

CDC Town Hall Teleconference

HIV Among Youth in the US

December 4, 2012  
2:00pm – 3:00pm EST

Coordinator: Welcome and thank you for standing by. At this time all participant lines are in a listen-only mode. After today's presentation, you'll have the opportunity to ask questions, and at that time you may press star then 1 on your phone's keypad to ask a question. Today's conference call is being recorded. If you have any objections to this please disconnect now. And now I would like to introduce your host for today, Dr. Judy Monroe. You may begin.

Judy Monroe: Thank you Operator. So good afternoon everyone. Thanks for taking time to join us. I am Dr. Judy Monroe, Director of CDC's Office for State, Tribal, Local and Territorial Support. Very happy that you could join us. But before we get started I want to go over a few housekeeping details.

Remember to go online and download today's PowerPoint presentation so you can follow along with the presenters. You can do this by going to the Web address, <http://www.cdc.gov/stlt>- that's S-T-L-T, public health, all one word, so S-T-L-T public health, and there's a link then directly to the Town Hall Web site that you'll find under the highlighted Products and Resources on the bottom right.

On this page you can also view the bios for each of our presenters today. This is where we will add the audio recording and the transcript for today's meeting. They should be available on the Web site the next week for you. Before beginning the presentations, I'd like to recognize certain audience members who will be joining the call today.

These are clinical educators and residency program staff who are part of CDC's Primary Care and Public Health Initiative. This is an exciting initiative for CDC that we launched in early 2012, that aims to improve health by integrating clinical medicine and public health through residency education.

And our hope is that this approach will be an effective way to address the significant health issues facing our nation, add to the multiple strategies that these complex problems take. More information can be found about that initiative at [www.cdc.gov/primarycare](http://www.cdc.gov/primarycare).

Today's joint call presents a unique opportunity for public health and primary care colleagues to interact, exchange ideas and learn more about today's important topic. During this teleconference we will discuss the latest *Vital Signs* report, which focuses on HIV among Youth in the United States.

With the 24th World AIDS day having been held this past Saturday, it must be noted that progress has been made over the years. However, the numbers are still staggering. Globally, an estimated 33.3 million people have HIV. Recent data for the United States alone indicate that one in four HIV infections occurs in youth ages 13 to 24, and moreover, 60% of youth are unaware that they're infected.

CDC is heavily engaged in this core public health issue. Our efforts include school-based prevention programs, the tracking of national surveillance data, and the provision of educational materials designed to promote behavioral intervention and risk reduction. We will learn more about each of these steps during today's presentations, as well as how schools in the Los Angeles area are addressing HIV/AIDS among youth.

On today's call we will hear from three distinguished colleagues who will share the latest statistics and insights regarding this crucial topic and what can be done to counter it. First we will hear from Dr. Linda Koenig, who serves as CDC's Associate Deputy Director for Behavioral and Social Science in the Division of HIV/AIDS Prevention, which is part of the National Center for HIV, Viral Hepatitis, STD and TB Prevention.

Dr. Koenig will discuss the latest data regarding youths living with HIV, as well as statistics regarding the rate and transmission of new infections. She will then hand the call over to Howell Wechsler, Director of CDC's Division of Adolescent and School Health, which is again part of the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention.

Dr. Wechsler will provide interesting data concerning HIV infection, testing and risk behavior among youth. He will also highlight tools that are helping schools implement effective policies and practices, such as promoting parent engagement in school health.

And our last presenter today will be Timothy Kordic, Program Manager of the HIV/AIDS Prevention Unit of the Los Angeles Unified School District. Mr. Kordic will talk about accomplishments and lessons learned in L.A. County, including a requirement that HIV/AIDS education be taught in schools.

He will also share two new innovative programs, one of which is called Project U, which is a sex information Web site developed by teens for teens. Please note there will be time for questions after the presentations, but you can get in the queue to ask a question at any time during the teleconference. Just press star 1 and record your name when prompted. And now I turn the call over to Dr. Koenig.

Linda Koenig: Thank you Dr. Monroe, and thank you everybody. Thank you for having me here today. As Dr. Monroe mentioned I'm going to be talking about data from our recently published *Vital Signs*. And in particular I will be talking about HIV infection and HIV testing among youths in the United States, focusing on our HIV surveillance data as well as data on HIV testing from the National Health Interview Survey. Next slide please.

In 2009, youths, which we defined as persons aged 13 to 24 years of age, represented 21% of the U.S. population. They comprised 6.7% of persons living with HIV, and more than half, 60% were unaware of their infection, the highest percentage unaware for any age group. Next slide.

In this report, we describe, among youth, the rates of those living with a diagnosis of HIV infection at the end of 2009, the estimated number of new infections in 2010, as well as the percentage of youth aged 18 to 24 who'd ever been tested for HIV. We also included data on testing among high school students, and Dr. Wechsler will be presenting that in a few moments. Next slide.

We used data from the National HIV Surveillance System to calculate the prevalence for 100,000 by state, among persons age 13 to 24 years living with diagnosed HIV infection at the end of 2009. And we also used National HIV Surveillance System data to calculate the number of new infections, that is the incidence among youth by sex, by race/ethnicity and by transmission category in 2010.

And finally, data from the 2010 National Health Interview Survey were used to calculate the percentages of persons aged 18 to 24 years who had ever been tested for HIV. We calculated this overall, and by sex, by race/ethnicity, and by whether they had an HIV risk factor. Next slide please.

So let me turn to the results. This figure that you're looking at shows the prevalence rates of persons aged 13 to 24 years who were living with a diagnosis of HIV infection in the U.S. at the end of 2009. And that prevalence was 69.5 per 100,000.

The rates varied widely by state, anywhere from 2.3 to 562.8 per 100,000 population. And as you can see by looking at the map, the rates were higher in the South and the Northeast than in the West and in the Midwest. Next slide please.

Turning to new infections, in 2010, of the 47,500 estimated new infections, 12,200 or 26% were among youth. Of these new infections among youth, 83% were among males and 17% were among females. Over half, 57% of the newly infected youths were blacks/African American, and 20% were Hispanics or Latinos, and 20% were white. Next slide.

This chart shows the new HIV infections among youth by sex and race/ethnicity. And what you can see here is that more new infections occurred among young African American males than in any other group of youth by race/ethnicity and sex. Nearly half of the new infections among youth, 46% were in black or African American males.

There were an estimated 7000 newly infected youths who were black or African American, 5600 were males, 1400 were females. There were an estimated 2390 infections among Hispanics/Latinos, 2100 among males, 290 among females, and 2380 among whites, 2100 among males and 280 among females. Next slide.

By transmission category, most - 72% of the new infections among youth were attributed to male-to-male sexual contact. Twenty percent were attributed to heterosexual contact, 4% were attributed to injection drug use and 4% were attributed to male-to-male sexual contact and injection drug use. Next slide.

So these charts you're looking at present the percentage distribution of new infections, either among females which is on the left, or among males which is on the right, by transmission category. So looking at the chart on the left, among female youth, most new infections, 86% were attributed to heterosexual contact, 13% of new infections were attributed to injection drug use.

And looking at the chart over on the right, for males, most new infections, 87% were attributed to male-to-male sexual contact, 6% were attributed to heterosexual contact, and a small percentage were attributed - sorry, a small percentage were infected through injection drug use, 2.2% to injection drug use alone and 4.5% to male-to-male sexual contact and injection drug use. Next slide.

Finally, this chart presents the percentage distribution of new infections attributed to male-to-male sexual contact by race/ethnicity. There were 8800 new infections among youth that were attributed to male-to-male sexual contact. Of these, over half, 54% were in blacks or African American. Hispanics/Latinos accounted for 22% and whites accounted for 20% of new infections.

Thirty-nine percent of the new infections, or 4800 out of 12,200 new infections among youth were in black/African American young men who have sex with men. Next slide. This table presents HIV testing in older youths.

These numbers are the percentages of person aged 18 to 24 years of age who had ever been tested for HIV, overall, in the Total column on the right, by sex, in the columns on the left and the middle, and then by race/ethnicity and by whether the person has an HIV risk factor.

In 2010, 34.5% of persons aged 18 to 24 years had ever been tested for HIV. Testing was higher amongst females, 45%, than among males, 24.1%. And testing was higher among blacks or African Americans, 53.3% than among Hispanics/Latinos, 36.2%, or among whites, 29.8%. Testing was higher for those, both males and females, who had an identified HIV risk factor. Next slide please.

In conclusion I'd like to make three points. First, young people are becoming infected at high rates. Youths accounted for one quarter of the new HIV infections in 2010. That's about 1000 young people infected with HIV every month, and most do not know that they're infected. Two, too few young people are getting tested for HIV. Youths who are at higher risk for HIV are more likely to get tested, but still many have never been tested. Next slide.

And finally, significant disparities exist. Young gay and bisexual men and African Americans are hit harder by HIV than their peers. Nearly half of the new infections among youth were in black or African American males, and the majority of which were attributed to male-to-male sexual contact.

This means that prevention efforts are needed at every level, public health agencies, healthcare providers, educators, families, communities, in order to achieve the goals of the National HIV/AIDS Strategy, which includes reducing new infections and reducing disparities. And prevention efforts are

also needed at every level if we're going to protect the health of a new generation. Thank you.

Howell Wechsler: So good afternoon, this Howell Wechsler. I'm the Director of the Division of Adolescent and School Health at CDC. Thank you Linda. Beyond the incidence data, last week's *Vital Signs* report tells us two important things. One, as Linda indicated, too few young people are getting tested for HIV, and two, young gay and bisexual men report much higher levels of risky behavior than their heterosexual peers.

Most of these data come from the Youth Risk Behavioral Surveillance System, which my division manages. As you can see on Slide 19, the YRBS tells us what high school students across the country are doing that might affect their health. We collect these data every two years and have been doing so since 1991, so we have tremendous trend data available.

Another great thing about the YRBS is that it gives us national data, but it also gives us, in most states and territories, data that's representative of high school students in those jurisdictions, as well as in a large number of large urban school districts. The surveys are anonymous and self administered, and to make sure that the schools keep on letting us in to do it, we keep it to a number of questions so that the kids can complete it in one class period.

But you can see, the YRBS covers the gamut of health issues related to the key factors that influence the health of young people, injuries, substance use, obesity related behaviors, and of course sexual behaviors. You see on the right side, with a click - thank you, if you click on your computer you will see another box there that indicates the type of sexual behavior information that we obtain.

We can see what percentage of young people have ever had sex, when they first had sex, whether they've had sex with multiple partners, if they had sex recently, do they use condoms and contraceptives, did they use alcohol or other drugs before having sex, and then the national data set, we collect information on whether they have been tested for HIV.

And in a growing number of the states, territories and cities, they collect data that allows us to classify youth based on their sexual minority status, which allows us to identify disparities that exist between sexual minority youth and their heterosexual peers.

If we go to Slide 20, you'll see that the state surveys cover most of the nation. We can get that data in most states. There are three states highlighted in white, Minnesota, Washington and Oregon, where they have pre-existing other school-based youth surveys, so they don't participate in this system.

And every time we administer it there's a couple of states that don't quite get enough samples. You can see the other four shaded states didn't quite get enough schools and students to participate in 2011. I should also add that there are five states that do not include in their YRBS the sexual behavior questions.

And if you're in Utah, Louisiana, Georgia, Virginia, you might want to ask why that's so, and you might want to educate the folks responsible there about why it's so important to have these data. In most states, it's administered by the education agency but in a growing number of states it is the health department that administers the YRBS.

If we go the next slide, 21, we'll see some of the data that was reported in the *Vital Signs*. Thirteen percent of our high school students across the nation have been tested for HIV, but this slide looks at the percentage of students

who've ever had sexual intercourse as the denominator, and we see 22% of high students who've ever had sexual intercourse reported that they had been tested for HIV.

Now this is much more common among females than males, and among black students compared with white or Hispanic students. You can see almost 1/3 of the black students have been tested for HIV. I can also tell you, though, that 60% of the black students reported that they have ever had sex. So we feel that this is a serious under-utilization of the importance of HIV testing.

If we go to Slide 22 we'll see data from another set of YRBS reports. This comes from 12 states and nine large urban school districts that did ask questions related to sexual minority status. They asked with whom the young people did engage in sex. And it compares the percentage of male high school students who reported having sex with males only, or with males and females versus those who have only had sex with females.

And you can see that the risk levels are much higher, there's a much higher percent of males who've had sex with males who report having four or more sex partners, a huge disparity in terms of ever injecting illegal drugs. And the young men who have sex are even, are considerably more likely to report that they had not been taught in school about AIDS or HIV infection, compared to young males who have had sex only with females.

You go to Slide 23 you'll see more disparities, young men who have sex with men are a little more than 50% more likely to report that they drank alcohol or used drugs before last sexual intercourse, compared to young men who've only had sex with females.

And then similarly, they are almost - the young men who've had sex with men are almost twice as likely to report that they did not use a condom at last sexual intercourse, compared to the young men who've had sex only with females.

These are very, very powerful data. They're supported by a number of other studies. And in fact many of their risk behaviors that we measure through YRBS, young men who have sex with men are at a disadvantage for. So it's very important that we focus on this population.

If you go to Slide 24, you'll see the actual list of states, cities and territories. There were 14 states, 11 cities and 2 territories that asked questions that allowed us to do these analyses based on sexual minority status in 2011. This is by far the most states, cities and territories that have done this, and we expect this number to grow in 2013.

Again, if most of you represent states that participate in the YRBS, and I urge you to engage in discussions about the importance of collecting these types of data. All right, if we go to Slide 25, you'll see - I wanted to just give you access to getting more information from the Youth Risk Behavior Surveillance System.

You can go to our Web site, [cdc.gov/yrbs](http://cdc.gov/yrbs), and we have an absolutely terrific online system that lets you manipulate the data and do all sorts of things. It's called Youth Online, and you can use it to create your own charts and graphs in a matter of seconds, that will compare results by demographic factors, show trends over time. And you can compare your state versus another state, or your city versus another, or your state or city versus the United States as a whole.

I want to take a few minutes and tell you a little bit more about the work that our division, the Division of Adolescent and School Health does in HIV/STD prevention. So if you go to Slide 26 it shows that we have two other surveillance systems that collect data on school health policies and practices, just what are schools doing to address the health problems that our young people face.

One of them collects data on a national basis, and the other provides you with data on what's going on in your state and in many large cities. These surveys cover the gamut. They cover all of those health issues that I mentioned before and quite a few others as well. But here are some of the HIV/STD related topics that are measured.

They give us information in your state, your city, across the nation on the extent to which schools are teaching the specific topics that need to be taught in sex education, the hours that they spend instructing students about HIV and STD prevention. Are condoms available in the school setting?

Do schools provide HIV counseling, testing and referral? Are there services specifically provided for gay, lesbian and bisexual students in the school setting? Just a sampling of the data that's available from the risk sources, the data that's available from these surveillance systems.

The next slide, 27 shows some of the products that come out of our division. We spend a lot of effort preparing research syntheses that enable us to provide evidence-based guidance to schools on what are the most effective policies and practices they can implement to prevent HIV and STD.

And then we develop tools to help schools implement those effective policies and practices. And here are some of our more prominent tools. On the left you

see a document that lays out strategies that schools can do to engage parents in a more effective way in school health programs. In the middle is the School Health Index, which is a self assessment and planning guide to help schools improve their policies and practices related to health.

And on the right is the HECAT, the Health Education Curriculum Analysis Tool, which is the standard tool in the field now that helps school districts select curricula in health education including sex education that are most likely to have an impact on student behaviors.

Finally, on Slide 28, summarizes our programmatic activity. We provide funding and technical assistance to just about every state, but it goes to the state education agencies, who should be working in collaboration with their state health departments. And we would love to work with you and help you collaborate more closely with them.

We also provide funding for six territorial education agencies, one tribal government, and 16 of the largest urban school districts in the country to implement HIV/STD prevention programs, and just in a moment you're going to hear from one of those, the leaders of one of those large urban school district programs.

Our programs focus on three particular areas. They help school districts and schools implement effective sexual health education, promote youth access to sexual health services including access to condoms and HIV/STD testing, often done in collaboration with their health departments.

And thirdly, they help schools establish safe and supportive environments for all students, including and especially the lesbian, gay, bisexual and transgendered students, who are such an important population for us to

address, and who suffer from so much stigma and discrimination, harassment and bullying, and we really have to do all we can to make the school environment more safe and supportive for these young people.

Finally, on Page 29, if you want to learn more about our division's activities, please go to our Web site. It's [cdc.gov/healthyyouth](http://cdc.gov/healthyyouth). Thank you very much, and I think we're going to go out to the West Coast now and hear from Tim Kordic in Los Angeles.

Timothy Kordic: Good afternoon everybody. Thank you for having me on today, and thanks to DASH, Division of Adolescent and School Health for all the funding that has created the foundation here at LAUSD for all the work that we do.

I'm going to go to Slide 31. I'm going to give you a brief background and - about our unit, and some program descriptions, some of the accomplishments and our lessons learned. However, this by no means will be the total of what we do. Due to time restrictions we only will give you a small snapshot of the strategies and activities we offer in Los Angeles.

So current HIV burden in Los Angeles County, well we have a very large population, as you know. We're the second largest city in the country. And we have approximately about 2-1/4 million youth in L.A. And of concern mostly are lower poverty, because we know racial, ethnic and socioeconomic groups infected with HIV increasingly are lower income people of color, especially our MSM populations.

The age and gender of these infected are most - are diverse, but an increasing proportion of these new infections are occurring among young adults, which we are seeing in our schools. Among these black and Latino YMSM in Los

Angeles are of concern for us, approximately 84% of people diagnosed with HIV annually are MSM.

MSM ages 13 to 29 years were the group most frequently diagnosed with HIV. Among YMSM, Latinos represent the largest number of new HIV infections, but the blacks, unfortunately, have the highest rates of new diagnoses, primarily based on population size.

If you go to 34 it'll give you a little map of our school district. We're the second largest in the nation. We have about 664,000 K through 12 students, however, we do have another almost 300,000 students that are involved in our adult education programs. Many of those are teen parents and dropout students so they're not included in this but they're a big part of our population as well.

We have about 85 middle school campuses, about 94 senior high school campuses. This represents campuses, not necessarily schools. We have several schools on a campus as well. So at any given time, we have really about 470 elementary schools, 229 - 296 secondary schools, and we have about 230 charter schools that are not accounted for here as well, and that makes a big difference in our numbers and the information that we seek.

And with this, we have about 9% to 12% of our high school youth identifying as gay - lesbian, gay and bisexual. If you include transgender, unsure populations and other surveys that we've done, it goes up to about 12%. On Slide 34 - I'm sorry, 35, required HIV/AIDS education in California, schools have education code that require all school districts to include HIV prevention education in Grade 7 through 12 at least once.

So we have, in our school district, we have Grade 7 and Grade 9 selected out to do that. We have a full semester course with a semester, with a credentialed health teacher that teaches that. Instructors must be trained in appropriate courses. That's partially my job. I train teachers to do that, and then our curriculum, our evidence-based curriculum.

This may not reflect or promote bias against any persons on the basis of sex, ethnic group, national origin, religion, color, mental or physical disability or sexual orientation. This is very big for us because we have a lot of resolutions, in our district in particular, especially for LGBT youth, and we want to make sure that those resolutions are followed, and this - and so our mission and our resolutions are a reflection of this.

On Slide 36, our prevention unit has lots of missions and goals. I wanted to give you a snapshot of that as well. We want to improve the quality of HIV instruction in our schools, collaborate with community partners, which truly are our partners. We cannot do the work that we do because we are so large. We're 210 square miles big.

We are not only large but we're also very region specific, culture specific, race specific, poverty specific, so building capacity with partners and make sure everything happens in Los Angeles is key to us. Monitoring health education programs and health behaviors that put us at risk for HIV infection, our LGBT youth right now are struggling and they are our most at risk population.

So we have tried to design programs in place that will make sure that we not only target our LGBT youth but also our black and Latino youth as well. Policy changes, innovative practices that we have are many in our inner schools and I'm going to talk about a few of them, and I'm going to give you a little bit of information around this.

So reshaping schools climate for LGBT and YMSM youth, we have a lot of board resolutions around this. We have a lot of effective programs in place. We have - I'll talk about it a little bit in the next slide, about some of the resources we offer to the schools around this as well.

We'd like to expand our opportunities for LAUSD to get access to prevention and testing, along with our policies and our board mandates for our full semester health courses, this is all incorporated within them. We also make sure that the prevention doesn't only include HIV but it also includes other aspects like violence, alcohol, drugs, things like that.

We also have the mental health piece of that around suicide, and we also make sure we have certain offices in place to make sure this is happening. In terms of projects for testing, we have done some wall to wall testing in some of our schools. We look to our DPH departments, our health departments to make sure that happens with us.

We go to public health for that information. We figure out what schools are having the biggest issues in our district, and we go and we target them usually with some STD testing. Of course, we use testing (vans) as well, but we have a lot of other models that we're looking at in the future, to make sure these kids are getting tested in high school, as they're in this community before they go to a new community in the college level.

Reshaping the school climate and the environment is not always easy, but we've been lucky enough to have the progressiveness of our board to be able to take this in that direction. So we have quite a few things that we make sure meet that requirement. For one, we have our evidence-based curriculum,

Positive Prevention for HIV and STDs. We have our Sexuality in Society textbook as well.

This is - goes alongside our Health textbook. Now the difference is that this particular - this covers comprehensive sexual health. And so we make sure that our education code is met through this book in particular. It's also the first book in the nation that has a chapter on LGBT relationships.

One of the big things that we pride ourselves on in the District is making sure that we are totally inclusive. Everything we do, all our resources, everything we have has to be inclusive to all populations. That's how we interpret the law here in California. We offer an LGBTQ Resource Tool Kit. We offered this for the first time a couple of years ago.

It offered several different resources for schools, specific to LGBTQ populations. We were lucky enough in this window of time when we had a lot of people looking at what was happening with our gay youth in our schools. We had a lot of the suicides going on. We had a lot of things happening in our school district, and we wanted to make sure we covered it.

And we are working with a coalition called Connect to Protect, also federally funded, and we had a Schools Committee. And the Schools Committee came up with an idea around a tool kit. This eventually evolved into many partnerships, with the GSA Network, with (Glissen). The Save Space kit was put in here. We had multiple resources around sexual orientation.

We had displayables for all the schools including all public areas like the libraries, that have specific - not just about the laws. They had a one on laws specific to harassment, things like that but also on services. So what in the District do we have that's specific to LGBTQ youth and what will help them?

What services we have in the community, we had separate displayables for all of those things that had never happened in our district before.

Professional development was a very big part of this as well. But we had to make sure that not only - due to the fact that we all know that students hear horrible things all the time, not only from their peers but also from our faculty. And so we wanted to make sure professionalism was a big part of this and making sure that the right language was being used, make sure that gender-neutral language was in place.

Things like that were key to a lot of this. Not only that, but also understanding the public health model. A lot of the time the District is coming from an academic perspective. Many of our teachers only know the educational pieces and strategies. And we have to go in and make sure they're understanding the public health language, making sure they're understanding how the public health models work, what's awareness, what are process-based things, skill-based things that actually change behavior.

We rely on a lot of the public health resources in our public health system here, and we have lots of partners with our L.A. County Department of Public Health to make sure that's happening, and I'll talk about those briefly in just a minute.

So expanding opportunities for HIV prevention and treatment services, so we have several things that we do, but one of the newest things that we have done is we had, we got some seed money from the CDC Division of Adolescent School Health to do something on new media. There were three sites left in the country. We were one of them, and we decided to go with technology in the form of mobile texting and also online stuff.

Online format was really key for us, but we knew that the mobile phone was really hitting our youth, and not only our youth that are in schools, but a lot of our homeless youth were using the phones as their kind of means to communication and interacting. And we also have a lot of reform going on in our district right now, where a lot of schools, charter schools in particular, have the option to do health and not do health, where our regulars have to do health education.

So we wanted to make sure we have something in place that was credible, vetted through our process, appropriate developmentally and had access to information that they may not otherwise have in their other schools. So we created Project U. This was to increase the percentage of L.A. students who receive HIV and STD prevention education, in particular those schools that I talked about and charter schools.

And some of our most targeted youth in continuation schools are most at risk. We had a lot of students who are homeless. We have about 16,000 in our district. This is for them as well, that weren't finding the proper channels in the academic system. Increase percentage of LAUSD high school students who use condoms and access to HIV testing and sexually active, there are several things that this does for you.

So we partner with many people. This couldn't happen without the partnerships that we had in place because we weren't funded enough to do this entire project. So we got about half the funding we needed, and we relied on capacity building through the Department of Public Health, through our City of L.A., through our higher learning institutions like UCLA.

We relied on departments in our district, our after school programs to make sure that was happening. We also relied on the Art Center of College Design

to develop this kind of design for us. I was able to convince the university, UCLA and Art Center to develop courses in their schools to be able to create a campaign, and they also created a curriculum around this as well.

So we were able to do a lot with this, and we'll move on to the next slide. It will show you what this looks like. Now this kind of looks like a - we have a new version of this. It's not on here, but the new version is a little bit - it's all one place but just, this is an easier snapshot for you to take a look at.

We had a blog that was very content rich - this is the Web based piece now, very content rich. It had lots of information, interactive games, a blog for youth, live discussion chats, lots of things that went on outside of the text messaging. The text messaging, if you look at the box on Slide 40, the top right, that gave four specific things.

The text messaging component gave push messaging, which gave them, it relayed messages on a weekly basis to youth on sexual health and HIV prevention, now expanded to healthy relationships and tobacco prevention and other things as well. It also gave on demand messaging where kids were able to actually put in words like condom or contraception and put them in and get prompted by our system that was already created, to answer questions for them as well.

It also has a clinic finder on here to find your closest clinic. It also has a condom request system. Now this was a specific partnership with L.A. County Department of Public Health. And what we do is the students can actually request the condoms. They get ten free condoms that's going to their house in discreet packaging, with information of course and lubricant and things like that, so a great partnership with the County Department of Public Health for that.

We also - obviously you can see the free condoms there as well. You can sign up here also. I Know is an actual pilot as well. It's also a relationship with the County Department of Public Health, and it's a home test kit for Chlamydia and gonorrhea for females, hopefully to expand to males in the future with, as new things develop. But right now it's one specific for females where it'll be, it'll actually be sent to their home anonymously.

And we are now working with a special pilot to have that same test kit available in a nurse's office. So they would go out and sign up, and they would bring a sheet to a nurse in the office, and the nurse would actually issue that for them. So it's a new pilot that we're doing as well.

And you can see we also have the clinic finder here on line as well. One thing you're not seeing, which is in a separate page is the blog that we have. But for the most part, this was kind of way, a very grass roots approach to this. I should go back - one more thing about this is that we knew that as adults, we give the information, it doesn't necessarily mean the kids are going to actually go to it.

So one of the things we made sure did happen was this was completely student driven. So we held three different youth summits for youth, about 700 youth altogether. We made sure that the research we had behind this was there is the - from them. They told us what they wanted. They reviewed several campaigns across the country, hated most of them, told us what they wanted, and then we went to the Art Center and they designed what the students wanted.

Then we went back and vetted the actual campaign with the youth as well to make sure this met their demand. And it absolutely did. And so that's where

we are now, and we've developed now, street teams out of those summits for these youth to actually go into the schools and make the school (by role) themselves.

So we're not looking for ourselves to advertise this for them. We're looking for the youth to take this on, with some support from us and to do that. The other thing that this does is create an incentive system for them to be able to gain points for different information. So you can actually search this Web site, gain points for it, and gain incentives around this as well.

One of the other major projects that we have going on is AMP, Arts-based Multiple-intervention Peer education programs. We were looking for different innovative approaches outside the direct instruction to be able to give some information to youth as well, and do it in a way that was interactive, it expressed how they wanted to express themselves, and we found this was one of the great formulas that worked for us.

We worked with this program for several years to tweak it, to make sure it happened. This introduced students to new artistic processes and simultaneously educates them on important sexual health issues, but using visual and performing arts around that.

And so how do you give prevention education to students but do it through that medium? And so we have now had - not only do we have this program in place but we also have trained teachers at our annual conference as well on how to use theater education styles and activities to be able to introduce these sexual health topics in a way that's more kinetic, that's more engaging, that's more fun.

It was developed through a collaboration at the Arts and Global Health Center at UCLA. We have done a lot of work with this particular group, and I want to say that this is a whole model. It has several different components to it. One is the AIDS Ambassadors that goes to the schools and speak around more factual information but do workshops around condom art and things like that as well.

They have an Art Moves project that has different pieces of art that moves to each school site. It used to be at UCLA but now moves from school to school to show art, but the art's around HIV and sexual health topics. Positively Speaking is an HIV speaker bureau that I run, and that we send with them as well to the school sites.

The UCLA Sex Squad is a favorite. And the Sex Squad is a group of youth, a performance team that go out and do performances on their own sexual experiences and infusing prevention messages in it, so we train them to infuse those messages and to be able to respond and react to questions and answers afterwards with the youth.

And then the Through Positive Eyes, which is a documentary style thing that we helped fund with DASH dollars in L.A. on people living with HIV that we use in our schools.

Howell Wechsler: Tim, this is Howell. You have one minute left.

Timothy Kordic: I'm going. So our accomplishments are reshaping school climate. Forty thousand LAUSD employees have been, received the District's anti-bias training. Again, this is based on the fact that, you know, we hear a lot of the students talk about what they hear from the faculty and making sure that happens.

Another big factor for us is making sure that 62% of our LAUSD schools have gay/straight alliances and increasing. We have over 90 some gay/straight alliances, about 16 in middle schools. We know students have an affirming environments actually have the same academic outcomes.

We are also expanding opportunities for intervention and treatment services through AMP as well. We know that we've done a mini research project on this, and we saw a four times increase in students actually getting tested for HIV. We just completed another pilot research study with UCLA on this as well. We're still waiting for the results on that. This one was done a couple of years ago.

We had a 21% increase in students feeling compassion for people living with HIV through this Through Positive Eyes piece and 38% increase in students who knew where to get tested locally, which is a big plus for us. Also expanding opportunities for HIV prevention and treatment services with Project U, we're now - we started off with 30 pilot schools. We're now in more than 200 schools.

The Web site receives between 800 and 2600 visits daily. We have an evaluation in progress. We used YRBS as our baseline. We also did a supplemental survey on online sexual behaviors that gave us some information on what our youth were doing. We also have other things like polls and surveys and things like that going on as well. And so we continue to collaborate with local community organizations as well. We're - that's a big part. It's all about relationships for us.

And our lessons learned, so opportunities for partnerships between education and health agencies, we couldn't do this without our public health agencies, not only for their models and behavior change, but also for the fact that we

utilize them for our testing pieces. When we did wall to wall testing, we only, we worked with the Department of Public Health to make sure they're in our schools with us, that we're following protocol.

It just wouldn't be fundable for us as well, so we rely on them very much. We also have our school-based clinics, not listed on here, but our school-based clinics is our big link as well right now that we have. A lot of lessons learned from our school-based clinics. We used to do a lot of work in our schools, but not necessarily the most effective work. And now our school-based clinics are all focused on STD, HIV and teen pregnancy.

We have 14 new ones opening up this year and we have about 40 total. Supporting in schools, GSAs is always really important. We have several departments in LAUSD that make sure that happens. Linking schools to organizations that provide service for LGBT, we talked about the LGBT resource packet and what we did for that.

We go - of course, this is Los Angeles, so we have a lot of services in L.A. And we're lucky to have, so we continue to build on that, though, and making sure those appropriate people are in our schools, and making sure those presentations like the (Trevor) project is located in Los Angeles. And we have a lot of those presentations for school on suicide and things that provide district and school training for staff is also key on all these subjects as well.

So we make sure that our staff is trained and well versed in not only the policy but also what kind of things are available, since I'm in charge of what's approved and vetted to go into the school sites, and not only resource wise, but also who can come into the schools and speak, outfit presenters, groups like the AMP project, groups like that.

And we have probably about 20 different groups that go into our schools and present in different types of strategies and activities around the same topic of sexual health and HIV education. So a big role in this, of course, all comes down to a couple of things. One, funding, obviously, DASH, thank you very much.

And then also our mandates in our district, and making sure the structural changes are in place as well. If those structural changes aren't in place first, then we'll have a lot of problems. And making sure from the top down that we have the support from our board, from our superintendent and everybody else.

And the next thing is, is the last thing I'd like to say is targeted approaches are very key. Our YMSM population have been at risk for a while. We've worked very hard to find strategies that worked for them, hitting topics. Our AMP project, our Sex Squad in particular hits a lot of LGBTQ topics in their presentations.

But we also need to focus on other areas as well that we're looking at, which is homeless youth and foster care as well. So targeted approaches are very key, and making sure all of that is very inclusive. Thank you very much.

Judy Monroe: Well thank you. Thanks Tim. Wow. These were excellent presentations. This is Judy Monroe again. What we want to do is move on to questions from the audience. We have a few minutes here to take questions. Let me remind you that you can get into the queue to ask a question by pressing star 1. And then you'll need to record your name when prompted, and then you'll be announced into the conference by the operator.

So Operator, let me turn to you. Do we have any questions in the queue at this point?