

**Program 1308 Guidance:**

**Supporting State and Local Education Agencies to  
Reduce Adolescent Sexual Risk Behaviors and  
Adverse Health Outcomes Associated with HIV,  
Other STD, and Teen Pregnancy**

Division of Adolescent and School Health  
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention  
Centers for Disease Control and Prevention

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## Overview

### Purpose

CDC provides funding for state and local education agencies to help districts and schools implement four approaches to reduce adolescent sexual risk behaviors and adverse health outcomes including HIV, other STD, and teen pregnancy. The four approaches are: (1) provide exemplary sexual health education (ESHE); (2) increase access to key sexual health services (SHS); (3) establish safe and supportive environments for students and staff (SSE); and (4) educate decision makers on policy and implement and track policies related to school-based HIV/STD prevention. These four approaches were selected based on evidence of effectiveness, evidence that they address known risk or protective factors, and an integrated approach to addressing multiple levels of the health impact pyramid (1-10). (See **Appendix A** for more information on the four approaches, **Appendix B** for information on the ecological model and the health impact pyramid, and **Appendix C** for a glossary of terms.) This *Program 1308 Guidance* provides support for these approaches as identified in CDC's Cooperative Agreement Program 1308 (Program 1308): Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance (11).

The aim of the five-year Program 1308 is for CDC-funded education agencies to improve the sexual health of middle school and high school students within their jurisdiction by helping them delay the onset of sexual activity and reduce the number of sexual partners; promote the dual use of condoms and a highly effective contraceptive method among those adolescents who are sexually active; increase STD and HIV testing, counseling, and treatment; and address key social determinants of health in addition to collecting epidemiological data to ensure that the strategies reach youth at most disproportionate risk for HIV infection and other STD (11).

The vast majority of youth in the United States attend school. In 2011, public primary and secondary school enrollment was estimated to be 49.4 million students. Pre-kindergarten through 8th grade students accounted for 34.9 million of the total; 14.5 million were in grades 9 through 12. An additional 6 million students were estimated to attend private schools (12). Schools are uniquely positioned to deliver ESHE emphasizing HIV and other STD prevention, increase adolescent access to key SHS, and establish SSE for students and staff. Moreover, implementing these approaches can help schools achieve the academic outcomes for which they are primarily held accountable as decreased sexual risk behaviors and adverse sexual outcomes among students are associated with better academic grades, less likelihood of dropping out of school, and aspirations to complete high school and attend college (13, 14).

### **How to Use the Program Guidance**

The *Program 1308 Guidance* is divided into four chapters which address: (1) cross-cutting actions, which include professional development, collaborations, evaluation, and policy implementation; (2) exemplary sexual health education; (3) key sexual health services; and (4) safe and supportive environments for students and staff. Each chapter provides guidance to support the implementation of each approach and relevant resources. The guidance is for use by CDC-funded state and local education agencies with the ultimate goal of reducing sexual risk behaviors and adverse sexual outcomes among middle school and high school students. The *Program 1308 Guidance* focuses on required activities in years two to five of the cooperative agreement program: As of this writing, education agencies are engaged in the required activities for year one. Year one activities are the foundation on which years two to five activities are based, and include an assessment of policies, programs, practices, and resources and developing activities to strengthen them on the state, district, and school levels. State and local education agencies that have not completed year one activities

should complete them before engaging in year two through five activities. The *Program 1308 Guidance* was developed by CDC staff based on scientific literature and expert input about what is most likely to be effective in reducing risk for HIV infection and other STD among adolescents.

State education agencies (SEAs) funded through Program 1308 are expected to:

- Develop or provide guidance, materials, and professional development to all districts in their jurisdiction to support policy and ESHE.
- Assist *priority districts* to support SHS and SSE activities in addition to implementing policy requirements and ESHE.
- Educate stakeholders about the importance of each program approach and develop state-wide, regional, and local collaborations with education, public health, and community organizations that support each approach.

SEAs, but not LEAs, will work statewide to take action on ESHE and policy.

Funded local education agencies (LEAs) are expected to:

- Develop or provide guidance, materials, and professional development.
- Help to implement policy, ESHE programs, and practices in all schools in their jurisdiction.
- Work with their *priority schools* to implement SHS and SSE activities in addition to implementing policy requirements and ESHE.

LEAs, but not SEAs, will implement approaches directly within schools, aiming to increase the capacity of schools to implement each approach.

Policy and ESHE are the approaches to be addressed at the entire state and district level because they are fundamental to school health efforts to prevent HIV and STD. SEAs and LEAs will

increase awareness of requirements, recommendations, and tools addressing policies and ESHE, and monitor the extent to which they are being implemented in all districts and schools.

The *Program 1308 Guidance* emphasizes *what* SEAs and LEAs can do to take action on the four approaches, but does not discuss *how* they can be implemented. CDC and national non-governmental organizations (NGOs) funded through Program 1308 will provide further tools, resources, and professional development to facilitate education agencies' implementation of the cooperative agreement. (See **Appendix D** for descriptions of the NGOs and the approaches they cover.)

## Summary of Recommendations

### Cross-Cutting Actions

#### Professional development

- Establish a systematic process and infrastructure for professional development.

- Conduct professional development that is likely to increase skills and change behaviors among education agency and school staff.

#### Collaborations

- Establish or strengthen multidisciplinary teams at the district and school levels.

- Support priority districts and schools to collaborate with community organizations.

- Employ best practices for effective collaborations.

#### Evaluation

- Consider the purpose and uses for evaluation findings.

- Evaluate the process and outcomes of program activities.

#### Policy

- Assess existing policies.

- Develop and disseminate guidance to support policy implementation.

- Deliver training and technical assistance to support the implementation of science-based policy related to ESHE, SHS, and SSE.

- Monitor the implementation of policies.

- Educate stakeholders on potential policy solutions regarding school health issues.

- Maintain existing strategic partnerships to support policy assessment and implementation monitoring and, if needed, develop new partnerships.

### Exemplary Sexual Health Education

Strengthen policies and build support for effective health education to prevent HIV, other STD, and teen pregnancy.

- Promote, implement, and monitor policies that inform the content and delivery of sexual health education to prevent HIV, other STD, and teen pregnancy.

- Build support and partnerships for effective health education to prevent HIV, other STD, and teen pregnancy.

Implement planned and sequential health education that addresses clear behavioral outcomes to prevent HIV, other STD, and teen pregnancy.

- Support and implement the middle school and high school health education curriculum.

- Select sexual health education materials that are effective and appropriate.

- Implement selected sexual health education programs with fidelity.

- When necessary, make appropriate adaptations to sexual health education programs to meet the needs of specific populations of youth.

Promote the effective delivery of sexual health education to maximize students' abilities to prevent HIV, other STD, and teen pregnancy.

- Ensure that all teachers responsible for the delivery of sexual health education have the requisite certification and competencies to implement exemplary sexual health education.

- Provide professional development, technical assistance, and follow-up support to improve teacher competencies and skills to implement curricula.



Implement activities that address the sexual health education needs of LGBT, homeless, and alternative school youth

- Choose sexual health education programs appropriate for specific groups of youth at disproportionate risk (YDR).

- Incorporate adaptations to existing lessons, instructional strategies, and student learning materials.

- Provide training and resources to teachers on the needs of YDR groups.

## **Sexual Health Services**

Assess and implement policies related to access to sexual health services among adolescents.

- SEAs and LEAs should be familiar with policies impacting delivery of sexual health services on-site or by referral.

- Student health information needs to be kept confidential to the fullest extent of the law, with the exception of mandated reporting requirements (e.g., suspected child abuse, self-injury, or suicide, or possible harm to others).

Support and implement strategies to increase student awareness of the need for and availability of sexual health services, both on-site and in the community.

- Give district and school staff the knowledge and skills necessary to lead efforts to increase student knowledge, dispel misconceptions about sexuality and about sexual health services, and promote healthy behaviors.

Promote and establish community partnerships to improve student access to sexual health services.

- Establish strong organizational partnerships with school-linked, community-based health, mental health, and social service providers, health departments, or others with expertise in adolescent sexual and reproductive health.

- Use health department data to target efforts at schools in zip codes with high STD or HIV rates, or teen pregnancy.

- Recruit experts in adolescent SHS to:

  - Participate in sexual health education instruction that teaches students about the importance of SHS and how to locate and access local services.*

  - Provide professional development for staff on SHS.*

  - Provide programmatic materials to promote SHS.*

- Partner with providers of SHS that are youth friendly, with policies and practices that attract young people to them, create a comfortable and appropriate setting, and meet young people's needs.

- Identify policies that create barriers to establishing organizational partnerships that would increase students' knowledge and access and address them.

Provide guidance for school health services staff to appropriately identify student SHS needs.

- Provide guidance to school health services staff on how to appraise students' sexual risk behaviors during routine healthcare interactions.

- Provide guidance or create policies for school nurses or other sexual or reproductive health services staff to take a basic sexual history when a student presents for a particular sexual or reproductive health service.

Establish and support a system to refer students to sexual health, mental health, and other community services.

- Help districts and schools establish a standardized process to refer students to either on-site or off-site sexual health services if none exists or the current one isn't well used.

- Districts considering tracking referrals actualized for evaluation purposes should consider building in a component to MOUs with the community-based SHS provider to collect and/or share relevant data.

Support priority districts and schools in understanding adolescent sexual health needs and ways to increase adolescent access to appropriate services.

- Identify areas for which district, school and health services staff need professional development and the appropriate audience for particular areas of capacity building.

Support provision of key SHS on-site in schools as possible.

- Review and educate stakeholders about policies impacting direct provision of SHS.

- Establish or strengthen relationships with state and local health departments.

- Make current services more appealing to students.

- Contract with third parties to set-up or create a school clinic.

- Partner with the state Child Health Insurance Program (CHIP) program and the federal or state health care exchanges serving the area to register students and families for insurance.

- Develop a condom availability program that provides access to condoms to students in high schools.

- Coordinate school-wide STD screening programs that screen high school students in areas of high STD prevalence for Chlamydia and gonorrhea and provide risk counseling and treatment.

- Provide information on HPV vaccination for parents of vaccine eligible students and coordinating HPV vaccination drives with SBHCs.

- Coordinate school-wide HIV testing programs.

Explore billing third parties for reimbursement for eligible services.

- Explore if there is state guidance on Medicaid reimbursement for schools and if other districts in the state provide services for which they receive reimbursement.

- Contact the state Medicaid agency for information and technical assistance regarding implementing a school health services program and seeking Medicaid funding for school health services.

- Encourage providers that come on site to provide services but don't bill, to do so in order to increase the program's sustainability and improve quality of care.

## **Safe and Supportive Environments**

Promote, implement, and monitor policies and programs to decrease bullying and sexual harassment.

- Promote, implement, and monitor anti-bullying policies.

- Promote, implement, and monitor policies to prevent sexual harassment.

- Consider promoting programs to prevent bullying among all students.

Promote school connectedness for all students and staff.

- Support and implement policies and programs that encourage positive conduct that benefits others (pro-social behavior).
- Facilitate linking students to mentorship and service learning opportunities.
- Support student participation in clubs and extracurricular activities.
- Promote parent engagement in schools.
  - Communicate frequently using a variety of dissemination methods.
  - Facilitate parent participation in school-based HIV/STD prevention-related activities.
- Promote safe and supportive environments that are inclusive of LGBT, homeless, and alternative school youth.
  - Implement anti-bullying and sexual harassment policies that protect students who are disproportionately likely to experience bullying or sexual harassment.
  - Promote a healthy school environment for youth at disproportionate risk for HIV and other STD.

## Chapter 1 – Cross-Cutting Actions

All education agencies funded through Program 1308 are expected to engage in four actions common to the three approaches (i.e., ESHE, SHS, and SSE), including providing professional development; fostering strategic partnerships; evaluating program activities; and engaging in policy activities. The general processes for each of these actions are discussed in this portion of the guidance; specific content is discussed in Chapters 2 - 4. SEAs and LEAs should assess their current resources, strengths, and needs in each of these areas and compare them to their program activities to increase the quality of their programs. These assessments help SEAs and LEAs better design and implement programs and use or strengthen resources to reach their intended outcomes.

### Professional Development

CDC's Division of Adolescent and School Health (DASH) defines professional development as the systematic process used to strengthen the professional knowledge, skills, and attitudes of those who serve youth to improve the health, education, and well-being of youth. Professional development is consciously designed to actively engage adult learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of professional development offerings (events, information sessions, and technical assistance) (15).

*Establish a systematic process and infrastructure for professional development.*

State and local education agencies may use their existing infrastructure, strengthen, or establish an infrastructure for professional development, such as designating master trainers who have been through professional development on a policy, program, or practice. Master trainers can instruct other educators and district and school administrators as part of a training-of-trainers system. State and local education agencies can also establish cadres of trainers who can provide professional development in a state, region, or district. Education agencies may also consider funding community-

based, state, or national education organizations to provide professional development. NGOs funded through Program 1308 and ETR Associates will also help to support SEA and LEA professional development efforts.

*Conduct professional development that is likely to increase skills and change behaviors among education agency and school staff.*

Professional development is particularly effective when it (16-19):

- Uses adult learning principles.
- Is based on staff knowledge, experience, and needs.
- Models behavioral change techniques.
- Provides opportunities to practice skills.
- Involves multiple sessions so that education agency and school staff can practice, report on their experiences, and receive feedback.
- Provides opportunities for education agency and school staff to share their experiences with peers during post-training sessions.
- Provides follow-up that includes technical assistance to education agency and school staff to further develop and implement their skills.

Professional development is best when timed to allow participants to implement expected activities. For example, professional development on a curriculum should occur in the months leading up to when teachers can implement it in the classroom and follow up training can occur during and after implementation. Professional development to update or refresh staff knowledge and skills can be delivered on an annual or biannual basis. Depending on the topics and needs of staff, professional development may be delivered at different intervals and in a number of ways including in-person and distance learning (19).

In general, professional development has a goal of increasing skills and changing behaviors among education agency and school staff. For example, health education teachers who receive topic-specific professional development include more instruction on those health topics within their lessons compared with teachers who do not receive topic-specific professional development (20).

## Collaborations

Education agencies funded through Program 1308 are expected to foster collaborations, including with other Program 1308-funded agencies and organizations; agencies and organizations funded by other federal agencies; and other national, state, and local agencies that support each approach (11). Collaboration can result in streamlined goals and resources, cross-training, and in-kind exchange of staff time and resources. Education agencies are expected to leverage funding through mechanisms such as government, private or corporate grants, in-kind labor, materials or other resources to maximize project outcomes as a result of developing strategic partnerships. NGOs can help SEAs and LEAs form and foster strategic partnerships and NGOs can themselves be valuable partners in implementing program activities (11).

*Establish multidisciplinary teams at the district and school levels.*

SEAs can develop collaborations that are helpful in establishing effective policies, programs, and practices, and can facilitate the development of the same kinds of collaborations at the district and school levels. An effective school health system uses a multidisciplinary team that includes educators, administrators, health and mental health care providers, other school staff, and public health agency staff. In addition, school health systems may include students, parents, and other community members to guide programming and facilitate collaboration between the school and community. At the district level, this group is typically called a school health council, and at the school level it is typically called a

school health team. A school health council is accountable to the district and community for program quality and effectiveness (21, 22).

Every district and school should consider designating a school health coordinator to oversee school health policies, programs, practices, and services, and to establish partnerships between schools, families, and community organizations. This coordinator also can help identify and involve key stakeholders, including the existing school health council or team (21, 22).

A school health council or team typically uses a program planning process to achieve health promotion goals. The school health plan is best aligned with district and school strategic documents, such as the School Improvement Plan, to link health objectives with learning outcomes. Effective plans maintain a focus on student outcomes and include multiple strategies to implement through multiple school components.

SEAs and LEAs that do not already have school health councils or teams are expected to develop them. They may do so by fostering existing collaborations and resources and should carefully assess who to partner with on school health councils and teams. It may also be that existing school health councils and the structure and staffing of the teams can be strengthened or improved to better implement program activities.

*Support priority districts and schools to collaborate with community organizations.*

In addition to fostering collaborations through school health councils and school health coordinators, state and local education agencies are expected to support priority districts and schools to collaborate with community organizations. Individuals, agencies, or organizations in the local community may be able to offer multiple resources to schools for HIV, other STD, and pregnancy prevention efforts (23, 24). For example, community members can help plan and implement HIV, other

STD, and pregnancy prevention and health promotion-related policies, programs, and practices. They can ensure that the community's culture is appropriately considered in the creation of policies, programs, and practices. Participation can result in greater awareness and buy-in among communities (11, 25-27).

Community collaborations can enable schools to refer students to youth-friendly prevention resources and sexual health services, provide families with information and resources, and increase student and family participation in prevention activities. Community collaborations may also enhance classroom-based and other school programs to prevent HIV, other STD, and teen pregnancy. As agencies consider what programs and services to make available to adolescents, they are expected to implement to the extent practical the program collaboration and service integration (PCSI) (28) approach to provide improved integration of HIV, viral hepatitis, STD, and TB prevention and treatment services. Other types of programs and services, including reproductive health, mental health, and social services may also be integrated into such an approach.

*Employ best practices for effective collaborations.*

Collaborations are more effective when they:

- Align with strategic goals and programs in the broader community.
- Align with strategic goals and programs in the school district and schools (such as School Improvement Plans).
- Base their efforts on evidence-based practices.
- Systematically determine how schools and communities can collaborate by first assessing existing policies, programs, and practices (29).



- Encourage all partners to clearly state their level of commitment to student health, their expected level of involvement, and their preferred role in making decisions.

Collaborations are strengthened when schools offer a respectful and welcoming climate to outside organizations and when district and school administration officials support outside involvement (30, 31). School and district officials also strengthen partnerships when they familiarize themselves with the policies, programs, practices, and services offered by community partners.

When working with community partners, partnerships are more effective when school and district officials provide guidance on:

- Confidentiality.
- Reportable student issues (such as reports of on-going physical or sexual abuse; intent to harm oneself or others; and statutory rape) and procedures to address them.
- Answering sensitive questions.
- Procedures for obtaining approval for written and verbal content provided to students.

In addition to establishing and maintaining a school health system, state and local education agencies are expected to maintain memoranda of understanding or agreement (MOU/MOA) with health departments to establish roles and responsibilities for each agency in carrying out program activities. State and local agencies should review their MOU/MOA annually to assure that the roles and responsibilities of each agency are clear and relevant to the activities being carried out (11). One component of the MOU/MOA is that education and health agency staff will serve on the HIV Materials Review Committee, which is a “panel of constituents convened by an HIV-funded federal grantee to review all written materials, audiovisual materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula and like materials for medical accuracy and appropriateness for the targeted audience” (11). These requirements enable SEAs and LEAs to work

more closely with health departments and with community members to collaborate on activities and materials and to align themselves with on-going public health and community activities and with community norms.

## Evaluation

*Consider the purpose and uses for evaluation findings.*

Districts and schools can develop and focus their evaluation activities by considering the purpose and uses to which they will put their evaluation findings. Evaluation can serve a variety of purposes, including:

- Improving the content, support for, and implementation of HIV, other STD, and pregnancy prevention policies, practices, programs, and services.
- Documenting changes within health education practices and programs, the school environment, and health and mental health services for students.
- Identifying strengths and weakness of policies, programs, practices, and services, and making a plan for improvement.
- Integrating new and changing needs of students and school teachers, staff, and administrators.

*Evaluate the process and outcomes of program activities.*

State and local education agencies funded through Program 1308 are expected to evaluate the process and outcomes of their activities. In process evaluation, educators collect and analyze data to determine how, when, and where activities are conducted, and who participates in each activity. DASH collects some process data through the Program Evaluation Reporting System (PERS). Some outcome data are collected through PERS and some are collected through DASH's School Health Profiles and the Youth Risk Behavior Surveillance Survey. Outcome evaluation explores whether intended outcomes

(e.g., increased use of sexual and reproductive health services) or other specific changes occur as a direct result of policies, programs, practices, and services. The outcome expectations for the four approaches are detailed through the performance measures (11).

In addition, state and local education agencies may wish to conduct evaluation of activities not addressed through PERS, Profiles, or YRBS. This can be done using the set-aside funds for evaluation. In planning for additional evaluation activities, education agencies should assess their time, staffing, resources, activities, reporting needs, and stakeholder interests. No research can be performed using Program 1308 funds. Technical assistance and further evaluation guidance will be provided throughout Program 1308.

## Policy

School health policies are official mandates adopted by a governing body (e.g., school district boards of education, state school board, state legislature, or other district or state agencies) that affect the environment in schools or throughout all school districts in a state. These include policies developed by education agencies or based on model policies that are often developed by national non-governmental organizations. Policies include legal codes, rules, standards, administrative orders, guidelines, mandates, or resolutions. Policies can be adopted at the school, district, state, or federal level but are implemented at the school level. They identify what should be done, why it should be done, and who is responsible for doing it.

Sound school health policies (29, 32):

- Inform, support, and direct individuals throughout the school system.
- Reassure families, students, and school staff that safety and health protection measures are in place.
- Provide legal protection for schools and personnel.

- Protect the rights of all students.
- Help contain or prevent controversy.

State and local education agencies:

- Assess existing policies.
- Provide guidance to translate policies for those who will implement them.
- Deliver training and technical assistance to support policy implementation.
- Monitor the implementation of policies and, in some cases, directly implement policy.
- Educate stakeholders on potential policy solutions regarding school health issues.
- Cultivate strategic partnerships to support policy assessment and implementation monitoring.

*Assess policies related to ESHE, SHS, and SSE.*

State and local education agencies should assess policies annually. For purposes of this guidance, policy assessment is a process to identify relevant policies; determine their alignment with requirements and community needs; identify gaps; and prioritize actions to address those gaps. State and local education agencies will likely find policies relevant to ESHE, SHS, and SSE in a wide variety of federal and state-wide legal codes, laws, regulations, and legislation governing education, public health, and justice. Relevant content also could include appropriations, accountability, curriculum training, and certification and licensure policies. NGOs can help identify and disseminate ESHE, SHS, and SSE policy approaches that have successfully addressed school-based HIV/STD prevention and identify policy options that will help sustain implemented ESHE, SHS, and SSE activities (11).

Once relevant policies are identified, they should be examined in the context of the broader policy landscape, such as the extent to which district policies and practices align with state requirements, and community needs, attitudes, and community norms. SEAs should examine priority

district policies to determine their alignment with state policies and funding allocations, opportunities, and restrictions. Priority district policies also can be examined in the policy landscape that grants schools and/or districts wide or limited decision-making responsibility regarding sexual education.

SEAs and LEAs can analyze relevant policies by comparing them to the Program 1308 performance measures and long-term outcomes by:

- Examining priority district policies to determine their alignment with state policies.
- Examining priority school practices to determine their alignment with district policies.
- Reviewing policies in light of current state and local data on HIV, other STD, and pregnancy outcomes and sexual risk behaviors of adolescents.
- Identifying existing HIV, other STD, and pregnancy prevention programs and services to ensure they are in alignment.
- Gathering information from students, teachers, other school staff, parents, and community members about their knowledge of and opinions about youth sexual health and risk behaviors and acceptability of policies, programs, and services.
- Analyzing relevant policies by comparing them to programmatic goals (e.g., Program 1308 Performance Measures) and collected data.

SEA and LEA staff can document areas that need additional attention and collaborate with agency leadership to prioritize actions for addressing identified gaps in policies.

*Develop and disseminate guidance to support the implementation of policies.*

Having a policy in place is not enough to lead to sustained, meaningful change. Ideally, policies are communicated to those who implement them, they are enforced, and the necessary resources and guidance are provided for those who will implement, manage, and enforce them. Policies state what to

do and policy guidance provides a set of strategies for how to do it. SEAs should inventory current state and district policy guidance and make it available both inside and outside the agency, to increase stakeholders' knowledge about what the policies are and how they should be implemented, enforced, and monitored. LEAs should do the same for district and school policy guidance. Funded agencies should review existing policy guidance to determine if it could address any identified policy gaps.

SEAs disseminate policy guidance to LEAs. LEAs are both the recipients and implementers of some types of guidance. Dissemination can occur through multiple channels (e.g., written fact sheets, presentations, website posting) and target multiple audiences (e.g., school administrators, teachers, parents, students, community partners). Communication about policy guidance should be maintained so that people are regularly reminded about the policy.

*Deliver training and technical assistance to support the implementation of science-based policy related to ESHE, SHS, and SSE.*

CDC's *School Health Index: A Self-Assessment & Planning Guide* (33) is an online self-assessment and planning tool schools can use to improve their health and safety policies and programs. The *School Health Index* is based on the same research and expert input used to develop this guidance document. The *School Health Index* enables schools to:

- Identify strengths and weaknesses of health and safety policies and programs.
- Develop an action plan for improving student health, which can be incorporated into a School Improvement Plan.
- Engage teachers, parents, students, and the community in promoting health-enhancing behaviors and better health.

The *School Health Index* self-assessment process involves members of a school community coming together as a team to discuss what the school is already doing to promote good health and to

identify strengths and weaknesses. It allows teams to assess the extent to which their school implements the types of policies and practices likely to result in improved health outcomes for students. After completing the self-assessment process, teams identify recommended actions their school can take to improve its performance in areas that received low scores. They are then guided through a simple process for prioritizing the various recommendations.

Implementation of a current or new policy can be a cooperative effort between the SEA, district, the school health coordinator, and school staff. LEAs should communicate the policy to schools and community stakeholders, and provide support for its implementation in schools. Schools need sufficient time and training to implement the policy, to gather any needed resources, and to make any changes in the school environment necessary to support it. Districts should prepare to address opportunities and challenges, such as perceived low priority of the policy; limited resources for full implementation; and parent concerns. School districts, along with community stakeholders such as parents, may monitor policy implementation to identify barriers and document successes.

#### *Monitor the implementation of policies.*

Policy monitoring is a continuous and systematic process of collecting and analyzing data to compare how well a policy is being implemented against its expected results. This information is most helpful when it is standardized so that it can be compared and aggregated across schools. Information can be reported to local education agencies and/or state education agencies to assess how and to what extent policies are being implemented as intended and enforced. State and local education agencies can review this information annually to determine how to strengthen policy implementation and enforcement, as well as what gaps may exist in the policy itself, and to communicate barriers and successes to decision makers (34).

*Educate stakeholders on potential policy solutions regarding school health issues.*

It is useful for state and local education agencies to include stakeholders in efforts to educate decision makers about policy options and opportunities. Choosing stakeholder groups with which to collaborate and the nature of the collaboration depends on the type of policy being addressed and goals or activities related to that policy.

Education agencies should be strategic in choosing stakeholder groups and the best format in which to engage them. It is important to educate stakeholders about the legal foundation for a policy and why it is needed, and to provide concise information about the content, implementation, and enforcement of the policy. In-person meetings may be a good way to educate stakeholders about policies and policy options, but teleconferences, print materials, trainings, conferences, websites, e-mail, and other formats may be equally effective depending on the stakeholders and what aspects of policies are being discussed.

Decision makers are often stakeholders, and as such are important allies in implementing policy solutions. Education agencies should consider the importance of educating the following stakeholders and decision makers:

- State-level policy and decision makers (e.g., state legislature, state board of education)
- State-level advisory councils or committees (e.g., state school health advisory council; special commissions)
- School district policymakers (e.g., local school boards, city or county commissioners)
- School district administrators and curriculum supervisors
- School district councils or committees (e.g., school health council)
- School district policy makers (e.g., local school boards)



- School district building administrators
- School-level school health team
- Lead health education teachers and other teachers of HIV, other STD, and teen pregnancy prevention education
- Parents
- Students
- Community groups and organizations
- Business and trade associations in the state or district with relevant policy positions or committees (e.g., regional chambers of commerce, charter school associations, chapters of statewide groups)
- City or county associations with positions on funding, taxation, development, health, or education
- Large institutions such as universities, hospitals, health plans, and other major employers in the area that have resources to contribute

*Maintain existing strategic partnerships to support policy assessment and implementation monitoring and, if needed, develop new partnerships.*

Any of the stakeholder groups above may serve as a strategic partner to support policy. Deciding which stakeholders are relevant to policy assessment and implementation monitoring depends on the type of policy under consideration and what the education agency wants to accomplish (e.g., revising, implementing, monitoring, or enforcing policies).

State and local education agencies should consider the outcomes they desire and their capacity to engage partners in order to assess and prioritize which stakeholders should become strategic

partners. Seeking consultation from the NGOs funded in this cooperative agreement may be helpful in this process. Partnerships are most useful when policy goals are challenging to attain, such as when policy is far reaching, meant to affect a significant need, is an object of controversy, or takes considerable resources.

Strategic partnerships may also involve stakeholders at one or more levels -- national, state, or local. Partners and the nature of the relationship may shift as the policy landscape changes. Strategic partners are often organizations, but they may also be individual champions or opinion leaders who can facilitate access to grassroots support, resources, key decision makers, or organizations (35).

It is often useful to engage professional assistance when planning strategic partnerships, including strengthening or re-engineering an existing partnership. An expert in both the process and the possible landscape for partnerships may be helpful as executing successful strategic partnerships takes specific skills.

It is useful to determine the type of collaboration between the education agency and the partner *with* the potential or current partner. However, common factors of successful collaborations include (34, 36, 37):

- Shared vision and purpose
- Respect, tolerance, and trust
- Designated leaders
- Consistent and sustainable leadership
- Clear decision-making and conflict management processes
- Inclusion of participants with diverse perspectives
- Consistent and clear communication

- Adequate resources, such as time, expertise, materials, and labor

## Resources

### Professional Development

- National Staff Development Council, Standards for Professional Learning  
<http://learningforward.org/standards#.U6hR33YpC70>

### Collaboration

- How Schools Can Implement Coordinated School Health  
<http://www.cdc.gov/healthyyouth/cshp/schools.htm>
- How Schools Work and How to Work with Schools  
[http://www.cdc.gov/healthyyouth/cshp/pdf/nasbe\\_howschoolswork.pdf](http://www.cdc.gov/healthyyouth/cshp/pdf/nasbe_howschoolswork.pdf)

### Evaluation

- CDC Evaluation Framework  
<http://www.cdc.gov/EVAL/framework/>
- DASH Evaluation Planning  
<http://www.cdc.gov/healthyyouth/evaluation/plan.htm>
- DASH Evaluation Data Collection and Analysis  
<http://www.cdc.gov/healthyyouth/evaluation/data.htm>
- DASH Evaluation Share Results and Improve Program  
<http://www.cdc.gov/healthyyouth/evaluation/share.htm>

### Policy

- Guidance for Implementing the Policy-Related Activities of Promoting Adolescent Health through School-Based HIV/STD Prevention (Forthcoming)  
<http://www.cdc.gov/healthyyouth>
- School Health Index: A Self-Assessment and Planning Guide  
<http://www.cdc.gov/healthyyouth/SHI/>
- National Association of State Boards of Education's State School Health Policy Database  
[http://www.nasbe.org/healthy\\_schools/hs/index.php](http://www.nasbe.org/healthy_schools/hs/index.php)
- National Association of State Boards of Education's Fit, Healthy, and Ready to Learn  
<http://www.nasbe.org/project/center-for-safe-and-healthy-schools/fhrtl/>

## Chapter 2 – Exemplary Sexual Health Education

This chapter discusses the implementation of exemplary sexual health education (ESHE) to help adolescents acquire the essential knowledge and critical skills needed to prevent HIV, other STD, and unintended pregnancy. ESHE is a systematic approach to sexual health education that is informed by scientific research and effective practice. It emphasizes planned, sequential learning across elementary, middle, and high school grade levels and the use of grade-specific lessons and materials that are medically accurate, developmentally and culturally appropriate, and consistent with the scientific research on effective sexual health education. ESHE is delivered by well-qualified and trained teachers and uses instructional strategies that are relevant and engaging.

### **Why address sexual health education as part of school-based HIV/STD prevention?**

- Independent reviews of the scientific evidence show that well-designed and well-implemented sexual education programs are effective in decreasing sexual risk behaviors among youth (2, 38-40). Specific outcomes include delaying first sexual intercourse (41-44), reducing the number of sex partners (44-47), decreasing the number of times students have unprotected sex(48-50), and increasing condom use (48, 51, 52).
- Increasing the number of schools that provide health education on key health problems such as HIV, other STD, and teen pregnancy are critical objectives for improving our nation's health (53, 54).

This guidance focuses on the three main components of ESHE: (1) policy and support, (2) curriculum, and (3) instructional delivery and includes actions to meet the sexual health education needs of youth at disproportionate risk (YDR). It provides recommendations for SEA and LEA activities in years two through five of Program 1308. All funded sites are responsible for implementing program activities that will support sexual health education policies and practices for all secondary school students within their jurisdictions. In addition, SEAs should provide consultation, training, and technical assistance on ESHE to priority districts; LEAs should provide the same to priority schools. All

funded SEAs and LEAs are expected to have completed the foundational year one activities before moving into subsequent year activities. These include:

- Establish or select a written curriculum framework for sexual health education.
- Establish a systematic process that districts can use for identifying, selecting or adopting, and implementing sexual health education lessons, instructional strategies, and student learning materials, including commercially packaged programs such as evidence-based interventions (EBIs).

Beginning in year one and continuing through year two, SEAs also should assist priority districts in selecting -- and LEAs should assist priority schools in delivering -- lessons, instructional strategies, and student learning materials consistent with the district-approved curriculum, including the selection and delivery of sexual health education programs with evidence of effectiveness for YDR, if applicable.

### **Strengthen policies and build support for effective health education to prevent HIV, other STD, and teen pregnancy**

*Promote, implement, and monitor policies that inform the content and delivery of sexual health education to prevent HIV, other STD, and teen pregnancy.*

State and local education agencies can promote policies that support the implementation of ESHE. State and local education agencies should educate policy and decision makers, and those that influence decision makers, about sexual health risks among school-age youth, the effectiveness of school-based sexual health education in reducing these risks, and the policy priorities that can help establish or improve ESHE implementation. Education agency staff should review existing policies for outdated or missing information and develop policy guidance.

SEAs should provide guidance and trainings on state policies to districts which, in turn, should explain and disseminate this guidance to schools. LEA leaders can develop and implement policies to

improve implementation of sexual health education, if not adequately addressed by state policy. State and local policies may address topics such as:

- Requirements for health education, including content specific to HIV, other STD, and teen pregnancy prevention, including
  - Student course and graduation requirements for health education in grades 6-8 and 9-12.
  - Essential sexual health curriculum expectations, including goals, objectives, and expected outcomes and a chart describing the annual scope and sequence of health education for students in grades pre-K–12, including sexual health education content for students in grades 6–12.
  - A systematic process for identifying, selecting or adapting, and implementing health education lessons, instructional strategies, and student learning materials, including commercially-packaged sexual health education programs.
  - Expectations for assessing student learning.
  - Options for parents who prefer that their child not participate in HIV, other STD, or teen pregnancy prevention education.
- Qualifications, competencies, and ongoing training required for health education teachers and especially those teaching sexual health education.
- Recommendations for appropriate classroom management and instructional strategies for those teaching sexual health education, including individuals from outside agencies who may be approved to provide HIV, other STD, and pregnancy prevention education to students in the classroom.
- Recommendations for determining the appropriateness, accuracy, and relevance of sexual health education lessons, instructional strategies, and student learning materials based on

students' needs, community priorities, school resources, relevant national or state health education standards, the characteristics of an effective health education curriculum, and other credible tools or resources (e.g., CDC's *Health Education Curriculum Analysis Tool*) (55).

- Recommendations for assessing sexual health education school policies and practices (e.g., through the use of CDC's *School Health Index*) (33).

It is important for SEAs and LEAs to monitor the extent to which policies are implemented at the district and school level.

*Build support and partnerships for effective health education to prevent HIV, other STD, and teen pregnancy.*

State and local education agencies should establish specific structures and processes that build support for effective health education to prevent HIV, other STD, and teen pregnancy. These structures and processes should not merely result in achieving agency or community concurrence with ESHE plans and expectations. They should help the agency achieve other ESHE objectives, such as:

- Educating stakeholders about the value of sexual health education.
- Endorsing a sexual health education curriculum and curriculum framework.
- Approving selected sexual health education lessons, instructional strategies, and student learning materials, which may include commercially-packaged programs.
- Strengthening policies related to sexual health education.
- Establishing and approving professional competencies for those teaching HIV, other STD, and teen pregnancy prevention and ensuring that teachers demonstrate these competencies.
- Upholding standards and expectations for assessing student's learning outcomes related to sexual health education.



- Designing and implementing professional development events and resources to improve the delivery of sexual health education in schools.
- Championing classroom lessons and materials with the highest level of scientific evidence possible. Ideally, this means the use of HIV, other STD, and teen pregnancy prevention programs that have been rigorously evaluated and found to be effective or promising in decreasing adolescent sexual risk behavior, when such programs are appropriate to the setting and to the population.
- Meeting the sexual health education needs of YDR including LGBT, alternative school, or homeless youth.

Building this support requires input and participation of partners. The selection and engagement of partners will vary based on the objectives to be accomplished. ESHE-related partnership activities could include:

- Working with health education teachers, school board members, school health council members, and parents to approve a sexual health education curriculum and curriculum framework.
- Partnering with health department and community organizations to more effectively educate others in the state or community about the value of school-based sexual health education.
- Partnering with state or local organizations with expertise and experience in working with specific populations of YDR to improve the impact of sexual health education.

### **Implement planned and sequential health education that addresses clear behavioral outcomes to prevent HIV, other STD, and teen pregnancy**

Sexual health education should address age-appropriate physical, mental, emotional, and social dimensions of human sexuality as part of planned and sequential health education. The specific

content to be addressed in health education, including sexual health education, is organized within an educational plan called a “curriculum.”

A curriculum is an educational plan that incorporates a structured, sequential, developmentally appropriate series of intended learning outcomes and associated learning expectations for students from pre-Kindergarten through 12<sup>th</sup> grade (55) and outlines the skills, performances, attitudes, and values students are expected to learn in a specific subject, such as health education, and priority topic, such as sexual health education. It includes:

- A set of intended learning outcomes or learning objectives that are directly related to students’ acquisition of health-related knowledge, attitude, and skills.
- A planned progression of developmentally appropriate learning expectations and content that lead to achieving these objectives.
- A continuity and sequence of concepts and content that clearly reinforces the adoption and maintenance of specific health-enhancing behaviors.

It can also include:

- Accompanying teaching lessons, materials, and activities to help teachers and students meet the learning objectives.
- Assessment strategies to determine if students achieve the desired learning.

A curriculum is typically conveyed in a written “curriculum framework” that lists standards, learning outcomes, and priority health content (e.g., sexual health education) to be emphasized across grade levels. It often includes a “scope and sequence”—a pre-K–12 chart that outlines the breadth and depth of key health learning concepts across grade level(s) (scope) and the logical progression of essential health knowledge, skills, and behaviors to be addressed at each grade level or grade group

(sequence). Some SEAs develop a curriculum and curriculum framework to guide planning and delivery of health education content, including content related to sexual health. Many LEAs adopt or adapt the state curriculum or develop their own curriculum to meet local needs. The scope and sequence, curriculum framework, and health education curriculum reflect a plan for effective health education for students across all grades. These terms, and others (e.g., course of study), are used in various ways and often interchanged, but it is the central concept that is important and each funded SEA and LEA should have an overarching plan for the provision of sexual health education to students in grades 6–12.

Creating and implementing an overarching plan for health education takes an initial investment of time, but an effective health education curriculum can (3, 55):

- Increase functional knowledge that will provide students with a foundation to engage in healthy sexual behaviors and avoid or reduce risk behaviors.
- Improve students' perceptions of the severity of and their susceptibility to sexual risks.
- Address attitudes, values, and beliefs to promote healthy sexual behaviors and avoid or decrease sexual risk behaviors.
- Correct perceptions of peer norms to provide students with a realistic view of the frequency and acceptability of sexual behaviors among their peers as unrealistic views of these peer norms may be associated with sexual risk behavior.
- Increase students' self-efficacy (i.e., their feelings of mastery) and their skills to engage in healthy behaviors and to avoid or reduce unhealthy or unwanted sexual behaviors.
- Improve students' intentions to avoid or decrease risky behaviors.
- Increase the quality of parent-child communication about sexuality.

The *National Health Education Standards* emphasize the general knowledge and skills that students should achieve following the completion of a high-quality health education curriculum (56). Many SEAs and LEAs have adopted their own health education standards using the national standards as a guide and use these to set criteria for student learning in health education. SEAs and LEAs should use the *Health Education Curriculum Analysis Tool* (HECAT) to confirm that their sexual health education curriculum contains the essential knowledge and skills students should have to prevent HIV, other STD, and teen pregnancy (55).

*Support and implement the middle school and high school health education curriculum.*

SEAs can provide a model health education curriculum that addresses sexual health education or provide examples that districts can adopt or adapt; they can also provide guidance on how to tailor and implement the sexual health education curriculum. LEAs should implement a strong curriculum that incorporates a scope and sequence for sexual health education and (55):

- Aligns with national, state, or local health education standards, benchmarks, and indicators.
- Aligns with the state health education framework.
- Shows an awareness of students' developmental needs.
- Is sequential, addressing the concepts and skills students need before risk behaviors and health needs emerge.
- Exhibits a scope reflective of effective coordination within a standard and across grades pre-K-12.
- Balances hours and grades of instruction so that any one grade is not over-loaded.
- Reinforces skills and concepts, without excessive repetition.

- Is tailored to the community's needs, including the specific HIV, other STD, and teen pregnancy prevention needs of local youth, and to the needs and instructional methods used in its schools.

LEAs can assist schools in implementing the curriculum by providing guidance and training on:

- Goals, objectives, and expected outcomes for sexual health education.
- A chart describing the annual scope and sequence of instruction for sexual health education.
- A written health education curriculum that includes objectives and content addressing sexual health education.
- Guidance on how lessons, instructional strategies, and student learning materials used within a given grade should fit within the overarching curriculum for sexual health education.
- Strategies that are age-appropriate, relevant, and actively engage students in learning.
- Methods to assess student knowledge and skills related to sexual health education.

*Select sexual health education materials that are effective and appropriate.*

SEAs should identify or develop a systematic process that districts can use for reviewing and selecting sets of lessons and materials, including commercially-packaged programs, and provide technical assistance, professional development, and guidance on both the selection and implementation process. Some states may have the authority to provide a list of materials that are both effective and appropriate for youth in a given district; other SEAs and LEAs may provide specific lessons and teaching materials, as a part of their curriculum, to more directly guide the instructional delivery of health and sexual health education at the school building and classroom level. SEAs that are not prohibited by law or regulation from doing so can consider this to reduce the burden on local districts and ensure there is a high level of quality and consistency across the state. LEAs should use available state guidance in reviewing and selecting sexual health education materials.

LEAs should select and approve sexual health education materials that closely align with their sexual health education curriculum framework, are medically accurate, and follow scientific evidence of changing sexual risk and protective behaviors. LEAs and schools should use materials that meet the highest level of scientific evidence possible. They should consider using evidence-based interventions (EBIs) that meet the sexual health curriculum learning outcomes for a specific grade or grade group. EBIs are sexual health education programs that have been rigorously evaluated and have demonstrated evidence of being effective or promising with school-aged youth. Lists of these programs are provided by various federal agencies (see Resources).

SEAs should provide guidance to districts to ensure that all sexual health education lessons, instructional strategies, and student learning materials are consistent with current and confirmed research and sound practices and emphasize the value of selecting rigorously evaluated programs as part of their curriculum. SEAs should also advise districts about the limitations of relying on commercially-packaged EBIs to meet all the curriculum expectations for sexual health education since it is unlikely that any single program would be able to do so. SEAs and LEAs should recognize the need to assess and select multiple sets of lessons and materials, including commercially-packaged programs, to accomplish fully the goals of the district's sexual health curriculum. In addition to making sure that health education materials meet curriculum expectations, are developmentally appropriate, focus on both knowledge and skills, and are consistent with evidence of effectiveness, LEA staff should also ensure that selected materials, including EBIs, can be feasibly delivered in the time allotted to sexual health education, are affordable, and are supported by appropriate professional development and technical assistance. Otherwise, the school's ability to effectively implement the health education curriculum may be compromised by practical limitations.

*Implement selected sexual health education programs with fidelity.*

Specific sexual health programs are only as effective as their implementation. To implement a commercially packaged program, such as an EBI, with fidelity means to commit to maintaining the core components of that program and the essential characteristics that are responsible for its effectiveness (57, 58). Categories of core components include the core learning objectives and activities, effective delivery, and maintaining the recommended structure of lessons (e.g., not reducing the length of time, maintaining interactive exercises). How well the program is implemented without compromising the core components is the key to replicating the results of effective curricula. Therefore, states and districts should provide guidance on how to maintain the core components of any selected program.

Some of the programs with the highest levels of evidence are developed for particular settings or groups of youth. Educators should be cautious about assuming that programs developed for one population will be effective in another or that an individual program intended to reach a general classroom of students will be effective with everyone in that classroom. If districts expect to impact youth in a given population or setting, they should choose programs or lessons designed for that specific population or setting; if none are available, educators can consider adapting existing programs (59).

*When necessary, make appropriate adaptations to sexual health education programs to meet the needs of specific populations of youth.*

Adaptation is the process of making changes to an existing program. Adaptations might be considered to accommodate local students' needs, district requirements, or differences in implementation schedules. Adaptations should not be made that contradict the core components necessary to meet the needs of a particular population or a school's capacity to implement a

curriculum. Some federal agencies provide information about allowable adaptations for some EBIs on their lists, but educators should consider general adaptation guidance, such as the “Green/Yellow/Red Light” guidance, to determine which adaptations are considered safe to make without compromising the fidelity of the core components of any program (57, 60).

### **Promote the effective delivery of sexual health education to maximize students’ abilities to prevent HIV, other STD, and teen pregnancy**

*Ensure that all teachers responsible for the delivery of sexual health education have the requisite certification and competencies to implement exemplary sexual health education.*

School staff who lead or implement sexual health education should be certified to teach health education and have specialized training related to sexual health. Classroom health education teachers who receive specialized training on health education topics have been shown to more effectively implement health education programs than those who do not receive training (61, 62). Those that teach or lead sexual health education should demonstrate relevant sexual health-related competencies, such as (63):

- Knowledge of effective strategies for addressing student health knowledge and skills in order to improve sexual health education instruction.
- Understanding of the laws, policies, codes, and ethical standards that set personal and professional boundaries, inform teaching methods, and guide instruction of sexual health education content.
- Accurate and current knowledge of multiple aspects related to adolescence and human sexuality.
- Comfort with and confidence in teaching sexual health education content.



- Respect and appreciation for family and cultural characteristics and experiences that might influence student learning.
- Understanding of the practices and pedagogy to plan and deliver sexual health education.
- Ability to create comfortable and safe learning environments for all students.
- Assessing student sexual health education learning outcomes.
- Knowledge of on-site or community-based health services for student referral.

These competencies can serve multiple purposes. For example, they can be used to inform criteria for state-level teacher certification, district-level personnel selection, and school-level teacher performance appraisal. Ideally, sexual health education teachers should have certification in health education, including training specifically in sexual health. If certification or training is not evident, then LEAs should establish a professional development plan to strengthen the capacities of those that teach sexual health education. These competencies can guide outcome expectations for professional development provided at the state and district levels.

Some studies have addressed general education classroom teachers' efforts to address sexual health education; however, little is known about teachers' preparation for teaching about HIV, other STD, and pregnancy prevention (64-68). Researchers find that those providing sexual health education often lack preparation, either in their teacher certification programs or through district or school in-service programs (69).

*Provide professional development, technical assistance, and follow-up support to improve teacher competencies and skills to implement curricula.*

Those responsible for planning and delivering health education should receive professional development to assure they have the most current information to effectively teach students about

how widespread HIV, other STD, and adolescent pregnancy are; the consequences of HIV, other STD, and adolescent pregnancy; the modes of transmission for HIV and other STD; effective prevention strategies; the populations of youth at highest risk for HIV, other STD, and unintended pregnancy (70, 71); the influence of social factors on sexual activity such as media and peer norms; characteristics of healthy relationships; and the necessary skills students need to avoid or decrease their risk of HIV, other STD, and pregnancy (3).

Professional development on health education is associated with successful implementation of classroom instruction (61, 62). Successful in-service programs have shown increases in both the amount of time teachers spend on health topics and their self-efficacy (67). Professional development should provide health education teachers with the necessary skills to use innovative, non-lecture techniques, such as active learning strategies, for developing students' knowledge, attitudes, and skills to prevent HIV, other STD and pregnancy (38, 55, 72). Professional development topics for those that teach sexual health education can include (70):

- Acknowledging educators' own beliefs about sexuality, and how to communicate acceptance of the values and beliefs of others through their words, body language, silences, and role modeling.
- Effective instructional strategies to deliver sexual health education content, including increased comfort in delivering material about sex and sexuality and handling topics that are potentially sensitive or embarrassing for students.
- Developing group facilitation skills to lead specific classroom activities included in sexual health education. Strategies to encourage discussions may include small-group exercises, whole-group discussions, interactive class activities, role-play, and homework with parents.

- How to deliver specific commercially-packaged programs with opportunity to practice skills and activities necessary for effective implementation.
- Classroom management techniques.
- State and district policies and guidance on what topics may be discussed in the classroom and how to handle questions.
- Strategies to assess students' knowledge and skills in sexual health education.
- Strategies for addressing sexual health education content as part of health education to address other health topics (e.g., alcohol and other drug use; mental and emotional health; violence prevention).

### **Implement activities that address the sexual health education needs of LGBT, homeless, and alternative school youth**

To address the needs of the YDR populations that are the focus of Program 1308 (i.e., LGBT, homeless, and youth in alternative schools), SEAs and LEAs should consider choosing health education programs specifically designed to meet the needs of their chosen YDR population; adapting existing sexual health education lessons, strategies, and materials; and providing training and resources to teachers and other school staff on the needs of YDR groups. In addition, schools should continue to implement the same policy and support, curriculum, and instructional delivery recommendations provided throughout this guidance.

*Choose sexual health education programs appropriate for specific groups of youth at disproportionate risk.*

Sexual health education programs are available that are associated with reductions in sexual risk behaviors among homeless and runaway youth (73, 74). These programs should be offered confidentially to students or in collaboration with other services specifically for homeless youth so

students are not stigmatized. In addition, a few HIV, other STD, and pregnancy preventions programs for youth in alternative schools have been developed and tested (75-78); these programs tend to incorporate various components, including skill-based curricula and service learning, and short-term reductions in unprotected sex have been documented (75, 77).

Although there are currently no rigorously evaluated programs that focus solely on the needs of LGBT youth, schools should consider adding lessons or materials to existing programs that specifically acknowledge and respond to the sexual health needs and perspectives of LGBT or gender variant youth. When provided within a non-discriminatory school climate and with adequate support services, the use of sexual health lessons, materials, and resources rated by health education teachers as appropriate for the needs of LGB youth has been associated with a reduction in sexual risk behaviors among LGB youth (79).

*Incorporate adaptations to existing lessons, instructional strategies, and student learning materials.*

Sexual health education lessons, strategies, or materials developed for a general school audience may not be effective for some subpopulations of youth or for youth in different institutional settings such as alternative schools or homeless shelters. Existing materials, including commercially packaged programs, may need to be adapted to make them appropriate and relevant for a specific setting or population. Educators should use adaptation guidance to plan for and make adaptations that retain the fidelity of the core components of specific programs (57, 60). Adaptations can range from adding activities or lessons inclusive of a population or setting to comprehensively changing language, content, and activities across the whole of the curriculum to address specific population needs.

*Provide training and resources to teachers on the needs of YDR groups.*

Education agencies should provide training and materials for priority district and school staff that familiarize sexual health education teachers with the needs of the selected YDR group. Information can include demographic data on the group; the group's health risks and protective factors; applicable laws, policy, or guidance, including those related to confidentiality; specific sexual health education content or instructional strategies that are helpful for engaging priority youth; and how to refer students appropriately, if additional services or care are warranted. These trainings and materials can be used to inform the selection, adaptation, and implementation of sexual health education that meets the needs of the selected YDR population.

## Resources

- School Health Index (SHI): Self-Assessment & Planning Guide 2012  
<http://www.cdc.gov/healthyyouth/shi/index.htm>
- National Health Education Standards  
<http://www.cdc.gov/healthyyouth/sher/standards/>
- Characteristics of an effective health education curriculum  
<http://www.cdc.gov/healthyyouth/sher/characteristics/index.htm>
- Health Education Curriculum Analysis Tool (HECAT)  
<http://www.cdc.gov/healthyyouth/HECAT/>
- Federal registries of evidence-based programs for youth  
<http://www.cdc.gov/healthyyouth/AdolescentHealth/registries.htm>  
[http://www.hhs.gov/ash/oah/oah-initiatives/teen\\_pregnancy/db/programs.html](http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs.html)  
<http://www.cdc.gov/hiv/prevention/research/compendium/rr/characteristics.html>
- Selecting and implementing sexual health education programs  
<http://www.cdc.gov/TeenPregnancy/PDF/LittlePSBA-GTO.pdf>  
[http://www.nrepp.samhsa.gov/Courses/Implementations/NREPP\\_0101\\_0010.html](http://www.nrepp.samhsa.gov/Courses/Implementations/NREPP_0101_0010.html)
- Developing or adapting sexual health education programs  
[http://pub.etr.org/upfiles/Reducing\\_Adolescent\\_Sexual\\_Risk.pdf](http://pub.etr.org/upfiles/Reducing_Adolescent_Sexual_Risk.pdf)  
<http://www.acf.hhs.gov/sites/default/files/fysb/prep-making-adaptations-ts.pdf>

## Chapter 3 – Sexual Health Services

The focus of chapter 3 is on improving schools' capacity to increase adolescents' access to key sexual health services (SHS) including HIV and other STD testing and treatment; pregnancy testing; access to condoms and condom-compatible lubricants (i.e., water or silicone-based); access to other contraceptives other than condoms; and HPV vaccination.

### **Why address sexual health services as part of school-based HIV/STD prevention?**

- In 2010, young people aged 13–24 accounted for 26% of all new HIV infections in the United States (80). Nearly half of the 19 million new STD reported each year are among young people ages 15–24 (81). Among U.S. high school students surveyed in 2011, almost half reported ever having had sex and one third of sexually active students did not use a condom at last sexual intercourse (82).
- Despite official guidelines and recommendations for adolescent preventive services to attend to these health problems (83-86), adolescents are medically underserved and may not seek health services because of unique barriers that particularly hinder use of sexual health services (87, 88).
- Schools in the United States have a critical role to play in facilitating delivery of preventive services for adolescents; schools have direct daily contact with almost 15 million students attending grades 9-12 (89) and are an appropriate venue for HIV, STD, and teen pregnancy prevention programs (90).

Aspects of the school infrastructure can support the delivery of SHS. Critical infrastructure components include school nurses and school-based or school-linked health centers (SBHCs) (91, 92). These resources are, however, often constrained by staffing limitations, increased demands from students with chronic conditions, and restrictions against providing onsite testing and treatment for STD, HIV testing, or contraceptive services (93). Given these limitations, strong referral systems and established partnerships with community providers are frequently important.

This guidance for SHS describes actions SEAs and LEAs can take in years two to five of their DASH-funded programmatic work to improve their schools' capacity to increase adolescents' access to key SHS by either (a) direct provision of services at schools (on-site) when possible or (b) referrals to youth-friendly, community-based health service providers (off-site) (94). Much of this work will happen within priority and funded districts and these recommendations are geared toward them, but state education agencies should facilitate this work by providing guidance, assisting with strategic partnerships, supporting policy activities, assisting with funding, and providing general technical assistance.

### **Assess and implement policies related to access to sexual health services among adolescents**

For the purpose of increasing student access to SHS, SEAs and LEAs should be familiar with policies impacting delivery of sexual health services on-site or by referral, including:

- Support for, rules, or prohibition of particular types of sexual health services, if any exist in state laws or district policies.
- Any contradictions in state or district policies with federal privacy and access laws.
- The extent to which students can consent for receipt of general or particular services on their own.
- School or district policies on absences due to seeking medical care.
- What type of information about students' sexual health may be shared with other health care providers; teachers, staff, and administrators; and with parents.

Student health information needs to be kept confidential to the fullest extent of the law, with the exception of mandated reporting requirements (e.g., suspected child abuse, self-injury, or suicide, or possible harm to others) (95). The Family Educational Rights and Privacy Act (FERPA) and the Health



Insurance Portability and Accountability Act (HIPAA) provide standards for privacy and confidentiality of educational and health records, respectively (96, 97). In order to adhere to legal requirements, the following activities may be necessary:

- Informing students what information is subject to mandatory reporting as well as what information is kept confidential (98).
- Establishing clear guidance on when and with whom to discuss student health issues that reflect a need-to know basis. Clear guidelines and procedures on receiving and providing medical information to outside health service providers without compromising students' confidentiality can also be useful (99).
- Educating students and their parents about the scope of federal, state, and local confidentiality laws for adolescents (100).
- Raising awareness about ways students' confidentiality may be inadvertently compromised, such as when insurance explanation of benefits statements are sent to adult primary policy holders or when school or district absenteeism policies lead to absences to receive sexual health services being reported to parents.

### **Support and implement strategies to increase student awareness of the need for and availability of sexual health services, both on-site and in the community**

SEAs and LEAs can give district and school staff the knowledge and skills necessary to lead efforts to increase student knowledge, dispel misconceptions about sexuality and about sexual health services, and promote healthy behaviors (5, 101-106). School-wide marketing campaigns can promote sexual and reproductive health service use among adolescents. For instance, ongoing social marketing campaigns, such as Get Yourself Tested (GYT), encourage youth to be tested for HIV and other STD through social marketing materials developed for school based health centers that link to community

resources (107). These or other campaign materials can be adapted to the local context of the district or school and can highlight SHS delivered on-site (e.g., testing events, SBHC services) or can market the guide of youth-friendly providers and the referral process.

### **Promote and establish community partnerships to improve student access to sexual health services**

Districts can establish strong partnerships with school-linked, community-based health, mental health, and social service providers, health departments, or others with expertise in adolescent sexual and reproductive health. These partnerships can be a source of referral for students to off-site sexual health services or can facilitate delivery of sexual health services onsite (e.g., via school-based events such as screenings or regular visits to SBHCs).

Districts should use health department data to target efforts at schools in zip codes with high rates of STD, HIV, or teen pregnancy. Districts can support schools by recruiting experts in adolescent SHS to participate in sexual health education instruction by teaching students about the importance of SHS and how to locate and access local services (108); providing professional development for staff on SHS; and providing programmatic materials to promote SHS. Districts and schools should partner with providers of SHS that are youth friendly, with policies and practices that attract young people to them, create a comfortable and appropriate setting, and meet young people's needs (5, 109).

Youth-friendly organizations have:

- Expertise in providing SHS to adolescents.
- Staff who respect young people, honor their privacy and confidentiality, are non-judgmental, and allow for adequate time to interact with youth.
- Convenient hours (including welcoming drop-ins), short wait times, an accessible location, adequate space and privacy, and affordable fees or opportunities for reimbursement.

- Comfortable surroundings, welcoming to both males and females and to youth of all sexual orientations.
- Youth-focused group discussions, peer counselors, information, and educational materials.
- Integrated SHS that allow adolescents to meet their needs for HIV, STD, and pregnancy prevention in one place (28).
- Medically accurate and up to date information about and access to services (110).
- Follow-up to encourage youth to return and to act on medical referrals.
- Ways to solicit youth feedback on their needs and how to improve services (111).
- Evidence-based practices.
- Professional development on youth-friendly topics and youth-engagement strategies (112).

Any providers coming onsite should adhere to state and district policies governing their activities. Districts and schools should identify any policies that create barriers to students' knowledge and access and address them.

### **Provide guidance for school health services staff to appropriately identify student SHS needs**

In an effort to either provide relevant SHS or referrals to relevant SHS, SEAs and LEAs should provide guidance to school health services staff on how to appraise students' sexual risk behaviors during routine healthcare interactions. Sexual health assessments and histories can be conducted a number of ways, often depending on the local district or school context. For instance, sexual risk assessment modules may be included on more comprehensive health and risk assessment questionnaires that are often performed by school nurses or in a clinic setting. Some examples of standardized sexual risk assessment tools for adolescents clinical assessments for adolescents include GAPS, Bright Futures, and RAPPS (see Resources).

Identifying student SHS need may also come from more informal, one-on-one conversations (113, 114). SEAs and LEAs can provide guidance or create policies for school nurses or other sexual or reproductive health services staff to take a basic sexual history when a student presents for a particular sexual or reproductive health service. Such conversations can identify additional services that may also be needed. Additionally, all school staff can make referrals based on their individual level of comfort and within the parameters for which they are trained. Often, the need for a referral can be identified without requiring a comprehensive assessment.

Students presenting with other health or mental health issues associated with sexual risk behaviors (e.g., depression, childhood trauma, substance use, physical abuse, or coerced sexual contact) should be assessed for sexual risks (115-117). School healthcare staff should coordinate such assessments with mental health and social service providers to provide students with the care that best addresses their life situation. When student assessments reveal health issues requiring urgent attention beyond the scope of school-based services, students should be referred to primary care providers for diagnosis and testing, treatment, or care (118).

### **Establish and support a system to refer students to sexual health, mental health, and other community services**

SEAs and LEAs can help districts and schools establish a standardized system to refer students to either on-site or off-site sexual health services if none exists or the current one is not well used (91). This system can build on work established in developing partnerships and may include developing a guide with youth-friendly service providers if such a resource does not already exist. An existing guide can be assessed to ensure it includes youth-friendly providers of sexual health services (e.g., verifying with students), the information is meaningful to students and up to date, and there is adequate awareness and use of the directory among staff and students. Such guides can be provided to school

health services staff, teachers, school administrators, and, in some cases, students. In addition to developing a referral guide, a referral system should include: review of federal, state, local, and school policies that impact referral of students for services; written steps to formalize procedures; designated referral staff; marketing and communicating the referral system and tools; monitoring and evaluating for impact; and overall management and oversight.

A variety of tools can facilitate use of a referral system. Examples of tools include:

- Guidance to match students with appropriate health, social, or mental health services providers.
- Information that students should be provided about their health concerns, including why the referral is being made, and information they should receive about the health services provider.
- Descriptions of policies governing the management and confidentiality of medical information between the school and the health services provider.
- Information on the role of parents (if any) in the referral.
- Tools for determining if and how the referral should be followed-up.

Depending on the health services infrastructure and other local contextual factors, students may be referred to a SBHC or to community-based SHS, their doctor, a social service, or a mental health service provider. The referral could be handled via a school nurse or other designated staff, in which case non-health services staff who may encounter a student in need of sexual or mental health services should be aware of how to connect students with the appropriate referring staff. In some cases, referral guides may be marketed directly to students who self-refer to clinics. Although tracking of SHS referrals is not required for this FOA, school health and mental health services staff can follow-up with students to make sure that they attend appointments, address barriers to accessing referred

health services, and assist students in making and attending follow-up appointments. Those LEAs considering tracking referrals actualized for evaluation purposes should consider building in a component to MOUs with the community-based SHS provider to collect and/or share relevant data.

### **Support priority districts and schools in understanding adolescent sexual health needs and ways to increase adolescent access to appropriate services**

Districts can identify areas for which district, school, and health services staff need professional development and the appropriate audience for particular areas of capacity building. For instance, these may include providing basic and current subject matter information (e.g., medically-accurate materials about HIV, other STD, and pregnancy prevention) to teachers, other school staff, and parents (101), or providing topic-specific trainings (e.g., how to identify youth-friendly providers) to relevant district-level staff. Training and technical assistance topics could include:

- Assessing and monitoring implementation of policies related to the provision of sexual health services.
- Clarifying and dispelling myths surrounding care and referral policies.
- Establishing new or strengthen existing organizational partnerships, whether formal or informal, between districts or schools and youth-friendly sexual health service providers.
- Helping families apply for or access insurance for children.
- Assessing sexual health service providers for youth-friendliness of clinical services.
- Developing or revising a written sexual health service referral procedure.
- Implementing a written sexual health service referral procedure.
- Assessing students for sexual health service needs.
- Creating a guide of youth-friendly sexual health service providers.

- Developing or revising a procedure for maintaining student confidentiality throughout the referral process.
- Implementing a procedure for maintaining student confidentiality throughout the referral process.
- Expanding onsite, youth-friendly school health services.
- Obtaining third-party reimbursement for the provision of school-based health services.
- Raising awareness and marketing of SHS, community providers, and referral services.
- Engaging youth in the design, delivery and evaluation of SHS.
- Managing controversy around SHS.

### **Support provision of key SHS on-site in schools as possible**

SEAs and LEAs can support school-wide programs to directly deliver SHS at schools. Relevant actions include:

- Reviewing and educating stakeholders about policies impacting direct provision of SHS.
- Establishing or strengthening relationships with state and local health departments.
- Making current services more appealing to students, including expanding services to male students (who are often underserved by SHS clinics) or building a clinic visit into health education curriculum.
- Contracting with third parties to set-up or create a school clinic.
- Partnering with the state Child Health Insurance Program (CHIP) program and the federal or state health care exchanges serving the area to register students and families for insurance.
- Developing a condom availability program (CAP) that provide access to condoms to students in high schools. These programs often include counseling or written information on topics such as

STD or HIV prevention and abstinence (119). Because evidence of their effectiveness is mixed (120-124) and these programs are often controversial, schools should carefully weigh community norms and preferences for students with the health benefits to be derived from this kind of program.

- Coordinating school-wide STD screening programs that screen high school students in areas of high STD prevalence for Chlamydia and gonorrhea and provide risk counseling and treatment. Although there is little evidence about their long-term or community-wide impact (125-127), school-wide screenings may be strengthened through strong partner services, careful consideration of the local epidemiology of STD, and follow-up testing and counseling of students who have tested positive (128, 129).
- Providing information on HPV vaccination for parents of vaccine eligible students and coordinating HPV vaccination drives with SBHCs.
- Coordinating school-wide HIV testing programs (109).

### **Explore billing third parties for reimbursement for eligible services**

Districts and schools should consider their possible roles in assisting students and their families to access and enroll in health insurance plans. SEAs and LEAs may want to set up direct third-party reimbursement for health services through programs such as Medicaid, the Children's Health Insurance Program (CHIP), and private insurance companies (105, 130). Districts should first explore if there is state guidance on Medicaid reimbursement for schools and if other districts in the state provide services for which they receive reimbursement. The Medicaid program recognizes the importance of school-based health services and allows states to use their Medicaid programs to help pay for certain health services delivered to children in the schools. Some states have developed additional guidance materials for their school based providers. Districts can also contact the state



Medicaid agency for information and technical assistance regarding implementing a school health services program and seeking Medicaid funding for school health services. School districts may consider working with these entities, the state or federal exchange, social security, the local health department, and social services that provide insurance assistance. This is not only helpful to students and families, but it could underwrite many school health services. Billing for third party reimbursement may apply to many health services and can have a broad positive impact on a school health services program. Providers that come on site to provide services but don't bill, may be encouraged to do so in order to increase the program's sustainability and improve quality of care.

Districts should first explore if schools in their districts or relevant medical partners are interested in billing for health care services. The SEA and LEA can initiate discussions with other school or community providers who provide health services, including SHS. They can also consider identifying partners who already bill for health services to learn from them how to navigate the process and identify other important issues. If interest exists, clinics can work with providers to learn what can be reimbursed and the process for billing.

## Resources

- CDC Fact Sheet on HIV Testing among Adolescents

[http://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/hivtesting\\_adolescents.pdf](http://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/hivtesting_adolescents.pdf)

- CDC Revised Recommendations for HIV Testing

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

- CDC STD Treatment Guidelines

<http://www.cdc.gov/std/treatment/2010/specialpops.htm>

- Bright Futures

<http://brightfutures.aap.org/index.html>

- Rapid Assessment for Adolescent Preventive Services

<https://www.raaps.org/>

- Ten Ways Schools Can Promote New Health Insurance Opportunities

<http://marketplace.cms.gov/getofficialresources/other-partner-resources/ten-ways-to-promote-new-insurance-opportunities-schools.pdf>

- How to Obtain Medicaid Funding for School-based Services

<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](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/2003_SBS_Admin_Claiming_Guide.pdf)

## Chapter 4 – Safe and Supportive Environments

This chapter focuses on the three aspects of safe and supportive environments (SSE) for students and staff emphasized in Program 1308: (1) preventing bullying and sexual harassment, including electronic aggression; (2) promoting school connectedness; and (3) promoting parent engagement in schools.\* It also outlines actions to meet the needs of youth at disproportionate risk; many of these actions are associated with improvements in the school environment for *all* students. Although this guidance is focused at the school-level, state education agencies (SEAs) and local education agencies (LEAs) can support school-based activities through professional development, technical assistance, and partnerships.

### **Why address safe and supportive environments as part of school-based HIV/STD prevention?**

- Perpetrators and victims of bullying and sexual harassment may be more likely to have casual sex and sex under the influence of drugs and/or alcohol (131).
- Adolescents who feel connected to their school and have engaged parents are more likely to delay initiating sexual activity, use condoms and other contraceptives, and have fewer sexual partners (7, 132).

### **Promote, implement, and monitor policies and programs to decrease bullying and sexual harassment**

*Promote, implement, and monitor anti-bullying policies.*

Strong anti-bullying policies include (133-135):

- A clear definition of bullying consistent with state laws.
- Specific locations where bullying takes place such as school grounds, school events, and the Internet.

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\* Parents are those adults who serve as the primary caregivers of a child's basic needs. They include biological parents and others who serve in this role including biological relatives such as grandparents, aunts, uncles, and siblings; and non-biologically related adults such as adoptive, foster, or step-parents.

- Graduated sanctions and consequences (including non-punitive alternatives) for incidents of bullying.
- A statement of rights to other legal recourse.

For guidance on naming (enumerating) specific individual characteristics in anti-bullying policies, please see pages 65-66.

In addition, districts and schools should consider procedures for the following (135):

- Reporting bullying with protection from retaliation.
- Investigating and responding to reports of bullying.
- Maintaining written records on incidents of and responses to bullying.
- Reporting bullying incidents to the state for monitoring, if required.
- Referring perpetrators and/or victims to counseling or other services.

All policies and implementation procedures should be clearly communicated to school staff, students, and families.

*Promote, implement, and monitor policies to prevent sexual harassment.*

Sexual harassment may be addressed in anti-bullying policies or separate policies specifically addressing sexual harassment. Regardless, policies addressing sexual harassment should comply with federal policy prohibiting sexual harassment (136, 137). In implementing these policies, schools and districts can:

- Sensitize school staff, students, and families to issues of sexual harassment.
- Implement procedures to document, investigate, and respond to complaints of sexual harassment.
- Communicate the policies to school staff, students, and families.

*Consider promoting programs to prevent bullying among all students.*

SEAs and LEAs should consider supporting effective school-based bullying prevention programs that involve a combination of whole-school programs with classroom curricula and small group or individual-level programs that include mentoring and address social skills (138-140).

Whole-school programs that attempt to alter the school environment and involve students, peer groups, teachers, and administrators appear most likely to be effective in reducing bullying (138). Such programs may include training in emotional control and peer counseling, in addition to anti-bullying policy (140). These activities require substantial resources; in general, programs with more components and greater duration and intensity for students and teachers are more effective than short, single-component interventions (141). State and local education agencies should carefully consider whether the resources are available to implement such programs in addition to other required Program 1308 activities. Partners can explore leveraging other funding related to bullying prevention and school climate (e.g., the U.S. Department of Education School Climate Transformation Grants). Information on rigorously-evaluated bullying prevention programs can be found at [StopBullying.gov](http://StopBullying.gov) (see Resources).

### **Promote school connectedness for all students and staff**

*Support and implement policies and programs that encourage positive conduct that benefits others (pro-social behavior).*

Comprehensive initiatives such as *School-Wide Positive Behavioral Interventions and Supports* provide a range of policies and programs that SEAs and LEAs can promote, including (142):

- Setting positive behavioral expectations school-wide.
- Implementing targeted behavioral interventions for students who are at risk for problem behaviors.

- Providing intensive and personalized interventions for students with more serious behavior problems.

Additionally, state and local education agencies should consider revising “zero tolerance” policies. There is no evidence zero tolerance policies are effective in deterring misbehavior (143, 144).

SEAs and LEAs can provide professional development to ensure that educators:

- Use language, behaviors, and environmental cues that can make adults more approachable to youth and promote positive peer norms.
- Implement classroom management techniques that set expectations and align with classroom disciplinary policies.
- Teach about acceptance, promote self-respect and respect for others, and acknowledge different viewpoints within the community and among students (145).
- Educate students about the prevalence of unhealthy behaviors by using statistics and classroom activities that demonstrate that fewer youth are engaging in risk behaviors than students may believe (146).

*Facilitate linking students to mentorship and service learning opportunities.*

SEAs and LEAs can support strategies to connect students to mentorship opportunities including:

- Offering personalized courses of study and engagement with students (147, 148).
- Providing an advisor who knows each student and who can help them with current academic needs (149).
- Providing one-on-one tutoring or mentoring for students as needed (147).

The Community Preventive Services Task Force recommends behavioral sexual risk reduction interventions in coordination with community service (150). These activities may take place in community settings, such as nursing homes, hospitals, or homeless shelters and can be incorporated into school curricula (151).

*Support student participation in clubs and extracurricular activities.*

SEAs and LEAs can help districts and schools establish programs delivered during and outside of the school day that build students' social and leadership skills, engage them in planning for their future, and help them learn from peers and community members with diverse backgrounds. Programs may include evidence-based HIV, other STD, and pregnancy prevention programs (152) as well as:

- Positive youth development programs (153)
- Academic clubs (e.g., science clubs, language clubs) or student government (154)
- Community-based groups (e.g., Boy Scouts and Girl Scouts, 4-H) (154)
- Sports (although athletic participation has been associated with increased sexual risk among boys) (154)
- Performance and fine arts-related activities (e.g., music, dance, drama, art) (154)

See page 67 for a discussion of gay-straight alliances and similar student-led clubs, which have been associated with reduced health risk behaviors for *all* students (155, 156). These activities can have a positive influence on adolescents' HIV, other STD, and pregnancy risk even if they do not have an explicit sexual health education focus.

### **Promote parent engagement in schools**

*Communicate frequently using a variety of dissemination methods.*

SEAs and LEAs should support strong communication systems between teachers, administrators, staff, parents, and students (25, 157). HIV, other STD, and pregnancy topics that schools might address with parents through routine communication include:

- Basic facts about sexual risk behaviors and HIV, other STD, and pregnancy among adolescents.
- Policies on sexual health education, sexual and reproductive health services, mental health services, non-discrimination, and confidentiality.
- Sexual health education content in classes in school.
- How to provide input on policies, curricula, and programs regarding prevention of HIV, other STD, and pregnancy.
- The importance of parents and trusted adults in influencing adolescents' sexual behavior, including the influence of specific parenting practices, such as parental monitoring and parent-adolescent communication (generally and about sex) (158).
- How to discuss sensitive topics such as adolescent sexual development, sexuality, sexual activity, abstinence from sexual activity, and how to provide developmentally-appropriate messages that are medically accurate and easy to understand.
- Information about the effects of media containing sexual content on sexual risk attitudes and behaviors (159-161).

SEAs and LEAs can help schools implement a mechanism to receive input from parents. For example, parents can serve on the school health council to participate in planning and decision-making (21, 162, 163).

*Facilitate parent participation in school-based HIV/STD prevention-related activities.*



SEAs and LEAs can support school-level efforts to create opportunities for parents and families to participate in school activities related to HIV/STD prevention. Schools can provide parents with:

- Opportunities to review sexual health curriculum materials and ask questions about the content.
- Opportunities and encouragement to volunteer their time and skills, including as educators/trainers for other parents.
- After-school programs, school events, and groups (e.g., PTA/PTO) related to HIV, other STD, and pregnancy that actively involve parents.
- Opportunities to participate in school-based HIV/STD prevention programs or activities that include a parental involvement component, such as family homework assignments on HIV, other STD, and pregnancy prevention.

Parent-centered programs have been shown to increase parenting practices, such as parental monitoring and parent-adolescent communication, associated with adolescent sexual risk reduction (164). SEAs and LEAs can help schools collect data on parents' needs and availability to maximize participation in such activities.

### **Promote safe and supportive environments that are inclusive of LGBT, homeless, and alternative school youth**

*Implement anti-bullying and sexual harassment policies that protect students who are disproportionately likely to experience bullying or sexual harassment.*

One method that states and localities use to protect students at disproportionate risk for bullying and sexual harassment is to list specific individual characteristics (enumeration) protected by the policy or policies. Enumerated policies list actual or perceived characteristics that bullying acts may be based on, such as sexual orientation, gender identity or expression, family status, physical

appearance, or obesity (165). The US Supreme Court has recognized the importance of enumerating sexual orientation and gender expression to protect LGBT persons from discrimination (166).

Enumeration may help teachers respond to instances of bullying more effectively and empower students to report bullying or harassment sooner and more often (166). Some research, albeit limited, suggests that anti-bullying policies that enumerate sexual orientation and/or gender identity may reduce bullying and/or improve other health outcomes for LGBT youth (167-169).

If states or districts enumerate specific characteristics, the policy and policy guidance should:

- Explain that students with certain characteristics, actual or perceived, may be disproportionately likely to experience bullying.
- Provide examples of specific characteristics.
- Acknowledge that not all acts of bullying are based on these characteristics.
- Clearly state that *all* students are protected under the policy, even if they are not represented by the enumerated characteristics.

As with any anti-bullying policy, just having a policy is insufficient. Staff must be trained to appropriately implement and enforce the policy and students must be made aware of the policy and related consequences. If enumerating specific characteristics is prohibited by law or otherwise not feasible, it is important to continue developing and/or implementing a generic (non-enumerated) anti-bullying policy that reflects the characteristics listed on page 59-60.

*Promote a healthy school environment for youth at disproportionate risk for HIV and other STD.*

For LGBT youth, SEAs and LEAs can consider (79):

- Ensuring that teachers have skills to provide HIV prevention instruction sensitive to LGBT youth (e.g., using gender neutral pronouns when referring to couples, using preferred gender pronouns that match the gender identity of the student).
- Promoting curricula that include LGBT characters and issues.
- Providing supplementary materials for LGBT students and their parents (e.g., CDC’s fact sheet *Parents influence on the health of lesbian, gay and bisexual teens: What parents and families should know* (170)).

Additionally, education agencies can help schools provide programmatic supports to LGBT students, such as Safe Zone programs that involve creating clearly identified safe spaces in schools where students can talk with a trusted adult (171). Education agencies can also support the development of student-led clubs to promote safe spaces, including Gay-Straight Alliances (GSAs) or similar youth-led clubs, and ensure that students understand that these resources are available to them (171-174).

For homeless youth, SEAs and LEAs can consider (175):

- Facilitating collaboration between state coordinators and local liaisons under the McKinney-Vento Homeless Education Assistance Act to enroll and retain homeless youth in schools.
- Supporting practices to improve school attendance, such as offering additional orientation activities for students who enroll after the start of the academic year, providing students with a secure place to store personal belongings, and allowing flexibility with school assignments, including deadlines and needed supplies.
- Partnering with community organizations to offer case management on issues such as housing, food, transportation, health and mental health care, and vocational training.

For youth in alternative schools, SEAs and LEAs can consider (176, 177):

- Promoting a variety of formats for assessment that minimize comparison between students.
- Incorporating flexibility in the curriculum so that the pace can be largely determined by students' ability and capacity and can vary between students.
- Promoting inclusiveness through culturally-appropriate curricula that account for students' literacy levels and language proficiency.

Policies and programs used in mainstream schools may need to be adapted to account for wide variation in alternative school settings, ranging from single classrooms to multi-building facilities, low literacy rates among students, and high levels of transience (178).

## Resources

### Preventing Bullying and Sexual Harassment

- StopBullying.Gov  
<http://www.stopbullying.gov/>
- Sexual Harassment: It's Not Academic  
<http://www2.ed.gov/about/offices/list/ocr/docs/ocrshpam.pdf>
- Electronic Media and Youth Violence: A CDC Issue Brief for Educators and Caregivers  
<http://www.cdc.gov/violenceprevention/pdf/EA-brief-a.pdf>
- APA's Zero Tolerance Task Force Report  
<https://www.apa.org/pubs/info/reports/zero-tolerance.aspx>

### Promoting 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](http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/connectedness_facilitator_guide.pdf)

- School Connectedness: Improving Students Lives

[http://www.jhsph.edu/research/centers-and-institutes/military-child-initiative/resources/MCI\\_Monograph\\_FINAL.pdf](http://www.jhsph.edu/research/centers-and-institutes/military-child-initiative/resources/MCI_Monograph_FINAL.pdf)

- Building Your GSA

<http://www.gsanetwork.org/resources/building-your-gsa>

### **Promoting Parent Engagement in Schools**

- Parent Engagement: Strategies for Involving Parents in School Health

[http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/parent\\_engagement\\_strategies.pdf](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](http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/parentengagement_facilitator_guide.pdf)

- National Coalition for Parent Involvement in Education

<http://www.ncpie.org/Resources/>

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## Appendix A -- Rationale for Program 1308 Approaches

### Exemplary Sexual Health Education (ESHE)

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 sexually transmitted diseases (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 (4-7).

Specific outcomes include:

- Delaying first sexual intercourse (8-11)
- Reducing the number of sex partners (11-14)

- Decreasing the number of times students have unprotected sex (15-17)
- Increasing condom use (15, 18, 19)

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 (6, 7). 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).

## **Key Sexual Health Services (SHS)**

In 2010, young people aged 13–24 accounted for 26% of all new HIV infections in the United States (24), and nearly half of the 19 million new STD reported each year are among young people ages 15–24 (25). 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 (26).

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 (27-30) including HIV testing beginning at age 13 except in those areas with lowest prevalence and gonorrhea and Chlamydia screening of sexually active females



ages 25 and younger. 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 (31-33).

Despite support for the provision of clinical preventive services for adolescents, only 38% of adolescents have had a preventive care visit in the previous 12 months and less than one-third of providers routinely discuss sensitive sexual health topics at these visits (34). 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 almost 15 million students attending grades 9-12 (35) and are an appropriate venue for HIV, STD, and teen pregnancy prevention programs (36). 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 (37) and approximately 2,000 school-based health centers (SBHCs) serve at least one grade of adolescents (sixth grade or higher) (38). 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 (36). There is also 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 (39).

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 (40). 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 (40).

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.

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

Two aspects of the school environment—climate and safety—are particularly important for HIV, STD and pregnancy prevention (41). Research shows that a positive school climate and school safety are associated with improved education and health outcomes for students (42, 43), including students at disproportionate risk for HIV infection and other STD (44, 45). Promoting and providing a learning environment in which all students and staff feel safe and supported is an essential function of schools (46). Moreover, schools can implement policies, practices, and programs that target specific elements of safety and the psycho-social climate and improve the overall school environment (47).

Three specific domains associated with safety and/or climate are the focus of the SSE approach: (1) bullying and sexual harassment, including electronic aggression; (2) school connectedness; (3) and parent\* engagement in schools.

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\* Those adults who serve as the primary caregivers of a child's basic needs. They include biological parents and others who serve in this role including biological relatives such as grandparents, aunts, uncles, and siblings; and non-biologically related adults such as adoptive, foster, or step parents.

- (1) Bullying and sexual harassment are highly prevalent in schools. About 20% of high school students report being bullied in the previous year, and 15% report being bullied electronically (48). Eight in 10 students (81%) experience some form of sexual harassment during their school lives (49). However, bullying and sexual harassment prevention, such as anti-bullying policies and staff training related to sexual harassment, are associated with improvements in school safety (50, 51).
- (2) Programs that promote students' sense of belonging to school, or school connectedness, are considered promising ways to improve adolescent health outcomes (52). Students who experience a high level of school connectedness generally also report a positive school climate (53).
- (3) Increasing parent engagement in schools can help foster positive health behaviors and outcomes among students (54). Such effects may result from improvements in school safety or climate. For example, parental involvement may increase the effectiveness of school-based bullying prevention (55).

In addition to increasing safety and improving psycho-social climate at the school level, we know that these specific domains also are associated with individual-level sexual risk and HIV, other STD, and pregnancy among adolescents.

- (1) Perpetrators and victims of bullying may be more likely to have casual sex, sex under the influence of drugs/alcohol, and sex with four or more partners compared to those students not involved in bullying (56). Sexual harassment of female students in middle and high school has been associated with lower self-esteem, mental health, physical health, and life satisfaction, and higher levels of substance abuse compared to their peers who had not been sexually

harassed (57). Bullying perpetration is also associated with sexual violence perpetration over time (58).

(2) School connectedness has been identified as a protective factor for adolescent sexual and reproductive health (59). For example adolescents who feel connected to their school are less likely to initiate sexual activity (60) or initiate sexual activity at an early age (59).

(3) Parental factors, including the quality of parents' communication and overall relationship with their adolescents, parenting styles, expectations, and level of supervision are associated with their adolescent's likelihood of engaging in risk behaviors, such as early sexual initiation, and health outcomes, including STI acquisition (59, 61). Parent engagement in school may include parent participation in school-based programs that promote positive parenting practices and reduce adolescent sexual risk (62).

Finally, in addition having direct effects of adolescent sexual risk, a safe and supportive school environment can decrease the likelihood that student become involved in substance abuse, violence, and other problem behaviors (42, 63, 64) that are associated with HIV and STD risk (65, 66). Given both direct and indirect effects of the school environment on adolescent sexual risk, addressing the school environments holds promise as a school-based HIV/STD prevention approach.

## **Youth at Disproportionate Risk (YDR)**

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

accounted for 15% of all adolescents aged 13–19 in the United States in 2010, they received 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 (67).

Among adolescent males aged 13–19 years, approximately 91% of diagnosed HIV infections in 2010 were among YMSM (68). 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 (69, 70). 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 (71). LGBT youth are more likely to have suicidal thoughts or attempts, personal safety issues, and lower academic achievement than their heterosexual peers (69, 72).

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 (73). 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 (74, 75). Further, homeless youth are disproportionately likely to be sexual minority youth. Although there are no national data available on HIV among homeless youth, community studies have demonstrated a higher sero-prevalence among homeless youth than among the general US youth population (76). 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 (75).

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 (15, 77). 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 (78). This pattern of sexual behavior contributes to a greater risk for HIV infection, other STD, and unintended 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. YDR may belong to several groups associated with heightened risk, and school policies, programs, and practices tailored to them help to assure that every student has access to education, skills-building, services, and environments that reduce their sexual risk. Such access helps to reduce stigma and may increase the likelihood that otherwise marginalized youth stay in school. 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!* (15).

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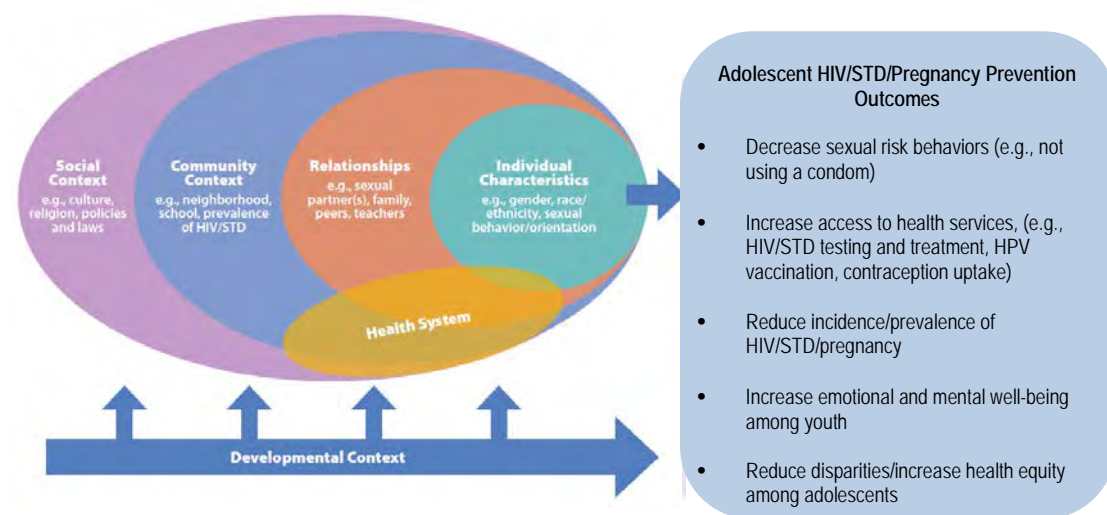
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## Appendix B -- Ecological and Coordinated School Health Models

### Ecological Models

DASH uses an ecological model as a conceptual framework to understand the factors that influence adolescent sexual risk for HIV, other STD, and pregnancy (Figure 1) (1-3). This model includes: (1) the individual young person's physical, cognitive, emotional, and behavioral characteristics; (2) the nested levels or environments that influence adolescents' behavior and outcomes, including relationships they have with their families, peers, and sexual or romantic partners; community contexts; and larger social contexts; (3) the interaction between the young person's characteristics and their environment; and (4) an understanding of how these individual and environmental factors change over time.

**Figure 1: An Ecological Model of Adolescent Sexual Behavior and Health Outcomes**



Some factors are *contextual characteristics* that cannot be altered or that are beyond the scope of most public health or educational policies, programs, and practices. Such characteristics may be socio-demographic, such as age, sex, race and ethnicity or socio-economic factors; others may refer to characteristics of groups or places, such as family structure or degree of urbanicity; and still others

refer to larger cultural forces, such as media and technology influences. Contextual characteristics may be associated with disparities in educational opportunities and health outcomes and should help guide the social determinants of health disparities. Policies, programs, and practices to reduce the risk of HIV transmission and of other STD among adolescents are often targeted to reach subpopulations of youth whose contextual characteristics put them at heightened risk of health disparities.

*Target characteristics* can be changed and are a focus of public health or education policies, programs, and practices. Target characteristics on the individual level include cognitive abilities, attitudes, self-efficacy, and negotiation skills; on the relationship level they include communication with parents, family connectedness, and peer norms; on the community level they include neighborhood disorganization, types of sexual health services available in a community, and how safe schools are for all students; and on the societal level they include policies and media. Policies, programs, and practices should address selected target factors that can be changed in order to reduce sexual risk behaviors and adverse sexual outcomes.

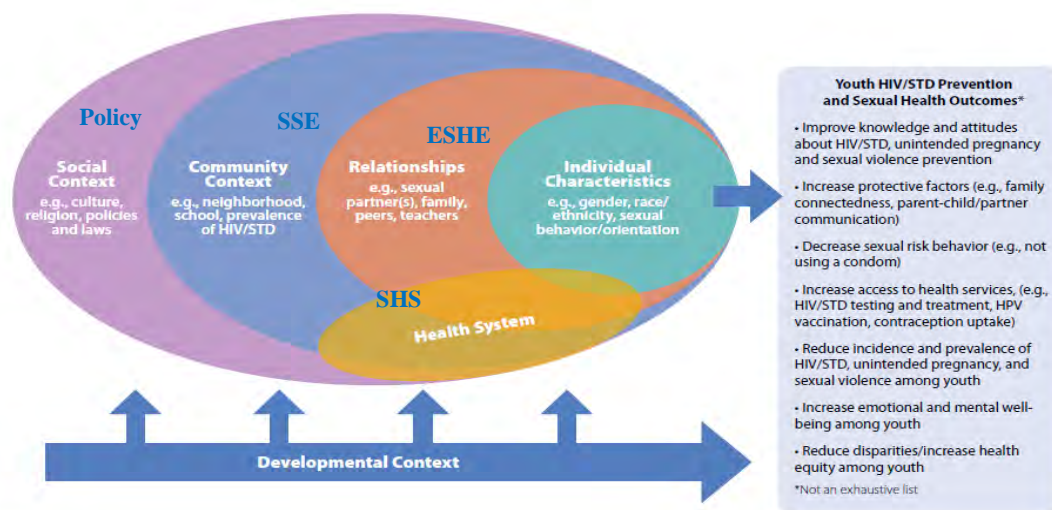
The ecological levels of the model are *nested*. That is, the left-most side of the model depicts factors that are the broadest societal influences that underlie sexual behaviors, and each level of the model as it moves to the right depicts influences that are closer to the individual level. Each broader level provides context and a foundation that profoundly influences the next, so that the societal level provides the foundation for community context; community context provides a foundation for relationships that adolescents engage in, and so on.

## **Schools and the Ecological Model**

CDC's Program 1308 for school-based HIV/STD prevention addresses each level of the ecological model as indicated in Figure 2. Exemplary sexual health education (ESHE) is most likely to

modify individual- or relationship-level factors (although some programs may also include activities at the community level, like community service or student advocacy). Safe and supportive environments (SSE) focuses on the relationship- and community-levels to provide a healthy psychosocial school climate and increase student safety (although some may change individual level factors like perceptions of peer norms, or negotiation skills). Sexual health services (SHS) addresses the health system, overlapping all of the levels from the individual (such as teaching skills to help adolescents access health care providers) to societal (including policies and laws that govern which services are available to adolescents and how they may access them). Policy spans all three approaches and operates at the societal level.

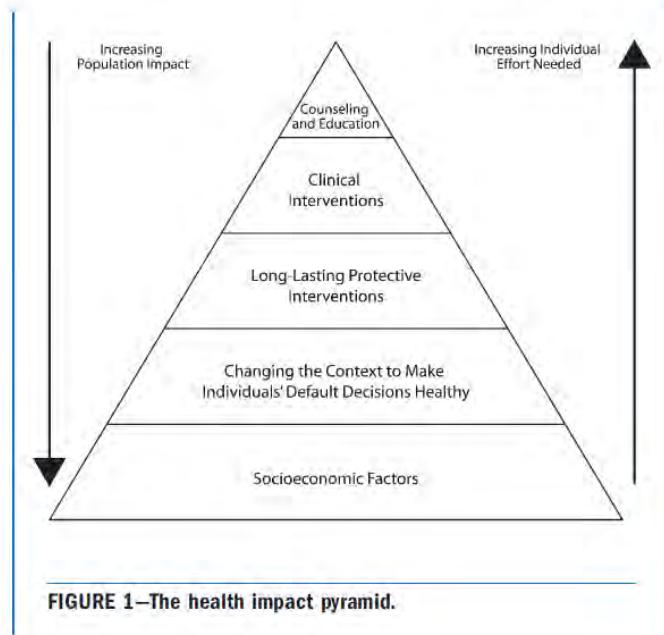
**Figure 2: The Ecological Model and Adolescent Sexual Risk Reduction Approaches**



Further, the policies, programs, and practices required in Program 1308 span the health impact pyramid, which suggests the types of policies, programs, and practices that are most effective at the different ecological levels. The health impact pyramid (4) emphasizes the need to take actions to change health for entire populations by changing socio-economic factors; changing environments; promoting long-lasting, scalable interventions; providing clinical interventions; and providing

counseling and education. Traditionally, DASH grantees have focused on counseling and education through sexual health education, the tip of the pyramid.

**Figure 3: The Health Impact Pyramid**



The required strategies of Program 1308 include clinical and long-lasting protective interventions through increased access to key sexual health services; changing school environments to lead to healthier decisions and outcomes; and include reaching the youth most vulnerable to adverse sexual outcomes by considering epidemiological factors and associated socio-economic factors. Further, improving academic achievement through decreasing adverse sexual outcomes is an important long-term consequence of the strategies of Program 1308.

## Coordinated School Health

The coordinated school health model can support school efforts to prevent HIV, other STD, and pregnancy. (See Figure 3 for the updated coordinated school health model, the Whole School, Whole Community, Whole Child model.) It is a cross-section of the ecological model that describes the



relationships among student health outcomes, structures and functions of schools, families, and communities. The coordinated school health approach is based on school and community needs, resources, and standards and engages students, families, school staff and administrators, and the broader community. The implementation of school health efforts is coordinated by a multidisciplinary team such as a school health council that is accountable to the school and community for program quality and effectiveness (5-8).

**Figure 3: The Whole School, Whole Community, Whole Child Model (WSCC)**



Every district and school also should designate a school health coordinator to oversee school health policies, programs, and practices, and to establish partnerships between schools, families, and community organizations. This individual also can help identify and involve key stakeholders, including the existing school health council or team. Key stakeholders in district- and school-level policy

processes include: students, families, health education teachers, school nurses, school principals and other administrators, staff from local health departments, other health care providers, staff from local community organizations and businesses, and faith-based organizations (5, 9).

School personnel, students, families, community organizations and agencies, and businesses can collaborate to successfully implement culturally-sensitive approaches to HIV, other STD, and pregnancy within the context of coordinate school health. For sexual risk reduction approaches, many student-level outcomes are relevant, particularly health, safety, engagement, and support. Of the school elements, health education, health services, counseling and psychological services, and social and emotional climate are particularly relevant to reduced risk. Family engagement and community involvement are also important aspects of reducing students' risk for HIV, other STD, and pregnancy.

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## Appendix C -- Glossary

**Adopted:** formal acceptance of an opinion, policy, procedure, protocol, curriculum, or practice by a vote or consensus decision by an authoritative decision making body (e.g., a school board vote).

**Age-appropriate:** the application of teaching methods, learning events, and services that reflect knowledge and understanding of the predictable developmental changes that occur at or near a specific chronological age or within an identifiable age range. These changes occur across multiple developmental domains including physical, emotional, social, linguistic, and cognitive. Learning should accommodate the developmental variations that occur among individuals at any age or within any age range.

**Assess the ability:** to determine the possession of the means or skills to do something.

**Assistance:** Targeted support provided to an individual or group of individuals with the intent to increase knowledge and skills to strengthen an organization's capacity to achieve 1308 FOA goals. Support may be provided through professional development events, technical assistance, the provision of guidance and resource materials, or referrals to other agencies or organizations.

**Bullying:** when one or more students tease, threaten, spread rumors about, hit, shove, or hurt another student repeatedly.

**Curriculum:** an educational plan incorporating a structured, developmentally appropriate series of intended learning outcomes and associated learning experiences for students; generally organized as a related combination or series of school-based materials, content, and events.

**Curriculum framework:** an organized plan or set of standards and learning outcomes that clarifies the content (essential knowledge, skills and behaviors) to be learned in sexual health education. A curriculum framework always includes standards and learning outcomes and may go beyond these to include a scope and sequence.

**Electronic aggression:** sometimes called cyber-bullying, means when students use a cell phone, the Internet, or other communication devices to send or post text, pictures, or videos intended to threaten, harass, humiliate, or intimidate other students.

**Evidence-based intervention (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. These measures specifically refer to 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. DASH considers interventions listed on Compendium of Evidence-Based HIV Behavioral Interventions and The Office of Adolescent Health's Teen Pregnancy Prevention Evidence-Based Programs as EBIs that are acceptable for implementation. More information on these two lists and other EBI lists can be found at: <http://www.cdc.gov/healthyyouth/adolescenthealth/registries.htm>.

**Exemplary 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.

**Expand onsite Sexual Health Services (SHS):** the increase in SHS provided onsite at schools, including in SBHCs, through expansion of the types of key SHS available, expansion of the populations of youth to whom onsite SHS are targeted, or an increase in the total number of students accessing services.

**Fall Enrollment Report/Fall Membership Report:** Reports that serve as the District's official count of student enrollment at each school building by grade and race/ethnicity, usually recorded on or before the first day of October in each school year.

**Gay-Straight Alliance:** a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth, regardless of sexual orientation or gender identity.

**Guidance:** a set of strategies to apply frameworks to develop procedures, protocols, curricula and instruction, and practices.

**Health education:** includes planned, sequential materials, instructions, and educational experiences delivered in the classroom setting that provide students with opportunities to acquire the knowledge and skills necessary for making health promoting decisions and achieving health literacy. Quality health education is based on sound theories of development and behavior change or empirically supportive practices that result in increased knowledge and positive behavior change.

**Health Education Curriculum Analysis Tool (HECAT):** a tool for state, regional, and local education agencies to assist with the selection or development of health education curricula, containing guidance, analysis tools, scoring rubrics, and resources for carrying out a clear, complete, and consistent examination of health education curricula (<http://www.cdc.gov/healthyyouth/hecat/index.htm>).

**Homeless youth:** (A) means 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). Per Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act (Title X, Part C, of the No Child Left Behind Act).

**Implement:** to put into effect according to or by means of a definite plan or procedure. When an intervention has planned and predetermined components, it should be put into effect completely and with as little adaptation as possible.

**Instance of referral:** a count of each time a student is referred for at least one key sexual health service, regardless of the number of providers or services for which the student is referred.

**Interact:** A two-way communication that includes an initial action followed by at least one response from the receiver(s). Both the action and response must deal with substantive assistance on activities pertaining to the cooperative agreement. Note that a one-way e-mail blast, single e-mail, or simple recommendation of resources/materials without a return communication/response from the receiver(s) does not fall under the definition of interact.

**Key Sexual Health Services (SHS):** includes the following: HIV testing, STD testing, STD treatment, pregnancy testing, provision of condoms and condom-compatible lubricants (e.g., water- or silicone-based), provision of contraceptives other than condoms (e.g., birth control pill, birth control shot, IUD), and human papillomavirus (HPV) vaccine administration.

**Materials:** resources approved by an HIV materials review committee, including written materials (e.g., curricula, training materials, and pamphlets); audio visual materials (e.g., motion pictures and video tapes); pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings); and electronic resources (e.g., web sites, PDF files, and PowerPoint files).

**Parent:** the adult primary caregiver(s) of a child's basic needs (e.g., feeding, safety). This includes biological parents; other biological relatives such as grandparents, aunts, uncles, or siblings; and non-biological parents such as adoptive, foster, or stepparents. Parents guide the child's upbringing, which includes the interaction processes between parent and child that contribute to the child's emotional and social development.

**Partnership:** a relationship among a group of individuals or organizations that agree to work together to address common goals. Partnerships involve mutual respect, coordination of administrative responsibility, establishment of reciprocal roles, shared participation in decision-making, mutual accountability, and transparency.

**Professional development (PD):** the systematic process used to strengthen the professional knowledge, skills, and attitudes of those who serve youth to improve the health, education, and well-being of youth. Professional development is consciously designed to actively engage learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of professional development offerings (events, information sessions, and technical assistance).

**Policies:** official mandates adopted by an authoritative governing body (e.g., school district boards of education, the state school board, state legislature, or other district or state agencies) that affect the environment in schools or throughout the state. These include policies developed by an agency or based on model policies developed elsewhere. Policies include legal codes, rules, standards, administrative orders, guidelines, mandates, or resolutions. Policies can be adopted at the school, state, or federal level but are implemented at the school level.

**Policy assessment:** a process to identify relevant policies; determine their alignment with requirements; identify gaps; and prioritize actions to address those gaps.

**Policy monitoring:** a continuous and systematic process of collecting and analyzing data to compare how well a policy is being implemented against its expected results.

**Priority districts:** school districts within the funded SEA in which youth are at high risk for HIV infection and other STD. These districts will be the primary focus of SEA technical assistance efforts throughout the duration of the FOA. SEAs have obtained written agreements from their priority districts in order to collaborate and provide support over the five years on implementing ESHE, SHS, and SSE.

**Priority schools:** schools within the funded LEA in which youth are at high risk for HIV infection and other STD. These schools will be the primary focus of LEA technical assistance efforts throughout the duration of the FOA. LEAs have obtained written agreements from their priority schools in order to collaborate and provide support over the five years on implementing ESHE, SHS, and SSE.

**Qualified personnel:** for the purposes of providing assessment of sexual health service needs, individuals (e.g., clinician, counselor, other trained staff member) who have received formal training on conducting a sexual health assessment and making referrals for adolescents.

**Recommend or require:** put forward (someone or something) with approval as being suitable for a particular purpose or role; or to demand or mandate as necessary and essential.

**Referral:** describes a process of assisting students in obtaining sexual health services through a variety of activities, including, but not limited to, connecting students to youth-friendly providers on the basis of an identified need. See also “Instance of Referral.”

**Safe and Supportive Environment (SSE):** an environment characterized by the absence of discrimination, intimidation, taunting, harassment, and bullying. Creating SSEs at schools involves school personnel, leaders of community organizations, parents, and youth building positive, supportive, and healthy environments that promote acceptance and respect. Schools can assist by implementing clear policies, procedures, and activities designed to prevent bullying and violence and promote health and safety.

**School-based Health Center (SBHC):** a health center on school property where enrolled students can receive primary care, including diagnostic and treatment services, usually provided by a nurse practitioner or physicians’ assistant.

**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.

**School Health Index (SHI):** an online self-assessment and planning tool schools can use to improve their health and safety policies and programs. (<http://www.cdc.gov/healthyyouth/shi/>)

**School staff:** includes a variety of individuals who are paid to provide specialized instruction, support, or services to students or staff in a school, whether employed by the school district or contracted through other agencies and organizations. School staff includes but are not limited to administrators, teachers, counselors, education support professionals (clerical staff, maintenance workers, paraprofessionals, school nurses, etc.), and substitute educators.

**Scope and sequence:** a pre K-12 curricular structure that outline the breadth and depth of key health learning concepts across grade level(s) (scope) and the logical progression of essential health knowledge, skills and behaviors to be addressed at each grade level or grade group (sequence).

Together a scope and sequence of learning bring order to the delivery of content, supporting maximum student learning and offering sustained opportunities for learning.

**Sexual Health Services:** See “Key Sexual Health Services.”

**Service learning:** a teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experience, teach civic responsibility, and strengthen communities.

**Sexual harassment:** unwelcome conduct of a sexual nature. Sexual harassment can include unwelcome sexual advances, requests for sexual favors, and other verbal, nonverbal, or physical conduct of a sexual nature.

**Technical assistance (TA):** the targeted provision of advice, assistance, and training pertaining to the development, implementation, maintenance, and/or evaluation of programs.

**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. 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.

## Appendix D – Program 1308 Strategy 3 Partners

CDC provides funding for national non-governmental organizations (NGO) to help state and local education agencies deliver exemplary sexual health education emphasizing HIV and other STD prevention (ESHE); increase adolescent access to key sexual health services (SHS); and establish safe and supportive environments for students and staff (SSE).

### CAI: LEA NGO – Sexual Health Services

Contacts      Amanda Brown  
212-594-7741 x.294  
[abrown@caiglobal.org](mailto:abrown@caiglobal.org)

Dawn Middleton  
212-594-7741 x 243  
[dmiddleton@caiglobal.org](mailto:dmiddleton@caiglobal.org)

Org website   <http://www.caiglobal.org/caistage/>

CAI is a leading mission-driven nonprofit organization that tackles the toughest health and social issues that confront low-income communities and underserved populations. They work as trusted partners with numerous client agencies to foster and inspire change that improves the health and well-being of vulnerable communities. CAI has a broad range of capacity-building services to help providers enhance their quality of care and increase access to resources for vulnerable populations and underserved communities.

**1308-Specific Services:** CAI will provide capacity-building assistance to 1308-funded LEA around establishing and implementing effective referral systems for priority schools. CAI offers assistance with:

- Tailored and individualized professional development
- Web-based learning opportunities
- Expert and peer-to-peer coaching
- Collaborative learning experiences
- Cluster training
- Electronic dissemination of resources and tools

Visit CAI's [website](http://www.caiglobal.org/caistage/) to learn more about their general services.



## National Coalition of STD Directors (NCSD): SEA NGO – Sexual Health Services

### Contact

Org website [www.ncsddc.org](http://www.ncsddc.org)

NCSD works toward the development of systemic change and promotion of sexual health and national awareness of policies related to sexually transmitted diseases. NCSD is a membership organization representing STD programs throughout the country. They use the collective knowledge and experience of their members to advocate for STD policies and funding that help promote and protect the sexual health of every American.

NCSD is the only national organization with members that provide frontline STD services, using their expertise to promote informed sexual health policymaking. NCSD proactively seeks to increase resources for core STD programs and services and responds swiftly on efforts to curtail access to services and sexual health information.

**1308-Specific Services:** NCSD provides tailored assistance to 1308-funded SEA related to increasing youth access to key sexual health services. NCSD offers assistance with:

- Educating key decision makers on the importance of sexual health services for youth
- Building the capacity of schools to deliver or refer students to sexual health services
- Establishing organizational linkages and partnerships
- Assessing clinical services for inclusion of key sexual health services, youth and LGBTQ friendliness, and cultural appropriateness
- Developing a referral system and protocols/policies
- Assessing reimbursement eligibility
- Assessing local and state sexual health service related policies
- Advancing sexual health plans, policies, and frameworks
- Strategic partnership and coalition building
- Action plan development

Visit their organization [website](http://www.ncsddc.org) to learn more about their general services.

## **GSA Network: LEA NGO – Safe and Supportive Environments**

Contact Christopher White  
415-375-9564  
[cwhite@gsanetwork.org](mailto:cwhite@gsanetwork.org)

Org website [www.gsanetwork.org](http://www.gsanetwork.org)

GSA Network is a national youth leadership organization that connects school-based Gay-Straight Alliances (GSA) to each other and community resources through peer support, leadership development, and training. GSA Network supports young people in starting, strengthening, and sustaining GSA and builds the capacity of GSA to:

- Create safe environments in schools for students to support each other and learn about homophobia, transphobia, and other oppressions
- Educate the school community about homophobia, transphobia, gender identity, and sexual orientation issues
- Fight discrimination, harassment, and violence in schools

**1308-Specific Services:** GSA Network will provide specific capacity-building assistance to 1308-funded LEA to help create and maintain safe and supportive environments for students and staff, increase the positive experiences of all young people in local jurisdictions, and support youth at disproportionate risk such as: LGBT youth, homeless youth, and youth in alternative schools. GSA Network offers assistance with:

- Educating policymakers on science-based policy
- Implementing and tracking policies
- Promoting school connectedness and parent engagement
- Establishing and strengthening Gay-Straight Alliance clubs or similar student-led groups
- Developing training programs for school staff
- Establishing organizational linkages and partnerships
- Increasing opportunities for mentoring and other activities with adults in schools
- Implementing LGBT-inclusive curricula and lesson plans

Visit their organization [website](http://www.gsanetwork.org) to learn more about their general services.

## American Psychological Association (APA): SEA NGO – Safe and Supportive Environments

Contact        Lacey Rosenbaum  
                    202-336-6055  
                    [lrosenbaum@apa.org](mailto:lrosenbaum@apa.org)

Org website   [www.apa.org](http://www.apa.org)

The APA is the largest scientific and professional organization representing psychology in the United States, with nearly 130,000 researchers, educators, clinicians, consultants and students as its members. The APA's mission is to advance the creation, communication, and application of psychological knowledge to benefit society and improve people's lives. Within the APA, the Lesbian, Gay, Bisexual, and Transgender Concerns Office (LGBTCO) works to advance the creation, communication, and application of psychological knowledge to improve the health and well-being of lesbian, gay, bisexual, and transgender (LGBT) people, to increase scientific understanding of gender identity and sexual orientation, and to reduce stigma, prejudice, discrimination and violence toward LGBT people.

**1308-Specific Services:** the Safe and Supportive Schools Project of APA will help 1308-funded SEAs create and promote safe and supportive environments to prevent HIV and other sexually transmitted infections among adolescents. Through customized training, technical assistance, and consultation, their project will work to increase capacity to help school districts create safe and supportive environments for all students and staff and for groups of youth at disproportionate risk.

The Safe and Supportive Schools Project promotes three key strategies:

- Preventing bullying, sexual harassment, and electronic aggression
- Improving school connectedness
- Promoting parental engagement in schools

APA offers assistance with:

- Identifying research, quality resources, and professional development on SSE
- Accessing online professional development, including follow-up support, about the evidence base for SSE, selecting and implementing SSE strategies, and assessing and monitoring SSE policies
- Developing and sharing resources for school counselors, psychologists, nurses, and social workers on establishing SSE

Visit their organization [website](http://www.apa.org) to learn more about their general services.

## Healthy Teen Network (HTN): LEA NGO – Exemplary Sexual Health Education

Contacts      Valerie Sedivy  
                    [valerie@healthyteennetwork.org](mailto:valerie@healthyteennetwork.org)  
                    Mila Garrido  
                    [Mila@healthyteennetwork.org](mailto:Mila@healthyteennetwork.org)  
                    Alexandra Eisler  
                    [Alexandra@healthyteennetwork.org](mailto:Alexandra@healthyteennetwork.org)

Org website    [www.healthyteennetwork.org](http://www.healthyteennetwork.org)

Healthy Teen Network fosters a national community where all adolescents and young adults are supported and empowered to lead healthy sexual, reproductive, and family lives. Located in Baltimore, HTN is the only national membership organization that serves as the leading voice for adolescent sexual and reproductive health professionals, offering a unique and integrated, *Youth 360°*, perspective on youth health and well-being, including pregnant and parenting teens. Since 1979, HTN has been providing education, advocacy, and networking to build the capacity of professionals and organizations to assist all adolescents and young adults to access the services and education that allow them to make responsible choices.

**1308-Specific Services:** HTN will provide capacity building assistance to help 1308-funded LEA implement all ESHE activities. They tailor their support to specific needs and may conduct site visits, virtual and in-person professional learning events, and/or remote capacity-building assistance. They offer assistance with:

- ESHE policy assessment
- Engaging stakeholders, including youth and parents, in ESHE
- Working with a SHAC
- Selecting, reviewing and adapting curricula to meet ESHE requirements
- Providing professional learning to teachers

Visit their organization [website](http://www.healthyteennetwork.org) to learn more about their general services.

## **Advocates for Youth (Advocates): SEA NGO – Exemplary Sexual Health Education**

Contacts      Mary Beth Szydlowski  
                    [marybeth@advocatesforyouth.org](mailto:marybeth@advocatesforyouth.org)

Org website   [www.advocatesforyouth.org](http://www.advocatesforyouth.org)

Advocates for Youth champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health. Since its founding in 1980, Advocates for Youth has served as a bold voice and respected leader in the field of adolescent reproductive and sexual health. For more than three decades, the organization has worked tirelessly to promote effective adolescent reproductive and sexual health programs and policies in the United States and the global south.

**1308-Specific Services:** Advocates can assist 1308-funded SEAs in assessing, adapting, and implementing policies and practices that support the implementation of ESHE to increase young people’s knowledge and skills to make healthy decisions about their sexual health.

Depending on specific needs, Advocates offers assistance with:

- Electronic and print resources and tools
- Individualized, intensive technical assistance
- Tailored, in-person training and follow-up support
- Peer-to-peer support and leadership coaching

Visit their organization [website](http://www.advocatesforyouth.org) to learn more about their general services.