions as well as an individual session and a trip to a community program. If you agree to participate in this program, here are the things you should know:

- Your participation is voluntary.
- Each group session will consist of 6 to 10 adolescents of both sexes.
- There are 10 sessions in total: 8 group sessions; 1 individual session; 1 trip to a community resource center.
- We meet 1-2 times per week for 90-120 minutes per session.
- You can choose not to answer any question at any time for any reason.
- To protect your privacy, your name and other identifying material will be treated in a confidential manner unless otherwise required by law.
- Your participation in these sessions poses few, if any, risks to you.
- You may choose to leave any group session at any time for any reason with no penalty or consequence. If you decide not to join this program or drop out later, it will not affect your participation in any other program here.

Ground Rules – Participant Guidelines

There are four guidelines that each of us must follow during this workshop:

1. Everything that is discussed in the 10 sessions is kept confidential! That means what is said must not be repeated to anyone who is not in this program, even if the person is a participant in other functions, groups, or workshops held by the agency.
2. Do not judge or criticize anything said by another participant, even if you disagree with him/her. Everyone can have his/her own opinion, feelings, and thoughts.
3. Say whatever you feel and think (as long as you don't put down another group member). Feel free to say whatever is on your mind because that is the only way we can help each other understand and use the information we share here. Remember – no one here will judge or criticize what you say.
4. Street Smart is not meant to be a place to work on romantic relationships. What goes on outside of this workshop is up to you, but please respect this important guideline while you participate in this workshop.

Contact Information: If you have questions about the program, please contact (FACILITATOR NAME) (FACILITATOR NUMBER)

Please sign below to indicate that you have read the above and agree to take part in this program/intervention.

Please print your name: _____

Please sign your name: _____

Witness Signature: _____

Date: _____

Section 5

Attendance Form

Description: This form is used to record which participants attend each session. Please record the identifier your agency chooses to use for each participant, be that their name or identification number.

When to use: This form should be used during each session.

Completed by: This form should be completed by the facilitators. **DONOT** distribute it to Street Smart participants.

Attendance Form

Today's Date: _____ Facilitator #1: _____

Group #: _____ Facilitator #2: _____

Session #: _____

Participant _____

Section 5

Pre- And Post-Test

Description: The pre- and post-test will help you assess the effectiveness of the StreetSmart intervention and make improvements as necessary. The completed tests are your personal evaluation tool. There is a separate pre-test and separate post-test. Please disseminate the correct test to the participants.

Please find an answer key and suggested scoring sheet after the post-test.

You are also welcome to use the questions/format on the following pages to create your own form if you have significantly tailored or modified the sessions to meet your target population's needs.

When to Use: The pre-test survey should be completed before the first session, preferably 5-10 minutes before Session 1.

The post-test survey should be completed after the last session.

Completed by: This form should be filled out by participants. Develop unique client identifiers that cannot be reconstructed to reveal a client's identity (Examples of identifiers that should NOT be used: date of birth, social security numbers, first or last name). Before collecting the forms from the participants make sure they have provided a unique identifier on the form. The same participant ID should be used for the post-tests.

Street Smart Pre-Test

Welcome to Street Smart. Before we get started, we would like to learn about how you feel and what you know. Please fill out this survey honestly and completely. You'll notice that we aren't asking you to put your name on this form; your answers are confidential. If you don't know an answer, that's okay—just check the “don't know” box.

First we'd like to know what you already know about HIV/AIDS and Sexually Transmitted Diseases. Please read each statement and check one box for your answer.

	True	False	Don't Know
1. There is a cure for HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. There are drugs that can treat HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. You can tell by looking at someone if they have HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Anyone who has unprotected sex can get HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Most people with HIV are homosexuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. HIV can be transmitted during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. You can get HIV from someone who doesn't feel sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. You can get HIV from kissing someone who is infected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Proper condom use reduces the risk of getting HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Pulling out early is just as good as condoms at protecting you from HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Lambskin condoms prevent HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. If you get a negative test result it means you definitely do not have HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Most people don't know they have Chlamydia unless they get an STD test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Untreated Gonorrhea can make you unable to have babies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Behaviors

Please look at each of the following sexual activities and think about how risky they are for getting HIV. Check the box for the level of HIV risk you think matches each activity.

	High Risk	Medium Risk	Low Risk	No Risk	Don't Know
15. Masturbating by myself	<input type="checkbox"/>				
16. Kissing	<input type="checkbox"/>				
17. Oral sex with a condom or dental dam	<input type="checkbox"/>				
18. Oral sex without a condom or dental dam	<input type="checkbox"/>				
19. Vaginal sex with a condom	<input type="checkbox"/>				
20. Vaginal sex without a condom	<input type="checkbox"/>				
21. Anal sex with a condom	<input type="checkbox"/>				
22. Anal sex without a condom	<input type="checkbox"/>				
23. Abstinence	<input type="checkbox"/>				
24. Fingering	<input type="checkbox"/>				
25. Back Rubs	<input type="checkbox"/>				

Attitudes

The next questions are about how you feel. Your choices range from “strongly agree” to “strongly disagree.” Please check the box for the answer that best reflects how you feel.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
26. Life without using drugs is boring	<input type="checkbox"/>				
27. The only way to deal with my feelings is to use drugs	<input type="checkbox"/>				
28. I can only have sex when I'm high	<input type="checkbox"/>				
29. If I get HIV, that's fate	<input type="checkbox"/>				
30. Wearing a condom takes all the fun out of sex	<input type="checkbox"/>				
31. If I use condoms, people will think I have an STD or HIV	<input type="checkbox"/>				

Confidence

Now we'd like to know how sure you feel that you can do certain things. Please read the statement below and check the box for the answer that best reflects how you feel. Your choices range from “strongly agree” to “strongly disagree.”

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
32. I can refuse to have sex with a partner who won't wear a condom	<input type="checkbox"/>				
33. I can properly put a male condom on myself or my partner	<input type="checkbox"/>				
34. I can properly put a female condom on myself or my partner	<input type="checkbox"/>				

Past Sexual Activity

How many sexual partners have you had in the last 30 days? _____ (write number)

Please read the following statements and check the box that corresponds to your answer. If you have never had sex, check the last box that says “I’ve never had sex.”

	Yes	No	Don't Know	I've Never Had Sex
36. The last time I had sex, I used a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. The last time I had sex, I was high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. The last time I had sex, my partner was someone I didn't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. In the last 3 months, I have been tested for STD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. In the last 3 months, I have been tested for HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Future Intentions

The last questions are about how you plan to act in the future. Your choices range from “strongly agree” to “strongly disagree”. Please check the box for the answer that best reflects how you feel.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
41. The next time I have sex, I plan to use a condom	<input type="checkbox"/>				
42. The next time I have sex, I plan to be sober	<input type="checkbox"/>				
43. The next time I have sex, I will know my partner	<input type="checkbox"/>				
44. I plan to get tested for HIV	<input type="checkbox"/>				
45. I plan to get tested for STDs	<input type="checkbox"/>				

Thank you for answering these questions!

Answer Key/Scoring

Knowledge

1. False
2. True
3. False
4. True
5. False
6. True
7. True
8. False
9. True
10. False
11. False
12. False
13. True
14. True

Provide one point for every correct answer. Answers of “don’t know” are considered incorrect. Add the points for this session to arrive at a Knowledge score out of 14.

Risk

15. No Risk
16. No Risk
17. Low Risk
18. Medium Risk
19. Medium Risk
20. High Risk
21. Medium Risk
22. High Risk
23. No Risk
24. Low Risk
25. No Risk

Provide one point for every correct answer. Answers of “don’t know” are considered incorrect. Add the points for this session to arrive at a Risk score out of 11.

Attitudes

For questions 26- 31, assign a point value to each answer using the following key:

Strongly Agree = 1

Agree = 2

Neutral = 3

Disagree = 4

Strongly Disagree = 5

Add up the points for questions 26-31 to arrive at an attitudes score out of 30.

Confidence

For questions 32-34, assign a point value to each answer using the following key:

Strongly Agree = 5

Agree = 4

Neutral = 3

Disagree = 2

Strongly Disagree = 1

Add up the points for questions 32-34 to arrive at an attitudes score out of 15.

Past Sexual Activity

Question 35 is a number and does not need to be scored.

For questions 36-40:

36. Yes

37. No

38. No

39. Yes

40. Yes

Provide one point for each of the optimal answers above. Answers of “don’t know” are considered undesirable and will be given no points. Add up all the points for questions 36-40 to arrive at a Past Sexual Activity Score out of 5. If the participant checked the “I’ve never had sex” box then do not assign them a Past Sexual Activity Score.

Future Intentions

For questions 41-45, assign a point value to each answer using the following key:

Strongly Agree = 5

Agree = 4

Neutral = 3

Disagree = 2

Strongly Disagree = 1

Add up the points for questions 41-45 to arrive at a Future Intentions score out of 25.

Analysis

When comparing pre- and post-tests, success is indicated by an increase in Knowledge Score, Risk Score, Attitudes Score, Confidence Score, Past Sexual Activity Score, and Future Intentions Score. For question 35, success is indicated by a decreased number of sexual partners. ***Do not add this number into any scores.***

Section 5

Fidelity Checklist

Description: This form asks for feedback from the facilitators on how they implemented each component or activity within the program. It can be used to assess whether Street Smart is being implemented as it was designed and to capture comments and suggestions concerning the program content, structure, and clarity of the materials. There is a separate portion for each session. This information should be reviewed with the facilitators' supervisor.

You are also welcome to use the questions/format on the following pages to create your own form if you have significantly tailored or modified the sessions to meet your target population's needs.

When to Use: This form should be completed promptly, ideally, immediately after a session. At the latest it should be done within 2 days of the session so that the experience is still fresh in the facilitators' minds.

Completed by: This form should be completed by the facilitators. DO NOT distribute it to Street Smart participants.

Instructions:

After each session, please complete the section of this form that matches the session number you just finished facilitating.

Provide as much feedback as possible. The more information you provide, the more helpful this evaluation tool will be in future implementations of the Street Smart program. Comments and suggestions concerning program content, structure, and clarity of the materials are particularly helpful and should be shared with your supervisor.

Session 1: Getting The Language Of Hiv And Other Stds

Today's Date: ___ ___ / ___ ___ / ___ ___ Group #: _____

Session 1 Details:	
Session Date: ___ ___ / ___ ___ / ___ ___	Facilitator #1:
Location:	Facilitator #2:
Time Started:	Time Ended:
Number of Participants Who Attended:	Incentive Provided:

Session 1 Exercises: <i>Check one box for each exercise</i>	
<p>Exercise 1: Introductions</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: What are the facts about HIV/AIDS and STDs</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: High-risk situations</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: Feeling situations</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>

<p>Exercise 5: You can never tell</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 6: Future dreams</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
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Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

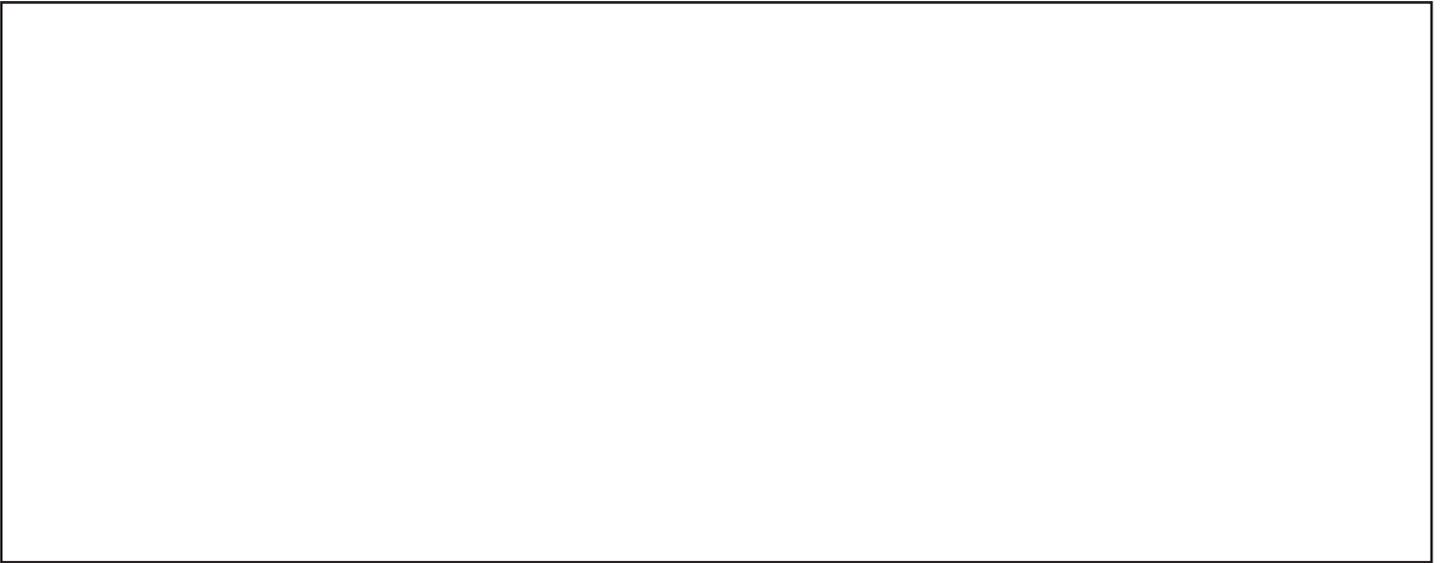
If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 1 Notes:

A large, empty rectangular box with a thin black border, intended for taking notes during the session.

Session 1: Assessing Personalized Risk

Today's Date: ____ / ____ / ____ Group #: _____

Session 2 Exercises: <i>Check one box for each exercise</i>	
<p>Exercise 1: Introductions</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: Exploring people's actions</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: How safe am I</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: What are my triggers</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 5: How to set your own limits</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 2 Notes:

Session 3: Learning How To Use Condoms

Today's Date: ___ ___ / ___ ___ / ___ ___ Group #: _____

Session 3 Details:	
Session Date: ___ ___ / ___ ___ / ___ ___	Facilitator #1:
Location:	Facilitator #2:
Time Started:	Time Ended:
Number of Participants Who Attended:	Incentive Provided:

Session 3 Exercises: <i>Check one box for each exercise</i>	
<p>Exercise 1: Introductions</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: Getting the feel of condoms</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: The steps in putting on male and female condoms</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: Practicing putting on male and female condoms</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 5: Selecting condoms</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 3 Notes:

Session 4: Learning About The Effects Of Drugs And Alcohol

Today's Date: ___ ___ / ___ ___ / ___ ___ Group #: _____

Session 4 Details:	
Session Date: ___ ___ / ___ ___ / ___ ___	Facilitator #1:
Location:	Facilitator #2:
Time Started:	Time Ended:
Number of Participants Who Attended:	Incentive Provided:

Session 4 Exercises: Check one box for each exercise	
<p>Exercise 1: Introductions</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: How do drugs and alcohol affect practicing safer sex</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: What do I believe about using drugs and alcohol</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: What are the pros and cons of substance use</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 5: How do drugs and alcohol affect me personally</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 6: How does substance use work</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 7: How to get back in control again</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 8: Dealing with risky situations</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 4 Notes:

Session 5: Recognizing And Coping With Feelings

Today's Date: ___ ___ / ___ ___ / ___ ___ Group #: _____

Session 5 Details:	
Session Date: ___ ___ / ___ ___ / ___ ___	Facilitator #1:
Location:	Facilitator #2:
Time Started:	Time Ended:
Number of Participants Who Attended:	Incentive Provided:

Session 5 Exercises: Check one box for each exercise	
<p>Exercise 1: Introductions</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: Feeling situations</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: Coping styles</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: How to solve a problem</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 5: How to use relaxations in tough situations</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 5 Notes:

Session 6: Negotiating Effectively

Today's Date: ____ / ____ / ____ Group #: _____

Session 6 Details:	
Session Date: ____ / ____ / ____	Facilitator #1:
Location:	Facilitator #2:
Time Started:	Time Ended:
Number of Participants Who Attended:	Incentive Provided:

Session 6 Exercises: <i>Check one box for each exercise</i>	
<p>Exercise 1: Introductions</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: What are my sexual values</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: What to do when the pressure is on</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: How to communicate with confidence</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 5: How safe is my partner</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 6 Notes:

Session 7: Doing Self Talk

Today's Date: ___ ___ / ___ ___ / ___ ___ Group #: _____

Session 7 Details:	
Session Date: ___ ___ / ___ ___ / ___ ___	Facilitator #1:
Location:	Facilitator #2:
Time Started:	Time Ended:
Number of Participants Who Attended:	Incentive Provided:

Session 7 Exercises: <i>Check one box for each exercise</i>	
<p>Exercise 1: Introductions</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: How to handle put downs</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: Switching from harmful to helpful thoughts</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: Giving myself some pats on the back</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 5: Using self talk in tough situations</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 7 Notes:

Session 8: Practicing Safer Sex

Today's Date: ___ ___ / ___ ___ / ___ ___ Group #: _____

Session 8 Details:	
Session Date: ___ ___ / ___ ___ / ___ ___	Facilitator #1:
Location:	Facilitator #2:
Time Started:	Time Ended:
Number of Participants Who Attended:	Incentive Provided:

Session 8 Exercises: <i>Check one box for each exercise</i>	
<p>Exercise 1: Introductions</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: How to handle difficult sexual situations</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: Dealing with rationalizations</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: Preparing for dealing with slips</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 5: Creating a media message</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 6: Ending the group</p> <p><input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise</p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 8 Notes:

Session 9: Individual Session

Today's Date: ____ / ____ / ____ Group #: _____

Session 9 Exercises: Check one box for each exercise

Step 1: Orienting the youth

- Facilitated as suggested
- Facilitated with changes
- Did not do exercise

What was changed and why? (or) What prevented you from doing the exercise?

Step 2: Creating motivation

- Facilitated as suggested
- Facilitated with changes
- Did not do exercise

What was changed and why? (or) What prevented you from doing the exercise?

Step 3: Identifying triggers

- Facilitated as suggested
- Facilitated with changes
- Did not do exercise

What was changed and why? (or) What prevented you from doing the exercise?

Step 4: Planning for success

- Facilitated as suggested
- Facilitated with changes
- Did not do exercise

What was changed and why? (or) What prevented you from doing the exercise?

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 9 Notes:

Session 10: Community Resource

Today's Date: ____ / ____ / ____ Group #: _____

Session 10 Exercises: Check one box for each exercise	
<p>Exercise 1: What should we look for at this community resource?</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 2: Introductions</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 3: What is the community resource like?</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 4: What are other local resources?</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 5: An informal meal (optional)</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	<p>Exercise 6: Follow-up</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>
<p>Exercise 7: How did you like the visit?</p> <p> <input type="checkbox"/> Facilitated as suggested <input type="checkbox"/> Facilitated with changes <input type="checkbox"/> Did not do exercise </p> <p><i>What was changed and why? (or) What prevented you from doing the exercise?</i></p>	

Were there any challenges or unusual circumstances with any of the exercises?

Yes No

If yes, please refer to the exercise by its number in your manual and explain your concerns.

Were there any challenges or unusual issues with any of the group members in this session?

Yes No

If yes, please refer to the group member by his/her initials and describe the problems or your concerns.

Did anything go on in the group that you felt you were not able to handle or did not handle well?

Yes No

If yes, please describe what happened.

Did anything unusual occur during the session (e.g., major interruptions like fire alarm, meeting space issues like disruptions from staff/other clients or other things apart from the session itself that were generally out of your control) that you think may have affected the session?

Yes No

If yes, please describe the occurrence and your concerns about how it may have affected the session.

Additional Session 10 Notes:

Section 5

Supervisor Rating Form

Description: This form can be used by a supervisor or senior facilitator when he/she is observing a Street Smart session. It asks them to assess whether the facilitators are following the curriculum in addition to their styles of delivery, level of facilitation skills, and their ability to appropriately and effectively use key facilitation tools and techniques. It should be used to provide written feedback to how well they are implementing Street Smart and in what areas they may need to improve.

You are welcome to use the questions/format on the following pages to create your own form if you have significantly tailored or modified the sessions to meet your target population's needs.

When to Use: This form can be completed *while observing a session* or viewing a videotaped session.

Completed by: This form should be completed by the facilitators' *supervisor* or a senior facilitator. DO NOT distribute it to Street Smart participants.

Supervisor Rating Form

Instructions:

Observation of Street Smart sessions is the process in which a supervisor or senior facilitator directly observes a session or reviews one by watching a videotape of a session.

While observing a session, complete one form for each facilitator. Rate each facilitator on the following competency areas by putting a check in the appropriate column. Afterwards, review the ratings with the facilitator to identify strengths and areas for improvement.

Facilitator: _____ Group #: _____

Supervisor: _____ Session #: _____

Session Date: ___ / ___ / ___ Review Date: ___ / ___ / ___

Method of Review: Attended session in person Recorded session on videotape

Competency Areas	(5) Excellent	(4) Good	(3) Adequate	(2) Needs Improvement	(1) Poor
EXAMPLE: Competency Area X	5	✓	3	2	1

Ability to meet the goals of the exercises

Effectively transitions into exercises	5	4	3	2	1
Maintains focus on topic	5	4	3	2	1
Demonstrates fidelity (follows manual)	5	4	3	2	1
Gives accurate information to participants	5	4	3	2	1
Exhibits familiarity and readiness with materials and exercises	5	4	3	2	1
Provides clear explanations and follow-up	5	4	3	2	1
Effectively sets and maintains pace of session	5	4	3	2	1
Follows guidelines	5	4	3	2	1

Facilitators style

Maintains appropriate behavior with participants	5	4	3	2	1
Validates and encourages youth participation	5	4	3	2	1
Shows interest and maintains patience	5	4	3	2	1

Competency Areas	(5) Excellent	(4) Good	(3) Adequate	(2) Needs Improvement	(1) Poor
Pays attention to participants and what they say	5	4	3	2	1
Responds appropriately to participants' needs	5	4	3	2	1
Demonstrates skill at probing reactions and comments	5	4	3	2	1
Demonstrates effective group management	5	4	3	2	1

Resourcefulness

Puts script into own words and uses examples that are relevant for the target population to connect session concepts.	5	4	3	2	1
Uses available visual aids, materials, techniques, and tools (e.g., Feeling Thermometer, SMART problem-solving) to further youth understanding.	5	4	3	2	1

Managing group behaviors/process

Modifies inappropriate behaviors	5	4	3	2	1
Uses tokens to shape behavior	5	4	3	2	1
Provides a safe environment	5	4	3	2	1
Encourages participation	5	4	3	2	1
Manages difficult issues that are raised (e.g., a participant reveals he/she has been abused or is HIV+)	5	4	3	2	1

Modeling behaviors

Uses positive reinforcement (tokens)	5	4	3	2	1
Gives appropriate feedback	5	4	3	2	1
Appropriate use of self as example	5	4	3	2	1
Is non-judgmental	5	4	3	2	1
Encourages group cohesiveness	5	4	3	2	1
Shows respect and keeps confidentiality	5	4	3	2	1

Relationship between facilitator and co-facilitator

Cooperative	5	4	3	2	1
Shares duties	5	4	3	2	1

Overall ratings

--	--	--	--	--	--

Competency Areas	(5) Excellent	(4) Good	(3) Adequate	(2) Needs Improvement	(1) Poor
Group atmosphere	5	4	3	2	1
Session Content	5	4	3	2	1

Section 5

Satisfaction Survey

Description: This survey is designed to assess a number of things including the effectiveness of the facilitators in presenting information, their ability to clearly answer questions, the effectiveness of group discussion, and areas that should be targeted for improvement. The information collected can be used to guide process improvements that will benefit future participants of Street Smart sessions.

You are also welcome to use the questions/format on the following pages to create your own form if you have significantly tailored or modified the sessions to meet your target population's needs.

When to Use: The survey should be completed *at the end of each session*.

Completed by: This form should be filled out by *participants*. Please be sure that participants are able to submit this form anonymously.

Section 5

Community Resource Center Event Log

Description: This form requests feedback from the facilitators on the activities taking place and the materials distributed during the visit to a community resource center.

You are welcome to use the questions/format on the following pages to create your own form if you have significantly tailored or modified the sessions to meet your target population's needs.

When to Use: This form should be completed *after the final session*.

Completed by: This form should be filled out by the *facilitator*. DO NOT distribute it to participants.

Community Resource Center Event Log

Instructions:

Please complete this form after the final session of Street Smart.

Staff Name:		Staff ID:	
Today's Date:	___ ___ / ___ ___ / ___ ___		
Start Time:		End Time:	
# of Participants:			

Name of Center:		Site ID:	
Name of Contact:		Phone number of contact:	
Street Address:			
City:		State:	
		Zip:	

I. ACTIVITIES

Please describe the activities that took place during this visit. Be as descriptive as possible using the space provided below.

II. MATERIALS DISTRIBUTION

Please describe any materials that were given to youth during the visit (e.g., informational brochures, food vouchers, male and female condoms, referrals to other resources, etc.).

III. YOUTH ENGAGEMENT

Please describe the group's level of engagement during the visit. Consider the following: How long did the visit last? Were most or all of the youth actively talking and asking questions during the visit? Did they have an overall positive experience? Would you take another group back to the same agency?

IV. ADDITIONAL NOTES (e.g., challenges, facilitating factors, other influencing events or issues, etc.)

Appendices



Appendix A

Glossary of Terms

Adaptation: Modification of the key characteristics of an intervention so as to deliver it to a different population, in a different venue, with a different message, or in a different manner than the one in which efficacy was originally demonstrated; altering the “who” or “where” of the intervention (e.g., Street Smart was originally tested in an urban setting, but has since been adapted to be used in a rural setting). While adaptation can ensure that the intervention is culturally-relevant to the target population, it must not change the program by diverging from the goals of the intervention or eliminating any Core Elements (see below).

Core Elements: Those parts of an intervention that must be present and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based and are thought to be responsible for the intervention’s effectiveness. Core elements are essential and cannot be ignored, added to, or changed.

Chlamydia: Any of several common, often asymptomatic, sexually transmitted diseases caused by the microorganism *Chlamydia trachomatis*.

Fidelity: The practice of staying within the parameters of the approved adaptation process; it is keeping the heart of the intervention unchanged so as to reproduce its effectiveness with another population or in a different setting.

Formative Evaluation: A series of activities undertaken to furnish information that will guide the Street Smart program adaptation and development process so as to be appropriate for youth from different populations in different settings than the original intervention.

Gonorrhea: A sexually transmitted infection caused by gonococcal bacteria that affects the mucous membrane chiefly of the genital and urinary tracts and is characterized by an acute purulent discharge and painful or difficult urination, though women often have no symptoms.

Key Characteristics: Crucial activities and delivery methods for conducting an intervention that may be adapted for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. Key Characteristics cannot be eliminated, but they can be adapted to different types of youth and agencies.

Reinvention: A modification of an intervention that changes (adds to, deletes, or alters) any part of an intervention's Core Elements. The CDC recommends that any program undergoing reinvention be renamed and be evaluated with an experimental design.

Self-efficacy: A person's belief in his or her ability to carry out and accomplish a specific task.

Sexually Transmitted Infection (STD): A condition caused by one of over 25 bacteria or viruses, usually spread by sexual intercourse but potentially through oral sex or other routes such as infected needles; the most common STIs include herpes, human papillomavirus (HPV), gonorrhea, syphilis, and Chlamydia.

Social Learning Theory: A theory describing an interpersonal process through which skills are acquired, strengthened and maintained. New skills are acquired when individuals see and model new behaviors, receive feedback on their own performance of the new behavior, and receive positive social- and self-reinforcement for exhibiting the new behavior. By practicing skills in a supportive social environment, individuals increase their motivation and self-efficacy in their ability to use these skills in a variety of contexts.

SMART Objectives: An objective that is Specific, Measureable, Achievable, Relevant, and Time-Bound.

Syphilis: A sexually transmitted disease caused by the spirochete *Treponema pallidum* that is characterized in its primary stage by genital sores. If untreated, skin ulcers develop in the next stage, secondary syphilis. As the disease progresses to potentially fatal tertiary syphilis, neurologic involvement with weakness and skeletal or cardiovascular damage can occur.

Target population: Any high-risk population in which there are established social networks, such as homeless or runaway youth, adolescent women of a particular ethnic or racial background, Native American reservation youth, etc.

Appendix B

Program Review Panel Guidelines For Content of AIDS-Related Written Materials



CONTENT OF AIDS-RELATED WRITTEN MATERIALS,
PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY
INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS
FOR DISEASE CONTROL AND PREVENTION (CDC)
ASSISTANCE PROGRAMS
(Interim Revisions June 1992)

Basic Principles

Controlling the spread of HIV infection and AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can fully protect themselves from acquiring the virus. These methods include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship with an uninfected partner. For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages can be controversial. These principles are intended to provide guidance for the development and use of educational materials, and to require the establishment of Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

- (a) Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.

Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of Section 2500 (b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

“SEC. 2500. USE OF FUNDS.

- (b) *CONTENTS OF PROGRAMS.* - All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities.
- (c) *LIMITATION.* - None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.
- (d) *CONSTRUCTION.* - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual’s risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene.”
- c. *Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.*
- d. *Messages provided to young people in schools and in other settings should be guided by the principles contained in “Guidelines for Effective School Health Education to Prevent the Spread of AIDS” (MMWR 1988;37 [suppl. no. S-2]).*

Program Review Panel

b. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

- (1) Understand how HIV is and is not transmitted; and
- (2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.

The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the recipient organization or local governmental jurisdiction.

Applicants for CDC assistance will be required to include in their applications the following:

- (1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in subsection (d) below. In addition:
 - (a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either

through representation on the panels or as consultants to the panels.

- (b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.
 - (c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.
 - (d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.
- (2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:
- (a) Concurrence with this guidance and assurance that its provisions will be observed;
 - (b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review Panel to fulfill this requirement. Such national/regional/State panels must include as a member an employee of a State or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1). Materials reviewed

by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization planning to use or distribute the materials. Such national/regional/State organization must adopt a national/regional/statewide standard when applying Basic Principles 1.a. and 1.b.

When a cooperative agreement/grant is awarded, the recipient will:

- (1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;
- (2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;
- (3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and
- (4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

http://www.cdc.gov/nchstp/od/content_guidelines/1992guidelines.htm

Appendix C

The ABCs of Smart Behavior



To avoid or reduce the risk for HIV

A stands for abstinence.

B stands for being faithful to a single sexual partner.

C stands for using condoms consistently and correctly.

Appendix D

Nonoxynol-9 Spermicide Contraception Use



Nonoxynol-9 Spermicide Contraception Use --- United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (1), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (2--4); one trial showed an increased risk (3). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (5,6), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%--18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%--5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9--lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9--containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

Reported by: The Alan Guttmacher Institute, New York, New York. Office of Population Affairs, U.S. Dept of Health and Human Services, Bethesda, Maryland. A Duerr, MD, C Beck-Sague, MD, Div Reproductive Health, National Center Chronic Disease and Public Health Promotion; Div of HIV and AIDS Prevention, National Center HIV/AIDS, STDs, and TB Prevention; B Carlton-Tohill, EIS Officer, CDC.

Editorial Note:

The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs (4,6, [HYPERLINK "http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm"](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm)7), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9--lubricated; this is consistent with trends in condom purchases among the general public (8). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in

protecting against the transmission of HIV infection and other STDs (HYPERLINK “<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm>”7). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9--lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms (HYPERLINK “<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm>”7).

Spermicidal gel is used in conjunction with diaphragms (1); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (1).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (9). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (1). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (2, HYPERLINK “<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm>”7). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

Region ^a	No. of women served	Male condoms		N-9 products [†]	
		No.	(%)	No.	(%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	4,315,040	527,248	(12)	92,997	(2)

^a Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Islands; Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Louisiana, New Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming; Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=Alaska, Idaho, Oregon, Washington.

[†] Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphragm), film, or suppositories.

TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1999

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods					
		Condoms with N-9	Condoms without N-9	Gel	Vaginal			Jelly	Foam
					Film	Insert			
Puerto Rico	15,103	148,072	5,000	12,900	0	NA [*]	12,841	2,400	
New York [†]	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830	
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900	
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920	
Tennessee	111,223	2,865,160 [‡]	717,088	0	94,500	12,528	756	2,758	
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200	
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0	
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007	

^{*} Not available.

[†] 41 of 61 grantees responded.

[‡] Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

Appendix E

CDC Statement on Study Results of Product Containing Nonoxynol-9

MMWR*Weekly*

Notice to Readers: CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9--14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (1). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, <http://www.cdc.gov/hiv>; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.

Appendix F

Condoms and STDs: Fact Sheet for Public Health Personnel



For more information:
CDC's National Prevention Information Network
(800) 458-5231 or www.cdcnpin.org
CDC National STD/HIV Hotline
(800) 227-8922 or (800) 342-2437
En Espanol (800) 344-7432
www.cdc.gov/std

Consistent and correct use of male latex condoms can reduce (though not eliminate) the risk of STD transmission. To achieve the maximum protective effect, condoms must be used both consistently and correctly. Inconsistent use can lead to STD acquisition because transmission can occur with a single act of intercourse with an infected partner. Similarly, if condoms are not used correctly, the protective effect may be diminished even when they are used consistently. The most reliable ways to avoid transmission of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are to abstain from sexual activity or to be in a long-term mutually monogamous relationship with an uninfected partner. However, many infected persons may be unaware of their infections because STDs are often asymptomatic or unrecognized.

This fact sheet presents evidence concerning the male latex condom and the prevention of STDs, including HIV, based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies assessing condom use and STD risk. This fact sheet updates previous CDC fact sheets on male condom effectiveness for STD prevention by incorporating additional evidence-based findings from published epidemiologic studies.

Sexually Transmitted Diseases, Including HIV Infection

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS. In addition, consistent and correct use of latex condoms reduces the risk of other sexually transmitted diseases (STDs), including diseases transmitted by genital secretions, and to a lesser degree, genital ulcer diseases. Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer.

There are two primary ways that STDs are transmitted. Some diseases, such as HIV infection, gonorrhea, chlamydia, and trichomoniasis, are transmitted when infected urethral or vaginal secretions contact mucosal surfaces (such as the male urethra, the vagina, or cervix). In contrast, genital ulcer diseases (such as genital herpes, syphilis, and chancroid) and human papillomavirus (HPV) infection are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical and empirical basis for protection. Condoms can be expected to provide different levels of protection for various STDs, depending on differences in how the diseases are transmitted. Condoms block transmission and acquisition of STDs by preventing contact between the condom wearer's penis and a sex partner's skin, mucosa, and genital secretions. A greater level of protection is provided for the diseases transmitted by genital secretions. A lesser degree of protection is provided for genital ulcer diseases or HPV because these infections also may be transmitted by exposure to areas (e.g., infected skin or mucosal surfaces) that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing risk of STD transmission among condom users with nonusers who are engaging in sexual intercourse. Accurately estimating the effectiveness of condoms for prevention of STDs, however, is methodologically challenging. Well-designed studies address key factors such as the extent to which condom use has been consistent and correct and whether infection identified is incident (i.e., new) or prevalent (i.e. pre-existing). Of particular importance, the study design should assure that the population being evaluated has documented exposure to the STD of interest during the period that condom use is being assessed. Although consistent and correct use of condoms is inherently difficult to measure, because such studies would involve observations of private behaviors, several published studies have demonstrated that failure to measure these factors properly tends

to result in underestimation of condom effectiveness.

Epidemiologic studies provide useful information regarding the magnitude of STD risk reduction associated with condom use. Extensive literature review confirms that the best epidemiologic studies of condom effectiveness address HIV infection. Numerous studies of discordant couples (where only one partner is infected) have shown consistent use of latex condoms to be highly effective for preventing sexually acquired HIV infection. Similarly, studies have shown that condom use reduces the risk of other STDs. However, the overall strength of the evidence regarding the effectiveness of condoms in reducing the risk of other STDs is not at the level of that for HIV, primarily because fewer methodologically sound and well-designed studies have been completed that address other STDs. Critical reviews of all studies, with both positive and negative findings (referenced here) point to the limitations in study design in some studies which result in underestimation of condom effectiveness; therefore, the true protective effect is likely to be greater than the effect observed.

Overall, the preponderance of available epidemiologic studies have found that when used consistently and correctly, condoms are highly effective in preventing the sexual transmission of HIV infection and reduce the risk of other STDs.

The following includes specific information for HIV infection, diseases transmitted by genital secretions, genital ulcer diseases, and HPV infection, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV, the virus that causes AIDS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS

HIV infection is, by far, the most deadly STD, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. The ability of latex condoms to prevent transmission of HIV has been scientifically established in “real-life” studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of HIV.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as urethral and vaginal secretions,

blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate that the consistent use of latex condoms provides a high degree of protection.

Other Diseases transmitted by genital secretions, including Gonorrhea, Chlamydia, and Trichomoniasis

Latex condoms, when used consistently and correctly, reduce the risk of transmission of STDs such as gonorrhea, chlamydia, and trichomoniasis.

STDs such as gonorrhea, chlamydia, and trichomoniasis are sexually transmitted by genital secretions, such as urethral or vaginal secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against diseases such as gonorrhea, chlamydia, and trichomoniasis by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of STDs such as chlamydia, gonorrhea and trichomoniasis.

Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Consistent and correct use of latex condoms reduces the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. Condom use may reduce the risk for HPV infection and HPV-associated diseases (e.g., genital warts and cervical cancer).

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through “skin-to-skin” contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/secretions. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are covered (protected by the condom) as well as those areas that are not.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms provide limited protection against syphilis and herpes simplex virus-2 transmission. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers associated with increased condom use in settings where chancroid is a leading cause of genital ulcers.

Condom use may reduce the risk for HPV-associated diseases (e.g., genital warts and cervical cancer) and may mitigate the other adverse consequences of infection with HPV; condom use has been associated with higher rates of regression of cervical intraepithelial neoplasia (CIN) and clearance of HPV infection in women, and with regression of HPV-associated penile lesions in men. A limited number of prospective studies have demonstrated a protective effect of condoms on the acquisition of genital HPV.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer, nor should it be a substitute for HPV vaccination among those eligible for the vaccine.

Department of Health and Human Services

For additional information on condom effectiveness, contact

CDC's National Prevention Information Network

(800) 458-5231 or www.cdcnpin.org

Appendix G

HIV Testing Fact Sheet

HOW CAN I GET TESTED?

You can get tested by your health care provider or by state or city health departments. Additionally, you can access testing through many community-based organizations (CBOs) that offer HIV prevention programs. There are two types of testing available: “Anonymous” and “Confidential.”

WHAT IS ANONYMOUS TESTING?

Anonymous testing means that your name is never used, and there are no records kept about your getting an HIV test. An anonymous test is best if you don't want anyone else but you to know you've gotten tested and what the results are.

WHAT IS CONFIDENTIAL TESTING?

Confidential testing requires that your name be obtained and a record of your HIV test results is maintained in your medical records. Certain people may have access to this information under certain circumstances. For anyone else to get this information, you have to give special permission.

HIV Antibody Testing Methods

Test	Advantage/Pros	Disadvantage/Cons
Traditional Blood Test	<ul style="list-style-type: none"> • A blood sample is drawn at one sitting and is used for the ELISA (screening) and Western Blot (confirmatory) HIV antibody tests • Accurate test 	<ul style="list-style-type: none"> • Needles are used to draw blood • Must return to test site to get results at a later date • May take up to two weeks to get the results
Rapid Test (for example, OraQuick or Unigold)	<ul style="list-style-type: none"> • Test results available within 15-60 minutes • Have option of using a needle stick (blood sample) or a swab (oral fluid sample) • Can be done at a clinic or non-clinical site • Accurate test, especially for negative test results 	<ul style="list-style-type: none"> • If the rapid test is positive, results must be confirmed with additional testing • Must return to the test site at a later date to get confirmatory results
OraSure: Oral Fluids Test	<ul style="list-style-type: none"> • No needles used • Can be done at a clinic or non-clinical site (ex: mobile van, outside of office) • Accurate test • One sample of oral fluids is used for screening and confirmatory testing 	<ul style="list-style-type: none"> • Not available at all locations • Must return to test site at a later date to get test results

WHAT HAPPENS WHEN I DECIDE TO GET TESTED?

When you decide to be tested, you will meet with an HIV Counselor or test provider who will talk with you about the test and answer basic questions you may have. Before being tested, you must sign an Informed Consent form. Getting an HIV test is voluntary and you cannot be tested against your will.

WHAT DO MY TEST RESULTS MEAN?

A NEGATIVE TEST RESULT MEANS ONE OF TWO THINGS:

Either the person is not infected, or

The person is in the window period and is infected, but has not developed enough antibodies for them to be detected by the test.

A POSITIVE TEST RESULT MEANS:

The person is infected with HIV, and
He or she can infect others.

AN INCONCLUSIVE TEST MEANS:

The test was unable to confirm whether or not the person was infected. If someone has an inconclusive result, he or she should retest.

HOW ACCURATE IS HIV TESTING?

Very accurate—the rate of true-positives with ELISA and Western Blot used together is about 99.9%.

WHAT IS THE “WINDOW PERIOD?”

The time between when a person is infected with HIV and when antibodies to HIV can be detected with the test is called the “window period.” The presence of HIV antibodies is used to determine if someone is infected. Most people will develop antibodies between 2 – 12 weeks after becoming infected, but some people may take as long as 6 months. During the window period someone may be infected and able to infect others, but test negative on an HIV antibody test.

WHAT ARE THE MINORS’ RIGHTS IN HIV TESTING?

Laws concerning consent and confidentiality for HIV care differ among states. Although public health statutes and legal precedents allow for evaluation and treatment of minors for STDs without parental knowledge or consent, not every state has defined HIV infection explicitly as a condition for which testing or treatment may proceed without parental consent. Therefore, you should seek out more specific information about the rights of minors in your state. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

Early diagnosis is critical so you can start effectively managing your health.

Appendix H

Resources

Capacity Building Assistance (CBA)

The CDC's Capacity Building Assistance program is designed to assist organizations in their ability to implement and sustain science-based and culturally-proficient HIV prevention behavioral interventions and HIV prevention strategies.

A CBA provider may be able to assist your organization in the development of logic models, evaluation tools, and other program needs to implement Street Smart effectively.

The following websites may be of assistance in determining whether CBA's contributions could aid your organization's implementation process and will guide you through the registration process for CBA:

www.cdc.gov/hiv/topics/cba/index.htm

www.cdc.gov/hiv/topics/cba/cba.htm

www.cdc.gov/hiv/topics/cba/cpp.htm

Logic Model Development Resources

The following websites may be helpful in providing assistance in the development of both theoretical and implementation logic models, regardless of whether or not your organization chooses to seek CBA.

www.cdc.gov/eval/resources.htm

www.insites.org/documents/logmod.pdf

(Everything You Wanted to Know About Logic Models But Were Afraid to Ask, by InSites and Professional Evaluation Services)

www.unitedwayatlanta.org/docs/ci/OM101.ppt

(United Way's Guide to Developing Logic Models)

Additional Resources

www.effectiveinterventions.org

(DEBI site)

www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15)

(cultural competence; preimplementation activities)

www.foundationcenter.org/

(information on philanthropic funding sources)

www.grants.gov

(information on government grants)

HIV and Adolescent Health Websites

The following websites provide information on HIV and adolescent health that may be of interest to you or your participants:

www.adolescentaids.org

www.advocatesforyouth.org

www.aids-ed.org

www.amfar.org

answer.rutgers.edu

www.thebody.com

www.cdc.gov/healthyyouth/yrbs/

www.cdc.gov/HealthyYouth/sexualbehaviors/index.htm

www.goaskalice.com

www.guttmacher.org

www.siecus.org

www.sexetc.org

www.youthresource.com

Appendix I

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Tools Used

The logic models and evaluation tools contained in this document were developed with the assistance of Macro International, Inc. See the resources listed below for additional information regarding the development of preparation, implementation, and maintenance materials.

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Macro International, Inc. (2007b). Evaluation capacity building manual (Developed for CDC under contract number 200-2006-18987). Manuscript in preparation. Atlanta, GA: Author.