PS18-1807
PROGRAM GUIDANCE

Guidance for School-Based HIV/STD Prevention
(Component 2) Recipients of PS18-1807

Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

For accessibility, explanations of figures are in
Appendix E: Explanation of Figures for Accessibility, page 119.

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U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Division of Adolescent and School Health

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Chapter 1:
PS18-1807 Program Guidance Introduction

Background

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

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

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

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

Program 1807 Overview

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

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

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

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

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

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

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

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

Component 2 Structure and Basic Expectations

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

Strategies and Overarching Domains

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

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

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

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

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

District-level Activities and Diffusion of School-level Activities

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

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

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

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

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

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

Other Key Expectations

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

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

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

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

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

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

Component 3A-C Structure and Basic Expectations

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

Special Considerations for Component 3A-C Recipients

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

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

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

Other Key Expectations

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

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

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

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

Important Theoretical Frameworks & Models

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

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

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

How to Use the Program Guidance

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

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

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

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

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

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

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

Chapter 1 References

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Chapter 2:
Component 2A—
Sexual Health Education (SHE)

SHE Rationale

Sexual health education (SHE) helps adolescents acquire the knowledge and skills to prevent HIV, other STDs, and unintended pregnancy. It is a systematic approach informed by research and practice that emphasizes planned, sequential learning across grade levels. As part of a school health education program, SHE uses learning objectives, lessons, materials, and assessments that are medically accurate, age- and developmentally-appropriate, and recognize the diversity of adolescents and their communities to enhance knowledge and skills to prevent negative sexual health outcomes.

Schools play an important role in the prevention of HIV and other STDs and can reduce adolescents' health risks through delivery of effective health education. Research suggests that well-designed and well-implemented school-based HIV and other STD prevention programs can decrease sexual risk behaviors among school-age adolescents, including delaying first sexual intercourse, reducing the number of sex partners, decreasing the number of times adolescents have unprotected sex, and increasing condom use.[1,2] Effective school health education programs are associated with reductions in adolescent risk behaviors and improved academic performance.[3,4] Moreover, health education tends to be more effective when it is taught by qualified teachers, connects students to health services, engages parents and community partners, and fosters positive relationships between adolescents and important adults.

SHE Overview

Table 2.1 provides a list of required and additional SHE activities that funded local education agencies (LEA) are expected to implement. Activities are organized according to the three overarching Component 2 domains: strengthen staff capacity, increase student access to programs and services, and engage parents and community partners. These domains reflect the primary population of focus: teachers and other school staff, students, and parents and community members, respectively.

Specific activities relevant to each domain are based on evidence of effectiveness, feasibility considerations, and potential reach. In addition to required activities, LEA may choose to implement additional activities related to strengthening staff capacity or increasing student access to programs and services. These activities have been designated as additional activities because when combined with required activities, they should enhance the impact of programmatic efforts to reach desired outcomes and help funded recipients meet performance standards. Required and additional activities are described in more detail below; all recipients are responsible for implementing the required activities that will support SHE for all secondary school students within their jurisdictions.

Table 2.1. SHE Required and Additional Activities Organized by Domains

Domains	Required SHE Activities	Additional SHE Activities
Strengthen staff capacity	■ Identify and approve a list of instructional competencies to be demonstrated by those teaching skills-based health and sexual health education in middle and high school. ■ Provide necessary training at LEA once per year to ensure school health and sexual health education teachers have content knowledge, comfort, and instructional competencies to effectively implement approved school health and sexual health education instructional programs.	■ Develop and implement a technical assistance plan that incorporates teacher observation, coaching, peer mentoring, and other methods to improve an individual teacher's sexual health education instruction in a select number of schools annually.
Increase student access to programs and services	■ Establish, adopt, and implement a skills-based health education course requirement, which includes sexual health education content, for all students attending middle and high schools in the district. ■ Develop and approve a health education scope and sequence that delineates sexual health education learning outcomes for all students in middle and high schools in the district. ■ Develop, revise, or select a sexual health education instructional program consistent with the approved scope and sequence (see previous bullet), and inclusive of instructional lessons, student learning activities, resources, and student assessment. ■ Develop, update, and foster use of teaching tools and resources (e.g., lesson pacing guide, specific lesson plans) for teachers to continuously improve delivery of the identified sexual health education instructional program.	■ Develop, revise, or select health education instructional programs for students in elementary grades that align with the priorities for health education and sexual health education established in the health education scope and sequence. ■ Incorporate specific changes to existing instructional programs to better meet the needs of LGBT youth. ■ Strengthen student assessment instruments to more accurately assess student mastery of health education knowledge and skills.
Engage parent and community partners	■ Establish and maintain a School Health Advisory Council (SHAC) that regularly provides district-level advice and guidance to improve health and sexual health education programs for students and health and sexual health education instruction for staff. ■ Integrate strategies to actively engage parents in sexual health education instructional programs.	N/A

The organization funded under Component 3A is expected to provide capacity-building assistance to all LEA to support their abilities to implement all required SHE activities throughout all secondary schools in the district. The Component 3A recipient cannot choose to support only select activities. Boxes throughout this chapter highlight the unique role that the Component 3A recipient can play in supporting Component 2 recipients for each activity.

Timing of Required Activities

Each LEA will differ in their capacity and readiness to implement required activities; however, a suggested order and priority for completing required activities are described below and depicted in Appendix C. For timing considerations, SHE activities are organized into two categories: contextual activities and direct implementation activities.

Contextual Activities

Throughout the project period, LEA should make progress toward the following contextual required activities:

a. Establishing, adopting, and implementing a skills-based health education course requirement, which includes sexual health education content, for all students attending middle and high schools in the district;

b. Establishing and maintaining a School Health Advisory Council (SHAC) that regularly provides district-level advice and guidance to improve health and sexual health education programs for students and health and sexual health education instruction for staff; and

c. Integrating strategies to actively engage parents in sexual health education instructional programs.

These required activities help foster a positive and supportive environment that will allow LEA to implement the remaining five SHE direct implementation activities. Recipients are required by law to establish and maintain an HIV Materials Review Panel (MRP) to review all educational and informational materials relating to HIV, and recipients can integrate this requirement into their district School Health Advisory Council (SHAC) activities. It is recommended that recipients establish a SHAC and an HIV MRP prior to other activities in order to comply with federal regulations. Recipients are encouraged to initiate the three contextual activities early in the project period, but may prioritize and phase them in consultation with their Program Consultant and TA Teams based on capacity, readiness, and feasibility of implementation.

Direct Implementation Activities

The five remaining SHE required activities comprise the direct implementation activities that support SHE in secondary schools. These direct implementation activities will require continued coordination and feedback from Program Consultants, TA Teams, and the Component 3A partner to ensure successful implementation. The three proposed phases of the direct implementation activities are described below.

Phase I includes three essential activities that lay the foundation for successful SHE among students in middle and high schools. LEA need to

1. develop and approve a health education scope and sequence inclusive of SHE content and learning objectives.
2. develop, select, or adapt a SHE instructional program aligned to the approved scope and sequence.
3. provide annual training for teachers and staff to increase knowledge, comfort, and instructional competencies to address and deliver SHE.

This combination of activities should be completed early in the project period and reviewed routinely with ongoing feedback and technical assistance from Program Consultants, TA Teams, and the Component 3A partner. The requirement for SHE teacher and staff training must be implemented annually. Phase II includes the remaining two direct implementation activities:

1. Identifying and approving a list of instructional competencies to be demonstrated by those teaching skills-based health and SHE.
2. Developing, updating, and fostering teaching tools and resources for teachers to continuously improve delivery of the identified SHE instructional program.

These activities build on the foundational efforts of Phase I. They will allow the LEA to further support teachers and staff delivering SHE and to improve students' receipt of effective programs and instruction. Finally, it is expected that by Phase III the LEA can demonstrate successful implementation of all five direct implementation activities for SHE.

Activity-specific Guidance

For each required and additional activity, we indicate the purpose of the activity in relation to intermediate program outcomes and summarize the rationale for implementing the activity as part of school-based HIV and other STD prevention. We describe activities and outline key considerations for implementation based on existing science and best practices. For each activity, we suggest specific resources to facilitate implementation. Where relevant, we highlight connections to SHS and SSE activities. This guidance focuses on activities implemented by LEA (Component 2A). As appropriate, we provide relevant guidance for capacity-building organizations (Component 3A recipients) to facilitate LEA SHE implementation.

Strengthen Staff Capacity

Required activity: Identify and approve a list of instructional competencies to be demonstrated by those teaching skills-based health and sexual health education in middle and high school.

Rationale

The purpose of this activity is to **increase teachers' ability to teach SHE effectively**. Teachers have a powerful, long-lasting influence on adolescents. Teachers affect how adolescents learn, *what* they learn, *how much* they learn, and the ways they *interact* with peers and the world around them,[5] making it critical to understand characteristics and skills that make teaching most impactful. Research suggests higher student achievement is associated with teachers who demonstrate competencies such as using a variety of teaching methods (e.g., instructional differentiation); demonstrate organization; foster safe classroom environments; establish clear student learning and behavioral expectations; show enthusiasm for content; build positive relationships with students; and treat students with care, fairness, and respect.[6–10] Understanding what constitutes teacher effectiveness and skillfulness can help LEA make decisions about instructional delivery, teacher preparation and recruitment, professional development, and evaluation.[11]

When combined with professional knowledge, practical application, and personal disposition, instructional competencies can increase student achievement and healthy behavior outcomes, making instructional competencies an important intervention point for LEA seeking to decrease adolescent risk for HIV and other STDs. Instructional competencies for SHE teachers, based on research and best practices from the field of school health, include[12]

a. possessing accurate and current knowledge of child and adolescent development and human sexuality.
b. understanding and addressing the needs of a demographically diverse student body to increase engagement and learning.
c. demonstrating content knowledge and mastery in core health topics, including sexual health.
d. understanding developmentally and culturally appropriate pedagogy practices and strategies.
e. demonstrating comfort with and confidence in teaching SHE content.
f. planning and delivering SHE instruction.
g. implementing effective strategies for addressing student health knowledge and skills in order to improve SHE instruction.
h. assessing student performance aligned with SHE learning objectives.
i. fostering safe and equitable learning environments for all students.
j. connecting students to on-site or community-based health resources or services for referrals.
k. understanding the laws, policies/codes, and ethical standards that set personal and professional boundaries, inform teaching methods, and guide SHE instruction.

The instructional competencies are structured based on the common pedagogical framework of designing, planning, implementing, and assessing student learning within SHE.[13] Key knowledge competencies (a-d) are required to enhance skill development and mastery over time for both classroom-level and school-level competencies affecting instruction (e-k). Competencies among SHE teachers, staff, and facilitators will continue to evolve and become stronger with skill-based practice and opportunities for critical reflection and feedback. LEA should identify a priority order to best address and enhance the instructional competencies among those who deliver SHE. In addition to tailored technical assistance, LEA can enhance instructional competencies through professional development, learning, and training.

Activity description

Health education instructional competency is a teacher's mastery of tasks needed to improve students' ability to learn essential knowledge and skills. These competencies tend to be skill-based and can be measured by observations and self-assessment. Mastery of these competencies is one essential piece of effective instruction.

LEA should use instructional competencies to strengthen staff capacity in delivering SHE. The instructional competencies of those delivering SHE should be tailored to the unique needs of students and staff within the district. Such tailoring can take place by adapting the instructional competencies presented above (a-k) or by collaborating with LEA staff to develop a set of desired competencies to be demonstrated by those delivering SHE. When adapting existing instructional competencies or developing new instructional competencies for SHE teachers, the LEA should consult with a variety of stakeholders (e.g., teachers, parents, curriculum specialists, and administrators) through a collaborative process to identify and refine appropriate instructional competencies for district staff. Sample strategies LEA could use to adapt or develop and approve a list of instructional competencies for those teaching SHE include

- consulting scientific literature, professional education standards (e.g., SHAPE's Appropriate Practice in School-based Health Education), and competency frameworks (e.g., The Danielson Group Framework for Teaching) to select research-based and practice-informed instructional competencies.
- conducting teacher observations and evaluations to determine areas of instructional strength and weakness.
- seeking feedback from school and community stakeholders (e.g., teachers, school administrators, curriculum and instruction experts, students, community partners) to determine the most appropriate instructional competencies needed to meet student and school needs.
- collaborating with SHACs or curriculum decision-makers to advocate for adopting instructional competency recommendations for all SHE teachers.

Once identified and approved, teacher instructional competencies can serve multiple purposes. The competencies should be used to create professional development (PD) training agendas, materials, and outcome expectations, as well as to provide a framework for assessing training needs among those delivering SHE. Instructional competencies can be useful when designing and implementing individualized coaching or mentoring programs, and teachers and staff should consider the instructional competencies when reflecting and adapting their SHE instructional strategies. Additionally, the competencies can be used to inform criteria for district-level personnel selection and school-level teacher observation and performance appraisal. LEA are encouraged to update their approved list of instructional competencies annually based on new recommendations and guidance from the field of school health or from feedback garnered from key stakeholders who are involved in the instructional decision making and delivery of SHE.

Key considerations: Additional characteristics of effective health education teachers

In addition to demonstrating the health education instructional competencies described above, individuals implementing SHE should be certified to teach health education and have specialized training related to SHE knowledge and skills. This means that teachers who implement SHE should be knowledgeable about the instructional program content and comfortable and skilled in implementing expected instructional strategies. A recent study showed that among health education teachers, those that had a degree in health education or were certified to teach health education were more likely than peers to report teaching SHE in their classrooms.[14] Health education teachers who receive specialized training on health education topics report more effectively implementing health education programs than those who do not receive training.[14–17] Ideally, SHE teachers would have certification in health education, including specific training in SHE. If existing SHE teachers lack certification or training, LEA should use PD to strengthen the instructional competencies of those teachers.

Component 3A recipients can

- Assist in determining an appropriate list of health education teacher instructional competencies.
- Aid in developing PD events or training materials which use the instructional competencies to build teacher knowledge and skills in SHE.

Resources

Selected resources to support SHE teacher instructional competency:

- **American Association for Health Education (AAHE)/The National Council for Accreditation of Teacher Education (NCATE).** ***2008 NCATE Health Education Teacher Preparation Standards*****.** This resource describes the eight professional teaching standards commonly used in teacher preparation programs to support instructional competency among health education teachers. https://www.shapeamerica.org/accreditation/upload/ncate-2008-standards.pdf
- **Healthy Teen Network (HTN).** ***Instructor Competency Assessment Tool*****.** This resource provides a rubric to assess health education teacher instructional competency in the classroom. http://www.healthyteennetwork.org/wp-content/uploads/2014/11/Instructor-Self-Assessment-Tool.pdf
- **Future of Sexuality Education (FoSE).** ***Performance Assessment Tool for Teacher Candidates Teaching Sexuality Education for use with Middle School and High School Levels*****.** This tool can be adapted to assist LEA in evaluating teachers' instructional competencies in SHE as framed by the National Teacher Preparation Standards for Sexuality Education. http://www.futureofsexed.org/documents/Teacher_Candidate_Evaluation_Forms.pdf

Additional activity: Develop and implement a technical assistance plan that incorporates teacher observation, coaching, peer mentoring, and other methods to improve an individual teacher's sexual health education instruction in a select number of schools annually.

Rationale

The purpose of this activity is to **increase teachers' ability to teach SHE effectively**. As described above, it is important for LEA to help teachers strengthen their teaching knowledge and instructional competencies.[11,18,19] One strategy for improving instructional competency is providing mentoring or peer coaching programs for those teaching SHE. A critical review of mentoring programs for beginning teachers describes positive effects on teachers' instructional activities and classroom management strategies, and higher scores on student achievement tests after participation.[18] Additional evidence describes the benefits of formal mentoring programs for first-year or beginning teachers[19,20] and shows instructional delivery, teacher satisfaction, and retention were positively associated with mentoring program participation.[18]

Activity description

In general, mentoring programs—whether formal or informal—provide a system to integrate teachers into school culture and expectations and provide professional support to enhance teaching performance and student achievement. Teacher mentoring programs should align to the needs and priorities of the district and teachers. Programs may be highly structured to include ongoing weekly or monthly meetings between mentors and mentees, whereas other structures might include single meetings or appointments on a needs-only basis. Face-to-face mentoring between novice and veteran teachers is the most traditional type of mentoring,[20] however, online and web-supported mentoring (e.g., tele-mentoring) programs can also provide teachers with necessary support.[20] If SHE teachers are new to the discipline or unfamiliar with SHE content, teacher learning communities, or Communities of Practice, may be an effective structure to provide support and mentorship.[20] Peer teaching or coaching programs, another tailored form of mentoring, can involve two or three teachers with varying levels of experience observing each other's lessons, sharing teaching materials and strategies, discussing solutions to common problems, and conducting peer assessment with one another.[20–22] Such approaches to teacher mentoring can help new or inexperienced SHE teachers share ideas and resources to improve instruction and also provide opportunities for teachers to confide in their fellow peer coaches.

Key considerations: Teacher mentoring programs

Potential elements of any teacher mentoring or peer coaching program should be tailored to the unique needs of district teachers and staff to most effectively enhance SHE. Important elements to consider when planning, implementing, and evaluating teacher mentoring or peer coaching programs include

- mentor and mentee(s) meeting on a regular or needs-only basis throughout the school year.
- conducting observations of SHE teacher in the instructional setting.
- connecting the SHE teacher to other staff members and resources that can provide direction and support, encouraging and helping to develop collegial relationships.
- assisting the SHE teacher in developing and maintaining an effective classroom behavioral management plan.
- offering suggestions regarding a variety of teaching methods, instructional approaches, and assessment strategies.
- participating in ongoing evaluation and making necessary annual adjustments.
- maintaining confidentiality regarding all aspects of the mentoring program, including the observations, conversations, etc. with the SHE teacher.

Component 3A recipients can

- Assist in developing a teacher mentoring, coaching, and observation system that promotes process evaluation and timely feedback on instructional practice and delivery.

Resources

Selected resources to support SHE teacher coaching/peer mentoring programs:

- **West Virginia Department of Education. *Collegial Coaching Toolkit*.** This toolkit provides guidance on how to establish a coaching and supervision system for teachers that uses activities designed to build collective leadership and continuously improve teacher instructional capacity and student learning.
  https://wvde.state.wv.us/titlei/documents/CoachingModelDefined.doc
- **The Alberta Teachers' Association. *Mentoring New Teachers Handbook*.** This ready-to-use handbook rovides guidance on developing and implementing school mentoring programs for teachers.
  http://ncee.org/wp-content/uploads/2017/01/Alb-non-AV-18-ATA-Mentoring-beginning-teachers.pdf

Required activity: Provide necessary training at LEA once per year to ensure school health and sexual health education teachers have content knowledge, comfort, and instructional com-petencies to effectively implement approved school health and sexual health education in-structional programs.

Rationale

The purpose of this activity is to **increase teachers' ability to teach SHE effectively**. PD on health education is associated with successful implementation of classroom instruction.[14–16] Successful in-service programs have been shown to increase both the amount of time teachers spend on health topics and their self-efficacy toward current and future SHE instruction.[23,24] Research has also shown that following PD, higher perceived teacher credibility and affinity (e.g., empathy) are significantly associated with increased student value of learning and knowledge.[25] Furthermore, a review of nineteen HIV and other STD prevention education curricula that significantly impacted adolescent sexual behaviors found that nearly all effective curricula trained their educators in curriculum implementation and delivery strategies, while programs that did not show significant positive impacts were less likely to so do.[26]

Activity description

PD should provide health education and SHE teachers with the necessary skills to use innovative, non-lecture focused approaches, like active learning strategies, for developing students' knowledge and skills to prevent HIV, other STDs, and pregnancy.[13,26,27] SHE coordinators and teachers should receive PD which provides up-to-date information and skill development on a number of SHE topics, including

- populations of youth at highest risk for HIV, other STDs, and unintended pregnancy.[28,29]
- prevalence of HIV, other STDs, and unintended pregnancy.
- consequences of HIV, other STDs, and unintended pregnancy.
- modes of transmission for HIV and other STDs.
- effective prevention strategies.
- skills needed (e.g., assertive communication) to avoid or decrease risk of HIV, other STDs, and pregnancy.[30]
- skills needed (e.g., self-efficacy) to access and use SHS.
- influences from social factors (e.g., peers, media) on sexual activity.
- characteristics of healthy relationships, personal safety, and setting boundaries.

All PD should be implemented in accordance with CDC's guidance on Professional Development Practices (See Chapter 5). The *Professional Development Practices (PDP)* resource provides guidance on planning, implementing, and evaluating PD for school health. This guidance recommends that PD opportunities for teachers and staff be grounded in adult-learning theory and use active learning strategies, including interactive training events, opportunities to practice skills (e.g., SHE lesson delivery), technology integration, peer observation and feedback, and professional coaching to build knowledge and skills. These intensive strategies can be complemented by more traditional, didactic approaches that outline best practices and direct SHE school or district staff to key tools and resources.

Key considerations: Important elements for SHE professional development

To complement the SHE topics detailed above, LEA should consider integrating the following key elements into the PD event(s) provided by the district for those delivering SHE:

- Acknowledging educators' own beliefs about sexuality and how to communicate acceptance of the values and beliefs of others through their words, body language, and role modeling.
- Using a variety of instructional strategies to deliver SHE content, including strategies to increase 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 SHE classroom activities. Strategies to encourage discussion may include small-group exercises, activity learning, technology-connected activities, role-play, and homework with parents and trusted adults.
- Delivering specific commercial programs with opportunities to practice skills and activities necessary for effective implementation and fidelity.
- Creating a comfortable and safe learning environment for students receiving SHE through effective classroom management techniques.
- Understanding current district or school board policies or curriculum guidance regarding SHE.
- Assessing students' knowledge and skills in SHE.
- Aligning lessons and materials with the district scope and sequence for SHE.
- Addressing SHE content as part of broader health education to address other health topics (e.g., alcohol and other drug use, mental and emotional health, or violence prevention).
- Connecting students to on-site or community-based SHS.

Component 3A recipients can

- Assist in providing training that targets SHE tools such as developing and revising a health education scope and sequence, Health Education Curriculum Analysis Tool (HECAT), or instructional pacing guide.

Resources

Selected resources to support SHE teacher professional development:

- **CDC. *Fostering Professional Development Practices*.** This resource provides guidance on planning, implementing, and evaluating PD for school health. https://www.cdc.gov/healthyyouth/fundedprograms/1308/pdf/practicessmartcardf3.pdf
- **CDC. *Professional Development 101: The Basics—Part I*.** An online video to introduce the six PD Practices and increase the skill-building capacity of staff as they work toward improving health and educational outcomes. https://www.cdc.gov/healthyschools/tths/pd101.htm
- **CDC. *Training Tools for Healthy Schools: Professional Development*.** An eLearning series that consists of five core training tools, including the Health Education Curriculum Analysis Tool, to support school health education and SHE. https://www.cdc.gov/healthyschools/trainingtools.htm
- **CDC. *E-learning Design*.** This resource assists e-learning developers in creating quality products and will help those new to e-learning understand the basics. https://www.cdc.gov/trainingdevelopment/e-learning-design/index.html

Increase Student Access to Programs and Services

Required activity: Establish, adopt, and implement a skills-based health education course requirement, which includes sexual health education content, for all students attending middle and high schools in the district.

Rationale

The purpose of this activity is to **increase student receipt of effective SHE**. Healthy People 2020 outlines priorities for improving the nation's health, and two of these priorities deal directly with school-based SHE. The first priority is to increase the number of schools that provide health education on key health topics such as HIV, other STDs, and unintended pregnancy. Roughly 20% of school districts still report that they have not adopted a policy stating that their high school would teach topics within SHE (i.e., HIV prevention, STD prevention, pregnancy prevention, or human sexuality).[31] The lack of SHE policy climbs to roughly 30-40% among middle schools. In addition, the percentage of middle schools and elementary schools that have a policy to teach HIV prevention has fallen since 2000.[31] Reversing these trends is critical to ensure that schools are teaching health education topics that are closely linked to priority public health issues, such as HIV and other STD prevention. The second priority is to increase the number of schools whose curricula course requirements support skills-based instruction and practice for adolescents.[32–34] According to an extensive review of HIV and STD prevention programs, skills-based curricula generally included many of the characteristics of effective curricula and were more effective at changing behavior. In contrast, curricula that lacked a focus on skill development did not include many of the characteristics of effective curricula and were found to be less effective at achieving desired behavior change among adolescents.[34]

Activity description

Skills-based health education, inclusive of sexual health content, uses lesson content, learning objectives and outcomes, teaching methodologies, and assessment strategies to foster a classroom environment where critical thinking, collaboration, and active learning are developed at the same time that knowledge is acquired.[35] A large portion of time is dedicated to practicing, assessing, and reflecting on skill development, and such education moves students toward independence, thinking critically, and solving problems. Key health education skills include analyzing influences which impact health, accessing valid and reliable health information and services, using decision-making and communication to improve health, and advocating for self or others to improve health.[35]

To accomplish both *Healthy People 2020* priorities, it is helpful to build support for a health education course requirement; this requires collaboration and input from a variety of stakeholders. LEA should work with school board members, curriculum decision-makers, SHACs, and/or similar committees/councils to gain momentum for creating or adopting formal health education course requirement policies for all secondary students in the district. LEA can provide technical assistance, professional development, or local-level guidance on implementing health education policies. Such policy development and implementation should focus on health education courses that demonstrate strong likelihood to enhance adolescents' skills to avoid or delay risk behaviors that contribute to HIV, other STDs, and unintended pregnancy. Resources such as the *National Health Education Standards (NHES)* and CDC's School Health Index (SHI) are available to guide LEA in creating or adopting supportive health education course requirement policies. Additionally, providing epidemiological (e.g., trends, prevalence, incidence rates), social determinants of health (e.g., education, income, housing), and national data that indicate how health education programs and SHE are linked to positive academic and health outcomes for youth can provide justification for health education course requirements.[4,34]

Resources

Selected resources to help establish, adopt, and implement skills-based health education:

- **National Health Education Standards (NHES).** The NHES provide a framework for teachers, administrators, and policy makers in designing or selecting curricula, allocating instructional re-sources, and assessing student achievement and progress. Importantly, the standards provide students, families, and communities with concrete expectations for health education. https://www.cdc.gov/healthyschools/sher/standards/index.htm
- **CDC. *School Health Index (SHI): Self-Assessment & Planning Guide*.** This resource is an online self-assessment and planning tool (also available in a downloadable, printable version) that schools can use to improve their health and safety policies and programs. It is easy to use and completely confidential. https://www.cdc.gov/healthyschools/shi

Required activity: Develop and approve a health education scope and sequence that delineates sexual health education learning outcomes for all students in middle and high schools in the district.

Rationale

The purpose of this activity is to **increase teachers' ability to teach SHE effectively**. Effective planning makes for effective instruction that accelerates student learning and achievement. School documents or plans which frame the work of teachers, at least to the extent of identifying the content to teach and the possible methods to use in the instructional process, are critical to successful implementation.[36] Research from curriculum planning and instruction describes scope and sequence charts and similar unit/lesson planning documents as effective resources for assessing, planning, and designing instruction.[37,38] One such planning resource is the health education scope and sequence (S&S). This document outlines the breadth and arrangement of key health topics and concepts across grade levels (scope) and the logical progression of essential health knowledge, skills, and behaviors to be addressed at each grade level (sequence) from pre-kindergarten to 12th grade.[39]

Activity description

An S&S provides a picture of a LEA's entire instructional program in a given subject area. It also identifies *what* the student should know and be able to do at the end of each grade or grade group and *when* content should be taught.[13] The S&S corresponds with national, state, or local health education standards, benchmarks, and requirements, while also reflecting locally identified priorities and needs. The S&S accounts for unique developmental needs and addresses SHE concepts and skills necessary to prevent adverse health outcomes during adolescence.[39] (Box 2.2)

Box 2.2. Elements of a Sexual Health Education Scope and Sequence[26]

- 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 no grade is over-loaded
- Reinforces skills and concepts without excessive repetition
- Is tailored to the community's needs, including the specific HIV, other STD, and unintended pregnancy prevention needs of local youth, and to the needs and instructional methods used in schools

Key consideration: Using the CDC's scope & sequence tools

CDC recommends LEA use the 11-step process outlined in the *Developing a Scope and Sequence for Sexual Health Education* guidance tool to create and implement a S&S. The development of a SHE S&S is usually facilitated by an experienced and knowledgeable leader, such as the School Health Coordinator, with assistance from others (e.g., teachers, curriculum directors, SHACs, or similar committees/councils). The leader establishes a regular meeting schedule and timeline for completion, and actively involves individuals with knowledge, expertise, and experience in SHE, curriculum development, and the sexual health needs

of youth. The S&S serves as a general guide for curriculum directors, administrators, teachers, parents, and school board members.

Additionally, CDC's HECAT provides valuable information to assist LEA in developing an S&S.[40] The HECAT articulates the NHES, identifies the healthy behavior outcomes (HBOs) of specific health content areas such as sexual health, and identifies the essential knowledge and skill expectations directly related to each healthy behavior outcome by standard and grade group. LEA should use the HECAT Sexual Health Module to identify the complete list of sexual health student knowledge and skills expectations to be delivered across each grade level in secondary schools.

Component 3A recipients can

- Assist with the S&S development process.
- Assist in evaluating existing S&S document(s) to identify gaps or areas of improvement to enhance SHE.

Resources

Selected resources to support developing and adopting a health education S&S:

- **CDC. *Developing a Scope and Sequence for Sexual Health Education.*** This resource outlines the 11-step process LEA can follow to create an S&S for SHE. https://www.cdc.gov/healthyyouth/hecat/pdf/scope_and_sequence.pdf
- **CDC. *Health Education Curriculum Analysis Tool (HECAT), Module Sexual Health*.** This resource provides the Sexual Health Education module from the CDC's HECAT that can be used to determine the HBOs to guide instruction in SHE. http://www.cdc.gov/healthyyouth/hecat/pdf/hecat_module_sh.pdf
- **The Michigan Model. *Scope and Sequence, Health Education, Grades 7-12*.** This resource provides a sample S&S document for health education in secondary schools. https://www.eupschools.org/cms/lib/MI17000134/Centricity/Domain/45/7-12%20scope%20and%20sequence.pdf
- **The Michigan Model. *Scope and Sequence, Health Education, Grades K-6*.** This resource provides a sample S&S document for health education in elementary schools. https://www.eupschools.org/cms/lib/MI17000134/Centricity/Domain/45/k-6_scope_and_sequence.pdf
- **CDC. *Sexual Health Education Instructional Pacing Guide Template*.** This resource provides a sample pacing guide template to help LEA guide SHE instruction. It is available through Program Consultants.

Required activity: Develop, revise, or select a sexual health education instructional program that is consistent with the approved scope and sequence (see previous required activity) and inclusive of instructional lessons, student learning activities, resources, and student assessment.

Rationale

The purpose of this activity is to **increase student knowledge, skills, and behaviors to avoid and reduce sexual risk**. Empirical evidence indicates a number of SHE programs demonstrate effectiveness in changing adolescent behaviors associated with HIV, other STDs, and unintended pregnancy. This includes delaying sexual activity, reducing the frequency of sex, reducing the number of sexual partners, and increasing condom or other contraceptive use.[1,41–46] Research also suggests that effective health education curricula, including SHE content, include program goals and objectives that explicitly seek to[30,47]

- increase functional knowledge that will provide adolescents with a foundation to engage in healthy sexual behaviors and avoid or reduce risk behaviors over a lifetime.
- improve adolescents' perceptions of the severity of and their susceptibility to negative health outcomes (e.g., HIV, STDs, or unintended pregnancy).

- address attitudes, values, and beliefs to promote healthy sexual behaviors and avoid or decrease sexual risk behaviors.
- correct perceptions of peer norms to provide adolescents 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 adolescents' self-efficacy (i.e., their feelings of mastery) and their skills to engage in healthy behaviors and to avoid or reduce unhealthy sexual behaviors.
- improve adolescents' intentions to avoid or decrease risky behaviors.
- increase the quality of parent-adolescent communication about health and sexuality.

Additionally, effective HIV and other STD prevention programs[13] are those that

- are implemented sequentially across grade levels using medically accurate, developmentally appropriate, and diversity-inclusive lessons and materials.
- include strong emphasis on skill-building.
- use instructional strategies that are relevant and engaging.
- focus on healthy behaviors in safe school environments.
- are delivered by well-qualified and trained instructors.
- integrate parents, youth-serving organizations, and community health partners.

Activity description

The specific content addressed in health education, including SHE, is organized within an instructional program. The instructional program incorporates a structured, sequential, developmentally appropriate series of intended learning outcomes and associated learning objectives for students from pre-kindergarten through 12th grade[13] and outlines the skills, performances, and attitudes adolescents are expected to learn in SHE (Box 2.3).

Box 2.3. Components of a Health Education Instructional Program

- A set of intended learning objectives and outcomes that are directly related to students' acquisition of health-enhancing knowledge, attitudes, and skills
- A sequential, planned progression of learning that uses developmentally appropriate learning objectives and content that leads to achieving outcomes
- A continuity and sequence of concepts and content that clearly reinforce the adoption and maintenance of specific health-enhancing behaviors
- 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

Key consideration: SHE instructional program selection

LEA should use a systematic process to develop, revise, or select SHE instructional lessons, materials, and activities that closely align with the skills-based health education course requirement. LEA should begin by reviewing their developed or selected instructional program materials using the CDC's HECAT, specifically Chapter 4: Preliminary Curriculum Considerations. Within this HECAT chapter, four assessment tools can help analyze and score the four important characteristics of any health education instructional program—accuracy, acceptability, feasibility, and affordability. LEA may find the tools useful for considering instructional program characteristics prior to investing extensive time in reviewing other curricula.[48] Furthermore, the Sexual Health module within the HECAT provides guidance to assess an instructional program's expected knowledge and

skill acquisition aligned to national health educational standards. This systematic tool can help LEA make decisions about SHE instructional program selection, revision, or adaptation.[13]

When possible, LEA should use SHE materials that meet the highest level of scientific evidence to change adolescents' sexual risk behavior.[30] Whereas some programs with the highest levels of evidence are developed for particular settings or groups of youth, LEA should be cautious about assuming that programs developed for one population will be effective in another. Similarly, individual programs intended to reach a general classroom of students may not be effective with everyone in that classroom (e.g., LGBT youth).[49] If LEA expect to impact youth in a given population or setting, they should choose instructional programs and lessons designed for that specific population or setting; if none are available, LEA should consider adapting existing programs, as long as programmatic fidelity is maintained,[50] and providing necessary training and resources to staff.

The NHES emphasize the general knowledge and skills that students should possess following an effective health education instructional program and that should be considered when developing, adopting, or selecting a SHE instructional program.[35] LEA may adopt their own health education standards using the NHES as a guide and use them to set criteria for their SHE instructional program. LEA should use the CDC's HECAT to confirm that their SHE content contains the essential knowledge and skills students need to prevent HIV, other STDs, and unintended pregnancy.[13]

LEA may also consider using evidence-based interventions (EBIs) that meet the SHE learning outcomes for a specific grade or grade group. EBIs are rigorously evaluated SHE programs that demonstrate evidence of effective or promising results among youth. EBIs are a valuable supplement to fulfill parts of a district-approved SHE S&S; however, they should not be used to replace a health or SHE instructional program. In the absence of available EBIs for SHE, LEA should consider other promising programs or practice-informed approaches that meet the SHE learning outcomes.[51] LEA must be aware of the limitations of relying on commercially packaged instructional programs to meet all the instructional expectations for SHE. LEA may need to select multiple sets of lessons and materials from various commercially packaged programs to accomplish the goals of the SHE instructional program.

Key consideration: Implementing SHE instructional programs with fidelity

To implement a commercially packaged or district-developed SHE instructional program with fidelity means to commit to maintaining the core program components and essential characteristics that are responsible for the program's effectiveness.[52,53] Categories of core components include maintaining the explicit learning objectives and activities and maintaining the recommended structure of lessons (e.g., not reducing the length of time, maintaining interactive exercises) through effective delivery. Implementation that includes the core components is key to replicating the results of effective instructional programs. Therefore, LEA should provide guidance to SHE teachers or facilitators on how to maintain the core components of any selected program. LEA staff should also ensure that selected SHE materials can be feasibly delivered in the time allotted, are affordable, and are supported by appropriate PD and technical assistance. Otherwise, the school's ability to implement the instructional program may be compromised by practical limitations.

Key consideration: Adapting SHE instructional programs to meet the needs 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 if they contradict the core components necessary to meet the needs of a particular population or a school's capacity to implement an instructional program. Existing materials, including commercially packaged SHE instructional 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.[52,54]

Adaptations can range from adding activities or lessons inclusive of a setting or population to comprehensively changing language, content, and activities across the whole of the instructional program to address specific population needs. Some federal agencies provide information about allowable adaptations for some specific SHE instructional programs, but LEA should also consider general adaptation guidance, such as ETR's Green/Yellow/Red Light guidance, to determine which adaptations are safe to make without compromising the fidelity of the core components of the SHE program.[52,54]

Component 3A recipients can

- Assist in identifying and selecting SHE instructional programs, lessons, and learning materials based on best available evidence from research and practice.
- Support in adapting instructional activities to reach the SHE learning objectives and health behavioral outcomes (HBOs).
- Collaborate with 3B and 3C organizations to identify cross-cutting opportunities for SHE implementation.

Resources

Selected resources to use when developing, revising, or selecting a SHE instructional program:

- ***National Health Education Standards (NHES).*** This resource provides written expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. The standards provide a framework for curriculum development and selection, instruction, and student assessment in health education. https://www.cdc.gov/healthyschools/sher/standards/index.htm
- **Future of Sex Education Initiative (FoSE).** ***National Sexuality Education Standards: Core Content and Skills, K-12.*** This resource provides core content for sexuality education that is developmentally and age appropriate for students in grades K–12. http://www.futureofsexed.org/nationalstandards.html
- **CDC.** ***Characteristics of an Effective Health Education Curriculum.*** This resource describes characteristics of effective health education curricula based on evidence from research and best practices. https://www.cdc.gov/healthyschools/sher/characteristics/index.htm
- **CDC.** ***Scope & Sequence for Sexual Health Education.*** These resources provide guidance on developing a scope and sequence for sexual health education. https://www.cdc.gov/healthyyouth/hecat/pdf/scope_and_sequence.pdf and https://www.cdc.gov/healthyyouth/hecat/pdf/developing_scope_factsheet.pdf
- **CDC.** ***Health Education Curriculum Analysis Tool (HECAT).*** This resource can help schools select or develop appropriate and effective health education curricula and improve the delivery of health education. The HECAT can be customized to meet local community needs and conform to the curriculum requirements of the state or school district. http://www.cdc.gov/healthyyouth/HECAT/
- **CDC.** ***HECAT Sexual Health Module*** https://www.cdc.gov/healthyyouth/hecat/pdf/hecat_module_sh.pdf
- **CDC.** ***E-learning Series: Training Tools for Healthy Schools, Health Education Curriculum Analysis Tool (HECAT)*** webinar https://www.cdc.gov/healthyschools/professional_development/e-learning/hecat.html
- **Healthy Teen Network.** ***HECAT Resources, All about the HECAT! Mini-Webinar Series*** https://www.healthyteennetwork.org/resources/hecat/
- **CDC.** ***Effective HIV and STD Prevention Programs.*** This two-page summary provides an overview of school-based HIV and other STD prevention programs evaluated by rigorous research and evaluation. https://www.cdc.gov/healthyyouth/sexualbehaviors/pdf/effective_hiv.pdf
- **ETR.** ***ReCapp: Tool to Assess Characteristics of Effective Sex Education.*** This planning tool outlines a set of questions designed to help practitioners assess whether curriculum-based programs have incorporated the common characteristics of effective programs in HIV, other STDs, and pregnancy prevention. http://recapp.etr.org/recapp/documents/programs/tac.pdf

- **ETR. *General Adaptation Guidance: A Guide to Adapting Evidence-Based Sexual Health Curricula*.** This resource describes guidelines on how to make appropriate adaptations to sexual health EBIs without sacrificing their core components. This guide provides general green (safe), yellow (proceed with caution), and red (unsafe) light adaptation guidance for practitioners considering making adaptations to sexual health EBIs. https://www.etr.org/ebi/assets/File/GeneralAdaptationGuidanceFINAL.pdf
- **ETR. *Program Success Planning Tool*.** This resource includes the Program Success Planning Tool to identify training or technical assistance support related to school health education. https://www.etr.org/ebi/program-success-framework/program-success-tool/
- **ETR. *Evidence-based Program Selection Tool*.** This resource provides an interactive set of questions to help guide LEA in selecting an instructional program for delivery in SHE. https://www.etr.org/ebi/programs/ebi-selection-tool/
- **ETR. *Reducing the Risk: Theoretical Guide to Develop and Adapting Curriculum-based Programs*.** This resource provides an overview of key considerations when developing or adapting curriculum-based programs in HIV, other STDs, and pregnancy prevention for adolescents. https://www.etr.org/store/product/reducing-adolescent-sexual-risk/ ($)

Selecting and implementing sexual health education instructional programs

- ***Family and Youth Services Bureau Making Adaptations Tip Sheet*.** This resource guide can be helpful when considering program adaptations. It provides information that can be utilized to implement appropriate adaptions in SHE instructional programs. http://www.acf.hhs.gov/sites/default/files/fysb/prep-making-adaptations-ts.pdf
- ***Promoting Science Based Approaches—Getting To Outcomes* (PSBA-GTO).** This resource offers a clear and accessible process for local practitioners to follow for delivering teen pregnancy prevention programs using a systematic and science-based approach to their work. https://www.cdc.gov/teenpregnancy/pdf/littlepsba-gto.pdf

Federal registries of evidence-based programs for youth

- ***Community Preventive Services Task Force Findings for HIV/AIDS, STIs and Teen Pregnancy*.** This resource provides a summary of the evidence and access to supporting materials for programs targeting HIV, STD, and pregnancy prevention among adolescents. https://www.thecommunityguide.org/content/task-force-findings-hivaids-stis-and-teen-pregnancy
- **CDC. *Registries of Programs Effective in Reducing Youth Risk Behaviors*.** This resource identifies several registries that include youth-related programs that are considered worthy of recommendation on the basis of expert opinion or a review of design and research evidence. http://www.cdc.gov/healthyyouth/AdolescentHealth/registries.htm
- **CDC. *Listing of All Risk Reduction Interventions, by Characteristic*.** This resource provides suggested HIV prevention programs based on unique demographic and risk factor characteristics by population sub-group. http://www.cdc.gov/hiv/prevention/research/compendium/rr/characteristics.html

Additional activity: Develop, revise, or select health education instructional programs for students in elementary grades that align with the priorities for health education and sexual health education established in the health education scope and sequence.

Rationale

The purpose of this activity is to **increase student knowledge, skills, and behaviors to avoid and reduce sexual risk**. A growing body of literature documents public support for SHE in younger grade levels. Empirical evidence describes parental support for implementing SHE among elementary-aged students and cites support for topics such as communication, anatomy, abstinence, HIV prevention, and gender and sexual orientation.[55] Health education that includes SHE in elementary grades can positively

contribute to knowledge and skill development that children need to prevent risky sexual behaviors and associated negative health outcomes during adolescence.

Activity description

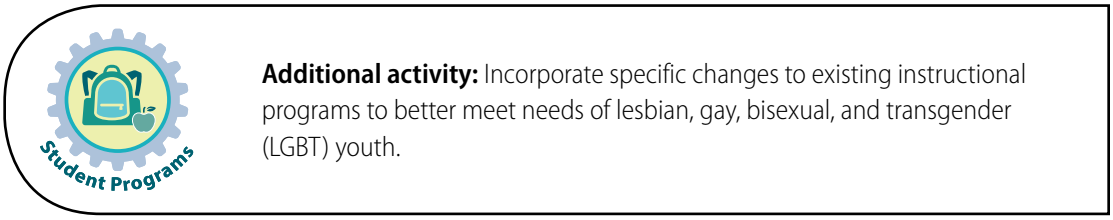
LEA interested in integrating SHE programs in elementary grades should consult a variety of stakeholders (e.g., teachers, parents, school health advisory council members, administrators, and community members) to determine level of interest, appropriateness, and need among youth. Using national education standards can then help LEA determine grade-specific health topics and content for elementary audiences. The National Sexuality Education Standards (NSES) provide a framework for designing or selecting curricula, allocating instructional resources, and assessing student achievement and progress.[56] The NSES, based on research and extensive professional expertise, outline minimum SHE content and skills for grades K-12 that consider students' needs and teachers' preparation, availability, and resources.[56]

The NSES include seven key topic areas: anatomy and physiology, puberty and adolescent development, identity, pregnancy and reproduction, STDs and HIV, healthy relationships, and personal safety. These standards provide guidance across all grade levels, beginning in second grade, and suggest a sequenced pattern of learning that integrates knowledge and skills content for youth in elementary and secondary settings.[56] LEA can use the NHES and NSES to design SHE, which is sequential and part of a broader health education approach for students beginning in elementary school.

Resources

Selected resources for integrating SHE instructional programs at the elementary level:

- ***National Health Education Standards (NHES).*** This resource provides written expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. The standards provide a framework for curriculum development and selection, instruction, and student assessment in health education. https://www.cdc.gov/healthyschools/sher/standards/index.htm
- **Future of Sex Education Initiative (FoSE).** ***National Sexuality Education Standards: Core Content and Skills, K-12.*** This resource provides a set of standards that outline essential content and skills for K-12 sexuality education. http://www.futureofsexed.org/nationalstandards.html



Additional activity: Incorporate specific changes to existing instructional programs to better meet needs of lesbian, gay, bisexual, and transgender (LGBT) youth.

Rationale

The purpose of this activity is to **increase student knowledge, skills, and behaviors to avoid and reduce sexual risk**. Schools play a vital role in educating young people about sexual health, and this venue is especially important for LGBT youth. Many school-based SHE programs do not address the needs of LGBT youth directly,[57,58] despite higher prevalence of many health risk behaviors among LGBT youth compared with their heterosexual peers.[59] Research reports that adolescent sexual minority males receive different messaging and content related to AIDS and HIV prevention education in their school-based SHE courses than do their non-sexual-minority male peers.[49] Additional studies with LGBT youth suggest school-based SHE provided information on safe sex behaviors (e.g., correct and consistent condom use) but lacked discussion of sexual orientation and related issues.[60] LGBT youth often describe their SHE as hetero-centric or heteronormative, and sometimes excluding LGBT content altogether.[61,62] A one-size-fits-all approach to SHE is not appropriate for LGBT youth as it lacks important context related to their particular risks and protective factors.[49]

Activity description

LEA should ensure SHE program design incorporates the needs and perspectives of LGBT youth by selecting LGBT-inclusive programs or adapting existing programs. LEA should use multiple strategies when creating or adapting teaching resources that address LGBT youth's needs and relevant topics within the context of SHE. LEA may systematically review and select HIV, other STD, and unintended pregnancy prevention teaching materials (e.g., textbooks, worksheets, and student learning activities) that integrate gender-neutral language, examples, and terminology, and representation from LGBT youth populations.[57,63] LEA can develop sexual health instructional programs that incorporate LGBT individuals, history, and events into teaching materials.[64] Such strategies have been shown to increase LGBT youth connectedness and feelings of inclusion with their peers and school community.[63,64] SHE teachers and staff can collaborate to develop or adapt LGBT-youth-inclusive classroom materials based on recommendations from research and practice and disseminate such instructional materials to other teachers in their school or district. Additionally, LEA should leverage the collective voice and expertise of their district SHAC or similar committee/council to help promote awareness and action toward implementing LGBT-youth-inclusive SHE programs among teachers, parents, school administrators, and community partners.

Resources

Selected resources to help implement LGBT youth-inclusive SHE:

- **CDC. *LGBT Youth Resources: Resources for Educators and School Administrators*.** This page provides resources from CDC, other government agencies, and community organizations for LGBT youth and their friends, educators, parents, and family members to support positive environments. https://www.cdc.gov/lgbthealth/youth-resources.htm#school
- **GLSEN. *LGBT-Inclusive Curriculum*.** This resource provides free lesson plans and support materials for LGBT-inclusive SHE instruction. https://www.glsen.org/educate/resources/curriculum

Additional activity: Strengthen student assessment instruments to more accurately assess student mastery of health education knowledge and skills.

Rationale

The purpose of this activity is to **increase teachers' ability to teach SHE effectively**. For schools to be successful in achieving expected health education outcomes, it is essential to assess student learning, the instructional environment, and instructional programs. Assessment provides evidence that students are acquiring the knowledge and skills that contribute to healthy behavioral outcomes and that the delivery of instruction and learning strategies are contributing to students' achievement of health education standards.[65]

Activity description

LEA should approach health education and SHE assessment through an iterative process of evaluating student work over time and providing descriptive feedback that supports opportunities for students to practice and improve health-related knowledge and skills. Assessment strategies used in SHE should target students' level of understanding of health-related concepts, their ability to demonstrate health-enhancing skills, and their efficacy to apply conceptual learning in ways that improve their personal health.[13,65]

Box 2.4 describes unique student assessment strategies appropriate for a SHE instructional program. An effective classroom assessment process occurs over time, includes a variety of methods, offers a personalized record of student achievement, and provides timely and descriptive feedback to the student. It is essential that students know the learning targets (standards) and the assessment criteria (rubric or performance checklist) and have continuous access to evidence of progress. Students can then collaborate with their teacher and

peers to work toward proficiency. Students will have the information they need to take responsibility for their learning, and teachers will have the information necessary to improve their instruction.

Box 2.4. Sample Assessment Instruments to Evaluate SHE

- Objective tests (multiple choice, true/false)
- Writing samples
- Checklists
- Reflective journals
- Portfolios or e-portfolios
- Concept maps
- Self-assessments
- Educational games

Resources

Specific resources to support SHE student assessment development and implementation:

- **CDC. *HECAT: Understanding Health Education Assessment***
  https://www.cdc.gov/healthyyouth/hecat/pdf/hecat_append_6.pdf

Required activity: Develop, update, and foster use of teaching tools and resources (e.g., lesson pacing guide, specific lesson plans) for teachers to continuously improve delivery of the identified sexual health education instructional program.

Rationale

The purpose of this activity is to **increase teachers' ability to teach SHE effectively**. Effective teachers use various teaching strategies and tools to support student learning and achievement.[5,66,67] Determining the appropriateness, accuracy, and relevance of SHE lessons, teaching tools, and learning materials should be based on students' unique needs, community priorities, school resources, relevant national or state health education standards, and characteristics of an effective health education curriculum.[68] SHE teaching tools and resources should recognize the diversity of the students and community and include a variety of activities and examples (e.g., gender identity, race, ethnicity, religion, age, physical/mental ability, and sexual orientation). Tool and resource characteristics such as promoting values, attitudes, and behaviors that acknowledge the demographic and cultural diversity of students; optimizing relevance to all students; and building on cultural resources of families and communities have been linked to effectiveness.[68]

Activity description

The specific design and elements of teaching tools and resources should reflect the unique needs of the adolescents and staff across the LEA. LEA should consider available scientific literature, national health education and sexuality education standards, and practice-informed approaches when developing and selecting teaching tools. Training and professional development opportunities that allow teachers to develop, test, and refine active learning strategies and teaching resources are needed to enhance the instructional practice of SHE teachers and staff.[67] Moreover, teachers may collaborate and share tools, resources, student activities, or materials with peers. As part of their instructional plan, LEA may provide specific lessons and teaching materials to guide the instructional delivery of health education and SHE at the district or school level. Tools such as lesson pacing guides, supporting materials (e.g., handouts), or assessment rubrics can assist teachers in continuously improving their SHE delivery.

Key considerations: Characteristics of teaching tools and resources for SHE

According to reviews of effective programs and curricula and experts in the field of health education, teaching tools and resources in SHE should include the following elements:[68]

- Address key health-related concepts.
- Be student-centered, interactive, and experiential (e.g., group discussions, cooperative learning, problem solving, role playing, and peer-led activities).
- Correspond with students' cognitive and emotional development.
- Help students personalize information and maintain their interest and motivation.
- Accommodate diverse capabilities and learning styles.
- Promote creative thinking and expression.
- Provide opportunities to share opinions, thoughts, or feelings.
- Foster new perspectives or considerations.
- Cultivate critical thinking and discussion.

Component 3A recipients can

- Assist in identifying and selecting appropriate teaching tools and resources to enhance SHE.
- Assist in adapting SHE teaching tools and resources to meet the unique needs of the LEA student and staff.

Resources

Selected resources to develop and adopt SHE teaching tools and resources:

- **CDC. *Health Education Teacher Visitation (Observation) Form*.** This resource provides a sample teacher observation template to assess classroom instruction in SHE. It is available through Program Consultants.
- **CDC. *Sexual Health Education Instructional Pacing Guide*.** This tool can be used to help teachers improve delivery of SHE content. It is available through Program Consultants.

Engage Parents and Community Partners

Required activity: Establish and maintain a school health advisory council (SHAC) that regularly provides district-level advice and guidance to improve health and sexual health education programs for students and health and sexual health education instruction for staff.

Rationale

The purpose of this activity is to **increase teachers' ability to teach SHE effectively and to increase student receipt of effective SHE**. A SHAC, or a similar council/committee, is an ongoing advisory group composed primarily of community members who assist the LEA in carrying out their responsibilities for promoting and protecting student and employee health.[69,70] An active SHAC can be an excellent mechanism for parent and community involvement and provides a way for schools to benefit from valuable resources and expertise in their communities.[69,71,72] The group acts collectively to provide advice and recommendations to the LEA about all aspects of school health, including but not limited to health education, health services and programs, and fostering SSE. SHAC efforts to support this broad school health framework can result in improved programs and services for students, staff, and the community. The council can advise an entire school district, but a SHAC or school health team may also be useful for a priority school desiring their own school-level advisory group.[69,70,72]

Activity description

A key first step in establishing a SHAC or similar council/committee is selecting appropriate members. Representation from various segments of the community can enrich the level of discussion and acceptance of proposed activities, and it is important to have a SHAC that accurately represents the demographic diversity of the community (e.g., age, sex, race, income, geography, ethnicity, profession, religious affiliation). Possible sources for SHAC membership include parents of students in the district, students and teachers, school administrators, health care and social service professionals, the business community, law enforcement, nonprofit organizations, local domestic violence prevention programs, media outlets, public health agencies, civic and service organizations, youth groups, housing authorities, before- and after-school organizations, and faith community leaders.

The SHAC is responsible for making school health recommendations to the school board and should work with school board personnel to determine feasibility, cost, and sustainability of recommendations.[70,73] For example, a SHAC might use the CDC's HECAT in collaboration with district curriculum and instructional staff to review and select SHE instructional programs for all secondary school students. Such analysis of SHE instructional programs could result in recommendations to the school board about adopting or adapting instructional programs. The LEA can designate a school health coordinator to oversee school health policies, programs, practices, and services, and to establish partnerships between schools, families, and community organizations. As an active member of the SHAC, this coordinator can also help identify and involve key stakeholders.

Key considerations: Process for establishing a SHAC

Recommendations by Howell (1991) and the Public Schools of North Carolina, Division of Curriculum and Instruction describe an in-depth process to establish and maintain an active SHAC.[69,74] These steps include

1. Review any established school system procedures for advisory councils.
2. Gather 3-5 interested persons to determine shared perceptions about the need for a SHAC.
3. Establish the general purpose and major functions of the SHAC.
4. Conduct a realistic analysis of challenges in the community and school system.
5. Identify potential categories of SHAC members and a tentative schedule.
6. Prepare a brief proposal on the formation of a SHAC.
7. Gain support from school system central office personnel.
8. Hold a first meeting to determine interest levels and support for a SHAC.
9. Revise and finalize membership roster.
10. Adopt by-laws and charter membership.
11. Conduct training for members.
12. Conduct needs assessment.
13. Devvelop task and project plans based on needs assessment.
14. Carry out proposed plans and monitor progress.
15. Establish mechanism for regular reporting to school system and community.

Resources

Selected resources to support developing and maintaining a SHAC:

- **Howell, K.; North Carolina State Department of Public Instruction, Raleigh Division of Curriculum and Instruction. *Establishing and Maintaining School Health Advisory Councils: A How-To Manual for Local Educational Agencies*.** This resource is for individuals seeking information on the development and operation of a SHAC. The information has been organized in an easy-to-use style

with the intent of serving as a how-to manual. https://files.eric.ed.gov/fulltext/ED336694.pdf

- **Public Schools of North Carolina. *Effective School Health Advisory Councils: Moving from Policy to Action*.** This resource guide will assist LEA in developing new SHACs or revitalizing or strengthening existing SHACs and maintaining them as effective entities that support and guide school health practices, programs, and policies. https://fns-prod.azureedge.net/sites/default/files/NC_effective_school_health_council_manual.pdf
- **American Cancer Society (ACS). *Promoting Healthy Youth, Schools, and Communities: A Guide to Community-School Health Councils*.** This resource will assist LEA in developing a new SHAC, strengthening an existing SHAC, and maintaining entities that support school health education programs. http://www.schoolwellnesspolicies.org/resources/AGuideToCommunitySchoolHealthCouncils.pdf

Required activity: Integrate strategies to actively engage parents in sexual health education instructional programs.

Rationale

The purpose of this activity is to **increase parent/student communication, both general and specific to sexual health**. CDC's framework for parent engagement in schools recognizes that parents can help school staff implement school-level policies and practices associated with reductions in adolescent sexual risk,[75] including SHE. The majority of parents support the provision of SHE in schools.[55,76] This support can be leveraged to facilitate implementation of SHE activities that can enhance staff capacity and increase student access to effective SHE programs. Moreover, SHE programs that involve parents have positive student-level effects, such as better communication and monitoring.[77] Promoting parent-adolescent communication through SHE can also complement parent activities related to SSE (see Chapter 4).

Activity description

CDC's *Parent Engagement: Strategies for Involving Parents in School Health* offers a process that can be used by LEA to better engage parents in SHE:[78]

1. Make a positive connection with parents.
2. Provide a variety of activities and frequent opportunities to fully engage parents.
3. Work with parents to sustain their engagement by addressing the common challenges to getting and keeping them engaged.

It is important to ensure activities are tailored to support SHE, even though parent engagement in schools may address broader goals and objectives. CDC's strategy guide outlines some strategies that are most closely linked to SHE: providing a variety of volunteer opportunities, supporting learning at home, and encouraging parents to participate in decision-making. LEA may consider incorporating activities relevant to SHE into school-wide parent engagement action plans and committees. Box 2.5 provides sample activities for each stage of this process specific to SHE and adolescents.[79,80]

Box 2.5. Parental Engagement Strategies that Support Sexual Health Education[70]

Strategy 1: Make a positive connection with parents

- Ask parents about their needs and interests regarding SHE and ways they would like to be involved in supporting implementation.

Strategy 2: Provide a variety of activities and frequent opportunities to fully engage parents

- Provide parents with seminars, workshops, and information on SHE that relate directly to lessons taught in the health education classroom.
- Train teachers to develop family-based education strategies that involve parents in discussions about health topics with their children (e.g., homework assignments that involve parent participation).
- Involve parents in choosing health education curricula, specifically SHE content, with the help of tools such as the HECAT.
- Use parents as members of and decision-makers on a SHAC.

Strategy 3: Work with parents to sustain their engagement by addressing the common challenges to getting and keeping them engaged

- Assess barriers parents face in engaging in SHE and identify potential solutions.

Resources

Selected resources to integrate parents into SHE:

- **CDC. *Parent Engagement: Strategies for Involving Parents in School Health*.** This 28-page reference describes a variety of approaches for getting parents engaged in school health activities. www.cdc.gov/healthyyouth/protective/pdf/parent_engagement_strategies.pdf
- **CDC. *Parent Engagement*.** This webpage provides a number of resources on the importance of parent engagement and ways to promote parent engagement in schools. https://www.cdc.gov/healthyyouth/protective/parent_engagement.htm
- **CDC. *Positive Parenting Practices*.** This resource includes fact sheets schools can disseminate about parental monitoring, the influence of fathers, and parents' influence on lesbian, gay, or bisexual teens. https://www.cdc.gov/healthyyouth/protective/positiveparenting.htm
- **United States Department of Education. *Family and Community Engagement (FACE)*.** This page provides several resources to engage families and community members in youth-centered programs, education experiences, and learning. https://www2.ed.gov/parents/academic/help/partnership.html
- **American Psychological Association (APA). *Safe and Supportive Schools Project*.** This resource center houses several tools and resources to help schools navigate successful parental practices and engagement opportunities with and in schools. www.apa.org/pi/lgbt/programs/safe-supportive/parental-engagement/default.aspx

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Chapter 3:
Strategy 2B—Increasing Access to Sexual Health Services (SHS)

SHS Rationale

This chapter addresses implementation of activities to increase student access to key preventive sexual health services (SHS), including specific services like HIV and STD testing and contraception and condom provision, as well as more broad preventive measures like conducting sexual risk assessments, creating adolescent-friendly clinical environments, and providing counseling about preventive behaviors.

Preventive SHS can have a significant impact on an adolescent's immediate and life-long trajectory of health by reducing risk behavior and preventing negative sexual health outcomes like unintended pregnancy, STDs, and HIV.[1–3] Despite a number of national guidelines and recommendations for routine provision of SHS for adolescents,[1,4–9] many young people do not have preventive care visits.[10,11] Even among those who do, missed opportunities for SHS are common. For instance, confidentiality and developmentally appropriate care are critical to adolescent SHS.[12–17] However, young people do not often receive time alone with their provider[11,18] and report concerns about the confidentiality of their care.[19] These types of issues may contribute to low SHS use among adolescents. As an example, one recent study found only 22% of sexually experienced high school students had ever been tested for HIV,[20] and another study found fewer than one in ten sexually active 15- to 19-year-olds report getting tested for chlamydia in the previous year.[21] In 2017, 46.2% of currently sexually active students did not use a condom the last time they had sexual intercourse.[22]

School health service providers have traditionally focused on managing chronic conditions or promoting nutrition and physical activity.[23] There has been less attention on how schools can improve adolescent sexual health despite evidence for promising approaches. For instance, research shows increases in contraceptive use and sexual health visits and declines in unintended pregnancy associated with school-based health centers (SBHC).[24–27] Likewise, a school-based referral program that helped school nurses connect students to adolescent-friendly community health care providers increased adolescent use of SHS (contraception, STD testing, counseling).[28–30] Other SHS-related programs that schools typically employ (e.g., condom availability programs [CAPs], school-based STD screening [SBSS] events, and sexual health awareness campaigns) have been shown to have a variety of health impacts, including improvements in students' beliefs and attitudes about condom use and STD testing, and increased use of SHS.[31–33]

For these reasons, CDC has identified increasing adolescents' access to key preventive SHS via direct provision of on-site services or referrals to adolescent-friendly community-based health service providers as a key Component 2 programmatic strategy.

SHS Overview

Table 3.1 provides a list of required and additional SHS activities for funded LEA. Activities are organized according to the three overarching Component 2 domains: (1) strengthen staff capacity, (2) increase student access to programs and services, and (3) engage parents and community partners. Although the role of parents and community partners in adolescent sexual health is important, and we provide examples of how to engage them in specific required activities below, there are no specific required activities within the "engage parents and community partners" domain. There are, however, suggested additional activities within that domain as well as in the "increase student access to programs and services" domain. When combined with required activities, additional activities can enhance the impact of programmatic efforts to reach the intermediate outcomes and help LEA meet performance standards. These may be activities in which partners are already engaged, and they can be considered part of the overall model of increasing student access to SHS. Additional activities may also be relatively feasible to enact (e.g., a strong partner wants to implement an SBSS event in a school where STD rates may be high). Both required and additional activities have been identified based on evidence of effectiveness, feasibility considerations, and potential reach, and they are described in more detail.

Table 3.1. SHS Required and Additional Activities Organized by Domains

Domains	Required SHS Activities	Additional SHS Activities
Strengthen staff capacity	■ Annually, provide training and professional development to school and/or health service staff to support SHS activities.	
Increase student access to programs and services	■ During year one, assess district and priority school capacity to implement activities to increase student access to SHS, in collaboration and coordination with the Component 3B recipient. ■ Annually, incorporate skill-based instruction to students on accessing school-based and community SHS into sexual health education lessons. ■ Annually, choose the area of focus below, appropriate to the recipient's health services infrastructure, to increase student access to and use of SHS through either on-site provision or referral to community-based sexual health providers: (a) Establish or improve use of a referral system to link sexually active students to community providers for SHS by using the referral system toolkit (see Glossary) to implement the seven core components of a referral system. (b) Improve student use and quality of SHS provided by School-Based Health Centers (SBHCs). ■ Implement school-wide, student-planned marketing campaigns that promote recommended health services for teens and selected school SHS programs.	■ Conduct school-based STD screening (SBSS) events. ■ Implement or improve a condom availability program (CAP).
Engage parent and community partners		■ Disseminate SHS-related materials for parents.

Organizations funded under Component 3B are expected to provide capacity-building assistance to LEA to support implementation of each required activity. Boxes throughout this chapter highlight the unique role that Component 3B recipients can play in supporting Component 2 recipients for each activity. Component 3B recipients cannot choose to support only select activities.

Timing of Required Activities

LEA will vary in their order and timing of required activities based on their readiness, capacity, and ongoing programs. They are, however, expected to begin year one by assessing their district's and priority schools' infrastucture and capacity in order to choose either implementation of a referral system or improving SBHC services. Once a primary mode to increase student access to SHS is chosen, LEA are expected to work on and show improvement on related activities annually. Early in the project period, LEA are expected to build and strengthen relationships with health departments, health care providers, and other relevant community partners in order to lay the foundation for implementing the required activities. LEA are also expected to annually provide SHS professional development, annually incorporate SHS into SHE, and implement a school-wide student-planned marketing campaign. LEA will prioritize and phase all activities in consultation with their Program Consultant and TA Teams based on capacity, readiness, and feasibility of implementation.

Activity-specific Guidance

For each required and additional activity, we indicate the purpose of the activity in relation to intermediate program outcomes and summarize the rationale for implementing the activity as part of school-based HIV and other STD prevention. We describe activities and outline key considerations for implementation based on existing science and practice. For each activity, we cite specific resources to facilitate implementation. Where relevant, we highlight connections to SHE and SSE activities. This guidance focuses on activities implemented by LEA (Component 2B). As appropriate, we provide relevant guidance for capacity-building organizations (Component 3B recipients) to facilitate LEA implementation.

Strengthen Staff Capacity

Required activity: Annually, provide training and professional development to school and/or health service staff to support SHS activities.

Rationale

The purpose of this activity is to ultimately reach the intermediate goals of **increasing student knowledge, skills, and behaviors to avoid and reduce sexual risk behaviors; increasing student awareness of SHS needs and services; increasing student HIV testing; and increasing student STD testing**. Professional development (PD) refers to a systematic process used to strengthen the professional knowledge, skills, and attitudes of a particular workforce. Given that school health staff are often heavily focused on chronic conditions and their preventive behaviors, school professionals, including school health professionals, may not have the training specifically relevant to provision of adolescent SHS. PD provides an excellent opportunity to ensure that teachers and school staff continually expand their knowledge and skills to implement SHS activities. Implementation of SHS activities requires knowledge of topics such as an adolescent's right to access SHS, how to maintain confidentiality, and the availability of local low- or no-cost services. Evaluation findings from previous CDC programs have suggested that school and school health services staff would benefit from training to increase their self-efficacy and make them more comfortable with providing or referring students to available SHS.[34] PD trainings have effectively changed the practices and self-efficacy of teachers and other non-health-related staff about addressing their students' sexuality. Trainings that are designed to develop staff comfort, capacity, and expertise in core adolescent sexual health areas and best practices have effectively improved clinical services in a variety of settings, including SBHCs.[35] PD trainings are also typically a staple component of effective quality improvement programs and interventions for health clinic and school health staff. [36]

Activity description

All PD should be implemented in accordance with CDC's guidance on Professional Development Practices (see Chapter 5). The Professional Development Practices (PDP) resource provides guidance on planning, implementing, and evaluating PD for school health. In addition to the activities outlined there, special considerations exist when selecting topics for SHS PD because of unique issues like the sensitive nature of sexual health information, the need to maintain student confidentiality, and dealing with stigma or biases. Box 3.2 provides a list of important topics for SHS PD.

Box 3.2. Examples of Important SHS PD Topics

The following list of PD topics for school, district, and/or school-health staff was developed through feedback from adolescent and school health experts' experience implementing school-based SHS programs, a review of available PD trainings (see resources), and assessment of previous CDC-funded SHS activities. As noted in the text above, topics will largely be driven by the particular SHS programs that are chosen and implemented.

SHS 101: The Basics/Foundational Knowledge

- Recommendations for adolescent SHS from professional medical and public health organizations
- Importance of including information about adolescent sexual risk behaviors and their adverse health consequences in adolescent SHS
- Relevant laws and policies—minors' rights to self-consent for SHS, Health Insurance Portability and Accountability Act (HIPAA), Family Education Rights and Privacy Act (FERPA), etc.
- The importance of confidentiality, ways it is inadvertently breached, and best practices to maintain it
- Parental consent policies and procedures

Making Referrals

- Assessing SHS providers for youth-friendliness of clinical services
- Creating and using a provider referral guide
- Making a referral

Providing On-site Services

- Establishing new or strengthening existing organizational partnerships
- Identifying student SHS needs (e.g., standardized screening for risk)
- Making SBHCs (more) adolescent friendly
- Establishing best practices for adolescent SHS provision

Other Supplemental Topics

- Engaging youth in the design, delivery, and evaluation of SHS programs
- Marketing SHS programs
- Ensuring services and programs are inclusive of LGBT students
- Managing controversy around SHS

As feasible, LEA should implement PD using active learning strategies, including classroom observations and feedback, as well as professional coaching to build classroom management skills. These intensive strategies can be complemented with more traditional, didactic approaches that outline best practices and direct teachers to tools and resources.

Key consideration: Who and what? Multiple audiences need professional development on varying topics

All school staff and faculty can be an important resource and support for adolescents and may be involved in connecting adolescents to SHS, whether at school or through referral programs. A broad selection of school staff (e.g., counselors, social workers, teachers, coaches, and/or security guards) could be given basic information about recommended adolescent SHS, a student's legal rights to access confidential SHS in accordance with state laws and regulations, school district policies impacting access to SHS, and resources for students that include information about where to locally obtain adolescent-friendly SHS. District staff may help school administrators identify good candidates for training depending on things like who has frequent contact and good rapport with students or who has shown interest in championing SHE or other efforts in the past.

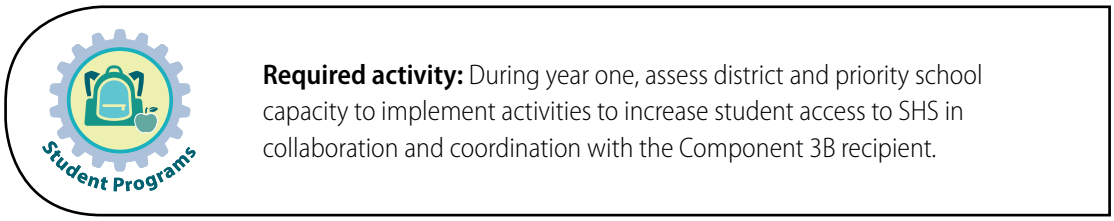
Beyond the PD needs of a broader audience, recipients may need to target trainings to particular district, school, or school health staff based on roles, responsibilities, and identified needs of staff, as well as selected program activities. That is, additional capacity building can be tailored to the selected programmatic area of focus (e.g., referral system, SBHC improvement, or awareness campaigns) and staff who will be directly involved in its implementation. For instance, recipients focusing on establishing or improving a referral system may want to provide PD to referral staff on how to use a referral guide and how to make a referral. Those focusing on improving services at an SBHC may need to train clinic staff on clinical best practices, creating an adolescent-friendly environment, or taking a sexual history. PD should include training staff on assuring and maintaining student privacy and confidentiality according to state laws and regulations, regardless of the specific program focus selected.

Resources

Selected resources to support SHS PD:

- **The National Network of STD Clinical Prevention Training Centers (NNPTC).** A CDC-funded group of training centers created in partnership with health departments and universities. The PTCs are dedicated to increasing the knowledge and skills of health professionals in the areas of sexual health. The NNPTC provides health professionals with a spectrum of state-of-the-art educational opportunities, including experiential learning, with an emphasis on STD treatment and prevention. http://nnptc.org/about-us/
- **Adolescent Health Initiative (AHI). *Spark Trainings*.** Free, packaged, and ready-to-use 15- to 30-minute presentations. Includes a PowerPoint presentation, a facilitator script, and follow-up materials. They are designed for providers or staff to deliver at staff meetings or PD opportunities. Spark trainings are specifically designed to "spark" discussion and reflection among a multidisciplinary audience. http://www.umhs-adolescenthealth.org/improving-care/spark-trainings/
- **Adolescent Health Initiative (AHI). *Customized Trainings*.** AHI offers customized web-based and in-person trainings to support organizations in becoming more adolescent-centered. AHI works with organizations to develop and facilitate engaging webinars on adolescent-centered care. http://www.umhs-adolescenthealth.org/improving-care/webinars-trainings/ ($)
- **Adolescent Health Initiative (AHI). *Starter Guides*.** AHI offers mini-toolkits that provide concrete, actionable steps to improve adolescent care. http://www.umhs-adolescenthealth.org/improving-care/starter-guides/

Increase Student Access to Programs and Services



Required activity: During year one, assess district and priority school capacity to implement activities to increase student access to SHS in collaboration and coordination with the Component 3B recipient.

Rationale

The purpose of this activity is to reach the intermediate goals of **increasing student knowledge, skills, and behaviors to avoid and reduce sexual risk behaviors; increasing student awareness of SHS needs and services; increasing student HIV testing; and increasing student STD testing**. Delivery of SHS can vary across districts and schools based on local context, such as school policies, health service infrastructure, partnerships, and community support. This point was evident in discussions among adolescent and school health experts at a 2012 CDC meeting to understand strategies education agencies and schools could use to increase students' access to SHS. In particular, participants there focused on infrastructure and suggested using a framework to make programmatic decisions based on whether a district or school had SBHCs, school nurses, and little or no access to health care provision on site.[37]

On-site health infrastructure is not necessary for delivery of services on site. Informed by observations and experience of previous CDC programs, several strategies emerged that transcended infrastructure.

For instance, school-linked approaches of periodic school-wide screening events or mobile SHS clinics are employed by some districts. Likewise, LEA often rely on the infrastructure of a referral system to link students to adolescent-friendly providers in the community. Further, other student supports, like counselors, social workers, and wellness centers, and student groups can act as valuable resources that impact how SHS may be delivered.

Infrastructure, along with other local contextual factors such as state and local policies or community support, can drive service delivery models and success. A thorough understanding of infrastructure and contextual factors is a critical foundation for designing an effective program.

Activity description

In efforts to link a district and a school's infrastructure and other local contextual features to the most relevant SHS programmatic focus, LEA will perform an SHS Context Self-Assessment early in year one of the project period.

The SHS Context Self-Assessment will include consideration of state, district, and school policies (e.g., ability to provide SHS on site or refer for SHS) and health service infrastructure (e.g., existence of school nurses, SBHCs, wellness centers, and/or referral system). The self-assessment will also consider the presence of supportive administrative and school staff, existing advisory groups, existing health education and SHE programs, school climate and community factors, and organizational partnerships. LEA will work with Component 3B recipients and Program Consultants to verify organizational and environmental supports and the existing capacity required to implement selected SHS programmatic activities.

This assessment activity will inform decisions about which school-wide program for students (see below required activity) is best suited for the LEA. The assessment will also help determine more immediate action steps, resources, and levels of support needed to implement the SHS student program and should inform specific staff roles and responsibilities, PD needs, and method(s) of monitoring implementation.

Component 3B recipients can

- Assist LEA in conducting and reviewing the self-assessment and translating results into action steps, staff roles and responsibilities, and other planning activities in efforts to implement school-wide program for students.

Resources

Selected resources to support this SHS-related assessment:

- **CDC. *Sexual Health Services (fact sheet)*.** This fact sheet outlines what schools, districts, and administrators can do to increase students' access to SHS. https://www.cdc.gov/healthyyouth/healthservices/pdf/sexualhealth-factsheet.pdf

Required activity: Annually, incorporate skill-based instruction to students on accessing school-based and community-based SHS into sexual health education (SHE) lessons.

Rationale

The purpose of this activity is to reach the intermediate goals of **increasing student knowledge, skills, and behaviors to avoid and reduce sexual risk behaviors; increasing student awareness of SHS needs and services; increasing student HIV testing; and increasing student STD testing**. SHE is a core component of school-based HIV and other STD prevention (see Chapter 2) that educates students about risks and preventive behaviors. Skills-based instruction in SHE provides opportunities for students to observe, practice, and master skills and behaviors needed to avoid or delay sexual risk. Although not always

addressed specifically in SHE curricula, instruction that focuses on identifying and assessing available services could provide an opportunity to help students develop the necessary capacity and skills specific to finding and accessing services.[38] For instance, research shows that awareness of clinic locations and having services that are easily accessible, free or low-cost, have teen-friendly hours, and are nearby are key factors related to adolescents' use of SHS.[38] More practically speaking, previous CDC programs found that school staff generally favor incorporating information about available SHS into SHE lessons and believe this is reasonably feasible. This activity also overlaps with SHE efforts and can serve as a leverage point across both strategies, offering a chance to coordinate programmatic efforts.

Beyond basic information about locally available adolescent-friendly SHS, there is increasing evidence suggesting that a skills-based approach to health education may be more effective than teaching knowledge alone.

In particular, allowing students to practice skills aligned to promoting health literacy (defined as the capacity to process health information to make health decisions) can improve health behaviors and service use.[39] CDC suggests that anyone, including SHE educators, who provides health information to others should teach skills to help people find and use services, communicate about their health needs, understand their health choices and consequences, and make decisions about the services that match their needs and preferences.[40] For SHS, this could mean that beyond telling students where local services are located, it is also important to teach them what SHS are recommended and why, what their rights and protections are for accessing confidential services, and how to communicate with providers and partners about their SHS needs and options. Preliminary, unpublished results indicate that students receiving lessons that emphasize their rights and responsibilities in managing their own health care, as well as communication with providers about sensitive topics like sexual health or substance use, better understood how to advocate for themselves in health care settings. CDC will share published evaluation of this program when it becomes available.

Box 3.3. Excerpt from HECAT Appendix 3: HECAT/Sexual Health Module—Skill Expectation for Skill Standard 3

Students will demonstrate the ability to access valid information, products, and services to enhance health. After implementing this curriculum, students will be able to demonstrate the ability to access valid information, products, and services to promote sexual health.

Activity description

Skill-based instruction is about planning, implementing, and assessing health-specific skills. In a skill-based classroom, the majority of instructional time is dedicated to practicing, assessing, and reflecting on skills. LEA will be expected to work with Component 3B recipients and Program Consultants to identify areas of the SHE instructional program where health-services-related skills can be addressed. SHS-specific work should strengthen the skills component of an existing program or create additional skill-based instruction to improve students' health literacy specifically for using SHS.

As discussed in greater detail in Chapter 2, one effective strategy for identifying and implementing effective health education instructional programs is through the use of the CDC's HECAT, which can help schools select or develop appropriate and effective health education curricula and improve the delivery of health education. In addition to a description of the health topic to be addressed and the associated healthy behavior outcomes, the HECAT outlines the sexual-health-specific skill expectations for each grade group.

Providing information about an SBHC or local clinic services, location, and hours of operation into SHE lessons is one example of how to incorporate SHS into SHE. Inviting service providers to teach about sexual and reproductive health and provide information about available services and what to expect with certain services may create familiarity with clinic staff that in turn improves student use. One such

example comes from Chicago Public Schools (CPS) who invited Health Corps volunteers and clinicians from a neighborhood school-linked clinic to participate in events as part of a broader sexual health awareness campaign. Evaluation of the program revealed that students said they felt more comfortable going to the clinic for services because they knew the staff. This type of activity may be a practical and relatively easily implemented strategy to increase student comfort with using SHS.

Planning a field trip to an SBHC or local referral clinic may also help acquaint students with available services and increase students' comfort accessing services. There are also existing lesson plans (see selected resources below) that can improve specific behaviors like condom use or communication with service providers and others.

Component 3B recipients can

- Develop guidance for LEA on how to plan a field trip to a local clinic, including example permission forms, instructions on how to engage students, and travel protocols.
- Review SHE curricula for inclusion of SHS-related information and skill-building exercises.
- Conduct a systematic review to inform availability of promising curricula.

Resources

Selected resources to support skills-based instruction for students on access SHS:

- **Healthy Teen Network.** ***Keep It Simple: A Lesson in Linking Teens to Sexual Health Care—Facilitator's Guide*****.** This resource includes a lesson plan and accompanying video, or motion graphic, designed to help link young men and women aged 15–19 years to trusted, "teen friendly" contraceptive and reproductive health care providers. The lesson addresses four key areas related to contraceptive and reproductive health: 1) adolescents' right to receive care, 2) the types of services available to them, 3) how services are provided, and 4) where they can go for contraceptive and reproductive health care in their community.
  https://www.healthyteennetwork.org/resources/keep-it-simple-guide/
- ***Recommendations for Preventive Pediatric Health Care*****.** These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures.
  https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
- **CDC.** ***Health Education Curriculum Analysis Tool (HECAT)—Sexual Health Module*****.** The HECAT can help school districts and schools conduct a clear, complete, and consistent analysis of health education curricula. The Sexual Health Module contains the tools to analyze and score curricula that are intended to promote sexual health and prevent sexual-risk-related health problems.
  https://www.cdc.gov/healthyyouth/hecat/pdf/hecat_module_sh.pdf
- ***Providers and Teens Communicating for Health (PATCH) Program*****.** The Wisconsin-based PATCH Program is an innovative educational program that strives to improve the ability of health care providers and teens to communicate effectively about sensitive health topics such as sexual health, mental health, alcohol and drug abuse, or safety, thereby improving the quality of care that teens receive. PATCH offers classroom lesson plans intended to be taught by trained health education teachers over the course of two days. www.patchprogram.org
- **Advocates for Youth (AFY).** ***Taking Care of Your Sexual Health—Lesson Plan*****.** AFY has developed a number of educational programs containing a wide range of skill-based lessons targeting young people ages 12–18. http://www.advocatesforyouth.org/storage/advfy/lesson-plans/lesson-plan-taking-care-of-your-sexual-health.pdf

Required activity: Annually, choose the area of focus below, appropriate to the recipient's health services infrastructure, to increase student access to and use of SHS through either on-site provision or referral to community-based sexual health providers.

The purpose of this activity is to reach the intermediate goals of **increasing student HIV testing and increasing student STD testing**. In order for LEA to select the best program for their local context, this required activity allows them to choose from one of two options depending on the results of their SHS Context Assessment: (a) establish or improve referral systems or (b) improve use and quality of SBHCs. Although Option A allows establishment or improvement of a referral system, Option B only requires improvement of existing SBHCs. The extent to which SBHCs can be established is largely dependent on factors (e.g., funding) that are beyond the scope of this funding. The intent of Option B is not to establish SBHCs, but rather to strengthen the provision and use of SHS within these existing school-based clinics.

Below we provide more specific guidance related to each option.

Option A: Establish or improve use of a referral system to link sexually active students to community providers for SHS by using the referral system toolkit (see Glossary) to implement the seven core components of a referral system.

Rationale

Many schools cannot supply ongoing SHS on school premises because they lack the infrastructure, resources, or supportive policies to do so. For this reason, schools often rely on linking students to adolescent-friendly providers in their communities when needs arise. Research shows this approach can work; students in south Florida high schools were more likely to get tested when they were referred by school staff.[34] The Project Connect Health Systems Intervention is one example of a model shown to increase referrals from schools to quality SHS providers. This evidence-based intervention, centered in the school nurse office, demonstrated an increase in sexually active adolescents' receipt of SHS and reproductive health services.[28–30]

Activity description

Informed largely by lessons learned from the original Project Connect intervention and subsequent adaptations, CDC and partners CAI and National Coalition of STD Directors (NCSD) created "Developing a Referral System for Sexual Health Services: An Implementation Kit for Education Agencies." This toolkit serves as a framework for a standardized approach to developing and implementing an SHS referral system in high school settings. The toolkit outlines seven core components of developing and implementing an SHS referral system. Each core component has a set of associated key activities and tools that can be used to plan, implement, and sustain an SHS referral system. Recipients choosing to focus on either establishing or improving their referral system will use the toolkit and ensure that activities are implemented to completely address all core components of an SHS referral system.

Key consideration: The referral guide

The cornerstone of any successful referral system is a referral guide. A referral guide is a paper-based (e.g., posters, palm cards, or tear-off sheets) or electronic (e.g., database, website, or mobile app) resource that lists youth-friendly sexual health service provider organizations. The referral guide will serve as the primary tool or resource that staff will use to guide the selection of an appropriate service provider with a student and facilitate making a referral. It also can serve as a stand-alone resource that, when distributed widely, can aid in raising awareness among the student population about services available and facilitate self-referral to care. At a minimum, the guide should include a list of school-based and community-based SHS

provider organizations and pertinent information about each one, including service(s) provided, target population served, and access information (e.g., location, cost, telephone number/website, transportation, and hours). It is important to pay special attention to youth who may be at disproportionate risk, such as LGBT youth. Ensure that your referral guide includes places that offer free services, providers in all parts of town, providers that speak multiple languages, and those that have experience providing LGBT-friendly care. This can help you ensure your guide is inclusive of all students and can meet their needs. More detailed guidance on how to develop and maintain a referral guide is available in the CAI and NCSD toolkit.

Key consideration: Partnering with community providers

To develop a successful referral system—from the initial creation of a referral guide, to building awareness among staff and students, to following up on services received—it is essential to establish positive working relationships with community providers. For instance, when developing a referral guide, districts can work with the local health department or other community-based organizations and clinics with whom they've established formal memoranda of understanding as part of the Program 1807 application process to identify all SHS providers within the zip codes where students live. Fostering relationships with SHS providers listed in the referral guide can serve to strengthen the referral system and increase connections between schools and communities over time. It can also make it easier to update the referral guide by increasing responsiveness to requests. Options for building relationships include hosting quarterly or yearly meetings where school staff and health care providers have the opportunity to meet, and providers can have the chance to outline the services they offer and ways for students to connect with them. Another option is to organize field trips for students and key school staff to visit the community-based provider organizations. Also, consider inviting provider champions to participate in the school or school district Health or Wellness Council. For ways to engage community partners, as well as strategies to establish and strengthen relationships, see "Establishing Organizational Partnerships to Increase Student Access to Sexual Health Services" in the resources listed below.

Key consideration: What makes a referral?

The term referral describes the process of helping students obtain preventive health services through a variety of activities that ultimately connect students in need to adolescent-friendly providers and support services. A referral system is a set of resources and processes that are designed to work together to increase student awareness of school-based and community-based SHS providers, increase referral of students to school-based and community-based SHS providers for sexually active adolescents, and increase the number of sexually active adolescents receiving key SHS. Although a referral system includes activities to raise student awareness of the need for and availability of services in general, referrals themselves can take many forms (e.g., peer-to-peer referrals, self-referrals, informal sharing of information between staff and students). However, for the purposes of evaluation for Program 1807, a referral is defined as a facilitated one-on-one directing of a student to SHS (either in the community or on site) by designated staff. To be counted as a referral, there must be active sharing of information between a designated school staff member and a student that directly links the student to a specific health care provider for needed SHS.

Component 3B recipients can

- Review LEA referral guides for inclusion of LGBT- and youth-friendly community providers.
- Ensure that tracking of referrals is not counterproductive to implementation of referral system (e.g., limiting referral staff to those trained on a formal system).

Resources

Selected resources to support use or improvement of a referral system:

- **CAI and National Coalition of STD Directors. *Developing a Referral System for Sexual Health Services*.** The toolkit provides a framework for developing and implementing a referral system to connect youth to school- or community-based SHS. http://www.ncsddc.org/resource/developing-a-referral-system-for-sexual-health-services/

- **CAI and National Coalition of STD Directors. *Establishing Organizational Partnerships to Increase Student Access to Sexual Health Services*.** This guide is a companion piece to the referral system toolkit described above and is meant to help in identifying, establishing, and strengthening relationships with community providers in order to improve referral systems, as well as other school-based strategies to increase student access to SHS. http://www.ncsddc.org/wp-content/uploads/2017/08/organizational_partnerships-10-17-16-2-1.pdf
- ***Project Connect website*.** The Project Connect Health Systems Intervention is an evidence-based, scalable intervention designed to increase youth access to sexual and reproductive health care services. https://www.cdc.gov/std/projects/connect/
- **Adolescent Health Initiative. *Building Effective Referral Systems*.** A starter guide on building formal relationships and developing effective referral systems to connect youth to needed health services. http://www.umhs-adolescenthealth.org/improving-care/referrals-linkages/ http://www.umhs-adolescenthealth.org/wp-content/uploads/2018/03/referral-infographic_lo3.pdf
- **CAI. *Lessons Learned from Implementing a School-Based Referral System for SHS webinar*.** CAI, in partnership with Duval County Public Schools and San Diego Unified School District, shares findings and lessons learned from two case studies on implementing a school-based referral system for SHS. https://register.gotowebinar.com/register/1803413863571506945?utm_source=getresponse&utm_medium=email&utm_campaign=connections_for_student_success&utm_content=5%2F9+Webinar+Registration+Now+Open+-+Lessons+Learned
- **Office of Adolescent Health. *Referrals and Linkages to Youth-Friendly Health Care Services*.** Provides a description of the 7 components of a referral system for linking youth to youth-friendly services that are available in their communities. https://www.hhs.gov/ash/oah/sites/default/files/referrals_and_linkages_to_youth_friendly_health_care.pdf

Option B: Improve student use and quality of SHS provided by school-based health centers (SBHCs).

Rationale

The purpose of this activity is to ultimately reach the intermediate goals of **increasing student awareness of SHS needs and services, increasing student HIV testing, and increasing student STD testing**. SBHCs have been delivering a range of comprehensive health services to children and adolescents for decades and often provide adolescents with critical access to confidential services including SHS,[41] often filling a gap in services for underserved and vulnerable populations.[42] Compared to other clinics (both private and public), SBHCs are more likely to serve students who don't have insurance and who have greater health care needs,[43] and SBHCs are used more often by racial minorities and students living in rural areas.[44]

The American Academy of Pediatrics notes that SBHCs can decrease the loss of students' time in class, serve as a more acceptable and welcoming setting for adolescents seeking confidential care, and increase student access to and use of all health services.[45] In terms of delivery of SHS, SBHCs are associated with greater use of contraception and STD testing,[46] decreased time to treatment for young people diagnosed with STDs,[47] and delivery of preventive counseling about STDs and pregnancy.[25]

The unique combination of school nursing services and SBHCs working together to meet the health needs of students and promote health in schools is a promising practice. School nurses and SBHC staff can work as partners to identify policy gaps, collect data, and evaluate processes to improve health outcomes for their students and communities.[48] Studies also show that young people are willing to use and actually prefer SBHCs for SHS, and the provision of confidential services is a main reason students visit them.[41,49]

Activity description

LEA with existing SBHC infrastructure should consider ways to increase the provision of quality care at those clinics. There are local level examples that demonstrate how to initiate sexual and reproductive health services

on site at their existing SBHCs after extensively engaging the local community and increasing awareness of the need for teen pregnancy prevention.50 Quality care at SBHCs is associated with increased contraceptive use by sexually active students and a resulting decrease in teen pregnancy.[51]

Recipients choosing this option will take steps to improve both quality services available at the SBHC and student awareness and use of available services. Improvements can come about by identifying and convening a group of stakeholders who go through a process to identify and act on needed clinic improvements. One such model that has shown improvements in SBHC care for young people includes a process in which "champions" actively assess clinical policies, practices, and needs; prioritize areas for improvement; conduct and attend trainings; and monitor impact (http://www.umhs-adolescenthealth.org/improving-care/adolescent-champion-model/). Creating a quality improvement action plan may help facilitate more specific steps for SBHCs to take as part of that process, like ensuring policies are supportive, creating protocols, improving awareness, and monitoring implementation. Another option for quality improvement may involve using the Plan-Do-Study-Act (PDSA) approach for improvement, aimed specifically at SBHC providers to improve the provision and quality of SHS in accordance with best practice guidelines. The PDSA four-step model for improvement provides a framework for developing, testing, and implementing changes leading to improvement.

Recommended areas for SBHC quality improvement include

- increasing the types of SHS provided in SBHCs.
- ensuring student privacy and confidentiality when providing STD/HIV preventive services in SBHCs.
- improving SBHC policies, practices, and environments to ensure clinics are adolescent friendly.
- ensuring SBHC policies, practices, and environments are LGBT inclusive.
- implementing a standardized sexual risk assessment for all students attending SBHCs.
- improving awareness of STD/HIV preventive services through school-wide marketing, teacher and staff trainings, and SBHC staff participation in health education lessons or school events.
- increasing enrollment of male students.

Component 3B recipients can

- Identify assessment processes and tools and lead LEA working with SBHCs in efforts to identify areas for improving quality care. These processes would be done with health systems running SBHCs; thus 3B recipients will need to facilitate quality partnerships between organizations.

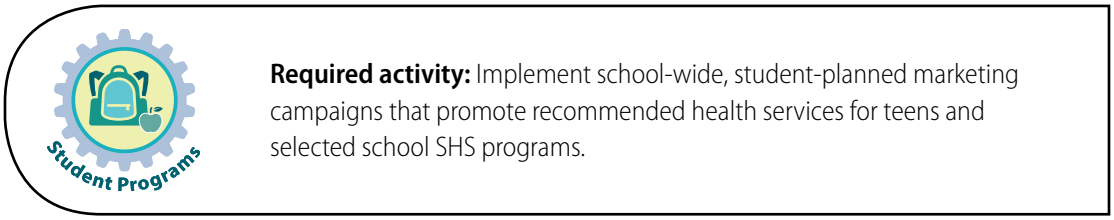
Resources

Selected resources to support student use of and quality of SHS at SBHCs:

- **CDC. *A Guide to Taking a Sexual History*.** A guide that provides parameters for discussion of sexual health issues and conducting a sexual history during a patient visit. https://www.cdc.gov/std/treatment/sexualhistory.pdf
- **American Academy of Pediatrics. *Caring for the Adolescent Patient*.** A set of videos that demonstrates conversations with adolescent patients about sexual health care issues, including how to take a sexual history, addressing gender identity, and serving LGBTQ patients. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/Sexual-History.aspx https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/adolescent-sexual-health/Pages/LGBTQ-Youth.aspx
- **Agency for Healthcare Research and Quality. *Plan-Do-Study-Act (PDSA) Directions and Examples*.** Starter materials to familiarize readers with the PDSA approach for SBHC quality improvement in accordance with best practice guidelines. The PDSA is a four-step model for improvement. http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool2b.html
- **Adolescent Health Initiative. *School-Based Health*.** This resource provides a set of mini-toolkits designed to provide actionable and concrete steps for improving adolescent care. Of particular interest

here is a guide on Primary Care—School-Based Health Center Collaboration that is expected to post soon. http://www.umhs-adolescenthealth.org/improving-care/school-based-health/

- **Adolescent Health Initiative. *Adolescent Champion Model*.** The Adolescent Champion model is a multi-faceted intervention to address a health center's environment, policies, and practices to ensure that all aspects of a visit to the health center are youth-centered. http://www.umhs-adolescenthealth.org/improving-care/adolescent-champion-model/



Required activity: Implement school-wide, student-planned marketing campaigns that promote recommended health services for teens and selected school SHS programs.

Rationale

The purpose of this activity is to reach the intermediate goals of **increasing student awareness of SHS needs and services, increasing student HIV testing, and increasing student STD testing**. As previously noted, adolescent use of SHS is low for a variety of reasons, including low knowledge about the need for and location of services and concerns about the confidentiality of their healthcare at certain settings.[10,11] One strategy to address these issues is to use communication or marketing campaigns to improve student awareness of available SHS, increase positive beliefs about getting SHS, and affect positive behavior change. These campaigns are generally described as organized intervention activities directed at a particular audience with the goal of changing a specific attitude or behavior.52 Communication campaigns can promote a wide variety of health behaviors for adolescent populations, including seat belt use, smoking cessation, and nutrition and exercise.[53–55]

A recent review of sexual health campaigns identified several campaigns that led to increases in STD testing and condom use.[56] Further, a recent pilot test in CPS showed an adapted "GYT: Get Yourself Tested" social marketing campaign in a high school setting increased testing for HIV and STDs at a local clinic as well as student awareness of available services.[57]

Activity description

Recipients will adapt, implement, and evaluate a successful SHS-related campaign for their local schools. CDC and its contractor ICF engaged experts in the fields of school and adolescent health to develop a toolkit to help districts, schools, and health clinics adapt and implement a Get Yourself Tested (GYT) campaign. The GYT for High Schools toolkit can be used to implement a student-led GYT campaign. The campaign should highlight and supplement the required activity of focusing on at least one model to increase student access to and use of SHS through either on-site provision or referral to community providers. An awareness campaign can highlight recommended SHS and providers of those services, such as SBHCs or community clinics or providers. Awareness campaigns can also highlight supplemental activities like school-based STD screening (SBSS) events, mobile clinic locations and hours, or condom availability programs (CAPs). Awareness campaigns should generally align messages and activities with core SHE curricula and policies. Framing a campaign as such can build support and ease any concerns among stakeholders.

Although use of the GYT for High Schools Toolkit is recommended, recipients are not limited to the GYT messages. Those with existing or home-grown campaign messages with a history of measured success in raising student awareness and use of SHS may choose to continue to use and develop those campaigns. Recipients using their preferred campaign messages should adhere to the principles laid out in the GYT toolkit in terms of creating a campaign that is heavily created and led by students; that takes place throughout a high school, primarily during school hours; that ensures that messages focus on an SHS-related outcome (e.g., STD testing); that is positive and empowering; and that includes all students regardless of race, ethnicity, gender, sexual orientation, or physical ability.

Resources

Selected resources to support the implementation of marketing campaigns to promote recommended SHS and SHS programs:

- **CDC. *GYT Toolkit Webinar: Using the GYT Toolkit*.** This webinar introduces a new CDC tool to help schools and partners implement a GYT social marketing campaign in their high school settings. https://www.youtube.com/watch?v=lRGcMw4vDGo&feature=youtu.be
- **School-Based Health Alliance. *Lead the Way: Engaging Youth in Health Care*.** School-Based Health Alliance's online youth engagement toolkit is designed for individuals who work in school-based or community health centers and who want to engage youth in their mission and work. http://www.sbh4all.org/training/youth-development/youth-engagement-toolkit/
- **Office of Adolescent Health, U.S. Department of Health & Human Services. *Promoting Adolescent Health through Youth Engagement: A Win-Win Strategy*.** Provides innovative ways for professionals to engage with young people as they promote adolescent health, with a focus on authentically engaging youth. https://www.hhs.gov/ash/oah/tag/game-plan-for-engaging-youth/promoting-adolescent-health-through-youth-engagement/index.html

Additional activity: Conduct school-based STD screening (SBSS) events

Rationale

The purpose of this activity is to reach the intermediate goal of **increasing student STD testing**. High schools can serve as a venue for mass screening events for chlamydia and gonorrhea because they provide access to a high-risk population, facilitate testing and treatment outside of traditional clinical settings, and make testing feasible in school settings. Across the country, high schools in places such as Washington DC, Chicago, Detroit, New Orleans, New York, and Philadelphia have years of experience implementing SBSS events and have found them a feasible means of identifying and treating a large volume of students in a short amount of time. In Detroit, SBSS events have been associated with a sustained reduction in chlamydia prevalence.[32] In addition, these programs can potentially serve other purposes including linking adolescents to broader medical services, building self-efficacy for seeking health care later, and providing risk-reduction counseling or education.

Activity description

This activity is distinct from required activity Options A and B above to increase access to SHS via either establishing or improving a referral system or improving quality SHS in SBHCs, but it is recommended in addition where and when possible. Recipients choosing to expand STD testing services through periodic on-site STD testing events will use CDC guidance documents (currently under development) to consider the need for and implementation of a chlamydia screening program in relevant high schools. Program Consultants will distribute guidance documents to LEA as they become available for broader dissemination. It should be noted that CDC does not recommend isolated HIV screening events under Program 1807. Rather, screening for STDs can identify students with positive results who can then be connected with HIV testing. Steps for implementation include

- considering local epidemiological STD data.
- forming partnerships with local health care organizations.
- garnering support of school district and administrative stakeholders.
- working with school administrators and teachers.
- helping recruit students.

- communicating programmatic events with parents.
- ensuring local policies and protocols for obtaining parental and student consents are met.
- supporting the screening events.
- providing confidential treatment for students and their partners.

LEA implementing school-based screening programs should include a brief educational component to ensure students have basic information to provide their informed consent/assent.

Resources

Selected resources to support the implementation of school-based STD screening event:

- **ETR. *Starting a School-Based Chlamydia Screening Program*.** This guide provides schools with a step-by-step process for implementing SBSS. http://recapp.etr.org/recapp/documents/theories/chlamydiaScreeningManual.pdf

Additional activity: Implement or improve condom availability programs (CAPs)

Rationale

The purpose of this activity is to reach the intermediate goals of **increasing student knowledge, skills, and behaviors to avoid and reduce sexual risk behaviors and increasing student awareness of SHS needs and services**. Research has found that CAPs can lead to increased condom use among students, and CAPs may be particularly impactful for adolescents who started having sex at a younger age, have sex frequently, and have more sex partners. These students were all more likely to have used a condom from a CAP than students with less risk behaviors.[58–60] No programs have reported any increase in sexual activity, number of sex partners, frequency of sex, or other sexual risk behaviors.[58,59,61–63]

Activity description

LEA without an existing CAP can consider the feasibility of and need for implementing one. If free or low-cost condoms are widely available to students in other venues where young people feel comfortable, a school-based CAP may not be needed. If, however, students need a place to confidentially get condoms for free or at low cost, LEA may consider the feasibility of implementing a CAP in their middle or high schools. Feasibility is largely based on state and local policies; partnerships; funding for buying condoms; and student, administrative, and parental support for a CAP. Many CAP programs began with creation or amendment of a policy that laid out how to provide condoms at schools. Most CAP programs combine condom distribution with educational messages that are aligned with existing SHE curricula, which ensures that programs function within other governing policies and procedures.[59] LEA with an existing CAP may want to review how their program is being implemented and assess its effectiveness. Researchers interested in improving existing CAPs in Los Angeles high schools found that implementation of a checklist with steps on how to provide CAP oversight, identify and train additional condom distributors, advertise the CAP, and manage parental notifications resulted in higher student awareness and CAP use.[31]

Resources

Selected resources to support the implementation or improvement of a CAP:

- ***Condom Availability Programs in Schools: A Review of the Literature.*** A peer-reviewed published manuscript that summarizes evaluations of CAPs in secondary schools. It provides discussion points about how CAPs can improve adolescent use of condoms without impacting sexual risk behaviors. It also describes key components of CAPs and highlights an intervention to improve implementation of CAPs. This resource is available from Program Consultants.

Engage Parents and Community Partners

Additional activity: Distribute parent materials to improve student use of SHS.

Rationale

The purpose of this activity is to reach the intermediate goals of **increasing student knowledge, skills, and behaviors to avoid and reduce sexual risk behaviors; increasing student awareness of SHS needs and services; and increasing parent/student communication about sexual health information and services**. Schools often disseminate information about health and wellness to parents and usually use an existing mechanism for doing so. Communicating with students' parents is a typical strategy that schools and districts use to increase engagement between the school and parents. Dissemination of materials to parents is also part of required SSE-related work (see Chapter 4), allowing efforts to potentially be coordinated or combined.

Although the notion of engaging parents around SHS may seem at odds with efforts to maintain student confidentiality mentioned throughout this chapter, there is support for involving parents in some aspects of adolescent clinical care.[64,65] CDC's *Promoting Parent Engagement in Schools to Prevent HIV and other STDs Among Teens: Information for State and Local Education Agencies* describes a framework and associated outcomes and activities that LEA can use to leverage parental influence on teens' sexual health decisions.[66] Further, this form of outreach has shown some evidence of influencing parental behavior that can have protective effects on adolescent sexual behavior. Specifically, one component of the Project Connect Health Systems Intervention was the distribution of resources that schools shared with parents, and it resulted in increased parental monitoring and communication.[67]

Activity description

LEA should carefully consider the most appropriate and feasible channels for dissemination (e.g., social media, email, newsletters, and/or handouts at parent-teacher conferences/open houses/health fairs) and if/how these resources can be integrated into existing processes for communicating with parents. Similar to the suggested principles of communicating with parents in the Chapter 4 required activities, materials should use plain language and avoid jargon. Recipients may want to consider leveraging work from the required SSE activities and likewise disseminate materials semi-annually. All resources should reflect principles for effective communication. Specifically, resources should be available, actionable, from credible and trusted sources, relevant to a parental audience, timely, and understandable. LEA may develop their own resources, but are encouraged to use existing resources that align with ways of improving adolescent use of SHS, such as time alone with a provider, recommendations for routine preventive care, and how to communicate with providers. Below are some links to specific existing resources that could be disseminated.

Resources

Selected resources to support the distribution of parent materials to support student use of SHS:

- **CDC. *Teen Health Services and One-On-One Time with a Healthcare Provider: An Infobrief for Parents*.** A one-page information sheet for parents on what they can do to help create a trusting relationship with a healthcare provider. https://www.cdc.gov/healthyyouth/healthservices/pdf/oneononetime_factsheet.pdf
- **CDC. *HPV Vaccine Information for Parents*.** Educational resources for parents to help them understand the importance of vaccinating their children and suggestions on how to use the resources. https://www.cdc.gov/hpv/hcp/provide-parents.html

- **Office of Adolescent Health. *Resources for Families*.** Tips on how to talk to teens about difficult subjects and steps to having a good conversation with teens. https://www.hhs.gov/ash/oah/resources-and-training/for-families/index.html
- **Adolescent Health Initiative. *Take Charge of Your Health Care* materials for parents.** Video gallery of parents and providers discussing how to balance parent engagement and confidentiality. Includes posters and accompanying teen and parent handouts. http://www.umhs-adolescenthealth.org/improving-care/parent-engagement/
- **Society for Adolescent Health and Medicine (SAHM). *Health Info for Parents and Teens*.** SAHM provides web-based resources that provide health information for teens, young adults, and their parents. http://www.adolescenthealth.org/About-SAHM/Health-Info-for-Parents-Teens.aspx http://www.adolescenthealth.org/About-SAHM/Healthy-Student-App-Info.aspx

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Chapter 4:
Strategy 2C—Safe and Supportive Environments (SSE)

SSE Rationale

Sexual health education (SHE) and sexual health services (SHS) address adolescents' knowledge and skills directly related to sexual health. In contrast, the safe and supportive environments (SSE) strategy focuses on factors within school and family environments that act as protective factors and reduce risk for HIV, other STDs, and unintended pregnancy.[1] Addressing these factors often involves system-level changes that yield substantial and sustained impact.[2]

School connectedness; parental monitoring; and parent-adolescent communication, both general and specifically about sex (see definitions in glossary),[3,4] are three specific factors known to promote behaviors that reduce HIV and other STDs among young people (e.g., delayed sexual initiation and/or condom use). Promoting these protective factors has resulted in positive, long-term sexual health outcomes.[5,6] Moreover, these factors have been linked to reductions in substance use, violence victimization and perpetration, and behaviors and experiences associated with adolescent sexual risk.[7] They have also been linked to academic achievement, an outcome particularly salient for schools. We also have evidence-informed strategies that schools can feasibly implement to address these factors.[8–10] Four of the five required SSE activities address school connectedness, and one activity focuses on promoting both parental monitoring and parent-adolescent communication.

In addition to directly contributing to HIV and other STD prevention, creating SSEs establishes a context necessary for the other approaches (SHE and SHS) to be effective. Students who do not feel safe and connected to school may be more likely to be absent and thus less likely to receive SHE and school-based support accessing SHS. Even for students in school, SHE delivered in the context of a poorly managed classroom will likely be ineffective. Moreover, specific SSE-related activities can potentially be leveraged to support SHE and SHS activities. As an example (discussed further in this chapter), gay-straight alliances or genders and sexualities alliances (GSAs) can be used to connect students to health services.

Although activities to support LGBT youth cut across the three Component 2 strategies, SSE in particular addresses this population of adolescents. Two of the five required SSE activities involve practices to support LGBT youth, because these youth are disproportionately likely to experience a negative school environment and report negative health behaviors and experiences. For example, LGBT students are more likely to be bullied at school than their heterosexual and cisgender peers.[11,12] LGB youth may also experience rejection and/or lack of family support at home,[13] making a supportive school environment all the more important. There is growing attention to the variety of ways that school-related protective factors can help LGBT youth thrive,[14] suggesting that promoting a safe and supportive school environment is a promising approach to support the health of this population.

SSE Overview

Table 4.1 provides a bulleted list of required and additional SSE activities that funded local education agencies (LEA) are expected to implement. Activities are organized according to the three overarching Component 2 domains: strengthen staff capacity, increase student access to programs and services, and engage parents and community partners.

Specific activities relevant to each domain were selected based on evidence of effectiveness, feasibility considerations, and potential reach. In addition to required activities, LEA may choose to implement two additional activities related to supporting efforts to engage parents. These activities have been designated as additional activities because they are particularly targeted and/or resource intensive efforts that complement the required activity of disseminating resources to parents. LEA should ensure that all required activities are implemented to scale before undertaking additional activities. Required and additional activities are described in more detail in the section that follows.

Table 4.1. SSE Required and Additional Activities Organized by Domains

Domains	Required SSE Activities	Additional SSE Activities
Strengthen staff capacity	■ Provide professional development to teachers on classroom management annually. ■ Provide professional development to all school staff on supporting lesbian, gay, bisexual, and transgender (LGBT) youth annually.	
Increase student access to programs and services	■ Implement mentoring, service learning, and/or other positive youth development programs for students, and/or connect students to such community-based programs. ■ Establish or enhance student-led clubs that support LGBT youth (often known as Gay-Straight Alliances or Genders and Sexualities Alliances).	
Engage parent and community partners	■ Disseminate resources to parents/caregivers on parental monitoring and parent-adolescent communication (generally and specifically about sex).	■ Disseminate resources specifically relevant to parents of LGBT students. ■ Implement and/or connect parents to skill-building parenting programs.

Organizations funded under Component 3C are expected to provide capacity-building assistance to LEA to support implementation of each required activity. Boxes throughout this chapter highlight the unique role that Component 3C recipients can play in supporting Component 2 recipients for each activity. Component 3 recipients cannot choose to support only select activities.

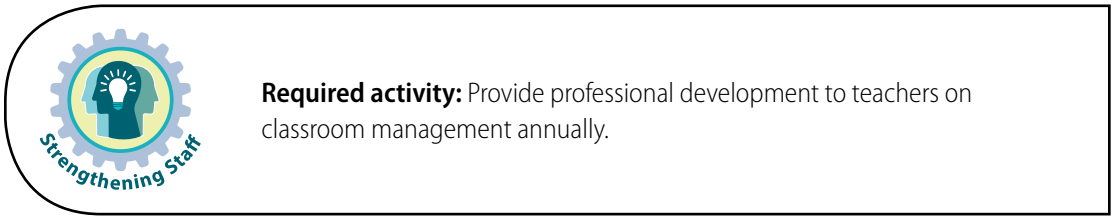
Timing of Required Activities

SSE activities do not need to be implemented in a particular order. LEA are expected to implement SSE professional development (PD) activities annually and disseminate information to parents semi-annually. Timing for implementing positive youth development programs and student-led clubs that support LGBT youth will vary based on LEA capacity and experience in these areas. However, progress related to these activities is expected each year.

Activity-specific Guidance

For each required and additional activity, we indicate the purpose of the activity in relation to intermediate program outcomes and summarize the rationale for implementing the activity as part of school-based HIV and other STD prevention. We describe activities and outline key considerations for implementation based on existing science and practice. For each activity, we cite specific resources to facilitate implementation. Where relevant, we highlight connections to SHE and SHS activities and identify these with the "opportunities for efficiency" icon.

Strengthen Staff Capacity



Required activity: Provide professional development to teachers on classroom management annually.

Rationale

The purpose of this activity is to **increase school connectedness**. Research suggests that effective classroom management is associated with higher levels of school connectedness.[15,16] Drawing on this

evidence, CDC's strategy guide for promoting school connectedness includes "effective classroom management" as a recommended strategy.[8] The benefits of effective classroom management extend to academic-related outcomes, including decreasing disruptive behaviors and increasing academic learning and engagement.[17] Research indicates that classroom management skills for teachers are fundamental to teacher effectiveness.[17] However, teachers have expressed a need for PD on implementing classroom management strategies,18 underscoring the importance of this activity.

Activity description

Classroom management is "the process by which teachers and schools create and maintain appropriate behavior of students in classroom settings."[19] Best practices for classroom management include[20,21]

- establishing rules, routines, and expectations.
- reinforcing positive behavior through praise.
- consistently enforcing consequences for misbehavior.
- maximizing structure.
- fostering student engagement by including opportunities for active student participation.

PD on classroom management should focus on knowledge and skills related to best practices. Teachers should receive specific suggested actions and resources (e.g., student behavior case study examples) for implementing best practices and have opportunities to practice strategies and receive feedback. As feasible, LEA should implement PD using active learning strategies, including classroom observations and feedback, as well as professional coaching to build classroom management skills. These intensive strategies can be complemented with more traditional, didactic approaches that outline best practices and provide teachers with tools and resources.

Key consideration: Consequences vs. punishment

Although appropriate discipline is a component of classroom management, it is important to note that enforcing consequences for misbehavior is distinct from punishment. Consequences are a logical outcome for inappropriate action that help students learn from poor behavior. In contrast, punishment is an unpleasant outcome that is not necessarily connected to the inappropriate action and does not facilitate learning.[22] Effective classroom management is about promoting pro-social behavior, which is accomplished in part by responding to inappropriate behavior in a positive, non-punitive way. For example, responses to student name-calling may involve immediate verbal or written apology to peers and reinforcement of classroom expectations rather than detention or a behavioral citation. "Zero tolerance" approaches to discipline have not been shown to be effective.[23]

Key consideration: Classroom management in sexual health education

Practices and strategies for effective classroom management are relevant to teachers of all subject areas. However, SHE teachers may need to pay particular attention to establishing and enforcing classroom rules and expectations given the potential for inappropriate behavior associated with discussing sensitive topics. SHE teachers also need to be prepared to appropriately address difficult or sensitive questions from students. Doing so may involve[24]

- using clear, concise language.
- acknowledging and promoting use of correct vocabulary.
- using non-judgmental body language.
- avoiding personal opinion.
- checking for understanding among students.

It is also important that teachers not disclose personal information or sexual behaviors with students and maintain clear boundaries between appropriate and inappropriate topics.[24]

Key consideration: Leveraging related efforts

LEA can implement classroom management PD as part of related initiatives. For example, classroom management is one component of a school-wide approach to promoting pro-social behavior, referred to as Positive Behavioral Interventions & Supports (PBIS). Likewise, social-emotional learning (SEL) is a complementary approach to a curriculum and school climate focused on fostering appropriate social and emotional development. LEA should assess current activities (and funding) related to PBIS and SEL and identify opportunities for integrating PD on classroom management. All PD should be implemented in accordance with CDC's guidance on professional development practices (See Chapter 5).

Component 3C recipients can

- Identify assessment processes and tools and lead LEA working with SBHCs in efforts to identify areas for improving quality care. These processes would be done with health systems running SBHCs; thus 3B recipients will need to facilitate quality partnerships between organizations.

Resources

Specific resources to support classroom management PD include

- **Association for Supervision and Curriculum Development. *Classroom Management Resources*.** This landing page includes links to articles, books, webinars, and online learning modules on classroom management. http://www.ascd.org/research-a-topic/classroom-management-resources.aspx ($)
- **American Psychological Association. *Classroom Management: Teacher Modules*.** This resource provides brief articles for teachers on topics relevant to classroom management (e.g., positive feedback), as well as practical implementation tools. http://www.apa.org/education/k12/classroom-management.aspx
- **Fred Jones. *Tools for Teaching*.** This well-respected professional development group offers a variety of resources on classroom management, some available for free (e.g., 12-week self-guided professional development course) and others for a fee. http://www.fredjones.com/resources ($)
- **Advocates for Youth. *Rights, Respect, Responsibility. A K-12 Sexuality Education Curriculum. Classroom Management: Answering Students' Questions.*** This specific module discusses classroom management within the context of SHE. https://advocatesforyouth.org/wp-content/uploads/3rscurric/teachers-guide.pdf
- **Wong HK, Wong RT. *The First Days of School*.** This book provides a guide for teachers on classroom management and designing lessons for academic success. https://www.amazon.com/First-Days-School-Effective-Teacher/dp/0962936022

Required activity: Provide professional development to all school staff on supporting LGBT youth.

Rationale

The purpose of this activity is to **increase school connectedness**, particularly for LGBT youth. LGBT youth are disproportionately likely to experience violence at school and have lower levels of school connectedness.[25,26] Many organizations, including CDC, GLSEN, the American Psychological Association (APA), and the Association for Supervision and Curriculum Development (ASCD) have identified PD with school staff as a best practice for improving safety and school connectedness overall for LGBT youth. In fact, research suggests that PD is one of the most impactful school-based practices to support the health and well-being of LGBT youth.[27]

Activity description

PD delivered to teachers and school staff annually should address fundamental knowledge about

- the concepts of sexual orientation and gender identity, including appropriate language.
- health risks faced by LGBT youth.
- effects of the school environment on the health of LGBT youth.
- supportive school policies and practices (e.g., GSAs, safe spaces, inclusive curricula).
- the unique needs of transgender and gender diverse students.

Awareness alone may not result in implementation of policies and practices that support LGBT youth.[28] In addition to increasing knowledge, PD should enhance relevant skills. For example, given that LGBT youth are more likely to experience bullying, harassment, and violence compared to their heterosexual and cisgender peers,[11] it is imperative that school staff have bystander intervention skills combined with a willingness to act on them. PD should thus involve critical reflection that helps school staff recognize and challenge both individually held and broader normative beliefs about sexuality and gender identity that can contribute to a negative school environment for LGBT youth.[29]

In terms of implementation, evidence suggests that brief trainings can be effective in changing school professionals' beliefs and self-efficacy related to supporting LGBT youth.[30,31] LEA may want to consider innovative PD delivery approaches, including online modules that can be completed in multiple, short sessions. All PD should be implemented in accordance with CDC's guidance on PD practices (See Chapter 5).

Key consideration: Leveraging other PD events

There are opportunities to integrate PD relevant to meeting the needs of LGBT youth in other PD events. For example, PD on SHE should address strategies for ensuring that information is relevant to LGBT youth (See Chapter 2). Likewise, PD on implementing anti-bullying policies should address bullying victimization based on perceived sexual orientation and gender identity. PD related to SHS should help school nurses and other school staff connect LGBT students to other youth-friendly providers with experience serving this population.

Component 3C recipients can

- Develop a process for assessing PD needs.
- Identify existing PD materials.
- Adapt existing PD materials, as needed.
- Develop PD materials, as needed.
- Implement a train-the-trainer model to develop a cadre of trainers.

Resources

PD curricula for teachers and other school staff on best practices for supporting LGBT youth have been developed. Examples include

- **American Psychological Association. *RESPECT Workshop*.** This workshop provides pre-service and in-service education for middle and high school counselors, school nurses, school psychologists, school social workers, and other specialized instructional support professionals. http://www.apa.org/pi/lgbt/programs/safe-supportive/training/respect-workshop.aspx
- **Los Angeles LGBT Center. *Out for Safe School Campaign*.** In addition to offering badges to identify allies, this campaign also includes a PD program to facilitate the creation of safe spaces for LGBT youth. https://lalgbtcenter.org/out-for-safe-schools/training-coaching
- **GLSEN. *Professional Development*.** These materials include toolkits, webinars, and workshops for educators. https://www.glsen.org/educate/professional-development
- **The Trevor Project. *Step In, Speak Up!*** This collaborative program between the Trevor Project and Kognito Interactive is a 30-minute online interactive training. https://www.thetrevorproject.org/about/programs-services/broken-step-in-speak-up/#sm.000ri4hby1dypepywz62l4lacj85k ($)

Other resources exist that may inform PD content and help facilitate implementation of practices discussed in PD events. The following examples can be distributed during PD events:

- **Gender Spectrum.** ***Schools in Transition: A Guide for Supporting Transgender Students in K-12 Schools*****.** A resource guide for supporting transgender students. https://www.genderspectrum.org/staging/wp-content/uploads/2015/08/Schools-in-Transition-2015.pdf
- **GLSEN.** ***Safe Spaces Kit*****.** An implementation resource on establishing safe spaces. https://www.glsen.org/participate/programs/safe-space
- **GLSEN.** ***Changing the Game: For Adults*****.** An implementation resource on making sports more inclusive for students; there is an educator-specific version. https://www.glsen.org/sports/adults

Increase Student Access to Programs and Services

Required activity: Implement mentoring, service learning, and/or other positive youth development programs for students, and/or connect students to such community-based programs.

Rationale

The purpose of this activity is to **increase school connectedness**. Positive youth development (PYD) programs strengthen young people's sense of identity; belief in future; self-regulation; self-efficacy; and social, emotional, cognitive, and behavioral competence. They also provide youth with networks of supportive adults.[32] Like school connectedness, these factors are considered to be "protective factors" because they are assets (internal to individuals) and resources (external to individuals) that counteract, reduce, or eliminate the adverse effects of risk factors.33 Unlike many prevention programs that focus solely on risk behaviors, PYD programs aim to develop and enhance positive characteristics of individuals and their surrounding context. By increasing protective factors rather than focusing on risk behaviors related to a single adverse outcome, PYD programs have benefits across a range of health and academic outcomes. Most salient to the current funding, these programs have been found to be effective in reducing sexual risk behaviors, HIV, other STDs, and unintended pregnancy.[32,34] PYD programs also have the potential to prevent substance use and violence behaviors that contribute to HIV and other STD risk.[35,36] Finally, PYD programs are associated with improvements in academic performance, which strengthens the rationale for school-based implementation.[37]

Activity description

Although definitions of PYD vary, a collaboration of 20 federal departments and agencies that support youth has defined this concept as

> "an intentional, prosocial approach that engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths."[38]

LEA are expected to implement PYD programs in schools or connect students to programs in the community through linkage and referral. We recommend that LEA choose either a school-based approach or a linkage and referral approach rather than trying to implement both models. The school-based approach involves identifying and, if necessary, adapting effective PYD programs. Developing a new program is discouraged considering existing programs and limited time and resources. Implementation will involve training facilitators/program leadership, advertising the program to students, and conducting program activities with fidelity. Given that implementing PYD programs can be resource intensive, LEA may want to consider facilitating school-community partnerships to connect students to community

partners implementing PYD programs instead of leading PYD programs (see key consideration below on community partnerships). Doing so will require establishing or utilizing existing partnerships with community resources and developing or adapting a process for linkage and referral to trusted organizations. The process is then implemented through staff training and identification of and/or advertisement to students.

Key consideration: Type of PYD program(s)

A recent review of school-based PYD programs suggests three main implementation approaches:[39]

- Curriculum-based methods
- Mentorship programs
- Youth leadership/service learning programs

Some school-based SHE curricula are considered to be PYD programs. Therefore, SSE implementation of PYD focuses on mentoring and service learning programs.

CDC's strategy guide for promoting school connectedness specifically identifies mentoring and service learning as student-level programs that can increase school connectedness.[8] Mentoring and service learning programs have also both been associated with reductions in adolescent sexual risk.[40,41] Below we describe specific characteristics for both types of programs. Across these approaches, effective programs are long-lasting (e.g., lasting throughout the course of the academic year) and adhere closely to the original program design.[36,39] In fact, even when not implemented in the context of SHE, principles of effective programs align with CDC's characteristics of effective curricula (see Chapter 2). Evidence is mixed regarding targeting youth at "high risk" versus including youth with different levels of risk.[39,42] Regardless of the approach, decisions about students' risk should take into account environmental risk factors (e.g., low levels of family support) in addition to individual risk behavior.[42]

Key consideration: Characteristics of effective mentorship programs

Mentoring has been defined as "formal relationships in which the mentor models positive behaviors to the benefit of the mentee and provides guidance, support, and skills through regular meetings to overcome health, social, and economic challenges."[40] The focus here is on adult-adolescent mentoring rather than peer mentoring that occurs between adolescents only. Mentoring programs can be group-based or one-on-one, although group-based mentoring programs have shown more effectiveness in reducing sexual risk.40 Infrastructure to support the mentor-mentee relationship is a key feature of effective mentoring programs. Three specific elements are particularly important:[43]

- Screening of potential mentors (e.g., interviews, review of personal references, etc.).
- Orientation and training of mentors (e.g., setting realistic expectations and/or building awareness and skill to build differences).
- Ongoing support and supervision (e.g., mentor support groups and/or check-ins from program leadership).

Other important characteristics include ongoing training, organized activities for mentors and mentees, clear and consistently reinforced expectations about frequency of contact, mechanisms for involving parents, and monitoring implementation.[42]

Of course, the mentor plays a central role in the effectiveness of mentoring programs. Effective mentors[43]

- act consistently and dependably.
- initiate contact.
- respect young people's viewpoints.
- involve youth in decision-making.
- interact with parents/other family members.
- seek and use advice of program leadership.

Key consideration: Characteristics of effective service learning programs

Service learning refers generally to "a teaching and learning strategy that connects academic curricula to community problem-solving."[44] This concept has been specifically defined in federal legislation (Box 4.2).[44] Service learning is distinct from volunteer work and community service in that it is linked to school curricula.[45] The National Youth Leadership Council has outlined standards for effective service learning programs. These include[46]

- active engagement of student participants.
- intentional linkages to curricula.
- reflection activities.
- promoting understanding of diversity.
- strong partnerships with the community.
- program monitoring.
- sufficient duration and intensity.

Strategies for feasibly implementing these requirements include leveraging existing state and district requirements related to service learning, as well as focusing on service learning within the context of SHE.

Box 4.2. Service Learning Definition*

In the context of this funded program, the term "service-learning" means a method

1. under which students learn and develop through active participation in thoughtfully organized service that
   - is conducted in and meets the needs of a community;
   - is coordinated with a secondary school or community service program, and with the community; and
   - helps foster civic responsibility; and
2. that
   - is integrated into and enhances the academic curriculum of the students or the educational components of the community service program in which the students are enrolled; and
   - provides structured time for the students to reflect on the service experience.

*Adapted from the Edward M. Kennedy Service America Act of 2009

Key consideration: Connecting students to community-based programs

If LEA choose to focus on connecting students to community-based programs, they will need to identify community organizations that can serve as partners in this effort. Organizations such as Boys and Girls Club or 4-H may be potential partners given their long-standing focus on PYD. PYD programs can also be implemented in clinic settings, so LEA could consider partnering with community-based health care providers or working with school-based health centers to implement PYD programs.[47] LEA should consider best practices for establishing school-community partnerships with trusted partners (see resources below).

In addition to establishing or strengthening existing community partnerships, LEA should have a systematic process in place to connect or refer students to programs led by community-based organizations. Depending on the scope of the partnerships, LEA may choose to develop a resource guide that outlines multiple programs, or they may focus on connecting students to a single community program. Protocols for communication and marketing should be established, and staff who will link students to the organizations should be identified and trained.

Component 3C recipients can

- Assess the capacity of LEA and community partners to inform decisions about implementing school-based programs or connecting students to community-based programs.
- Identify PYD programs for implementation.
- Implement train-the-trainer models to develop a cadre of PYD program facilitators.
- Partner with 3A and 3B organizations to identify cross-cutting opportunities for PYD implementation (e.g., in the context of SHE).

Resources

For information on specific school-based PYD programs, please refer to these resources:

- **Office of Adolescent Health. *Evidence-Based Teen Pregnancy Prevention Programs*.** This list of evidence-based teen pregnancy prevention programs includes positive youth development programs that can be implemented in school or community settings. https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/evidence-based-programs/index.html
- **Youth.gov. *Positive Youth Development*.** This site compiles resources across federal agencies, including select programs and links to additional tools. https://youth.gov/youth-topics/positive-youth-development
- **National Mentoring Resource Center. *Mentoring Program Reviews*.** This resource synthesizes evidence of effectiveness for specific mentoring programs in relation to a range of different outcomes. https://nationalmentoringresourcecenter.org/index.php/what-works-in-mentoring/reviews-of-mentoring-programs.html

Additional resources to support implementation of mentoring and service learning programs include

- **National Youth Leadership Council. *K-12 Service-Learning Standards for Quality Practice*.** This resource explains each of the standards for quality service learning programs. https://nylcweb.files.wordpress.com/2015/10/standards_document_mar2015update.pdf
- **National Mentoring Resource Center. *Resources for Mentoring Programs*.** This site provides resources for mentor training, program management, and recruitment and marketing, among other topics. https://nationalmentoringresourcecenter.org/index.php/what-works-in-mentoring/resources-for-mentoring-programs.html
- **Act for Youth. *Service-Learning and Adolescent Sexual Health*.** This resource provides an overview of service learning and its association with adolescent sexual health. http://www.actforyouth.net/sexual_health/community/service-learning.cfm
- **Youth.gov. *Service Learning*.** This site compiles resources across federal agencies on service learning programs. https://youth.gov/youth-topics/civic-engagement-and-volunteering/service-learning
- **Youth.gov. *Mentoring*.** This site compiles resources across federal agencies on mentoring programs. https://youth.gov/youth-topics/mentoring

Resources to support school-community partnerships include

- **Coalition for Community Schools. *Strengthening Partnerships: Community School Assessment Checklist*.** This checklist outlines considerations for establishing strong community-school partnerships. http://www.communityschools.org/assets/1/AssetManager/strength_part_assessment.pdf#xml=http://pr-dtsearch001.americaneagle.com/service/search. asp?cmd=pdfhits&DocId=410&Index=F%3a%5cdtSearch%5ccommunityschools&HitCount=9&hits=6+c+d7+e5+101+150+160+272+2ad+&hc=97&req=checklist
- **National Education Association. *Family-School-Community Partnerships 2.0 Collaborative Strategies to Advance Student Learning*.** This strategy document outlines practices for establishing strong community-school partnerships. http://www.nea.org/assets/docs/Family-School-Community-Partnerships-2.0.pdf

Required activity: Implement student-led clubs to support LGBT youth (often known as Gay-Straight Alliances or Genders and Sexualities Alliances).

Rationale

This activity is intended to **increase school connectedness** for all students, including LGBT students. Gay-Straight Alliances or Genders and Sexualities Alliances (GSAs) have been associated with improvements in school safety, a key component of school connectedness, for all students.[48–50] Research specifically links the presence of a GSA to greater feelings of school connectedness among LGBT students.51 GSAs are also linked to positive youth development and increasing young people's sense of purpose, self-esteem, and agency.[52,53] These positive effects likely explain observed relationships between GSAs and reduced risk across outcomes related to HIV and other STDs, including violence victimization,[48] illicit drug use and prescription drug misuse,[54] and suicidal ideation.[49] Prevention benefits have been documented for heterosexual youth in addition to LGBT youth.[49,55]

Activity description

A GSA is a student-led club, typically run in a middle or high school, which creates a safe space for students to socialize, support each other, discuss issues related to sexual orientation and gender identity and expression, and work to end homophobia and transphobia in their school and/or broader community.[56] GSAs align with models of positive youth development in that they are structured to foster youth empowerment, with student members at the center of decision-making, while also connecting youth to adult support, usually in the form of a faculty advisor. Typical implementation involves regular group meetings as well as supplemental events and activities. These clubs function broadly in several ways, including[52]

- providing opportunities for socialization and group support.
- delivering information and resources.
- facilitating student advocacy.

Each function serves to increase school connectedness and positive youth development.[53] Across these functions, organizational structure (e.g., check-in at the start of meetings, follow-up on prior meetings, agendas, and meeting facilitation) combined with flexibility to address emergent or urgent issues may optimize positive effects.[52,53]

To implement this activity, LEA will first need to determine which schools have GSAs. LEA can then create and implement a plan for establishing GSAs in schools that do not already have them and strengthening GSAs in schools that do (see key consideration below on enhancing existing GSAs).

Key consideration: GSA programming

Although GSAs share common features, there is no standard GSA programming. Activities related to each function should be balanced to meet specific needs and interests of members.[57] For example, social events may include dances, movie nights, talent shows, or poetry slams.

Information and resource sharing provides an opportunity to complement activities related to SHE and SHS. Group meetings can be used to discuss health topics that disproportionately affect LGBT youth, such as mental health, substance use, and sexual health, drawing on experiences and insights from peers.[50,58] Likewise, members can receive information about health clinics, hotlines, and community-based organizations that provide support to LGBT youth.[50] GSAs may even be an appropriate setting for faculty advisors to make referrals to health, social, and psychological services.

Student advocacy activities generally center on promoting inclusion for LGBT youth in the school more broadly. For example, GSAs may use materials from GLSEN to support implementation of a variety of awareness days/weeks, such as Ally Week, Day of Silence, or No Name-Calling Week. Other advocacy-related activities may include tabling at open houses, presenting in classrooms, or decorating school bulletin boards.[57] Using these activities to establish partnerships between GSA members and school administrators can further serve to connect LGBT students to supportive adults.[50] Advocacy efforts can also extend beyond the school setting. For example, GSA members can partner with LGBT community organizations, strengthening connections between GSA members and community resources.

Key consideration: GSA inclusivity

A defining characteristic of GSAs is their aim to connect LGBT youth with supportive heterosexual and/or cisgender allies. An inclusive, respectful environment is thus essential.[59] GSAs should include both boys and girls of varying sexual orientations and should be welcoming to transgender and gender non-conforming students as well as racial/ethnic minorities.[53] Concerted programmatic efforts are warranted in this regard given outstanding questions about the extent to which GSAs meet the needs of multiple groups.[60]

Key consideration: GSA faculty advisors

The role of the faculty advisor(s) and the relationship between advisors and student GSA members is critical. Following principles of positive youth development, faculty advisors should allow for group-level decision-making and empower student members to achieve their goals. Encouraging students to express their opinions and allowing respectful disagreement and discussion so that students feel their voice is being heard can help increase engagement in GSAs.[61] Facilitators can help provide an appropriate organizational structure that allows GSA members to lead decision-making processes. Structure is associated with increased student engagement up to a point. Too much structure, however, can have the opposite effect.[61] Research has demonstrated that students with GSA faculty advisors who have held the position for longer are more likely to have positive outcomes related to youth development, and PD specifically for faculty facilitators may be useful.[53] In particular, advisors should receive in-depth training related to best practices for fostering a broadly inclusive school environment for LGBT youth (see section on PD to support LGBT youth).

Key consideration: Enhancing existing GSAs

Component 2 recipients that already have established GSAs across the district should engage in additional activities to strengthen the clubs. Such activities may include

- increasing membership and participation.
- implementing specific positive youth development programs within the GSA.
- conducting enhanced PD with GSA faculty advisors.
- integrating GSAs into other school-based activities.
- fostering collaboration between GSAs across schools.
- fostering collaboration between GSAs and LGBT-youth-serving organizations in the community.

GSAs should ideally be one practice within a system of school-based supports for LGBT youth, including safe spaces, effective implementation of anti-bullying policies, and PD for school staff. Such broader policies and practices may affect the implementation of GSAs. LEA can consider working with existing clubs to contribute to the development of a broad supportive climate.[53]

Component 3C recipients can

- Implement train-the-trainer models for GSA faculty advisors.
- Establish processes for LEA to select appropriate strategies for enhancing existing clubs.

Resources

GLSEN and the Genders and Sexualities Alliance Network (GSAN) provide specific resources for establishing and enhancing GSAs:

- **GSAN. *Building Your GSA*.** This organization has a number of different resources for establishing and strengthening GSAs, including this resource on creating GSAs. https://gsanetwork.org/resources/building-your-gsa
- **GLSEN. *Gay-Straight Alliances*.** This organization has a number of different resources for establishing and strengthening GSAs. https://www.glsen.org/gsa

Engage Parent and Community Partners

Required activity: Disseminate resources to parents/caregivers on parental monitoring and parent-adolescent communication (both general and specifically about sex).

Rationale

The purpose of this activity is to **increase parental monitoring and parent-adolescent communication**. These parenting practices are considered to be protective factors because they are associated with reductions in adolescent sexual risk as well as reductions in related health risks (e.g., substance use and/or violence).[4,62] This activity aligns with CDC's strategy guide for parent engagement in schools, which identifies supporting positive parenting practices and communicating with parents as two specific types of engagement.[63] CDC's rationale for parent engagement in schools as a strategy related to school-based HIV and other STD prevention characterizes this type of activity as one in which staff help parents address parental factors related to sexual risk behaviors.[64] Distribution of materials is a low-cost activity that has been associated with improvements in parenting practices.[10]

Activity description

For this activity, LEA will disseminate resources to parents to address each of these three parenting practices:

1. Parental monitoring
2. General parent-adolescent communication
3. Parent-adolescent communication about sex

Parental monitoring refers to parental knowledge of adolescents' companions, whereabouts, and activities and enforcement of rules, particularly about friends and dating.[65] Research has shown that adolescent disclosure is the primary source of parental knowledge,[66,67] suggesting that parental monitoring requires parents' active participation and communication between parents and adolescents. Parental monitoring is also influenced by the quality of the parent-adolescent relationship.[68] In this context, parental monitoring is specifically about adolescents' social processes. It does not refer to monitoring of academic performance.

Parent-adolescent communication is a distinct but related concept. Six process dimensions have been identified as particularly relevant:[69]

- Frequency/duration
- Self-disclosure
- Initiation
- Recognition
- Style
- Satisfaction

Regardless of topic, communication should be ongoing and substantial, open and honest, equally initiated by both parents and adolescents, acknowledging of individual attitudes and values, reflective of an authoritative parenting style (i.e., provide emotional support while also enforcing high standards),[70] and mutually satisfying. See the key consideration below on general communication vs. communication specifically about sex.

LEA may choose to disseminate resources about each topic separately or together. Regardless of the approach, the connections between these parenting practices should be made clear to parents. The goal of this activity is not to promote one practice over another, but rather to support a constellation of parenting practices known to reduce sexual risk. Resources about these topics should address both knowledge and skills. Specifically, information should include

- key definitions and explanations of the concept(s).
- a brief summary of its benefits as well as challenges to implementation and potential solutions.
- key action steps for parents to strengthen the practice.

LEA are encouraged to identify and, if necessary, adapt existing resources from credible sources rather than develop new resources. LEA should carefully consider the most appropriate and feasible channels for dissemination (e.g., social media, email, newsletters, handouts at parent-teacher conferences/open houses/health fairs) and if/how these resources can be integrated into existing processes for communicating with parents. At a minimum, resources should be disseminated semi-annually.

Key consideration: General communication vs. communication about sex

Funded partners are expected to address parent-adolescent communication, both general and specifically about sex. The six process dimensions noted above apply to both types of communication. The primary distinction is that the type of content discussed varies. Content areas to be addressed in general parent-adolescent communication may include social/relationship issues, academic and extracurricular interests, politics, future plans/goals, and general problems. Content to be addressed in parent-adolescent communication about sex includes but is not limited to expectations about dating/relationships; consent; behavioral strategies for preventing unintended pregnancy, HIV, and other STDs (e.g., condom use or delaying the onset of sexual activity); and SHS. This communication should prepare students for and reinforce information from school-based SHE. There are some unique barriers to communicating about these topics that parents may need help overcoming, such as embarrassment or inadequate parental knowledge.[69]

Key consideration: Leverage other communication with parents

Because parent engagement activities cut across SHE, SHS, and SSE, LEA can consider leveraging other activities to facilitate dissemination of resources. For example, parent engagement in SHE through homework assignments may offer an opportunity for dissemination. LEA should also consider if and how relevant information from other domains should be incorporated into dissemination materials. For example, information about parental monitoring may note that it is developmentally appropriate for adolescents to have time alone with a medical provider and increasingly be able to access care independently.

Key consideration: Communication best practices

Dissemination of resources should follow communication best practices. Materials should use plain language and avoid jargon. All resources should reflect principles for effective communication. Specifically, they should be available, actionable, from credible and trusted sources, relevant to a parental audience, timely, and understandable.[71]

Component 3C recipients can

- Assess parents' preferences for communication channels and formats.
- Identify existing resources for schools to disseminate (e.g., create a repository of resources).
- Adapt existing resources as needed.
- Partner with Component 3A and 3B recipients to identify cross-cutting opportunities for dissemination of resources.
- Assess capacity of the LEA to implement additional activities.

Resources

LEA may develop their own resources but are encouraged to use existing resources that align with the content described above. Some examples include

- **CDC. *Monitoring Your Teen's Activities: What Parents and Families Should Know*.** This infobrief outlines action steps for parents to monitor their teens. https://www.cdc.gov/healthyyouth/protective/pdf/parental_monitoring_factsheet.pdf
- **CDC. *Talking with Your Teens about Sex: Going Beyond "the Talk"*.** This infobrief outlines action steps for parents to talk with their teens about sex. https://www.cdc.gov/healthyyouth/protective/pdf/talking_teens.pdf
- **CDC. *Ways to Influence Your Teen's Sexual Risk Behavior: What Fathers Can Do*.** This infobrief outlines action steps for fathers related to positive parenting practices. https://www.cdc.gov/healthyyouth/protective/pdf/fathers_influence.pdf
- **Office of Adolescent Health. *Resources for Families*.** This site compiles resources for parents, including those related to monitoring and communication. https://www.hhs.gov/ash/oah/resources-and-training/for-families/index.html

Resources related to communication best practices include

- **CDC. *Gateway to Health Communication & Social Marketing Practice*.** This resource outlines best practices for health communication materials. https://www.cdc.gov/healthcommunication/
- **CDC. *Everyday Words for Public Health Communication*.** This resource outlines plain language considerations for health communication materials. https://www.cdc.gov/other/pdf/everydaywords-060216-final.pdf
- **World Health Organization. *Framework for Effective Communications*.** This resource outlines best practices for health communication materials. http://www.who.int/communicating-for-health/en/

Additional activity: Disseminate resources specifically relevant to parents of LGBT students

Rationale

LEA may also consider disseminating resources specifically relevant to parents of LGBT students. Although evidence is limited and somewhat mixed, parental monitoring and parent-adolescent communication may not always be protective for LGBT, depending on how parents implement these practices.[72,73] In fact, in some cases they could have risks (e.g., a parent rejects an adolescent's sexual identity). Parents of LGBT youth may benefit from resources about how best to support their LGBT youth, including using appropriate parental monitoring and respectful parent-adolescent communication.

Activity description

LEA can incorporate specific considerations for LGBT youth in dissemination materials about parental monitoring or parent-adolescent communication. They can also develop materials specifically about parental support of LGBT youth. Schools should disseminate such resources in a way that avoids targeting LGBT students and families and potentially disclosing students' sexual orientation or gender identity. For example, schools can post materials online and advertise to all families that these materials are available.

Resources

Resources have been developed to help give parents fundamental knowledge and skills related to supporting the health and well-being of their LGBT teen. These include

- **CDC. *Parents' Influence on the Health of Lesbian, Gay, and Bisexual Teens: What Parents and Families Should Know*.** This infobrief outlines action steps parents can take to support their LGBT teens. https://www.cdc.gov/healthyyouth/protective/pdf/parents_influence_lgb.pdf
- **PFLAG. *Our Children: Questions and Answers for Families of Lesbian, Gay, Bisexual, Transgender, Gender-Expansive and Queer Youth and Adults*.** This resource for parents provides answers to common questions about sexual orientation and gender identity to support parents of LGBT youth. https://www.pflag.org/sites/default/files/OUR%20CHILDREN_PFLAGNational_FINAL.pdf

Additional activity: Implement and/or connect parents to skill-building parenting programs

Rationale

LEA can consider implementing skill-building programs for parents/caregivers to **increase parent-adolescent communication and parental monitoring**. Numerous parenting programs have been developed to build parents' skills to effectively communicate with their adolescents and reduce sexual risk;[9,74] fewer interventions address parental monitoring, but there are some that show promise.[75,76] Programs for parents have also been developed to increase parenting practices that support the health and well-being of LGBT youth.

Activity description

Implementing this activity will involve steps that are similar to the steps for implementing a PYD program for students; LEA will first need to decide whether they will lead programs in the school setting or connect parents to community programs through linkage and referral. Again, we recommend that LEA choose either a school-based approach or a linkage and referral approach rather than trying to implement both models. The school-based approach will involve identifying and, if necessary, adapting effective parenting programs. Developing a new program is discouraged considering existing programs and limited time and resources. Implementation will involve training facilitators and program leadership, advertising the program to parents, and conducting program activities with fidelity. SHE programs for students may also include a component for parents to build their capacity to communicate with their teens about sex.[77]

Given that implementing parenting programs can be resource intensive, LEA may want to consider facilitating school-community partnerships to connect parents to community partners who can lead parenting programs. Doing so will require establishing new or using existing partnerships with community resources and developing or adapting a process for linkage and referral that can then be implemented through staff training and advertisement to parents. As with connecting students to community-based PYD programs, best practices for school-community partnerships should be implemented.

Resources

Specific resources related to parenting programs include

- **CDC. *Talking with Your Teens about Sex: Going Beyond "the Talk."*** This infobrief lists parenting programs that promote parent-adolescent communication. https://www.cdc.gov/healthyyouth/protective/pdf/talking_teens.pdf
- **Advocates for Youth. *Parent-Child Communication Programs*.** This resource lists parenting programs that promote parent-adolescent communication. http://www.advocatesforyouth.org/parent-child-communication-programs
- **Family Acceptance Project. *Training*.** This website includes parent trainings specifically designed to support LGBT youth. https://familyproject.sfsu.edu/training
- **LA LGBT Center. *Supportive Families, Safe Homes Training*.** This resource includes parent trainings specifically designed to support LGBT youth. https://lalgbtcenter.org/rise/lgbtq-training-coaching/lgbtq-training-for-families

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Chapter 5:
Cross-Cutting Actions

Recipients funded through Program 1807 are expected to engage in actions that cut across components, strategies, and domains. These actions include policy implementation, collaboration, professional development, evaluation, and an emphasis on addressing health disparities (including disparities among LGBT youth). The general processes for each of these actions are discussed in this portion of the guidance; actions specific to sexual health education (SHE), sexual health services (SHS), and safe and supportive environments (SSE) are discussed in Chapters 2-4.

Policy Implementation

The CDC definition of policy is "a law, regulation, procedure, administrative action, incentive or voluntary practice of governments and other institutions." There are several types of policies, each of which can operate at different levels (national, state, local, or organizational):

- Legislative policies are laws or ordinances created by elected representatives (e.g., state or local legislatures).
- Regulatory policies include rules, guidelines, principles, or methods created by government agencies with regulatory authority for products or services (e.g., state or local departments of education).
- Organizational policies include rules or practices established within an agency or organization (e.g., state department of education, school district, or other state agency).[1]

Health professionals and educators play important roles as partners to identify issues, provide important information, and propose policy options. Stakeholders, such as key constituent groups and decision makers, also play important roles in policy development. Strong policies describe what should be done, why it should be done, and who is responsible for doing it. CDC has described the policy process as consisting of problem identification, policy analysis, strategy and policy development, policy enactment, and policy implementation. Information on the CDC policy process is available at https://www.cdc.gov/policy/analysis/process/index.html.

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. Education agencies and partners should review this information annually to determine how to strengthen policy implementation and enforcement. Review can also determine gaps that may exist in the policy, as well as how to communicate barriers and successes to decision makers.[2]

State and local policies provide a foundation for school health efforts to prevent HIV and STDs. Policies that govern SHE, adolescent access to SHS, and SSE vary from state to state and locality to locality. If state or local policies prohibit specific activities required in Program 1807, recipients will work with their Program Consultants to determine alternative activities.

Recipients of federal funding must continually refer to the Anti-Lobbying Restrictions for CDC Grantees (http://www.cdc.gov/grants/documents/Anti-Lobbying-Restrictions.pdf) to ensure that activities are conducted in accordance with the restrictions and requirements of federal law and policy. Program 1807 recipients who undertake any policy-related activity must follow Additional Requirement 12 (AR 12) which is incorporated into the recipients' Notice of Award letter. This guidance details the restrictions placed on the use of federal funding for certain types of policy activities, including the restrictions on using any federal funding to support direct or grassroots lobbying. All recipients must ensure that activities are conducted in accordance with the restrictions and requirements of federal law and policy.

Program 1807 recipients are expected to share select data, outcomes, successes, and best practices with policy makers and stakeholders, such as local school boards, community leaders, area coalitions, and other important community leaders, in an effort to strengthen school health policy development and support informed policy implementation. Component 3A-C recipients should consider how to assist LEA in those efforts. Recipients are expected to work with CDC to promote program successes and highlight important outcomes.

Collaboration

Rationale for Collaboration

Collaboration can result in streamlined goals and resources, cross-training, and in-kind exchange of staff time and resources. Education agencies funded through Program 1807 are expected to foster collaborations, including collaborations with other Program 1807-funded agencies and organizations; with relevant CDC contractors and partners; with local health departments; with agencies and organizations receiving other CDC or federal agency funding (e.g., health departments); and with other national, state, and local agencies that support each approach. Education agencies are expected to leverage funding through mechanisms such as government, private, or corporate grants or in-kind labor, materials, or other resources to maximize project outcomes through strategic partnerships. LEA that are funded as consortia will function through collaborative strategies to fulfill the requirements of Program 1807. Component 3A-C recipients can help LEA form and foster strategic partnerships, and they can also be valuable partners in implementing program activities.

Strategies to work with other organizations can be thought of as a continuum. Figure 5.1 illustrates Himmelmann's (2002) strategies for building partnerships and collaborations that vary in the amount of formality, time, resources, trust, and turf required when organizations work together.3 The partnership continuum pictured below is most effective when there are common vision and purpose, mutual learning, and accountability to results among collaborating groups. These tiered strategies include

- networking, which is primarily sharing information.
- coordination, which requires a moderate amount of time and some alterations in activities to make programs, practices, and services more accessible to their users.
- cooperation, which includes resource sharing and a substantial investment of time to change programs, practices, and services to achieve a shared purpose.
- collaboration, in which organizations share and merge resources and services to increase each other's capacities to achieve a common goal.

Each strategy builds on the strengths of the previous, emphasizing a developmental continuum of effective collaboration.[3] This framework can assist decision-makers in determining appropriate partner relationships and can be helpful when assessing multi-organizational readiness and capacity.[3] No one of these strategies is better than another; LEA should choose the strategies most appropriate to what they want to achieve.

Figure 5.1. Himmelmann's Strategies for Building Partners and Collaboration

For accessibile explanation of this figure, go to Appendix E, page 119.

			Collaboration Enhancing each other's capacity for mutual benefit
		Cooperation Sharing resources	Sharing resources
	Coordination Altering activities/ways of working to achieve a common purpose	Altering activities/ways of working to achieve a common purpose	Altering activities/ways of working to achieve a common purpose
Networking Exchanging information for mutual benefit	Exchanging information for mutual benefit	Exchanging information for mutual benefit	Exchanging information for mutual benefit

Actions for Collaboration

Establish multidisciplinary teams at the district and school levels

LEA can develop collaborations that are helpful in establishing effective policies, programs, and practices. They can also facilitate the development of collaborations at the school level. One district-level group that facilitates collaboration is a school health advisory council (SHAC) or similar advisory council. At the school level, such collaborative groups might be called a school health team, school improvement team, or school wellness team. An effective SHAC comprises district and school staff, students, parents, and other community members to guide programming and facilitate collaboration between the school and the community. A SHAC or similar advisory council uses collaboration and strategic program planning processes to achieve health promotion goals.[4,5] 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.

Under Component 2A (the SHE strategy), LEA are required to establish and maintain an active SHAC or similar advisory committee to provide guidance and recommendations on aspects of school health education and programs. This group can effectively link district, school, and community resources that support all program activities across the three strategies: SHE, SHS, and SSE. The LEA 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 can also help identify and involve key stakeholders, including existing SHACs or school-level teams.

LEA that do not already have SHACs or similar advisory councils are expected to establish them over the project period. They may do so by fostering existing collaborations and resources, and LEA should carefully consider potential participants on SHACs or school health teams. It may also be possible for existing SHACs and teams to be strengthened or improved to better implement program activities.

Support priority schools to collaborate with community organizations

In addition to fostering collaborations through SHACs and school health coordinators, LEA are expected to support schools in collaborating with community organizations to build support for and implement Program 1807 activities. 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.[6,7] For example, community members can help plan and implement HIV, other STD, and pregnancy prevention and health promotion-related policies, programs, and practices. Specifically related to Program 1807, community collaborations can enable schools to provide or refer students to youth-friendly prevention resources and SHS, connect them to positive youth development programs, or enhance GSA programming. Community collaborations may also enhance classroom-based and other school programs to prevent HIV, other STDs, and teen pregnancy by engaging parents and community members in the development, revision, and/or selection of SHE instructional programs. Collaborations can also help ensure that the community's culture is appropriately considered in the creation of policies, programs, and practices, and this can result in greater awareness and buy-in among communities.[6,8–10]

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).
- focus on implementing evidence-based practices.
- systematically determine how schools and communities can collaborate by first assessing existing policies, programs, and practices.[11]

- 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.[12,13] School and district officials also strengthen partnerships when they familiarize themselves with the policies, programs, practices, and services offered by community partners.

In addition to establishing and maintaining collaborations with organizations that provide SHS to youth, LEA 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. Health departments could help with various Program 1807 activities (e.g., serving on a SHAC, helping implement school-based STD screening, or assisting with referral guides). Regardless of what form collaboration takes, LEA should review their MOU/MOA annually to assure that the roles and responsibilities of each agency are clear and relevant to the Program 1807 activities being carried out. 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".[8] Additional requirements for the MOU/MOA are outlined on page 23 of the Program 1807 Notice of Funding Opportunity (NOFO). These requirements enable LEA to work more closely with health departments and community members to collaborate on activities and materials and to align themselves with ongoing public health and community activities and community norms.

There may be special circumstances when Program 1807 activities are best facilitated by bringing community partners into the school to help support or provide programs or services (e.g., STD testing or positive youth development programs). In these situations, LEA will benefit from clear, written guidance to determine which partners will serve in such roles and for what purposes. When working with community partners who will be within school buildings, school and district administration are encouraged to have guidance to deal with issues such as

- confidentiality.
- reportable student issues (e.g., reports of ongoing physical or sexual abuse, intent to harm oneself or others, or statutory rape) and procedures to address them.
- answering sensitive questions.
- procedures for obtaining approval for written and verbal content provided to students.

Resources

Specific resources related to collaboration include

- **Agency for Toxic Substances and Disease Registry. *Principles of Community Engagement*.** This document is a guide for understanding the principles of community engagement for those who are developing or implementing a community engagement plan. https://www.atsdr.cdc.gov/communityengagement/
- **Community Tool Box. *Section 7. Working Together for Healthier Communities: A Framework for Collaboration among Community Partnerships, Support Organizations, and Funders*.** This resource describes seven essential ingredients that contribute to community change. https://ctb.ku.edu/en/table-of-contents/overview/model-for-community-change-and-improvement/framework-for-collaboration/main.
- **National Association of Chronic Disease Directors. *Local Health Department and School Partnerships: Working Together to Build Healthier Schools*.** This resource provides case studies that show how local health departments and schools can partner with each other. http://c.ymcdn.com/sites/www.chronicdisease.org/resource/resmgr/school_health/NACDD_Health_Department_and_.pdf

- **National Association of State Boards of Education.** ***How Schools Work and How to Work with Schools.*** A guide to how schools are structured and some issues that community organizations may encounter in working with them. http://www.nasbe.org/wp-content/uploads/2019/02/How-Schools-Work-2014.pdf
- **School-based Health Alliance.** ***Youth Engagement Toolkit.*** A toolkit to recruit, retain, and develop youth leaders. https://www.sbh4all.org/training/youth-development/youth-engagement-toolkit/

Professional Development

Rationale for Professional Development

Professional development (PD) refers to a systematic process for strengthening the professional knowledge, skills, and attitudes of a particular workforce. It is a critical strategy for changing practice in the school setting to reach the desired outcomes for Program 1807 for SHE, SHS, and SSE. Research about PD shows that training works, and the way training is designed, delivered, and implemented matters.[14] Effective PD requires well-organized time that is carefully structured; directed; and focused on content, pedagogy, or both.[15] PD should be research-based to engage the participant in active learning, resulting in meaningful discussions, thoughtful planning, and practice.[16]

The focus should be on strengthening the quality of PD to ultimately improve the application of new knowledge and skills. CDC is aware that organizations and individuals involved with Program 1807 already plan and/or provide PD and may have been doing so for a long time. For this project, we are asking recipients to adopt a framework that is a set of Professional Development Practices (PDP) that have been developed over many years of working with education agencies and PD experts (see Box 5.2). These practices are based on learning theory, research, and best practices, and they are designed to increase the actual implementation of what is presented in the PD setting. The PDP provide optimal conditions for implementation to occur. The PDP encompass the delivery of PD both in a group setting (e.g., trainings or presentations) and one-on-one (e.g., general technical assistance or coaching/mentoring).

Box 5.2. Professional Development Practices (PDP)

SUSTAIN a Professional Development Infrastructure: A clearly defined process is a key element of a PD infrastructure. Education agencies should leverage their existing infrastructure, strengthen, or establish an infrastructure to support the provision of professional development.

PROMOTE Professional Development: Use promotional strategies that capture the attention of your target audiences and get them to request your professional development services. Communicate clearly about what we want participants to learn and be able to access as a result of professional development offering and disseminate widely.

DESIGN Professional Development Offerings: Design trainings and technical assistance programs that are based on adult learning research, content based on learning theory and best practice, and the length is aligned with training needs.

DELIVER Professional Development: Use trainings and technical assistance designs that will have a positive effect on learning and create change. The delivery phase is where all the effective training and technical assistance that has been designed and promoted is executed.

Provide FOLLOW-UP Support: The process reinforces the information provided at the professional development offering and is intended to strengthen the transfer of learned strategies or skills so they will be retained and applied effectively.

EVALUATE Professional Development Processes: This is the process of systematically monitoring and evaluating your professional development events by collecting data and using it to improve future efforts.

Whether PD is focused on teaching a new skill, increasing confidence, enhancing knowledge, or expanding the use of technology, practice with follow-up support remains vitally important for benefits of PD to be fully realized (see Box 5.2). Follow-up support is necessary to mitigate implementation dips that occur after introducing a new skill or concept. Michael Fullan defines an implementation dip as "a dip in performance and confidence as one encounters an innovation that requires new skills and new understandings."[17] In other words, as staff start to apply what they have learned in PD and encounter problems, they may find themselves feeling uncertain and unable to continue comfortably without support. When designing PD, anticipate the implementation dip by providing booster sessions and technical assistance. Build in additional time for educators to meet together to help solve implementation challenges and be part of the solution process.

Component 2 and 3 Required PD Activities

Component 2 recipients are expected to provide PD to support the required activities outlined for each strategy. PD-related activities are outlined in Chapters 2-4 (designated with the "strengthening staff capacity" icon). Component 3 recipients are required to provide PD, technical assistance, and capacity-building assistance to support Program 1807. Recipients of components 3A-C are funded to provide direct support to Component 2 recipients.

All PD offering should incorporate purposeful, intentional, research-based/informed, and practice-oriented approaches. Both Component 2 and Component 3 recipients are required to develop an annual PD work plan (see Box 5.3).

Box 5.3. Annual Professional Development Work Plan

The annual professional development work plan should

- Detail plans to design and deliver PD opportunities annually for each strategy.
- Describe the learning objectives that will support the purpose and key topics throughout the year and engage participants in a variety of PD learning opportunities to advance implementation, address challenges, and evaluate progress.
- Identify the primary target audience and promote the PD opportunity clearly.
- Identify the type of PD that will be provided—skill-building, presentation/awareness, meeting, or technical assistance.
- Describe the mode (see Box 5.4) of each PD offering.
- Provide a year-at-a-glance overview of planned PD.

Support for PD in Components 2 and 3

CDC will have substantial involvement beyond site visits and regular PD performance monitoring and will partner with recipients to ensure success in meeting program requirements and outcome measures. Specifically, CDC will

- provide hands-on technical assistance to revise annual PD work plans.
- provide PD expertise and resources.
- collaborate with the PD contractor and Component 3 recipients to design a tiered approach to provide technical assistance and support on all CDC PDP.
- work with recipients to determine program impact through process and outcome evaluation measures.
- support recipients in using evaluation findings to guide technical assistance and additional PD efforts.
- support recipients in collecting and disseminating success stories as accomplishments or milestones are achieved.
- facilitate connections between Program 1807 recipients and CDC's PD contractor as needed.

Role of the 1807 PD contractor

As indicated above, CDC is contracting with an organization that will provide high-quality, evidence-based PD and technical assistance on PD so that LEA can provide effective PD to district and school staff to prevent HIV and other STDs among adolescents.

The contractor will use a variety of skill-building training and technical assistance PD modes (see Box 5.4) and strategies to increase the ability of Component 2 and 3 recipients to implement CDC PDP.

Box 5.4. PD Modes

- Coaching/Mentoring
- Community of Practice
- Conferences
- Face-to-face
- Live virtual
- Self-paced e-module
- Site visit
- Blended training approaches using a combination of modes

Component 2 and 3 recipients will likely interact with CDC's PD contractor as the contractor

- reviews and provides guidance to improve PD work plans and to design PD and technical assistance offerings.
- develops, disseminates, and delivers PD training modules to increase the skills of Component 2 and 3 recipients to effectively use the PDP.
- facilitates the development of a Community of Practice to advance PD skills and abilities through a variety of strategies.
- develops training and technical assistance tips and tools to support training cadre implementation.
- consults with Component 3A-C recipients to develop high-quality training objectives for each of the three approaches (SHE, SHS, and SSE).
- provides one in-person PD training annually to improve the skills of Component 2 and 3 recipients to provide effective, high-quality PD.
- provides PD and technical assistance on program evaluation to increase the capacity of Component 2 and 3 recipients to collect, manage, interpret, and use program evaluation data.

Building a Personalized PD Framework

It is vital to build a strong PD framework from the onset. Every PD framework will look different from district to district and organization to organization. Consider how to create a sustainable PD framework that will last beyond Program 1807. See Appendix D for a set of questions that can help you gain a better understanding of your LEA's PD requirements and opportunities.

The Program 1807 coordinator is not expected to be an expert in all PD areas. The coordinator should serve as a facilitator of the work, identifying where and how to best leverage content expertise both within and outside the district for SHE, SHS, and SSE. The following actions should guide the development of PD activities:

- Identify a lead PD contact who oversees the planning of annual PD, is responsible for PD tracking, and oversees the work plan activities.
- Establish a thorough planning process based on PDP that is designed and delivered to engage adult learners.
- As necessary, select a cadre of trainers who can provide PD, booster sessions, and follow-up support.
- Use a variety of PD modes to meet the needs of staff and address objectives and implementation challenges (see Box 5.4).
- Use evaluation findings to review, plan, and improve PD implementation practices.
- Engage capacity-building providers (e.g., Component 3 recipients, CDC's PD contractor, and/or TA teams) for assistance in planning content-specific PD opportunities.

In summary, PD is a critical element for implementing effective programs and practices and has a vital role in Program 1807 activities. Recipients are expected to be intentional and strategic in their PD offerings, with the goal of positive change in staff practice and, ultimately, in student knowledge, skills, and behaviors.

Resources

Specific resources related to professional development are posted on the NPIN website (requires a login) and include

- **CDC. *Professional Development Practices (PDP).*** Outlines six CDC PD practices that are based on research and best practices and provide optimal conditions for implementation to occur. https://www.cdc.gov/healthyschools/professional_development/documents/professional-development-practices-508.pdf
- **CDC. *Big Picture PD Planning Worksheet.*** Worksheet designed to facilitate high-level thinking and brainstorming (not all the details) to plan a PD event that includes implementation of the CDC PDP. Timeline estimates are also provided. This is a generic worksheet which can be customized to fit big-picture thinking for specific approach trainings (e.g., ESHE teacher competency training). https://npin.cdc.gov/resource/big-picture-pd-opportunity-planning-worksheet
- **CDC. *Professional Development Evaluation Toolkit for DASH Partners.*** This CDC toolkit provides funded agencies and organizations with the foundational guidance and practical tools necessary to plan and conduct PD evaluation for staff and to use evaluation data to report on the impact that PD has had on achieving performance and process measures. https://npin.cdc.gov/resource/professional-development-evaluation-toolkit-dash-partners
- **ETR. *Checklist for In-Person Skill-Building Training Design and Delivery.*** Checklist reflecting critical research-based components for the design and delivery of an effective skill-building PD process (training process) within two of the PDP: Design PD Offerings and Deliver PD Offerings. https://npin.cdc.gov/resource/checklist-person-skill-building-training-designs
- **ETR. *Live Virtual Event Agenda Design and Delivery Guidance and Template.*** A menu detailing some of the possible ways trainers/facilitators can implement the best practices of agenda design and delivery in live virtual training sessions. https://npin.cdc.gov/resource/live-virtual-event-agenda-design-and-delivery-guidance-and-template

- **Harvard Family Research Project. *A Conversation with Thomas R. Guskey*.** Thomas Guskey, a renowned expert in PD evaluation, answers questions about his five-step process for evaluating PD in education and how it connects to PD planning. This brief article provides a succinct overview of Dr. Guskey's approach. http://mdk12.msde.maryland.gov/instruction/teacher_induction/pdf/AConversationwithThomasGuskey_OCT022012.pdf

Evaluation

Expectations for Evaluation in Program 1807

Program 1807 Component 2 and 3 recipients are required to set aside at least 6% of their award for evaluation purposes. CDC encourages Component 2 and 3 recipients to engage evaluators (either internal staff or contractors) to assist in performing evaluation activities. These funds are expected to support Component 2 and 3 activities, not Component 1 activities. The evaluation set-aside should be used to support

- semi-annual collection of evaluation data for Components 2 and 3.
- additional evaluation reflecting Program 1807 activities not captured in evaluation measures.
- development of an evaluation plan that includes the performance and evaluation measures as specified in the NOFO, locally collected data, and program strategies.
- use of evaluation data to facilitate program improvement.
- presentation of findings through reports and practical and engaging data visualizations.

Component 2 and 3 recipients are required to submit evaluation data through the Program Evaluation Reporting System (PERS) website on a semi-annual basis starting in year 2. The evaluation measures will ask about activities at the district level and at the priority school level using a combination of yes/no, multiple response, and short answer items. Consortia LEA are expected to report their activities as well as those of their priority schools. Lead LEA are responsible for ensuring that accurate and complete evaluation data are submitted. Component 3 recipients will report on their activities in providing individual technical assistance and PD to state and local education agencies as appropriate.

Component 2 recipients will report on the activities of their priority schools through PERS. LEA may find that their priority schools change throughout the project period, and they have the option to drop priority schools if necessary (e.g., a school decides not to implement Program 1807 activities, they are reorganized, or the school closes). Once a school is dropped, it cannot be re-added. Additionally, priority schools cannot be added to PERS over the course of Program 1807. It is expected that Program 1807 recipients will work to retain all of their priority schools for the duration of Program 1807 funding. In alternating years, School Health Profiles or the Youth Risk Behavior Survey (YRBS) will measure school activities at the middle and high school levels and student outcomes at high schools across the district.

Component 2 and 3 recipients will be required to complete a full evaluation plan six months after award to describe their evaluation activities, as well as a data management plan that describes how Program 1807 recipients will share data. CDC also encourages additional evaluation activities that can provide an expanded view of program activities and outcomes, such as focus groups, interviews, or data collection on specific activities not captured in other evaluation measures.

Evaluation Measures

Component 2 and 3 recipients are expected to evaluate both the process and outcomes of their activities. For process evaluation, LEA staff and evaluators should collect and analyze data to determine how, when, and where activities are conducted, and who participates in each activity. CDC collects some process data through PERS. 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. Outcome data are collected through PERS as well as through the School Health

Profiles and YRBS. Component 2 consortia will also provide process and outcome data, although these include the activities of each funded LEA (not simply the lead LEA) and may measure relationships and coordination among the consortium LEA.

Component 3 recipients are also expected to conduct evaluation. Component 3A-C recipients will provide evaluation data on their activities to deliver PD and technical assistance to Component 2 recipients. Because they build the capacity of Component 2 recipients, the outcomes of Component 3 recipients' activities are measured by the success that Component 2 recipients have in their process and outcome measures. Component 3E recipients are expected to collect data for process and outcomes. Some process and outcome measures will be measured through PERS, and others may be measured through School Health Profiles and the YRBS.

All of the measures listed in the Program 1807 NOFO are draft measures and will be further refined by CDC. We will ask for Program 1807 recipients to provide feedback on the draft measures before we finalize them.

Consider the Purpose and Uses for Evaluation Findings

Districts and schools should develop and focus their evaluation activities by considering the purpose and uses for their evaluation findings. Evaluation can serve a variety of purposes, including

- documenting program accomplishments and strengths and sustaining those program elements.
- identifying areas in which programs can be improved or in which new needs emerge and refining program activities.
- communicating program accomplishments and needs to stakeholders.

The Phases of Evaluation

Over the five years of funding we recommend following a four-phase evaluation cycle: (1) planning the evaluation, (2) collecting and managing data, (3) analyzing data, and (4) disseminating findings.[18] At the beginning of Program 1807, recipients should plan evaluation activities for all five years. For Component 2 and 3 recipients, this cycle will be repeated for each of the eight times that data are collected through PERS.

Phase 1—Planning an evaluation, evaluators should

- engage stakeholders to provide input and participation in evaluation activities (stakeholders are individuals who have a vested interest in a program, such as district and school staff and administrators, parents, community members, and youth).
- describe the program so that evaluators and stakeholders understand what the program activities are, who is involved in the program, and what processes and outcomes are associated with the activities.
- focus the evaluation design by understanding the purpose of the evaluation; how to collect, manage, and analyze the data; and how findings will be disseminated.

Phase 2—Collecting and managing data, evaluators should

- gather credible evidence needed for the evaluation.
- make sure that the information collected is accurate and complete:
  - » Responses should be internally consistent—for example, if a school reports delivering no instructional program in the six-month period, then it should not provide the name of an instructional program that was delivered during that reporting period.
  - » Responses should be in a credible range—if a school with 500 students reports implementing a sexual health curriculum, reporting that the curriculum reached 1 student is too low a value, and reporting that it reached 10,000 students is too high a value.
  - » Responses should be complete—all data should be provided without filler text (such as question marks or x's).
  - » Responses should be understandable—limit use of acronyms and abbreviations.
  - » Responses should be relevant to the question asked—for example, when listing the names of curricula implemented, do not list the organization of the instructor instead of the curriculum name.

Phase 3—Analyzing data, evaluators should

- analyze and synthesize the data that were collected.
- draw on and synthesize multiple sources of relevant data.
- draw conclusions justified by the data.
- facilitate recommendations for program and evaluation data collection improvement.
- develop reports and other data visualizations tailored to particular stakeholders.

Phase 4—Disseminating findings, evaluators should

- ensure use of data by program staff and other stakeholders and share lessons learned.
- assist in planning and implementing PD and technical assistance related to evaluation findings.

Actions to Take for Evaluation

LEA program coordinators, evaluators, and CDC all have a role to play in evaluation and all take responsibility for various parts of the evaluation process. The next few sections detail roles, expectations, and (for evaluators) deliverables for evaluation under Program 1807. In consortia, lead LEA are responsible for managing the evaluation process and evaluators and for submitting complete and accurate evaluation data to CDC. All other consortium LEA are to collect and provide accurate and complete data to their lead LEA.

LEA Program Coordinator Roles and Responsibilities

LEA program coordinators have the following responsibilities:

Provide CDC with

- feedback on CDC draft performance and process measures (at the beginning of funding).
- a full evaluation plan (6 months after funding).
- a data management plan (6 months after funding).
- prompt communication of changes in priority sites.
- complete and accurate data on performance and evaluation measures entered into PERS semi-annually.

Communicate with their evaluator regarding

- Program 1807 NOFO and program information.
- evaluation requirements and deadlines.
- performance and evaluation measures and surveys.
- changes in evaluation requirements, deadlines, and survey items.
- current information on priority schools and points of contact to provide evaluation data from the schools.
- how to request technical assistance from CDC evaluation staff, evaluation contractors, and subject matter experts.
- how to request technical assistance from Component 3 recipients.
- CDC evaluation reports and recommendations for evaluation and program activities.
- how to create reports on evaluation findings.
- how to disseminate findings to stakeholders and communicate with priority sites about findings.

Provide their evaluator with

- a list of priority school points of contact that is updated as necessary.
- information (including student enrollment, demographics, grade ranges, and requirements) for each priority school.
- feedback on staff roles and responsibilities, and processes for data collection, data management and entry, developing reports, and providing feedback and training to stakeholders (district and school staff, students, parents, and community organizations).

- assistance in resolving ambiguity about program activities as reported in evaluation data.
- feedback on evaluation reports and recommendations to improve programs and highlight successes.
- feedback on useful data visualizations and dissemination strategies to stakeholders.

Provide district and priority school staff with

- evaluation results.
- engaging and practical data visualizations.
- PD and technical assistance on program improvement and evaluation data collection.

Evaluator Actions and Deliverables

Evaluators will provide activities and products that assist with all phases of evaluation, including evaluation planning, data collection and management, analysis of data, and dissemination of findings. We expect evaluators to abide by the American Evaluation Association's guiding principles for evaluators and CDC's standards for evaluations.[18,19]

Table 5.5 outlines, by phase of evaluation, evaluator actions and likely deliverables that will provide complete, professional assistance to fulfill CDC evaluation requirements. It is expected that the phases of evaluation will be completed for each PERS data collection period.

Table 5.5. Evaluator Actions and Possible Deliverables by Phase of Evaluation

Phase of Evaluation	Evaluator Actions	Possible Deliverables
Planning an evaluation (Engage stakeholders, describe the program, and focus the evaluation design)	■ Meet with project coordinator and other staff to learn about program ■ Determine roles, responsibilities, and processes for evaluation with the project coordinator ■ Discuss the uses of various kinds of evaluation data ■ Draft and refine an evaluation plan ■ Draft and refine a data management and data entry plan ■ Gather lists of points of contacts at the district level and at priority sites ■ Draft and finalize surveys (and any other data collection instruments)	■ Documentation on program activities and requirements of Program 1807 (such as a logic model) ■ Evaluation plan ■ Documentation of processes, roles, and responsibilities for evaluation ■ List of points of contact ■ Surveys (and other data collection instruments) ■ Any necessary documentation about surveys (and other data instruments)
Collecting and managing data (Gather credible evidence)	■ Provide oversight to administer and receive surveys (and other types of data) ■ Collaborate with the project coordinator and school points of contact to make sure that data collected are accurate and complete and to resolve incomplete, inconsistent, out-of-range, non-credible, or irrelevant responses ■ Ensure that accurate and complete data are entered into PERS with consistency checks between data received from schools and data as entered into PERS ■ Consult with project coordinator to address any issues with data collection to be resolved before the next data collection period	■ Raw data set ■ Accurate and complete data set ■ Accurate and complete data entered into PERS ■ Documentation on data sets, including data dictionary and code book ■ Documentation of all edits made to data

Continued

Phase of Evaluation	Evaluator Actions	Possible Deliverables
Analyzing data (Justify conclusions)	■ Review PERS, success stories, YRBS, and Profiles reports ■ Analyze additional evaluation data and other local data ■ Synthesize PERS, success stories, YRBS, Profiles, additional evaluation data, and additional local data to draw conclusions about Program 1807 activities and provide recommendations for program improvement ■ Consult with project coordinator and other stakeholders on reports and other recommendations	■ Analysis and findings shared with project coordinator and project staff ■ Program recommendations refined and shared with project coordinator and project staff ■ Evaluation reports developed ■ Data visualizations developed
Disseminating findings (Ensure use of data and share lessons learned)	■ Provide data visualizations and success stories to appropriate stakeholders ■ Provide evaluation and data reports to appropriate stakeholders ■ Assist in developing and implementing professional development and technical assistance	■ Disseminated data visualizations and success stories ■ Disseminated evaluation and data reports ■ Completed professional development events and technical assistance on collecting and refining programs using evaluation data ■ Completed professional development events and technical assistance on collecting accurate and complete evaluation data

CDC Support for Evaluation in Components 2 and 3

Throughout the project period, CDC will help provide support for recipients' evaluation activities through both CDC staff and CDC contractors. Specifically, CDC will provide

- access to the PERS website for data entry.
- surveys for program evaluation.
- PD and technical assistance on all aspects of evaluation and the evaluation process, including technical support for the PERS website.
- PD and technical assistance on implementing programmatic and evaluation recommendations from evaluation findings.
- guidance on evaluation, evaluation plans, and data management plans.
- sites' evaluation data on request.
- documentation on evaluation requirements, the PERS website, and data sets.
- reports on evaluation findings for each reporting period and trends across reporting periods.

Resources

The following resources can assist with engaging an evaluator:

- **American Evaluation Association (AEA).** ***Find an Evaluator.*** This resource can be used to identify AEA members available for evaluation consulting: http://www.eval.org/p/cm/ld/fid=108
- **American Evaluation Association (AEA).** ***American Evaluation Association Guiding Principles for Evaluators*****.** This resource lists the AEA's Guiding Principles for Evaluators and includes revisions ratified by AEA in August of 2018. http://www.eval.org/p/cm/ld/fid=51
- **CDC.** ***CDC evaluation brief #1: Selecting an Evaluation Consultant*****.** This resource describes considerations for selecting an evaluation consultant. https://www.cdc.gov/healthyyouth/evaluation/pdf/brief1.pdf

The following resources can assist with the evaluation process:

- **CDC.** ***CDC Approach to Evaluation*****.** This resource explains how CDC evaluates health programs. https://www.cdc.gov/eval/approach/index.htm
- **CDC.** ***A Framework for Program Evaluation*****.** This resource presents and explains the stages of program evaluation. https://www.cdc.gov/eval/framework/index.htm
- **CDC.** ***Evaluation Planning, Data Collection & Analysis, Sharing Results & Improve Program*****.** This is a collection of evaluation resources specifically for CDC funding recipients. https://www.cdc.gov/healthyyouth/evaluation/index.htm
- **CDC.** ***Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide*****.** This a guide to help people unfamiliar with evaluation understand the CDC approach to evaluation. https://www.cdc.gov/eval/guide/index.htm

The following are general resources related to evaluation:

- **American Evaluation Association (AEA).** ***AEA 365: A Tip-a-Day by and for Evaluators*****.** This is an archive that covers a large number of evaluation issues and questions. http://aea365.org/blog/
- **Kellogg Foundation.** ***The Step-by-Step Guide to Evaluation*****.** An excellent detailed guide to evaluating education and health programs. https://www.wkkf.org/resource-directory/resource/2010/w-k-kellogg-foundation-evaluation-handbook

Emphasis on Addressing Health Disparities

There are a number of disparities related to sexual health risk behaviors and outcomes among adolescents. Throughout Program 1807 work, recipients should consider groups of adolescents experiencing health disparities in HIV, STDs, or teen pregnancy and design their work plans with an underlying goal of decreasing these disparities. Recipients can address adolescents experiencing health disparities in a number of ways, such as selection of priority schools, diffusion of activities, and content and delivery of activities. For example, selection of priority schools should be based on public health data to identify the schools with the highest need where the potential for positive impact among underserved populations is greatest. Efforts to diffuse activities across the district could also prioritize schools with a greater percentage of youth at disproportionate risk for sexual health risk behaviors and negative outcomes. Furthermore, as specific activities are implemented, groups at disproportionate risk may warrant special attention in material development and implementation.

LGBT youth face substantial health disparities, including disparities in HIV, STDs, and teen pregnancy. For this reason, several required and enhanced activities within Components 2 and 3 highlight LGBT youth. The emphasis on meeting the unique needs of LGBT youth does not rest in any single component or strategy, but instead reaches across the work of Program 1807, with SHE, SHS, and SSE all containing activities intended to better support LGBT youth. This approach not only offers a cross-cutting method for recipients to address health disparities faced by LGBT youth; it also provides an example for how other adolescent populations experiencing health disparities could be addressed through material development and implementation. Table 5.6 (on next page) provides an overview of how LGBT youth may be addressed in each Program 1807 strategy.

Table 5.6. Examples of Addressing Health Disparities in LGBT Youth across the Program 1807 Content Areas

Strategy	Rationale	Approach to Addressing Health Disparities	Outcome
Sexual Health Education	■ Well-designed and implemented SHE helps adolescents acquire the knowledge and skills to reduce HIV, STDs, and teen pregnancy; however, without being thoughtfully designed and delivered, SHE could exclude or misrepresent LGBT youth.	■ Develop, adapt, and select instructional programs that include medically accurate and age-appropriate information about sexual orientation and gender identity that is designed with the needs of LGBT students in mind. ■ Provide PD to teachers on how to deliver SHE content on sexual orientation and gender identity in a manner that is effective and supportive.	■ SHE instructional programs better reflect the sexual health needs of LGBT students, and information can be used in their relationships and sexual decision-making. ■ Teachers foster a positive learning environment for LGBT students.
Sexual Health Services	■ School provision of on-site and off-site SHS increases adolescent access to key SHS such as HIV and other STD testing; however, some providers may lack comfort and competency with LGBT youth.	■ Identify health service providers that are known for LGBT-friendly care, and communicate this designation in referral guides and materials to highlight health service providers that are known for providing LGBT-friendly care.	■ Referral guides better support the unique needs of LGBT students and connect them with relevant health care.
Safe and Supportive Environments	■ School environments that are safe and supportive can increase adolescent connectedness to school and improve parental communication; however, many LGBT youth experience high levels of bullying and harassment in school environments.	■ Provide PD to all school staff on supporting LGBT youth. ■ Implement student-led clubs that support LGBT youth, often known as Gay-Straight Alliances or Genders and Sexualities Alliances (GSAs).	■ Teachers, administrators, and staff are better equipped with the knowledge and skills necessary to foster an SSE for LGBT students. ■ LGBT youth may build up peer support and connections to supportive faculty advisors.

Recipients are expected to use data from their own communities to identify any additional youth populations that may need special consideration in the design, implementation, or diffusion of activities. Recipients may use the structure of the approach used for LGBT youth to inform their efforts.

Chapter 5 References

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Afterword

This program guidance document is intended to provide Program 1807 recipients with an overview of the Program 1807 required activities and additional information to guide implementation of these activities. This document also outlines a number of additional activities that, although not required, are within the scope of Program 1807 and may help facilitate progress on key outcomes. To the extent that CDC has identified key resources to support the work of Program 1807, these resources have been provided. Additional tools and resources will be developed by CDC and its partners throughout the project period, and these will be shared as they become available. All Program 1807 recipients are encouraged to work closely with their Program Consultants and TA teams to establish and revise work plans, refine program activities, share challenges and opportunities, and strategize about the best ways to make progress toward key Program 1807 outcomes.

Appendices

Appendix A: Component 2 Required Activities by District and School Level

Sexual Health Education (SHE)

Component 2 Required Activities	District Level	School Level*
Identify and approve a list of instructional competencies expected to be demonstrated by those teaching skills-based health and sexual health education in middle and high school.	Yes	
Provide necessary training at LEA once per year to ensure school health and sexual health education teachers have content knowledge, comfort, and instructional competencies to effectively implement approved school health and sexual health education instructional programs.	Yes	
Establish, adopt, and implement a skills-based health education course requirement, which includes sexual health education content, for all students attending middle and high schools in the district.	Yes	
Develop and approve a health education scope and sequence that delineates sexual health education learning outcomes for all students in middle and high schools in the district.	Yes	
Develop, revise, or select a sexual health education instructional program consistent with the approved scope and sequence, and inclusive of instructional lessons, student learning activities, resources, and student assessment.	Yes	
Develop, update, and foster use of teaching tools and resources (e.g., lesson pacing guide, specific lesson plans) for teachers to continuously improve delivery of the identified sexual health education instructional program.	Yes	
Establish and maintain a School Health Advisory Council (SHAC) that regularly provides district-level advice and guidance to improve health and sexual health education programs for students and health and sexual health education instruction for staff.	Yes	
Integrate strategies to actively engage parents in sexual health education instructional programs.	Yes	

Sexual Health Services (SHS)

Component 2 Required Activities	District Level	School Level*
Annually, provide training and professional development to school and/or health service staff to support SHS activities.		Yes
During year one, assess district and priority school capacity to implement activities to increase student access to SHS, in collaboration and coordination with the Component 3B recipient.	Yes	Yes
Annually, incorporate skill-based instruction to students on accessing school-based and community SHS into sexual health education lessons.		Yes
Annually, choose the area of focus below, appropriate to the recipient's health services infrastructure, to increase student access to and use of SHS through either on-site provision or referral to community-based sexual health providers: (a) Establish or improve use of a referral system to link sexually active students to community providers for SHS by using the referral system toolkit (see Glossary) to implement the 7 core components of a referral system. (b) Improve student use and quality of SHS provided by School-Based Health Centers (SBHCs).		Yes
Implement school-wide, student-planned marketing campaigns that promote recommended health services for teens and selected school SHS programs.		Yes

Continued

Safe and Supportive Environments (SSE)

Component 2 Required Activities	District Level	School Level*
Provide professional development to teachers on classroom management annually.		Yes
Provide professional development to all school staff on supporting lesbian, gay, bisexual, and transgender (LGBT) youth annually.		Yes
Implement mentoring, service learning, and/or other positive youth development programs for students and/or connect students to such community-based programs.		Yes
Establish or enhance student-led clubs that support LGBT youth (often known as Gay-Straight Alliances or Genders and Sexualities Alliances).		Yes
Disseminate resources to parents/caregivers on parental monitoring and parent-adolescent communication (generally and specifically about sex).		Yes

*School-level activities should at minimum be implemented in all priority schools, with a goal to implement these activities in all schools district-wide by the end of the 5-year project period. See the Component 2 narrative in the "Strategies and Activities" section of the PS18-1807 NOFO for more information on this diffusion process.

Appendix B: Glossary

Activities: The actual events or actions that take place as a part of the program.

Adolescents: Individuals in the 10-19 years age group.

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).

Alternative School: An educational or instructional facility established for students at disproportional risk for failing or dropping out of regular high school or who have been removed from their regular high school because of drug use, violence, or other illegal activity or behavioral problems.

Blended Training: Combines live virtual training with traditional, in-person training methods.

Bullying: Attack or intimidation with the intention to cause fear, distress, or harm; a real or perceived imbalance of power between the bully and the victim; and repeated attack or intimidation between the same children over time. Bullying can include aggression that is physical, verbal (e.g., name calling, teasing), psychological/social (e.g., spreading rumors, leaving out of group), or electronic (e.g., social media, technology).

Cadre of Trainers: A designated, highly proficient core group of individuals who provide professional development to others on particular programs, topics, methods, or skills.

Capacity Building: The process of improving an organization's ability to achieve its mission. It includes increasing skills and knowledge; increasing the ability to plan and implement programs, practices, and policies; increasing the quality, quantity, or cost-effectiveness of programs, practices, and policies; and increasing the sustainability of infrastructure or systems that support programs, practices, and policies.

Capacity-Building Assistance (CBA): The transmission of knowledge and building of skills to improve an organization's ability to achieve its mission. CBA involves using diverse program activities, including training, professional development, staff development, technical assistance (see technical assistance), or technology transfer.

Classroom Management: The process by which teachers and schools create and maintain appropriate behavior of students in classroom settings.

Coaching: Two or more educators working together on reflecting, refining, and building new skills and ideas to improve implementation or solve problems.

Coalition: A formal arrangement for cooperation and collaboration among groups or sectors of a community in which each group retains its identity, but all agree to work together toward a common goal.

Collaborate: To actively engage with one or more partners in planning, implementing, or evaluating programs, practices, and policy activities with defined roles and responsibilities for each partner.

Community of Practice: Provides expertise and resources necessary to support collaboration and communication; dissemination of best practices and lessons learned within a district, district consortium, or group of districts.

Competencies: An integrated set of knowledge, skills, and attitudes that supports successful performance.

Contracts: An award instrument used to acquire (by purchase, lease, or barter) property or services for the direct benefit or use of the Federal Government.

Cooperative Agreement: A financial assistance award with the same kind of interagency relationship as a grant, except that it provides for substantial involvement by the federal agency funding the award. Substantial involvement means that the recipient can expect federal programmatic collaboration or participation in carrying out the effort under the award.

Culturally Appropriate: Considering the cultural knowledge, prior experiences, frames of reference, and performance styles of diverse students to make learning encounters more relevant and effective for them. Culturally appropriate educational programs encourage children and teachers to view events and situations from multiple perspectives.

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.

Diffusion: Spreading the implementation of required activities beyond priority schools.

Evaluation (program evaluation): The systematic collection of information about the activities, characteristics, and outcomes of programs (which may include interventions, policies, and specific projects) to make judgments about that program, improve program effectiveness, and/or inform decisions about future program development.

Evaluation Plan: A written document describing the overall approach that will be used to guide an evaluation, including why the evaluation is being conducted, how the findings will likely be used, and the design and data collection sources and methods. The plan specifies what will be done, how it will be done, who will do it, and when it will be done. The NOFO evaluation plan is used to describe how the recipient and/or CDC will determine whether activities are implemented appropriately and outcomes are achieved.

Evidence-Based Approaches: Ways of addressing disease prevention and health promotion by using best practices in the field as determined through the use of peer-reviewed research and scientific studies.

Evidence-Based Intervention (EBI): A program that has been proven effective on the basis of rigorous scientific research and evaluation and identified through a systematic independent peer-review. Program 1807 is specifically interested in those EBIs that show effectiveness in changing behavior associated with the risk factors for HIV and other 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. More information on federal lists of EBIs can be found at http://www.cdc.gov/healthyyouth/adolescenthealth/registries.htm.

Evidence-Informed Program: A program that is informed by scientific research and effective practice. Such a program replicates evidence-based programs or substantially incorporates elements of effective programs. The evidence-informed program shows some evidence of effectiveness, although it has not undergone enough rigorous evaluation to be proven effective.

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

Gay-Straight Alliances (GSA): A student-run club, typically in a high school or middle school, that provides a safe place for students to meet, support each other, talk about issues related to sexual orientation and gender identity and expression, and work to end homophobia and transphobia.

Gender-Sexuality Alliance (GSA): 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.

Goal: A statement of the overall mission or purpose(s) of the program.

Health Disparities: Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

Health Education: Education that includes planned, sequential materials, instructions, and educational experiences delivered in the classroom setting to 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: A set of instructional strategies and learning experiences that provide students with opportunities to acquire the attitudes, knowledge, and skills necessary for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviors, and promoting the health of others. A health education curriculum should have

- a set of intended learning objectives or learning outcomes that are directly related to students' acquisition of health-related knowledge, attitude, and skills.
- a planned progression of developmentally appropriate lessons or learning experiences that lead to achieving these objectives.
- continuity between lessons or learning experiences that clearly reinforce the adoption and maintenance of specific health-enhancing behaviors.
- accompanying content or materials that correspond with the sequence of learning events and help teachers and students meet the learning objectives.
- assessment strategies to determine if students achieved the desired learning.

Health Equity: Striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

Health Instruction: The process, including delivery of lessons, facilitation of learning, directing of activities and learning events and other components of the classroom experience, designed to provide an opportunity for students to acquire developmentally appropriate health knowledge and attitudes and improve health-enhancing skills and behaviors.

HIV Materials Review Panel: A panel of constituents convened by an HIV-funded federal grantee to review all written and audiovisual materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula, and like materials for medical accuracy and appropriateness for the targeted audience (https://www.cdc.gov/healthyyouth/fundedprograms/1807/resources.htm).

Inclusion: Refers to both the meaningful involvement of community members in all stages of the program process and maximum involvement of the target population in the benefits of the intervention. An inclusive process assures that the views, perspectives, and needs of affected communities, care providers, and key partners are actively included.

Instructional Competency: The functions a teacher should be able to perform that result in improved student learning. In health education, instructional competencies are the functions a teacher performs to improve a student's acquisition of essential knowledge and skills that contribute to health-enhancing behaviors. Competencies include instructional approaches that are structured, sequenced, relevant, and engaging, and consist of elements that are medically accurate, age and culturally appropriate, and consistent with the scientific research on effective health education and SHE.

Learning Objectives: Learning objectives are written to relate directly to the goals of the educational activity. The planning committee, content experts, and presenters determine the goals and objectives of the activity based on identified need. Sound objectives or outcomes are measurable, concise, specific, and adequately define the level of the learning activity and the learners' scope of practice.

Learning Outcomes: Statements that describe significant and essential learning that students have achieved, and can reliably demonstrate at the end of a health education course or program. Learning outcomes identify what the learner should know and be able to do by the end of a course. The intended goals of a course, program, or learning experience including the knowledge, skills, and habits of work that students are expected to acquire by the end of an instructional period (course, program or school year).

Live Events: Category of educational activity presented in a live format with limited-time availability.

Live Virtual Event: Gathering of individuals who meet through a multi-faceted, computer-generated environment that is user friendly and highly interactive. Individuals gather at a prearranged time in order to acquire knowledge, share information, interact with each other, and engage in activities of common interest.

Lobbying: Direct lobbying includes any attempt to influence legislation, appropriations, regulations, administrative actions, executive orders (legislation or other orders), or other similar deliberations at any level of government through communication that directly expresses a view on proposed or pending legislation or other orders, and that is directed to staff members or other employees of a legislative body, government officials, or employees who participate in formulating legislation or other orders. Grass roots

lobbying includes efforts directed at inducing or encouraging members of the public to contact their elected representatives at the federal, state, or local levels to urge support of or opposition to proposed or pending legislative proposals.

Logic Model: A visual representation showing the sequence of related events connecting the activities of a program with the program's desired outcomes and results.

Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA): Document that describes a bilateral or multilateral agreement between parties expressing a convergence of will between the parties, indicating an intended common line of action. An MOU or MOA is often used in cases where the parties either do not imply a legal commitment or cannot create a legally enforceable agreement.

Mentoring: Refers to a youth-supportive practice that matches youth, or mentees, with responsible, caring mentors, usually adults. Components of a mentoring relationship include creating caring, empathetic, consistent, and long-lasting relationships, often with some combination of role modeling, teaching, and advising. In the context of using mentoring for professional development with staff, mentoring refers to providing peer feedback from a more experienced colleague to a newer colleague.

Model Policy: For the purpose of this NOFO, a model policy is a framework to assist school officials in developing their own state or local policies. Model policies are written as statements of best practice, which can be adapted to fit local circumstances. Model policies also reflect state-of-the-art, scientifically reliable information on what constitutes effective school health programs and expert opinions. Included in model policies are excerpts or references to actual national, state, and local policies; a statement of purpose or goals and rationale; and definitions.

Outcome: The results of program operations or activities; the effects triggered by the program. For example, increased knowledge, changed attitudes or beliefs, reduced tobacco use, and reduced morbidity and mortality are all program outcomes.

Pacing Guide: A written schedule or chart displaying the concepts, topics, and skills related to a health education unit or curriculum to be addressed over a defined period of time. A pacing guide is an itinerary for teaching. The guide maps out the topics that will be covered throughout the health education unit or curriculum and includes all essential information (e.g., learning objectives, instructional activities, etc.).

Parent-Adolescent Communication: Conversations that occur between parents/caregivers and adolescents, which can generally be characterized by five components: the source of communication, the communication message/content, the medium or channel of communication, the recipient/audience of the communication, and the context in which the communication occurs.

Parental Monitoring: Parents' knowledge of their adolescents' whereabouts, companions, and activities, obtained by parental supervision, parental solicitation, parental control (i.e., enforcement of rules), and/or youth disclosure.

Performance Measurement: The ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals, typically conducted by program or agency management. Performance measurement may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), or the results of those products and services (outcomes). A program may be any activity, project, function, or policy that has an identifiable purpose or set of objectives.

Period of Performance (formerly known as the project period): The time during which the recipient may incur obligations to carry out the work authorized under the federal award. The start and end dates of the period of performance must be included in the federal award.

Period of Performance Outcome: An outcome that will occur by the end of the NOFO's funding period.

Policies: Official mandates adopted by an authoritative governing body (e.g., school district board of education, the state school board, state legislature, or other district or state agency) 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 they are implemented at the school level.

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.

Positive Youth Development (PYD): An intentional, prosocial approach that engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths.

Presentation: A speech or visual display tailored to specific audiences such as school administrators, faculty, education and health professionals, adolescents, parents, college students, legislators, or community groups.

Priority Schools: Secondary schools (high schools or a combination of middle and high schools) within the funded LEA in which youth are at high risk for HIV infection and other STDs. These schools will be the primary focus of LEA technical assistance efforts throughout the duration of the NOFO.

Professional Development (PD): A systematic process used to strengthen the knowledge, skills, and attitudes of a particular professional workforce. PD for those who serve adolescents is intended to help improve the health, education, and well-being of youth. This type of PD is consciously designed to actively engage learners and includes the planning, design, marketing, delivery, evaluation, and follow-up of training offerings (events, information sessions, and technical assistance).

Professional Development (PD) Event: A set of skill-building processes and activities designed to assist targeted groups of participants in mastering specific learning objectives. Such events are delivered in an adequate time span (at least three hours) and may include curriculum and other training, workshops, and online or distance learning courses.

Professional Development (PD) Offering: Events, information and presentation sessions, and technical assistance.

Professional Development Practices (PDP): Based on research and best practices, these CDC recommendations provide the best conditions for professional development implementation to occur. They encompass the delivery of PD in a group setting (trainings, presentations, meetings) and one-on-one (general technical assistance, coaching/mentoring). There are six practices: sustain, design, market, deliver, follow up, and evaluate.

Referral System: A set of resources and processes that are aligned to increase student awareness of school- and community-based SHS providers, increase referral of students to school- and community-based SHS providers for sexually active adolescents, and increase the number of sexually active adolescents receiving key SHS. For the purposes of this NOFO, there are seven core components of a referral system: (1) policy, (2) referral staff, (3) procedures, (4) referral guide, (5) communications and marketing, (6) monitoring and evaluation, and (7) management and oversight.

Referral System Toolkit: Refers to the CDC resource titled, *Developing a Referral System for Sexual Health Services: An Implementation Kit for Education Agencies and its companion guide Establishing Organizational Partnerships to Increase Student Access to Sexual Health Services*. The toolkit provides a framework and guidance for developing and implementing a referral system to connect youth to school- or community-based sexual health services. The framework can also be used to establish referrals for substance abuse treatment, mental health, after-school activities, job training, and housing support. (https://www.cdc.gov/healthyyouth/healthservices/index.htm)

Risk Behavior: A lifestyle activity that places a person at increased risk of suffering a particular condition, illness, or injury.

School-Based: Used to describe any activity or project that is conducted or completed in schools or on school grounds, or a school-sponsored event.

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 physician 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 District: Refers to an education agency at the local level which exists primarily to operate public schools or to contract for public school services. Synonyms include local basic administrative unit, local education agency (LEA), parish, and independent school district.

School Environment: The overall school climate (including educational, cultural, social, professional, and physical circumstances or conditions; staffing attributes; and school/community programs) that can affect student and staff safety and health.

School Health Advisory Council (SHAC): A council made up of a broad cross-section of parents, business and community leaders, and school personnel. A SHAC facilitates communication and problem solving about health-related issues of children and youth. A district-level SHAC can assist schools in carrying out responsibilities for promoting and protecting the health of students and employees, and it can be an excellent mechanism for parent and community involvement at the district level. The School Health Advisory Team, consisting of a group of individuals representing different segments of the community, operates at the school-building level to provide advice to a school building on aspects of the school health program.

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

Scope and Sequence (S&S): Essential element of a curriculum framework intended to serve as a guide for curriculum directors, administrators, teachers, parents, and school board members. A health education S&S outlines the breadth and arrangement of key health topics and concepts across grade levels (scope), and the logical progression of essential health knowledge, skills, and behaviors to be addressed at each grade level (sequence) from pre-kindergarten through 12th grade. A sexual health education S&S should identify what the student should know or do and when it should be taught for each grade or grade group to lower their risk of HIV, STDs, and unplanned teen pregnancy. The S&S should be aligned with the national, state, or local health education standards, benchmarks, and performance indicators.

Secondary Schools: Middle, junior high, and/or high schools or schools of corresponding grade levels.

Service Learning: A strategy that integrates meaningful community service with instruction and self-reflection to support academic learning, teach civic responsibility, and strengthen communities.

Sexual Health Education (SHE): 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. SHE provides adolescents the essential knowledge and critical skills needed to avoid HIV, other STDs, and unintended pregnancy. SHE 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.

Sexual Health Services (SHS): Also referred to as key sexual health services, includes risk assessment and sexual risk counseling, anticipatory guidance for HIV/STD and unplanned pregnancy prevention including delaying the onset of sexual activity, HIV and other 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.

Sexually Transmitted Disease (STD): A disease transmitted by sexual contact, such as syphilis, gonorrhea, chlamydia, viral hepatitis, genital herpes, or trichomoniasis. Individuals who are infected with an STD are at least two to five times more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact.

Skill-Based Instruction: A form of instruction (i.e., teaching) that fosters classroom environments where critical thinking, collaboration, and active learning are developed at the same time as knowledge is acquired. A large portion of time is dedicated to practicing, assessing, and reflecting on skill development, and this instruction moves students toward independence and learning how to think critically and solve problems.

Stakeholders: Individuals or organizations that have an interest in or are affected by your program or activity or its results. Engaging a range of stakeholders with different perspectives can help build both internal and external buy-in and support for a program or activity.

Statute: A formal law passed by a legislative body.

Student Assessment: The process of gathering, describing, or quantifying information about student performance and level of achievement based on established standards.

Success Stories: Brief written reports that demonstrate the progress of a program or activity and how the results can affect the health of a community over time. Success stories highlight activities, such as a new intervention, or feature evaluation data from a completed project.

Training: An instructional experience provided primarily by employers for employees, designed to develop new skills and knowledge that are expected to be applied immediately upon arrival or return to the job.

Technical 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 PS18-1807 NOFO 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.

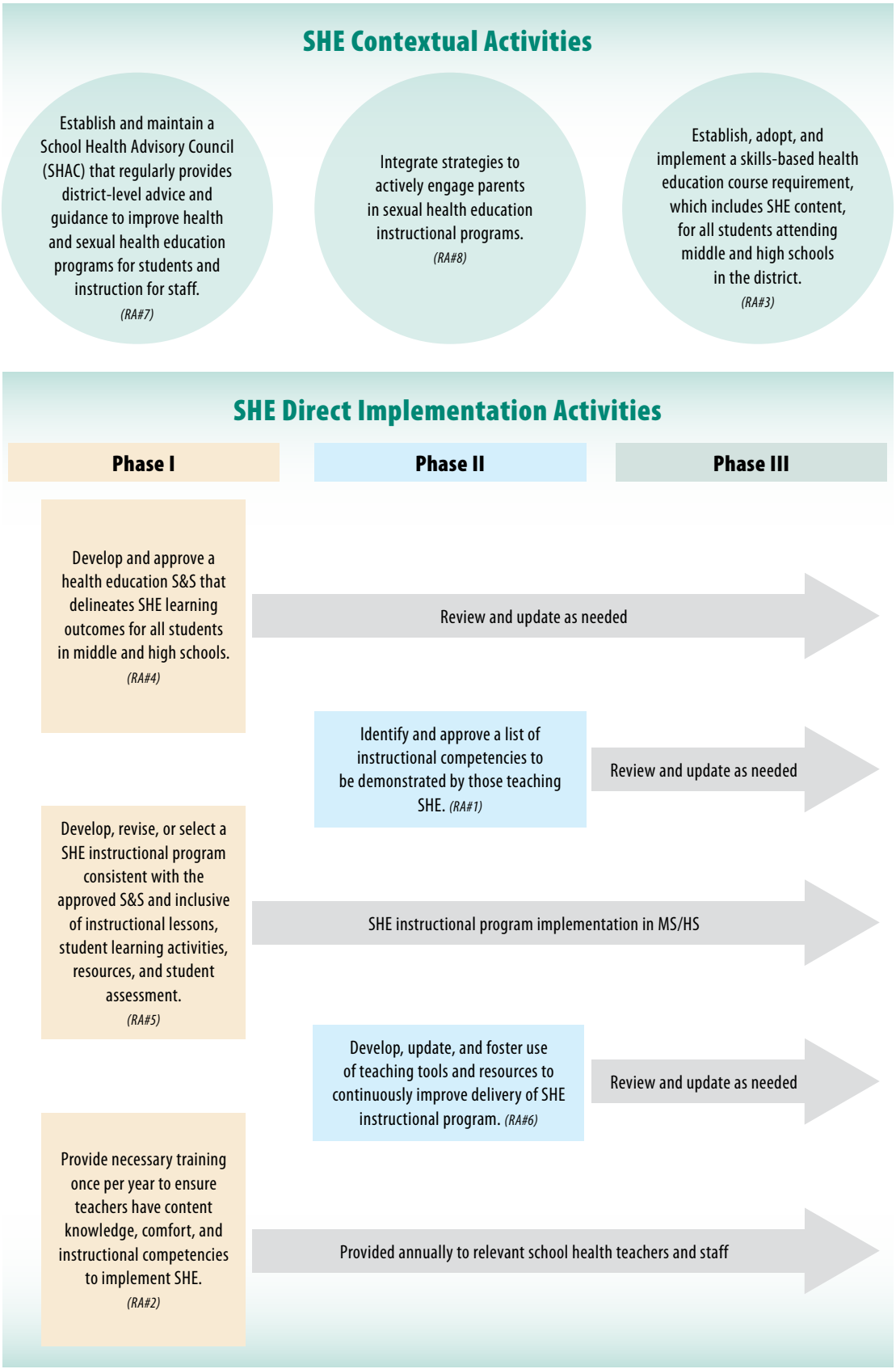
Unintended Pregnancy: A pregnancy that is reported to have been either unwanted (that is, the pregnancy occurred when no children or no more children were desired) or mistimed (that is, the pregnancy occurred earlier than desired).

Work Plan: The summary of period of performance outcomes, strategies and activities, personnel, and/or partners who will complete the activities, and the timeline for completion. The work plan will outline the details of all necessary activities that will be supported through the approved budget.

Youth-Friendly Services: Services with policies and attributes that attract young people, 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 C: Required Activity Context and Timing for Sexual Health Education (SHE) Activities

For accessibile explanation of graphic model in Appendix C, go to Appendix E, page 119.



Appendix D: Understanding Professional Development in Your School District

It is vital to build a strong professional development (PD) framework from the onset. This framework will help you identify the right people to train and ensure the right people are attending the PD you are providing. PD takes time to do well, and we want you to get the most out of your planning efforts for each PD opportunity you provide. Begin by answering the following questions pertaining to your district regarding PD.

Start Here—Know PD in Your School District

- Is there a policy on PD in your school district?
- What are the school district PD requirements?
- Does your school district have a specific unit that plans and coordinates PD for your district?
- How many days of PD are required annually?
- How many hours of PD are required annually?
- Who is the school district contact person for staff PD?
- Is there a system to track PD participation?
- Is there a system to post PD training materials?
- Is there release time built into the school calendar to support PD?
- How much do substitutes cost in your school district, and is there adequate substitute availability?
- What options are available for you to provide attendees with credit for participation?
- Where does PD on SHE, SHS, and SSE fit in the requirements in your school district?
- Are there any Program 1807 PD or content requirements that might fit into PD for other subjects?

Appendix E: Explanation of Figures for Accessibility

Figure 5.1

Figure 5.1 depicts Himmelmann's strategies for building partners and collaboration. The image is similar to a staircase. Networking is the bottom step in the staircase, and is described as exchanging information for mutual benefit. The next step up is coordination, described as altering activities/ways of working to achieve a common purpose. The third step up is cooperation, described as sharing resources. And finally, the top stair is collaboration. Collaboration is described as enhancing each other's capacity for mutual benefit.

Appendix C

Appendix C describes the required activity context and timing for sexual health education (SHE) activities. On the top of the page, there are three SHE activities described as contextual in nature. These include "establish and maintain a School Health Advisory Council (SHAC) that regularly provides district-level advice and guidance to improve health and sexual health education programs for students and instruction for staff (required activity number 7)," "integrate strategies to actively engage parents in sexual health education instructional programs (required activity number 8)," and "establish, adopt, and implement a skills-based health education course requirement, which includes SHE content, for all students attending middle and high schools in the district (required activity number 3)." These are considered to be foundational and among the important activities to be considered first in the timing of implementation.

At the bottom of the page, there is a section labeled "SHE Direct Implementation Activities." In this section, there are three vertical columns shown. The column on the left is labeled as "phase 1" and includes 3 required activities: "develop and approve a health education scope and sequence that delineates SHE learning outcomes for all students in middle and high schools (required activity number 4)," "develop, revise, or select a SHE instructional program consistent with the approved scope and sequence and inclusive of instructional lessons, student learning activities, resources, and student assessment (required activity number 5)," and "provide necessary training once per year to ensure teachers have content knowledge, comfort, and instructional competencies to implement SHE (required activity number 2)." Phases 2 and 3 (depicted in the middle and right columns) reflect the need to review and update the scope and sequence as needed, implement the instructional program in middle and high school, and provide training annually to relevant school health teachers and staff. Additionally, Phase 2 (the middle column) depicts the addition of two more required activities: "identify and approve a list of instructional competencies to be demonstrated by those teaching SHE (required activity number 1)," and "develop, update, and foster use of teaching tools and resources to continuously improve delivery of SHE instructional program (required activity number 6)." In Phase 3, the figure shows that these two activities should be reviewed and updated as needed.

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