Chapter 1:
PS18-1807 Program Guidance Introduction

Background

Behaviors and experiences during adolescence set the stage for health into adulthood.[1] In particular, health behaviors and experiences related to sexual behavior, high-risk substance use, violence victimization, and mental health and suicide contribute to substantial morbidity for adolescents, including risk for HIV, sexually transmitted diseases (STDs), and teen pregnancy.[1] In 2017, 39.5% of high school students in the United States had ever had sexual intercourse, and 28.7% were currently sexually active. Among currently sexually active students, 46.2% did not use a condom the last time they had sexual intercourse, and 13.8% did not use any method to prevent pregnancy the last time they had sexual intercourse.[2] While the proportion of high school students who are sexually active has declined over the past decade,[1] half of the 20 million new STDs reported each year are among young people between the ages of 15 and 24.[3] Young people aged 13–24 years account for 21% of new HIV diagnoses in the United States.[4]

One venue that offers valuable opportunities for improving adolescent health is school. Schools have direct contact with over 50 million students in kindergarten through 12th grade for at least 6 hours a day, and students generally attend school through 13 key years of their social, physical, and intellectual development.[5,6] In addition, many schools have staff with knowledge of critical health risk and protective behaviors and have pre-existing infrastructure that can support a varied set of helpful interventions. This makes schools well-positioned to help reduce adolescents' risk for HIV infection and other STDs through sexual health education (SHE), access to sexual health services (SHS), and safe and supportive environments (SSE). Addressing the broader school environment can promote protective factors, such as school and family connectedness, which reduce sexual risk as well as co-occurring risk behaviors and experiences, including high-risk substance use, violence, and suicide.

Accordingly, the Centers for Disease Control and Prevention (CDC) has funded Program PS18-1807 (Program 1807) to improve the health and well-being of our nation's youth by working with education and health agencies and other organizations to reduce HIV, STDs, teen pregnancy, and related risk behaviors among middle school and high school students.[7] This funding supports a multi-component, multi-level effort to support youth reaching adulthood in the healthiest way possible.

To support this work, CDC has developed this *PS18-1807 Program Guidance*, which is intended for use by funded local education agencies and organizations. This guidance is based on scientific literature and expert input about what is most likely to be effective in reducing risk for HIV infection and other STDs among adolescents. *PS18-1807 Program Guidance* is divided into 5 chapters: (1) this introduction; (2–4) 3 chapters outlining Component 2 recipient activities, highlighting connections across SHE, SHS, and SSE, and drawing attention to opportunities for engagement with Component 3 recipient activities; and (5) a chapter outlining key cross-cutting program actions.

Program 1807 Overview

Program 1807 offers an approach that includes three overall components: **Component 1**—School-Based Surveillance; **Component 2**—School-Based HIV/STD Prevention; and **Component 3**—Technical Assistance and Capacity Building.

Component 1 establishes and strengthens systematic procedures to collect Youth Risk Behavior Survey (YRBS) and School Health Profiles (Profiles) data. Recipients will report results to help support development of policies and practices to reduce priority health risk behaviors among youth. During the project period, recipients will systematically collect, analyze, and disseminate data using the YRBS to monitor adolescent health risk behaviors (in odd-numbered years) and Profiles to monitor school health policies and practices (in even-numbered years). Component 1 staff receive handbooks for conducting the YRBS and Profiles and technical assistance from CDC and CDC's survey technical assistance contractor.

This *PS18-1807 Program Guidance* focuses on Component 2. Component 2 includes 3 strategies: (2A) sexual health education (SHE), (2B) sexual health services (SHS), and (2C) safe and supportive environments (SSE). These strategies are mirrored in Components 3A, 3B, and 3C, respectively. Although the work of

Component 3A-C recipients is referenced in this document, additional guidance for Component 3A-C recipients is under development and will be provided through Program Consultants. Component 3D, which has not been funded, and Component 3E, which has been funded, will not be described in this program guidance. Guidance for Component 3E recipients is under development and will be made available through Program Consultants.

Each Component 2 strategy includes required activities intended to achieve short-term and intermediate outcomes over the five-year project period. Required activities are described in the following chapters. As appropriate, additional activities that may support progress toward outcomes are also described.

Short-term outcomes for Components 2 and 3A-C and their relationship to the strategies are described in the logic model included in the Program 1807 Notice of Funding Opportunity (NOFO). The short-term, intermediate (to be achieved by the end of the 5-year project period), and long-term outcomes are provided in Table 1.1.

Table 1.1 Short-term, Intermediate, and Long-term Outcomes for Components 2, 3A, 3B, and 3C

Component 2 Strategy and Component 3 Subcomponent	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
Strategy 2A (Sexual Health Education) & Component 3A	■ Teachers' ability to teach SHE effectively ■ Student receipt of effective SHE	■ Student knowledge, skills, and behaviors to avoid and reduce sexual risk behaviors ■ Student awareness of SHS needs and services ■ Student HIV testing ■ Student STD testing ■ Student reproductive healthcare visits ■ Access to confidential SHS in accordance with state laws ■ Parental monitoring ■ Parent/student communication about sexual health information and services ■ Student connectedness to school	■ Delayed onset of sexual activity ■ Decreased sex without a condom ■ Increased use of contraceptives ■ Decreased risk behaviors that place youth at higher risk of adverse health outcomes including substance use, violence, and mental illness ■ Reduced HIV infection and other STDs ■ Decreased teen pregnancy rates ■ Increased student academic success
Strategy 2B (Sexual Health Services) & Component 3B	■ Access to on-site and off-site SHS ■ Delivery of on-site SHS ■ Referrals for SHS to community providers		
Strategy 2C (Safe and Supportive Environments) & Component 3C	■ Teacher implementation of best classroom management practices for SSE ■ Student participation in positive youth development activities		

Component 2 Structure and Basic Expectations

Component 2 is structured so that recipients (either local education agencies [LEA] or LEA consortia) will use a multi-level approach to implementation across the three strategies of SHE, SHS, and SSE. Activities in each strategy align with three overarching domains, or types, of work. These domains, the multi-level implementation approach, and other key expectations are described in the section below.

Strategies and Overarching Domains

As previously described, Components 2 and 3A-C address three key strategies: SHE, SHS, SSE. Across these strategies, required and additional activities share a common framework. Specifically, each strategy includes activities within three overarching domains: strengthen staff capacity, increase student access to programs and services, and engage parent and community partners.

Strengthen staff capacity focuses on professional development and other activities for teachers and other school staff. Activities in this domain prepare staff to implement SHE, increase student access to health services, and create and maintain SSE for students.

Increase student access to programs and services focuses on implementation of student-level programs, providing these programs directly to students or using such programs to directly link students to necessary services.

Engage parent and community partners focuses on working with key stakeholders—parents and community partners, in particular—to help schools implement the activities in the other domains. This domain also focuses on helping schools provide education and support for parents to implement practices (e.g., parental monitoring, encouraging time alone with health care providers) that can help prevent HIV and other STDs among youth. For the purpose of this program, "parents" is defined as the primary adult caregiver(s) of an adolescent's basic needs. This includes biological parents; other biological relatives such as grandparents, aunts, uncles, or siblings; and non-biological parents such as adoptive, foster, or stepparents.

In the chapters that follow for each Component 2 strategy, you will find guidance about required and additional activities organized by these three domains. Organizing activities according to this common framework may help recipients implement activities more efficiently.

District-level Activities and Diffusion of School-level Activities

Component 2 recipients will implement activities that take place at either the district level (the LEA level) or school level. Appendix A shows which required activities will be implemented primarily at the district or school level. School-level activities will be differentiated by scope of implementation, being implemented in either a subset of schools or all schools. This creates three categories to consider in implementation: district-level activities, activities in priority schools, and activities in all middle and high schools. Together, the three categories represent the interconnected roles of school districts and schools and the value of implementing new strategies in a subset of priority schools before expanding implementation to as many middle and high schools as possible in the district. This is intended to facilitate a manageable initial workload for Component 2 recipients while working toward the goal of expanding program reach throughout the district. This approach is referred to as diffusion.

District-level activities are activities that need to be implemented by the LEA to establish the environment for successful implementation of required activities in middle and high schools throughout the district. These are activities that involve district-level decision makers to establish policies and practices.

Activities in priority schools are required activities that are initially implemented within a subset of schools before expanding to as many middle and high schools as possible in the district. Schools selected as priority schools provide an opportunity to try new programs and strategies, learning what works well and what should be improved, prior to implementation in a larger set of schools. Each Program 1807

recipient must select at least 10 priority schools (reaching a minimum total of 10,000 secondary school students) in which to implement required activities before diffusing those activities to as many middle and high schools in the district as possible.

Activities in all secondary schools are required activities that are ready for diffusion to all middle and high schools in the district after they have been refined and successfully implemented in priority schools. Diffusion may happen over time.

Some variation in diffusion activities across recipients is expected. For example, LEA previously funded by CDC should be ready for diffusion of at least some activities early in the five-year project period. Newly funded recipients may need more time to test and establish program activities in priority schools before diffusion to more schools or district-wide. In addition, LEA consortia may have additional considerations in planning their diffusion approach, given that multiple school districts will be included in their work, and some activities may also be diffused from a subset of districts to all districts over time. Teams of CDC staff with expertise spanning the breadth of Program 1807, also known as TA teams, will work with recipients to determine optimal diffusion approaches throughout the project period, taking each recipient's unique context into consideration.

Other Key Expectations

Each recipient is required to establish and maintain infrastructure that is responsive to Program 1807 requirements and designed to maximize outcomes. This includes allocating at least 1.0 full-time equivalent (FTE) staff to the program. Because recipient contexts vary, this FTE may be allocated across up to 3 staff, by effort, or among the 3 strategy areas of Component 2.

Recipients are expected to work closely with their Program Consultant and other technical assistance providers, including their CDC TA team, in formulating and implementing work plans, professional development plans, evaluation plans, and other important programmatic activities. This work will begin early in the project period, including at an orientation event, and will continue throughout the project period. Evolution in plans throughout funding is to be anticipated, and modifications to workplans will be made collaboratively with CDC staff to maximize program outcomes.

Recipients funded as a consortium will experience opportunities and challenges unique to their structures. Program Consultants and the CDC TA Team will work with consortium recipients to consider their context when developing work plans, evaluation plans, budgets, and program implementation strategies.

Each recipient is required to establish and maintain surveillance and evaluation capabilities throughout the project period. Data collection and analysis should directly influence program plans and activities. Surveillance and evaluation plans will be developed in coordination with CDC. Further information about surveillance and evaluation expectations may be found in the Program 1807 NOFO, the cross-cutting chapter of this program guidance document (Chapter 5), and CDC evaluation resources.

Throughout Program 1807, recipients will submit success stories documenting effective approaches and their outcomes as they achieve significant accomplishments or milestones. TA teams will work collaboratively with recipients to identify and promote these successes.

Component 2 recipients will work closely and collaboratively with recipients of Component 3A-C funding and with CDC's professional development and evaluation contractors. Program Consultants will work with each recipient to foster these collaborations. In addition, recipients are expected to maintain and, when needed, enhance relationships described during the application process. These relationships are outlined in the Memorandum of Understanding with the local health department and Letter of Commitment with internal LEA offices.

Component 3A-C Structure and Basic Expectations

Component 3 is designed to provide intensive technical assistance and capacity-building support for Program 1807. Recipients of Components 3A-C will provide direct support to LEA and LEA consortia funded under Component 2 related to SHE, SHS, and SSE, respectively.

Special Considerations for Component 3A-C Recipients

Each Component 3A-C recipient will provide technical assistance and capacity-building support in accordance with the strategy for which they are funded. Component 3A-C recipients are expected to provide capacity-building support related to all required activities for their respective strategy. Chapters 2-4 address the scientific foundation and implementation of each strategy and highlight opportunities for Component 3A-C recipients to support Component 2 activities. Recipients should refer to this information often as they consider specific approaches to LEA assistance. Additional program guidance for Component 3A-C recipients is under development and will be shared through Program Consultants.

In subcomponents where more than one recipient is funded, CDC expects those recipients to work closely together. Program Consultants will work with these recipients to ensure that work plans are well coordinated and that efforts are complementary. Although each recipient has requirements they must meet independently, CDC views these recipients as a team that is charged to maximize program outcomes together.

One important aspect of Component 3A-C funding is a tiered LEA assistance plan. While each recipient will work with all LEA funded for Component 2, the level of assistance will vary according to identified LEA needs. Component 3A-C recipients will stratify Component 2 recipient needs into 3 tiers, including those in need of general technical assistance, specialized capacity building, and intensive program implementation support. CDC will work collaboratively with Component 3A-C recipients to refine and implement those plans.

Other Key Expectations

Component 3A-C recipients will work closely with their Program Consultants and other CDC staff in formulating and implementing work plans, professional development plans, evaluation plans, and other important programmatic activities. This work will begin early in the project period, including at an orientation event, and will continue throughout the project period. Evolution in plans is likely throughout funding, and modifications will be made collaboratively with CDC staff to maximize program outcomes.

Similar to Component 2 recipients, Component 3A-C recipients will use data to inform their work. Each Component 3A-C recipient will collect information from each LEA recipient on their implementation of program activities relevant to the specific strategy for which they provide assistance. This information will form the basis of an annual inventory of recipient activities. Each Component 3A-C recipient will also implement an annual assessment of the capacity of all LEA recipients, including barriers, facilitators, and opportunities related to implementing required activities and training and technical assistance needs of the LEA and their priority schools. Component 3A-C recipients will use this information in the creation and implementation of their capacity-building plans. Additional information on these activities, including the distinctions between annual assessments and the annual program inventory described in the NOFO, will be provided in additional guidance for Component 3A-C recipients by Program Consultants.

Additional requirements of Component 3A-C recipients include resource identification, synthesis, and dissemination; connecting funded LEA to professional development, training, and technical assistance; and success story collection and dissemination. Like other activities, CDC will work collaboratively with recipients of Components 3A-C on planning and implementation.

Finally, recipients of Component 3A-C funding are expected to work collaboratively with each other and with CDC's professional development and evaluation contractors. CDC will work with each recipient to foster these collaborations.

Important Theoretical Frameworks & Models

A couple of theoretical frameworks and models may be useful to recipients of Components 2 and 3 in conceptualizing and implementing their work. In particular, both an ecological model and the Whole School, Whole Community, Whole Child (WSCC) model may prove useful in framing and conducting Program 1807 activities.

An ecological model is a conceptual framework to understand the factors that influence adolescent health, including sexual risk for HIV, other STDs, and pregnancy. The model describes characteristics of individuals, such as physical, cognitive, emotional, and behavioral characteristics, as well as the nested levels or environments that influence adolescents' behaviors and outcomes, such as relationships with families, peers, and sexual or romantic partners; community contexts; and larger societal contexts such as the policy environment.[8–10] The ecological model highlights the interactions between a young person's characteristics and their environment as well as an understanding of how the many factors included in the model can change over time.[8–10] The required activities of Program 1807 are designed to address the various nested levels of the ecological model.

The WSCC model outlines a coordinated framework for program implementation and parent/community engagement in schools.[11] This model brings many of the pieces of an ecological model into schools, emphasizing the many ways schools and communities can influence adolescent health.

How to Use the Program Guidance

The following chapters use a common format to provide guidance on implementing Component 2 Program 1807 activities for SHE, SHS, and SSE, respectively. Each of these chapters begins with an overarching rationale for the strategy and then provides descriptions of required and additional activities. These are organized by domain, and include key considerations for implementation and relevant resources. Resources with a potential cost associated are denoted with a "$" at the end of the resource description. Chapters 2, 3, and 4 also provide suggestions for ways Component 3 recipients can help support the activities of Component 2 recipients, allowing all recipients to consider opportunities for working together.

Chapter 5 outlines general program actions that apply to multiple aspects of Program 1807 work. These cross-cutting actions are policy implementation, collaboration, professional development, evaluation, and an emphasis on addressing health disparities—including, but not limited to, disparities among lesbian, gay, bisexual, and transgender (LGBT) youth. As with the other chapters, we provide relevant resources for many of the cross-cutting actions.

Throughout all chapters, recurring concepts and ideas are designated to highlight connections both within and across chapters. Please refer to Table 1.2 for a legend of key icons (on next page).

Finally, *PS18-1807 Program Guidance* ends with a glossary (Appendix B) and other appendices that provide information to supplement the chapters' text.

Program 1807 recipients will work with TA teams to implement this guidance. The scientific foundation it provides is critical to program success. Throughout the project period, CDC will develop tools to assist with implementing this guidance. Work plans, professional development plans, evaluation plans, Component 3A-C technical assistance and capacity-building plans, and other Program 1807 activities should be closely tied to the information presented in this document.

Table 1.2. Key Icons in *PS18-1807 Program Guidance*

Icon	Concept Represented
	**Strategy 2A: Sexual health education (SHE)**
	**Strategy 2B: Sexual health services (SHS)**
	**Strategy 2C: Safe and supportive environments (SSE)**
	**Domain: Strengthen staff capacity**
	**Domain: Increase student access to programs and services**
	**Domain: Engage parents and community partners**
	**Opportunities for efficiency**

Chapter 1 References

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