

Exemplary Sexual Health Education (ESHE)

Rationale:

Just as schools are critical to preparing students academically and socially, they are also vital partners in helping young people take responsibility for their health and adopt health-enhancing attitudes and behaviors that can last a lifetime. Health education is integral to the primary mission of schools, and provides young people with the knowledge and skills they need to become successful learners and healthy and productive adults. Increasing the number of schools that provide health education on key health problems, such as HIV, other STD, and pregnancy, is a critical objective for improving our nation's health.^{1,2}

Thirty-three states currently mandate HIV education; of those, 20 mandate additional sexual education (e.g., programs that describe sexual development, provide skills to establish healthy relationships and prevent behaviors that increase the risk of HIV, other STD, and unintended pregnancy).³ Regardless of the emphasis in content, sexual health education programs should be medically accurate; consistent with scientific evidence; tailored to students' contexts and the needs and educational practices of communities; and should use effective classroom instructional methods. Sexual health education should allow students to develop and demonstrate developmentally appropriate sexual risk avoidance and reduction-related knowledge, attitudes, skills, and practices.

Independent reviews of the scientific evidence show that well-designed and well-implemented HIV/STD prevention programs are effective in decreasing sexual risk behaviors among youth.^{4,5}

Specific outcomes include:

- Delaying first sexual intercourse⁶⁻⁹
- Reducing the number of sex partners⁹⁻¹²
- Decreasing the number of times students have unprotected sex¹³⁻¹⁵
- Increasing condom use^{14,16,17}

Notably, the HIV prevention programs were not shown to hasten initiation of sexual intercourse among adolescents, even when those curricula encouraged sexually active young people to use condoms.^{18,19}

In addition, effective HIV/STD prevention programs can be cost-effective. An economic analysis of one school-based sexual risk reduction program found that for every dollar invested in the program, \$2.65 was saved in medical costs and lost productivity.²⁰ Other studies have found similar savings for HIV prevention programs focusing on youth who are at disproportionate risk for HIV, including young gay and bisexual men^{21,22} and urban African American male adolescents.²³

Definitions:

1. Evidence-Based Interventions (EBI): A program that has been (i) proven effective on the basis of rigorous scientific research and evaluation and (ii) identified through a systematic independent review. This funding opportunity announcement (FOA) is specifically interested in those EBIs that show effectiveness in changing behavior associated with the risk factors for HIV/

STD infection and/or unintended pregnancy among youth; these behaviors may include delaying sexual activity, reducing the frequency of sex, reducing the number of sexual partners, and/or increasing condom or contraceptive use.

2. Evidence-Informed Programs (EI): “A program that is informed by scientific research and effective practice. Such a program replicates evidence-based programs or substantially incorporates elements of effective programs. The program shows some evidence of effectiveness, although it has not undergone enough rigorous evaluation to be proven effective”.²⁴
3. Exemplary²⁵ Sexual Health Education (ESHE): A systematic, evidence-informed approach to sexual health education that includes the use of grade-specific, evidence-based interventions, but also emphasizes sequential learning across elementary, middle, and high school grade levels. ESHE provides adolescents the essential knowledge and critical skills needed to avoid HIV, other STD, and unintended pregnancy. ESHE is delivered by well-qualified and trained teachers, uses strategies that are relevant and engaging, and consists of elements that are medically accurate, developmentally and culturally appropriate, and consistent with the scientific research on effective sexual health education. For more information: www.cdc.gov/healthyouth/sher/characteristics/index.htm and [www.cdc.gov/healthyouth/hecat/pdf/HECAT Module SH.pdf](http://www.cdc.gov/healthyouth/hecat/pdf/HECAT_Module_SH.pdf).

Resources:

- Characteristics of an effective health education curriculum
<http://www.cdc.gov/healthyouth/sher/characteristics/index.htm>
- Analysis of health education curriculum
<http://www.cdc.gov/healthyouth/HECAT/>
- Federal registries of evidence-based programs for youth
<http://www.cdc.gov/healthyouth/AdolescentHealth/registries.htm>
- Selecting and implementing evidence-based sexual health education programs
<http://www.cdc.gov/TeenPregnancy/PDF/LittlePSBA-GTO.pdf>
http://www.nrepp.samhsa.gov/Courses/Implementations/NREPP_0101_0010.html
- Adapting sexual health education curriculum
<http://www.acf.hhs.gov/sites/default/files/fysb/prep-making-adaptations-ts.pdf>

References:

1. The White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States. Washington, DC: White House; 2010. Available at <http://aids.gov/federal-resources/national-hiv-aids-strategy/nhas.pdf>.
2. U.S. Department of Health and Human Services. *Healthy People 2020*. U.S. Department of Health and Human Services Web site. Available at <http://www.healthypeople.gov/2020/default.aspx>.

3. Guttmacher Institute. State Policies in Brief: Sex and HIV Education (As of January 1, 2013). Guttmacher Institute Web site. Available at http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf.
4. Mathematica Policy Research and Child Trends. *Identifying Programs That Impact Teen Pregnancy, Sexually Transmitted Infections, and Associated Sexual Risk Behaviors: Review Protocol 2.0*. U.S. Department of Health and Human Services/Adolescent School Health Web site. Available at <http://www.hhs.gov/ash/oah/oah-initiatives/tpp/eb-programs-review-v2.pdf>.
5. Chin HB, Sipe TA, Elder R, Mercer SL, Chattopadhyay SK, Jacob V, et al. The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: two systematic reviews for the Guide to Community Preventive Services. *American Journal of Preventive Medicine* 2012;42(3):272–294.
6. Tortolero S, Markham C, Peskin M, Shegog R, Addy R, Escobar-Chavez L, et al. It's your game: keep it real: delaying sexual behavior with an effective middle school program. *Journal of Adolescent Health* 2010;46(2):169–179.
7. Coyle K, Kirby D, Marín B, Gómez C, Gregorich S. Draw the line/respect the line: a randomized trial of a middle school intervention to reduce sexual risk behaviors. *American Journal of Public Health* 2004;94(5):843–851.
8. Sikkema K, Anderson E, Kelly J, Winett R, Gore-Felton C, Roffman R, et al. Outcomes of a randomized, controlled community-level HIV prevention intervention for adolescents in low-income housing developments. *AIDS* 2005;19(14):1509–1516.
9. Jemmott J, Jemmott L, Fong G. Efficacy of a theory-based abstinence-only intervention over 24 months: a randomized controlled trial with young adolescents. *Archives of Pediatrics & Adolescent Medicine* 2010;164(2):152–159.
10. Villarruel A, Jemmott J, Jemmott L. A randomized controlled trial testing an HIV prevention intervention for Latino youth. *Archives of Pediatrics & Adolescent Medicine* 2006;160(8):772–777.
11. Koniak-Griffin D, Lesser J, Nyamathi A, Uman G, Stein J, Cumberland W. Project CHARM: an HIV prevention program for adolescent mothers. *Family & Community Health* 2003;26(2):94–107.
12. Shrier L, Ancheta R, Goodman E, Chiou V, Lyden M, Emans J. Randomized controlled trial of a safer sex intervention for high-risk adolescent girls. *Archives of Pediatrics & Adolescent Medicine* 2001;155:73–79.
13. Markham CM, Tortolero SR, Peskin MF, Shegog R, Thiel M, Baumler ER, et al. Sexual risk avoidance and sexual risk reduction interventions for middle school youth: a randomized controlled trial. *Journal of Adolescent Health* 2012; 50(3):279–288.
14. Coyle K, Kirby D, Robin L, Banspach S, Baumler E, Glassman J. All4You! A randomized trial of an HIV, other STDs, and pregnancy prevention intervention for alternative school students. *AIDS Education and Prevention* 2006;18(3):187–203.
15. Jemmott J, Jemmott L, Braverman P, Fong G. HIV/STD risk reduction interventions for African American and Latino adolescent girls at an adolescent medicine clinic: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine* 2005;159:440–449.
16. DiClemente R, Wingood G, Rose E, Sales E, Lang D, Caliendo A, et al. Efficacy of sexually transmitted disease/human immunodeficiency virus sexual risk-reduction intervention for African American adolescent females seeking sexual health services: a randomized controlled trial. *Archives of Pediatric & Adolescent Medicine* 2009;163(12):1112–1121.
17. DiClemente R, Wingood G, Harrington K, Lang D, Davies S, Hook E III, et al. Efficacy of an HIV prevention intervention for African American adolescent girls: a randomized controlled trial. *Journal of the American Medical Association* 2004;292:171–179.
18. Kirby D. *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen Pregnancy;2007.
19. Kirby D. The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior. *Sexuality Research & Social Policy* 2008;5(3):18–27.
20. Wang L, Davis M, Robin L, Collins J, Coyle K. Economic evaluation of Safer Choices: a school-based HIV/STD and pregnancy prevention program. *Archives of Pediatrics & Adolescent Medicine* 2000;154(10):1017–1024.
21. Tao G, Remafedi G. Economic evaluation of an HIV prevention intervention for gay and bisexual male adolescents. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 1998;83–90.
22. Kahn J, Kegeles S, Hays R, Beltzer N. Cost-effectiveness of the Mpowerment project, a community-level intervention for young gay men. *Journal of Acquired Immune Deficiency Syndrome* 2001;27(5):482–491.
23. Pinkerton S, Holtgrave D, Jemmott J. Economic evaluation of HIV risk reduction intervention in African-American male adolescents. *Journal of Acquired Immune Deficiency Syndrome* 2000;25(2):164–172.

24. Djamba YK, Davidson TC, Aga MG. Sexual Health of Young People in the U.S. South: Challenges and Opportunities. Montgomery, Alabama: Center for Demographic Research. March 2012. Available at http://www.demographics.aum.edu/uploadedfile/CDR_SexualHealth_6-1.pdf.
25. CDC. Indicators for School Health Programs. HIV Prevention: State Education Agencies. 2011. Available at http://www.cdc.gov/healthyouth/evaluation/indicators/pdf/questionnaires/quest_hivsea_2012.pdf.

Key Sexual Health Services (SHS)

Rationale:

In 2010, young people aged 13–24 accounted for 26% of all new HIV infections in the United States,¹ and nearly half of the 19 million new sexually transmitted diseases (STD) reported each year are among young people ages 15–24.² Roughly 25% of women aged 14–19 have had a human papillomavirus (HPV) infection, the most common STD, which is linked to negative health outcomes including genital warts and cervical, vaginal, vulvar, anal, penile, and oral cancers.³ Many adolescents engage in sexual risk behaviors that can result in such unintended health outcomes. For example, among U.S. high school students surveyed in 2011, almost half reported ever having had sex. Of those sexually active in the previous 3 months, about a third did not use a condom.⁴

Preventive services provided by medical providers can have a significant impact on reducing risk behavior and the testing and treatment of infections to help stop the spread of STD and HIV. Several official and national guidelines for adolescent preventive care specifically include recommendations for the provision of sexual and reproductive health services for adolescents to attend to these health problems and to provide preventive services^{5–8} including HIV testing beginning at age 13 in areas more affected by HIV; gonorrhea and Chlamydia screening of sexually active females ages 25 and younger, and Human Papilloma Virus vaccination beginning at ages 11–12. Guidelines for HIV and STD testing emphasize adolescents because of the increased burden among this age group and the importance of establishing a pattern of routine testing early in life.^{9–11} CDC guidelines recommend routine vaccination of young adolescents^{12–13} against HPV, largely because first infection is often acquired shortly following sexual initiation¹⁴ and because people have better immune response to HPV vaccine at younger ages.¹⁵

Schools in the United States have a critical role to play in facilitating delivery of such needed preventive services for adolescents; schools have direct daily contact with more than 30 million adolescent students¹⁶ and are an appropriate venue for HIV, STD, and teen pregnancy prevention programs.¹⁷ Many U.S. schools already have healthcare service infrastructure in place and can play an important role in providing adolescents access to sexual health services. A recent census report indicated that 73,697 registered nurses work in schools,¹⁸ and approximately 2,000 school-based health centers (SBHCs) serve at least one grade of adolescents (sixth grade or higher).¹⁹ There is evidence that such resources have some impact on increasing adolescent use of sexual health services. For instance, adolescents in a school with a school-linked clinic and on-campus counselors had a lower pregnancy rate than students in a comparison school.¹⁷ There is also some evidence that a school-based referral program helped school nurses connect students to adolescent-friendly community providers and increased adolescent use of reproductive health services (contraception, STD testing, counseling), especially among sexually active females.²⁰

These resources, however, may be constrained by budgets, local policies on service provision, limited staff, and other issues. A 2008 survey of school nurses found that less than half of schools have a full-time registered nurse on staff, and most nurses serve multiple schools. In addition, students with exceptional medical needs—whose numbers have been increasing—take up a major proportion of nurses’ time. The average number of total students served per nurse is 1,151.²¹ SBHCs are somewhat limited in number and geographic location, and not all are permitted to provide on-site testing and treatment for STDs (68%) or HIV testing (64%); about one third (60%) are prohibited from providing contraceptive services.¹⁹

One way to help schools meet the physical health needs of students within these constraints is to strengthen schools’ ability to provide services or to connect students to community resources. For these reasons, one of DASH’s key programmatic strategies is to improve schools’ capacity to increase adolescents’ access to key preventive sexual health services via either direct provision of on-site services or referrals to adolescent-friendly community-based health service providers.

Definitions:

1. **Key Sexual Health Services (SHS)**: For the purpose of this FOA, key SHS include anticipatory guidance for prevention, including delaying the onset of sexual activity; promoting HIV and STD testing, counseling, and treatment, and the dual use of condoms and highly effective contraceptives among sexually active adolescents; HIV and STD testing, counseling, and referral; pregnancy testing; and HPV vaccinations.
2. **Linkage**: For the purpose of this FOA, linkage describes an organizational partnership, whether formal or informal, between schools and adolescent-friendly providers to improve student access to preventive health services.
3. **Referral**: For the purpose of this FOA, the term “referral” is used to describe a process of assisting students in obtaining preventive health services through a variety of activities, including, but not limited to, connecting students to adolescent-friendly providers on the basis of an identified need.
4. **School-Based Health Centers (SBHC)**: According to 42 USCS § 1397jj [Title 42. The Public Health and Welfare; Chapter 7. Social Security Act; Title XXI. State Children’s Health Insurance Program], school-based health center means “a health clinic that -- (i) is located in or near a school facility of a school district or board or of an Indian tribe or tribal organization; (ii) is organized through school, community, and health provider relationships; (iii) is administered by a sponsoring facility; (iv) provides through health professionals primary health services to children in accordance with State and local law, including laws relating to licensure and certification; and (v) satisfies such other requirements as a State may establish for the operation of such a clinic.”
5. **School-Linked Health Centers (SLHC)**: Youth-focused health care programs (e.g., clinics, health service providers) commonly characterized by the following attributes: are located off school grounds; often serve more than one school; have established methods of referral,

communication, and follow-up with SBHC partners; often have extended hours beyond the school day; and often provide a broader scope of services than those available through SBHC.²²

6. Sexually Transmitted Disease (STD): A disease transmitted by sexual contact, such as syphilis, gonorrhea, chlamydia, viral hepatitis, genital herpes, and trichomoniasis. Individuals who are infected with STD are at least two to five times as likely as uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact.²³
7. Youth-Friendly Services: “Services with policies and attributes that attract young people to them, create a comfortable and appropriate setting, and meet young people’s needs”.²⁴ Youth-friendly services ensure confidentiality, respectful treatment, and delivery of culturally appropriate care in an integrated fashion at no charge or low cost; and are easy for youth to access.

Resources:

- Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>
- CDC Vital Signs: HIV Among Youth in the US
<http://www.cdc.gov/vitalsigns/HIVAmongYouth/>
- Fact Sheet on HIV Testing Among Adolescents: What Schools and Education Agencies Can Do
http://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/hivtesting_adolescents.pdf
- STD Treatment Guidelines, 2010, Special Populations (includes screening of adolescents)
<http://www.cdc.gov/std/treatment/2010/specialpops.htm>
- How to Obtain Medicaid Funding for School-Based Services: A Guide for Schools in Systems of Care Communities
<http://www.tapartnership.org/docs/obtainingMedicaidFunding.pdf>
- CMS Medicaid School-based Administrative Claiming Guide
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/2003_SBS_Admin_Claiming_Guide.pdf

References:

1. CDC. Vital Signs: HIV infection, testing, and risk behaviors among youth – United States. *MMWR* 2012;61(47):971–976. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6147a5.htm?s_cid=mm6147a5_w.
2. Weinstock H, Berman S, Cates W Jr. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspectives on Sexual and Reproductive Health* 2004;36(1):6–10.
3. Dunne EF, Unger ER, Sternberg M, McQuillan G, Swan DC, Patel SS, et al. Prevalence of HPV infection among females in the United States. *Journal of the American Medical Association* 2007;297(8):813–819.
4. CDC. Youth risk behavior surveillance—United States, 2011. *MMWR* 2012;61(SS-4). Available at <http://www.cdc.gov/MMWR/PDF/SS/SS6104.PDF>

5. U.S. Public Health Service. *Clinician's Handbook of Preventive Services: Put Prevention into Practice*. 2nd edition. Alexandria, VA: International Medical Publishing; 1998.
6. Elster AB, Kuznets NJ, editors. *AMA Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale*. Baltimore: Williams & Wilkins; 1994.
7. Green M, Palfrey JS, editors. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*. 2nd edition. Arlington, VA: National Center for Education in Maternal and Child Health; 2000.
8. U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*. 2nd edition. Alexandria, VA: International Medical Publishing; 1996.
9. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR* 2006;55(RR-14). Available at <http://www.cdc.gov/mmwr/pdf/rr/rr5514.pdf>
10. *Screening for Gonorrhea*, Topic Page. October 2011. U.S. Preventive Services Task Force. Available at <http://www.uspreventiveservicestaskforce.org/uspstf/uspstf/gono.htm>.
11. *Screening for Chlamydial Infection*, Topic Page. June 2007. U.S. Preventive Services Task Force. Available at <http://www.uspreventiveservicestaskforce.org/uspstf/uspstf/schl.htm>.
12. CDC. FDA licensure of bivalent human papillomavirus vaccine (HPV2, Cervarix) for use in females and updated HPV vaccination recommendations from the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2010;59(20):626–629. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a4.htm>.
13. CDC. Recommendations on the use of quadrivalent human papillomavirus vaccine in males — Advisory Committee on Immunization Practices (ACIP). *MMWR* 2011;60(50):1705–1708. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6050a3.htm>
14. Winer RL, Feng Q, Hughes JP, O'Reilly S, Kiviat NB, Koutsky LA. Risk of female human papillomavirus acquisition associated with first male sex partner. *Journal of Infectious Diseases* 2008;197:279–282.
15. Block S, Nolan T, Sattler C, Barr E, Giacchetti KED, Colin DM, et al. Comparison of the immunogenicity and reactogenicity of a prophylactic quadrivalent human papillomavirus (types 6, 11, 16, and 18) L1 virus-like particle vaccine in male and female adolescents and young adult women. *Pediatrics* 2006; 118(5):2135–2145.
16. United States Census Bureau. *School Enrollment*. U.S. Department of Commerce, Census Bureau Web site. Available at <http://www.census.gov/hhes/school/>.
17. Zabin LS, Hirsch MB, Smith EA, Streett R, Hardy JB. Evaluation of a pregnancy prevention program for urban teenagers. *Family Planning Perspectives* 1986;18(3):119–126.
18. U.S. Department of Health and Human Services, Health Resources and Services Administration (2010). *The Registered Nurse Population Initial Findings from the 2008 National Sample Survey of Registered Nurses*. Available at <http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyinitial2008.pdf>.
19. National Assembly on School-Based Health Care. *School-Based Health Centers: National Census School Year 2007-2008*. National Assembly on School-Based Health Care Web site. Available at <http://ww2.nasbhc.org/NASBHCCensusReport07-08.pdf>.
20. Dittus P, Loosier P, DeRosa C, Ethier K, Jeffries R, Afifi A, et al. The Project Connect health systems intervention: sexual and reproductive health outcomes for sexually active youth (Paper presented at the March 2011 Society for Adolescent Health and Medicine Annual Meeting, Seattle, WA.)
21. National Association of School Nurses. *School Nursing in the United States: Quantitative Study*. National Association of School Nurses Web site. Available at http://www.nasn.org/portals/0/2007_Burkhardt_Report.pdf.
22. Fothergill K, Orlick B. *The School-Linked Health Center: A Promising Model of Community-Based Care for Adolescents*. 1997. Advocates for Youth. Available at http://www.advocatesforyouth.org/index.php?option=com_content&task=view&id=543&Itemid=177.
23. CDC. *The role of STD detection and treatment in HIV prevention - CDC Fact Sheet*. 2007. Available at <http://www.cdc.gov/std/hiv/STDFact-STD-HIV.htm>.
24. PATHS: *Providing Access to HIV Testing Through Schools: A Resource Guide for Schools*. ETR Associates. Scotts Valley, CA. 2011 Available at <http://recapp.etr.org/recapp/documents/programs/PATHS.pdf>.

Safe and Supportive Environments for All Students and Staff (SSE)

Rationale:

Adolescents spend a large proportion of their day in school or involved in school-related activities. Although the main purpose of school is to help students develop academically, the school environment influences students' social, emotional, and ethical development as well as their physical and mental health and safety. For students at heightened risk of HIV/STD, such as young men who have sex with men (YMSM), the school environment is an especially important factor in keeping them healthy and engaged. The school environment is shaped by district and school policies and practices; school structure and decision-making processes; and classroom factors, such as teachers' classroom management methods, curricular tasks, and peer-peer/teacher-student relationships.¹

Promoting and providing a learning environment in which all students and staff can expect to feel safe and supported is an essential function of schools.² Research shows that safe and supportive school environments are associated with improved education and health outcomes, including sexual health outcomes, for all students³, and are especially important for those students at disproportionate risk of HIV/STD, such as YMSM, who often experience increased victimization^{5,6}. Several approaches to promoting a safe and supportive school environment include a) enhancing safety by preventing bullying and sexual harassment; b) promoting school connectedness; and c) promoting parent engagement.

Research on prevention of school-based bullying and harassment has identified promising practices such as implementing and enforcing a school-wide anti-bullying and harassment policy; improving the supervision of students; and using school rules and behavior management techniques in the classroom as ways to keep students safe.⁷ Research shows that supportive schools foster positive attitudes, prosocial attitudes and behaviors, and positive health behaviors and outcomes by promoting parent engagement in schools and students' sense of connectedness during the school day.⁸⁻¹⁰

School connectedness and parent engagement in schools have been identified as promising protective factors for adolescent sexual and reproductive health risk behaviors and outcomes, including ever had sex, early sexual debut, frequency of sex, and pregnancy/birth.^{4,9,10} In addition, when students find their school environment to be supportive and caring and their parents engaged in their school lives, they are less likely to become involved in substance abuse, violence, and other problem behaviors^{3,10,11} that are associated with HIV and STD risk.^{12,13}

Definitions:

1. **School Environment:** The overall school climate (including educational, cultural, social, professional, and physical circumstances or conditions; staffing attributes; and school-community programs) that can affect student and staff safety and health.¹⁴
2. **School Safety:** Refers to the security of the school setting and school-related activities as perceived and experienced by all stakeholders, including families, caregivers, students, school staff, and the community. School safety encompasses both emotional and physical safety, and

is influenced by positive and negative behaviors of students and staff as well as the presence of substance use in the school setting and during school-related activities.¹⁵

3. School Engagement: A process of events and opportunities that lead to students gaining the skills and confidence to cope and feel safe in the school environment. These events and opportunities include relationships, respect for diversity, and school participation.¹⁶
4. Bullying: “Attack or intimidation with the intention to cause fear, distress, or harm; a real or perceived imbalance of power between the bully and the victim; and repeated attacks or intimidation between the same children over time. Bullying can include aggression that is physical (hitting, tripping), verbal (name calling, teasing), or psychological/social (spreading rumors, leaving out of group).”¹⁷
5. Electronic aggression: “Bullying that occurs through e-mail, a chat room, instant messaging, a Web site, text messaging, or videos or pictures posted on websites or sent through cell phones.”¹⁸
6. Harassment: Threatening, harmful, or humiliating conduct based on race, color, national origin, sex, religion, or disability. Harassment may result in a hostile environment that interferes or limits a student’s ability to participate in or benefit from the services, activities, or opportunities offered by a school. Harassment, unlike bullying, does not have to include intent by the perpetrator to harm, be directed at a specific person, or involve repeated incidents.¹⁹
7. Sexual harassment: “Unwanted and unwelcome advances of a sexual nature. It could be a touch, written note, joke, picture, etc. It can be intentional or unintentional.”²⁰
8. School connectedness: “The belief held by students that adults and peers in the school care about their learning as well as about them as individuals.”²¹
9. Parent engagement in schools: “Parents and school staff working together to support and improve the learning, development, and health of children and adolescents.”²²
10. Prosocial behaviors: Positive actions that benefit others, prompted by empathy, moral values, and a sense of personal responsibility rather than a desire for personal gain.²³
11. Mentoring: “Matches youth or “mentees” with responsible, caring “mentors,” usually adults... Components of a mentoring relationship include creating caring, empathetic, consistent, and long-lasting relationships, often with some combination of role modeling, teaching, and advising.”²⁴
12. Service learning: “Strategy that integrates meaningful community service with instruction and self-reflection to support academic learning, teach civic responsibility, and strengthen communities.”²⁵

Resources:*Safety*

- Understanding Bullying
<http://www.cdc.gov/ViolencePrevention/pdf/BullyingFactsheet2012-a.pdf>
- Electronic Media and Youth Violence: A CDC Issue Brief for Educators and Caregivers
<http://www.cdc.gov/violenceprevention/pdf/EA-brief-a.pdf>
- Technology and Youth: Protecting your Child from Electronic Aggression
<http://www.cdc.gov/violenceprevention/pdf/EA-TipSheet-a.pdf>
- Protecting Students from Harassment and Hate Crime
<http://www2.ed.gov/offices/OCR/archives/Harassment/harassment.pdf>
- Sexual Harassment: It's Not Academic
<http://www2.ed.gov/about/offices/list/ocr/docs/ocrshpam.pdf>

School Connectedness

- School Connectedness: Strategies for Increasing Protective Factors Among Youth
<http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/connectedness.pdf>
- Fostering School Connectedness Staff Development Program
http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/connectedness_facilitator_guide.pdf

Parent Engagement

- Parent Engagement: Strategies for Involving Parents in School Health
http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/parent_engagement_strategies.pdf
- Facilitator's Guide for Staff Development on Promoting Parent Engagement in School Health
http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/parentengagement_facilitator_guide.pdf

References:

1. Roeser RW, Urdan TC, Stephens JM. School as a context of student motivation and achievement. In: Wentzel K, Wigfield A, editors. *Handbook of Motivation at School*. New York: Routledge; 2009:381–410.
2. U.S. Department of Education. Safe Supportive Learning. U.S. Department of Education Web site. Available at <http://safesupportiveschools.ed.gov/index.php?id=01>.
3. Hawkins JD, Catalano RF, Kosterman R, Abbott R, Hill KG. Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatrics & Adolescent Medicine* 1999;153:226–234.
4. Markham CM, Lormand D, Gloppen KM, Peskin MF, Flores B, Low B, et al. Connectedness as a predictor of sexual and reproductive health outcomes for youth. *Journal of Adolescent Health* 2010;46(3 Suppl):S23–41.
5. CDC. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9–12—youth risk behavior surveillance, selected sites, United States, 2001–2009. *MMWR Early Release* 2011;60[June 6]:1–133. Available at <http://www.cdc.gov/mmwr/pdf/ss/ss60e0606.pdf>.
6. Espelage DL, Aragon SR, Birkett M, Koenig BW. Homophobic teasing, psychological outcomes, and sexual orientation among high school students: what influence do parents and schools have? *School Psychology Review* 2008;37(2):202–216.
7. Farrington DP, Ttofi MM. School-based programs to reduce bullying and victimization. Systematic review for The Campbell Collaboration Crime and Justice Group; 2010. National Criminal Justice Reference Service Web site. Available at www.ncjrs.gov/pdffiles1/nij/grants/229377.pdf.

8. Epstein JL. *School, Family, and Community Partnerships: Preparing Educators and Improving Schools Second Edition*. Boulder, CO: Westview Press; 2011.
9. Guilamo-Ramos V, Jaccard J, Dittus P, Bouris A, Gonzalez B, Casillas E, et al. A comparative study of interventions for delaying the initiation of sexual intercourse among Latino and Black Youth. *Perspectives on Sexual and Reproductive Health* 2011;43(4):247–254.
10. Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, et al. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association* 1997;278(10):823–832.
11. Battistich V, Hom A. The relationship between students' sense of their school as a community and their involvement in problem behaviors. *American Journal of Public Health* 1997;87:1997–2001.
12. Van Tieu H, Koblin BA. HIV, alcohol, and noninjection drug use. *Current Opinion in HIV/AIDS* 2009;4(4):314–318.
13. Maman S, Campbell J, Sweat MD, Gielen AC. The intersections of HIV and violence: directions for future research and interventions. *Social Science and Medicine* 2000;50(4):459–478.
14. U.S. Department of Education. School Environment. U.S. Department of Education Web site. Available at <http://safesupportivelearning.ed.gov/index.php?id=36>, and Roeser RW, Urda TC, Stephens JM. School as a context of student motivation and achievement. In: Wentzel KR, Wigfield A, editors. *Handbook of Motivation at School*. New York: Routledge; 2009:381–410.
15. U. S. Department of Education. School Safety. U.S. Department of Education Web site. Available at <http://safesupportivelearning.ed.gov/index.php?id=37>
16. U. S. Department of Education. School Engagement. U.S. Department of Education Web site. Available at <http://safesupportivelearning.ed.gov/index.php?id=34>.
17. Farrington DP, Ttofi MM. School-based programs to reduce bullying and victimization. Systematic review for The Campbell Collaboration Crime and Justice Group; 2010. Available at www.ncjrs.gov/pdffiles1/nij/grants/229377.pdf.
18. David-Ferdon C, Hertz MF. Electronic Media and Youth Violence: A CDC Issue Brief for Researchers. Atlanta (GA): Centers for Disease Control; 2009. Available at <http://www.cdc.gov/ViolencePrevention/pub/EA-brief.html>.
19. U.S. Department of Education. Dear Colleague Letter: Harassment and Bullying. U.S. Department of Education Web site. Available at <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.pdf>.
20. CDC. Sexual Harassment. CDC Office of Diversity Management and Equal Employment Opportunity (ODMEE) Web site. Available at <http://www.cdc.gov/diversity/faqs/discrimination.htm>
21. CDC. *School Connectedness: Strategies for Increasing Protective Factors Among Youth*. Atlanta, GA: U.S. Department of Health and Human Services; 2009. Available at <http://www.cdc.gov/healthyyouth/adolescenthealth/connectedness.htm>
22. CDC. Parent Engagement: Strategies for Involving Parents in School Health. Atlanta, GA: U.S. Department of Health and Human Services; 2012. Available at http://www.cdc.gov/healthyyouth/adolescenthealth/parent_engagement.htm
23. Gavin LE, Catalano RF, Markham, CM. Positive youth development as a strategy to promote adolescent sexual and reproductive health. 2010. *Journal of Adolescent Health*, 46(3 Supplement): S1–S6.
24. Find Youth Info. Mentoring. Find Youth Info Web site. Available at <http://www.findyouthinfo.gov/youth-topics/mentoring>, and DuBois DL, Doolittle F, Yates BT, Silverthorn N, Tebes JK. Research methodology and youth mentoring. 2006. *Journal of Community Psychology*, 34(6): 657-676.
25. Find Youth Info. Service Learning. Find Youth Info Web site. Available at <http://www.findyouthinfo.gov/youth-topics/service-learning>.

Youth at Disproportionate Risk (YDR)

Rationale:

Young people who share certain demographic characteristics are disproportionately affected by HIV infection and other STD. Black and Latino young men who have sex with men (YMSM), homeless youth, and youth enrolled in alternative schools are affected at particularly high rates.

Regardless of income level, black and Latino adolescents are disproportionately affected by HIV infection and other STD and have higher rates of pregnancy than white adolescents. Although blacks comprised only 15% of all adolescents aged 13–19 in the United States in 2010, they accounted for 69% of all diagnoses of HIV infection among adolescents. Also in 2010, more Hispanic/Latino adolescents were diagnosed with HIV infection than white adolescents even though there are nearly three times as many white adolescents as Hispanic/Latino adolescents living in the United States.¹

Among adolescent males aged 13–19 years, approximately 91% of diagnosed HIV infections in 2010 were among YMSM.² Youth who identify as lesbian, gay, bisexual, or transgender (LGBT) are more likely than their heterosexual peers to engage in sexual risk-taking behaviors, including earlier age at first sexual intercourse, more lifetime and recent sex partners, and drinking alcohol or using other drugs prior to last sexual intercourse; and are less likely to use a condom during intercourse.^{3,4} Additionally, LGBT students are frequently bullied and harassed and are more likely than heterosexual students to experience a higher prevalence of dating violence and forced sexual intercourse.⁵ As a result, LGBT youth are more likely to have suicidal thoughts or attempts, personal safety issues, and lower academic achievement than their heterosexual peers.^{3,6}

Homeless youth are a vulnerable population with high rates of sexual risk-taking behaviors, substance use, and mental health problems. It is estimated that 1.5 to 2 million youths per year are homeless or have run away from home.⁷ Homeless youth are highly likely to experience early sexual debut, have multiple sex partners, engage in unprotected sexual intercourse, and use alcohol or other drugs prior to sex, resulting in a high risk of acquiring HIV.^{8,9} Although there are no national data available on HIV among homeless youth, community studies have demonstrated a higher seroprevalence among homeless youth than among the general US youth population¹⁰ Some homeless youth may be at additional risk because of a history of childhood sexual abuse and a lack of connectedness to trusted adults and family.⁹

Students in alternative school settings are more likely than students in mainstream schools to engage in sexual risk-taking behaviors. Students in alternative high schools are nearly twice as likely to report ever having sexual intercourse, compared with students in mainstream high schools, and are three times as likely to report having four or more sexual partners during their lifetime.^{11, 12} Among students who are sexually active, alternative school students are less likely to have used a condom during sexual intercourse and are nearly twice as likely to use alcohol or drugs prior to sexual intercourse compared to mainstream high school students.¹³ This pattern of sexual behavior contributes to a greater risk for HIV infection, other STD, and unplanned pregnancy.

Given the disproportionate risk faced by these subpopulations of youth, DASH has asked sites to develop or strengthen efforts for addressing the needs of LGBT youth, homeless youth, or youth in alternative school settings in one of the FOA strategy areas. Sites should choose specific evidence-informed practices on the basis of their particular needs, but might include strategies such as identifying LGBT-friendly health providers; developing guidance to link homeless students to necessary health and social services; and implementing evidence-based interventions that have been designed for use in alternative school settings, such as All4You!

Definitions:

1. Youth at Disproportionate Risk (YDR): Youth at disproportionate risk are defined as youth aged 10–19 that are most likely to be infected with HIV or other STD or become pregnant as a result of social environments where youth are exposed to multiple risk factors and have limited exposure to protective factors, including:
 - youth in communities and/or families already at higher risk as a result of poverty, HIV/AIDS, drug abuse, mental illness, stigma, discrimination, violence, and lack of access to services (e.g., rural areas);
 - youth who live outside of the protective influences of supportive family or school environments (e.g., youth on the street, homeless and runaway youth, youth in foster care, incarcerated youth, youth in gangs, youth subjected to abuse or neglect); and
 - youth who represent the current or emerging face of the HIV epidemic in the United States (e.g., YMSM and youth living in the South).¹⁴

For the purpose of this FOA, YDR for HIV infection and other STD will focus primarily on lesbian, gay, bisexual, and transgender youth, with an emphasis on young men who have sex with men; homeless youth; and youth enrolled in alternative schools.

2. Alternative Schools: An educational or instructional facility established for “students who are at risk for failing or dropping out of regular high school, or who have been removed from their regular high school because of drug use, violence, or other illegal activity or behavioral problems.”¹⁵
3. Homeless Children and Youth: Per Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act (Title X, Part C, of the No Child Left Behind Act), “homeless children and youth mean (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and (B) includes—(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965)

who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).”

4. LGBT Youth: Lesbian, Gay, Bisexual, Transgender

- **Lesbian:** Females who identify as being emotionally, romantically, or sexually attracted primarily to other females.¹⁶
- **Gay:** Males who identify as being emotionally, romantically, or sexually attracted primarily to other males.¹⁶
- **Bisexual:** A person who identifies as being emotionally, romantically, or sexually attracted to both males and females.¹⁶
- **Transgender:** “Individuals whose gender, identity, expression, or behavior is not traditionally associated with their birth sex. Some transgender individuals experience gender identity as incongruent with their anatomical sex and may seek some degree of sex reassignment surgery, take hormones, or undergo other cosmetic procedures. Others may pursue gender expression (masculine or feminine) through external presentation and behavior.”¹⁷ Transgender people may identify as female-to-male (FTM) or male-to-female (MTF).

5. Young men who have sex with men (YMSM): adolescent or young adult males who have engaged in sexual activity with partners of the same sex. For the purpose of this FOA, activities designed to meet the HIV/STD prevention needs of 13–19 year-old YMSM also will aim to meet those needs for teenage males who have not engaged in sexual activity with partners of the same sex but are attracted to others of the same sex; or who identify as gay or bisexual or have another non-heterosexual identity.

Resources:

LGBTQ Youth

- The US Department of Health and Human Services Bullying and LGBT Youth Web page <http://www.stopbullying.gov/at-risk/groups/lgbt/index.html#creating>

Homeless Youth

- The US Department of Health and Human Services Administration for Children and Families Runaway & Homeless Youth Web page <http://www.acf.hhs.gov/programs/fysb/programs/runaway-homeless-youth>

Also see resources for [Sexual Health Services](#), [Exemplary Sexual Health Education](#), and [Safe and Supportive Environments](#)

References:

1. CDC. *HIV Surveillance in Adolescents and Young Adults*. U.S. Department of Health and Human Services, CDC Web site. Available at <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm>.
2. CDC. Diagnoses of HIV infection and AIDS among adolescents and young adults in the United States and 5 U.S. dependent areas, 2006–2009. *HIV Surveillance Supplemental Report 2012*;17(No. 2). Available at <http://www.cdc.gov/hiv/topics/surveillance/resource/reports/>.
3. Blake SM, Ledsky R, Lehman MA, Goodenow C, Sawyer R, Hack T. Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: the benefits of gay-sensitive HIV instruction in schools. *American Journal of Public Health* 2001;91(6):940–946.
4. Garofalo R, Deleon J, Osmer E, Doll M, Harper W. Overlooked, misunderstood and at-risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health* 2006;38:230–236.
5. CDC. Sexual identify, sex of sexual contacts, and health-risk behaviors among students in grades 9–12 — youth risk behavior surveillance, selected sites, United States, 2001–2009. *MMWR Early Release* 2011;60[June 6]:1–133.
6. Kosciw JG, Greytak EA, Diaz EM, Bartiewicz MJ. *The 2009 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools*. New York: Gay, Lesbian and Straight Education Network (GLSEN); 2010.
7. Naranbhai V, Abdool Karim Q, Meyer-Weitz A. Interventions to modify sexual risk behaviors for preventing HIV in homeless youth. *Cochrane Database of Systematic Reviews* 2011, Issue 1. Art. No: CD007501. DOI: 10.1002/14651858.CD007501.pub2. Available at <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007501.pub2/pdf/standard>.
8. Gangamma R, Slesnick N, Toviessi P, Serovich J. Comparison of HIV risks among gay, lesbian, bisexual and heterosexual homeless youth. *Journal of Youth and Adolescence* 2008;37(4):456–464.
9. Solorio MR, Rosenthal D, Milburn NG, Weiss RE, Batterham PJ, Gandara M, et al. Predictors of sexual risk behaviors among newly homeless youth: a longitudinal study. *Journal of Adolescent Health* 2008;42(4):401–409.
10. Beech BM, Myers L, Beech B, Kernick NS. Human Immunodeficiency Syndrome and Hepatitis B and C Infections Among Homeless Adolescents. *Seminar in Pediatric Infectious Diseases* 2003; 14(1): 12-19.
11. Markham C, Tortolero S, Escobar-Chaves S, Parcel, G, Harrist R, Addy R. Family connectedness and sexual risk-taking among urban youth attending alternative high schools. *Perspectives on Sexual and Reproductive Health* 2003;35(4):174–179.
12. Coyle KK, Kirby DB, Robin LE, Banspach SW, Baumler EE, Glassman Jr. All4You! A randomized trial of an HIV, other STDs, and pregnancy prevention intervention for alternative school students. *AIDS Education and Prevention* 2006;18(3):187–203.
13. Tortolero S, Markham C, Addy R, Baumler E, Escobar-Chaves S, Basen-Engquist K, et al. Safer choices 2: rationale, design issues, and base-line results in evaluating school-based health promotion for alternative school students. *Contemporary Clinical Trials* 2008;29(1):70–82.
14. National Institutes of Health. RFA-DA-04-012: HIV/AIDS, drug use, and highly vulnerable youth: targeting research gaps. Available at <http://grants2.nih.gov/grants/guide/rfa-files/RFA-DA-04-012.html>.
15. CDC. Youth risk behavior surveillance -- National Alternative High School Youth Risk Behavior Survey, United States, 1998. *MMWR Surveillance Summaries*. 48(SS07);1-44. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss4807a1.htm>.
16. American Psychological Association. *Sexual Orientation and Homosexuality: Answers to your questions for a better understanding*. 2008. Available at <http://www.apa.org/topics/sexuality/orientation.aspx?item=2>
17. CDC. HIV/AIDS and Transgender People: A Factsheet. 2001. CDC Web site. Available at <http://www.cdc.gov/lgbthealth/pdf/FS-Transgender-06192007.pdf>

School-Centered HIV/STD Prevention for Young Men who have Sex with Men (YMSM)

Rationale:

Compared with HIV infections in the general population, HIV infections among young men who have sex with men (YMSM) continue to be disproportionately high, especially in communities of color. In 2010, one-quarter (25.7%) of all new HIV infections were among youth aged 13–24, and YMSM accounted for 72.1% of all new HIV infections in that age group. More than half of all the HIV infections among YMSM aged 13–24 were among African Americans (54.4%) and more than one-fifth were among Latinos (20.5%).¹

Increasing attention has been given to the HIV prevention needs of YMSM; however, these efforts have largely focused on young adults rather than on adolescents. Although teen YMSM (13–19 years old) have typically received HIV prevention services from community-based organizations (CBOs) that focus primarily on runaway or out-of-school youths, there is evidence that YMSM who are in school also are at risk for HIV infection. Review of data from the Youth Risk Behavior Surveillance System (YRBSS) conducted from 2009 to 2011 among the 12 states and 9 school districts that include same-sex behavior questions indicates that YMSM high school students are more likely than other males to engage in sexual risk-taking behaviors (e.g., ever having had sexual intercourse with four or more persons, not using a condom during last sexual intercourse, having drunk alcohol or used drugs before last sexual intercourse). MSM were also significantly less likely to report having ever been taught in school about acquired immunodeficiency syndrome (AIDS) or HIV infection.¹

CDC recommends that all adolescents and adults aged 13–64 get routine HIV testing and MSM get HIV testing at least annually.² Although many adolescents engage in sexual behaviors that place them at risk for HIV infection, relatively few have been tested for HIV; only 22% of sexually experienced high school students had ever been tested for HIV.³ In 2011, male high school students (17.6%) were significantly less likely than female high school students (27.2%) to get tested for HIV.¹

These statistics highlight the need for programs targeted specifically for teen YMSM with a focus on increasing their access to sexual health services, including HIV and STD testing and treatment, and decreasing sexual risk behaviors. Schools can connect YMSM to HIV and STD testing and other sexual health services in their communities, and some schools can offer those services directly to youth. In addition, evidence-based interventions (EBIs) that were developed for other populations of youth or for young adult YMSM can be adapted to reduce HIV risk among youth, specifically by delaying initiation of sexual intercourse and decreasing other sexual risk behaviors (e.g., decreasing the number of sex partners, decreasing the number of times students have unprotected sex, increasing condom use). Schools can connect youth to CBOs that provide these EBIs or offer such programs onsite. Because YMSM are more likely to miss school or drop out, a core component of an HIV prevention program for teen YMSM is creating safe and supportive environments for all students and increasing protective factors through interventions focused on school connectedness and parent engagement.

Definitions:

1. Young Men who have Sex with Men (YMSM): adolescent or young adult males who have engaged in sexual activity with partners of the same sex. For the purpose of this FOA, activities designed to meet the HIV/STD prevention needs of 13–19 year-old YMSM also will aim to meet those needs for teenage males who have not engaged in sexual activity with partners of the same sex but are attracted to others of the same sex; or who identify as gay or bisexual or have another non-heterosexual identity.

Resources:

- Fact Sheet on HIV and YMSM
http://www.cdc.gov/healthyouth/sexualbehaviors/pdf/hiv_factsheet_ymsm.pdf
- Fact Sheet on HIV Testing Among Adolescents
http://www.cdc.gov/healthyouth/sexualbehaviors/pdf/hivtesting_adolescents.pdf
- CDC Vital Signs: HIV Among Youth
<http://www.cdc.gov/vitalsigns/HIVAmongYouth/>
- CDC LGBTQ Programs At-a-Glance
<http://www.cdc.gov/lgbthealth/youth-programs.htm>
- FOA PS11-113: HIV Prevention Projects for Young Men of Color Who Have Sex with Men and Young Transgender Persons of Color
<http://www.cdc.gov/hiv/topics/funding/PS11-1113/>

Also see resources for [Sexual Health Services](#), [Exemplary Sexual Health Education](#), and [Safe and Supportive Environments](#)

References:

1. CDC. Vital Signs: HIV infection, testing, and risk behaviors among youth – United States. *MMWR* 2012;61(47):971–976. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6147a5.htm?s_cid=mm6147a5_w.
2. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR* 2006;55(RR-14). Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.
3. CDC. HIV testing among adolescents: what schools and education agencies can do. CDC Web site. Available at http://www.cdc.gov/healthyouth/sexualbehaviors/pdf/hivtesting_adolescents.pdf.