

Building Healthier Communities:

Local Health Department
and School Collaboration for
Adolescent HIV/STI Prevention



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Adolescent HIV/STI Prevention as a Public Health Issue

The human immunodeficiency virus (HIV) and sexually transmitted infections (STIs) are among the issues identified as crucial health concerns for adolescents.¹ The majority (64.6%) of 12th graders in United States schools report having had sexual intercourse, with 14.9 percent of adolescent students in grades 9–12 reporting intercourse with four or more partners.² Of 9–12th grade students who reported having sex, 61.5% had used a condom at last intercourse. The number of adolescent males who reported having used a condom at last intercourse was 68.5 percent, while adolescent females reported having used a condom with less frequency than males, at 54.9 percent.³

Other outcomes associated with unprotected sexual behavior among adolescents include rates of STIs that far exceed those of any other age group in the United States. Roughly nine million new STIs are diagnosed among adolescents 15–19 years in the United States each year.⁴ Female rates of chlamydia and gonorrhea are higher among adolescents 15–19 years than in any other age group.⁵ STIs often go undetected and can result in serious complications, including adverse pregnancy outcomes and pelvic inflammatory disease.

It is likely that most HIV-infected adolescents in the United States have not been identified and are therefore unaware of their infection.⁶ In 2006, 5,259 adolescents aged 13–24 years were diagnosed with HIV in the 33 states with confidential name-based reporting.⁷ Between 1985 and 2006, a total of 42,935 adolescents aged 13–24 years had been given an AIDS diagnosis.⁸

Since the earliest days of the HIV epidemic, local health departments (LHDs) have worked directly and in conjunction with community partners and concerned, affected, and at-risk populations to understand and address the HIV prevention needs of their communities. They have an even longer history of working with these entities around STI prevention issues. Collaboration with schools is one way that LHDs have reached adolescents either to conduct directly or ensure that HIV/STI prevention efforts reach adolescents in their communities.

The Role of LHDs and NACCHO

The National Association of County and City Health Officials (NACCHO) believes that collaboration at the local level is essential to safeguarding the health of communities. Local education agencies and LHDs are natural allies who share the goal of a student population that is healthy and ready to learn. While schools are not the only venue through which LHDs can reach adolescents, they are often the entity with the greatest potential for reaching a large portion of the adolescent population with HIV/STI prevention education and related services.

NACCHO serves as the national connection for local public health and is often the vehicle through which LHDs connect with one another to share program ideas. Health officials and program staff serving LHDs have demonstrated great interest in learning about what other LHDs across the country are doing to address various public health issues and concerns. Compendia of programs are one way that NACCHO has addressed this interest.

This compendium provides LHDs and others in the public health and education systems with resources and models for school and LHD HIV/STI partnerships. This document can serve as a catalyst for ideas, partnerships, and new or expanded HIV/STI prevention initiatives and can facilitate informal peer technical assistance from those with listed programs to those interested in implementing similar strategies.

Development of the Compendium

This compendium presents examples of LHDs across the United States that are prioritizing adolescent HIV/STI prevention, particularly through partnerships with schools. Each entry in this compendium profiles a different LHD's school-based HIV or STI prevention program or initiative. Entries were solicited through NACCHO's e-mail distribution lists for adolescent health, HIV/STI prevention, and maternal and child health as well as via an e-mail distribution list of school health education contacts. Entries were selected on the basis of a variety of factors, including the type of program, the type of jurisdiction served, and the degree to which collaboration among schools and the LHD was documented. Each entry was either written and submitted by the LHD staff directly responsible for the program or was drafted by NACCHO staff following a telephone interview.

Each of the entries includes background and demographic information on the LHD and the population it serves, the community dynamics, a description of the program, program development, program outcomes, barriers and challenges, and future plans. Contact information for each program is listed at the conclusion of each entry to encourage exchange of information with other LHDs and schools committed to improving the health of adolescents. The compendium attempts to offer contacts and lessons learned, and it seeks to generate new ideas. Several other compendia of programs are available via NACCHO's Web site at www.naccho.org. Additional resources are also available on the Web site, including NACCHO's Model and Promising Practices online searchable database of LHD-initiated, evidence-based public health practices.



Austin/Travis County Health and Human Services Department

Family Health Program

LOCATION

Austin, TX

POPULATION

866,349

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

70.5% White, 32.1% Hispanic or Latino (of any race), 7.9% Black or African-American, 5.5% Asian, 0.4% American Indian and Alaska Native, 0.1% Native Hawaiian and Other Pacific Islander, 13.8% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$48,026

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

The Austin/Travis County Health and Human Services Department (A/TC HHSD) Family Health Program serves Texas' capital, Austin, and Travis County, located in central Texas. Within the county, eastern Travis County is disproportionately affected by STIs and teen pregnancies. African-American females aged 15–24 years in eastern Travis County have rates of chlamydia exceeding 1,000 per 100,000, well over the statewide average of 314 per 100,000. In 2002, the highest teen pregnancy rates were among Hispanic teens at 53.3 pregnancies per 1,000 females. The teen pregnancy rate among African-American teens was significantly lower at 30.3 per 1,000. Both teen pregnancy rates were significantly higher than the rate among White teens (8.2 per 1,000). Asset mapping and windshield surveys revealed scarce prevention services that target teen males for teen pregnancy or STI transmission.

NATURE OF COLLABORATION WITH SCHOOLS

The LHD invited school participation on LHD-led community coalition and program planning initiatives.

DESCRIPTION OF PROGRAM

The Maternal and Child Health project is a part of the A/TC HHSD Family Health Program. The goals of the project are to improve birth outcomes in Travis County by increasing adequacy of prenatal care for all women and decreasing the incidence of STIs for high-risk youth ages 13–17. A/TC HHSD is accomplishing these goals by working with community partners to do the following:

- Create referral mechanisms and links among community-based organizations to increase use of existing, successful prenatal and STI services;

- Increase knowledge, healthy attitudes, and behaviors related to prenatal care and STIs through sustainable, evidence-based health education, outreach, and media campaigns; and
- Address individual, interpersonal, organizational, community, and societal factors that affect access to prenatal care for women and sexual risk behavior among youth.

PROGRAM DEVELOPMENT

High rates of gonorrhea and chlamydia among adolescents aged 13–17 years and reports of inadequate prenatal care prompted the LHD staff to develop the Maternal and Child Health project to address these concerns.

To assess the specific needs for the project, county epidemiologists first identified those zip codes within Travis County with both elevated rates of STIs among adolescents and elevated rates of inadequate prenatal care among young women. Staff then convened an ad hoc group of approximately 30 representatives from city departments and community-based organizations to help select a six-zip code project area.

To understand the resources and environmental factors impacting access to prenatal care and STI rates in these six zip codes, staff also conducted a windshield survey. In addition, staff created an asset-mapping database of all service providers within the selected zip codes to document available STI prevention and prenatal care resources. Project evaluators conducted focus groups and key informant interviews to understand the barriers and facilitators to receiving prenatal care services and STI testing and treatment services in these communities.

COMMUNICATING WITH THE SCHOOL/COMMUNITY

A/TC HHSD worked with numerous community-based agencies and city departments in designing and implementing the program. The staff conducts monthly Maternal and Child Health Coalition meetings with community-based organizations to help advise project staff on the direction of the project and to implement interventions. Key partners include the Women, Infants and Children Program (WIC), Planned Parenthood, the City of Austin Community Health Centers (CHCs), People's Community Clinic, Family Connections, Lifeworks, Any Baby Can, Capital Metro Transit Authority, El Buen Samaritano, and the City of Austin Healthy Neighborhoods Unit.

A/TC HHSD has leveraged community resources by increasing collaboration and communication among the agencies that participate in the monthly Maternal and Child Health Coalition meetings. Coalition meetings also provide networking opportunities for participants to find ways to address prenatal care and STI prevention issues collectively.

PROGRAM OUTCOMES

The LHD hired an independent public health evaluation consultant group to evaluate the project. Evaluation consultants are conducting pre- and post-tests for educational interventions designed to reduce STIs, and these consultants are also evaluating the LHD's media campaign to encourage adolescents to get tested for STIs. This campaign, called "Get the Facts, Get Tested," was originally developed by the Texas Department of State Health Services and has been refreshed by A/TC HHSD through the use of additional media channels such as cinema advertising and MySpace.com advertising. The evaluation consultants are also conducting interviews with key stakeholders to evaluate the impact of the project and the Maternal and Child Health Coalition.

A/TC HHSD found that this project has linked Coalition members with timely information and research, such as information about new funding sources for prenatal care. Coalition members value the monthly meetings because they are able to receive important updates and information. In addition, the staff hosted an Adolescent Health Symposium for healthcare providers and found that this continuing education opportunity increased providers' awareness of the special needs of adolescent patients.

BARRIERS AND CHALLENGES

Texas' abstinence-based education policy limits the extent to which contraception and safer sex can be discussed in schools. A/TC HHSD has focused on developing partnerships with community-based organizations that work with youth to promote the project outside of the school setting.

FUTURE PLANS

A/TC HHSD will continue its efforts to provide outreach and education to the community on the importance of prenatal care through partnerships with the business and faith-based communities and will continue to encourage collaboration and systems changes through the Maternal and Child Health Coalition. A/TC HHSD will implement "Get the Facts, Get Tested" one additional time to build awareness of the importance of STI testing. In addition, the staff will host a second Adolescent Health Symposium for healthcare providers to address access and acceptability of STI testing and treatment for adolescents. The staff will also expand sexuality education in the community by providing an additional skills-building workshop on sexuality education for community-based organizations.

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Stamford Department of Health and Human Services

Frisky Business Project

LOCATION

Stamford, CT

POPULATION

118,568

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

71.3% White, 20.6% Hispanic or Latino (of any race), 12.6% Black or African-American, 6.2% Asian, 0% American Indian and Alaska Native, 0% Native Hawaiian and Other Pacific Islander, 8.5% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$66,638

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

The City of Stamford Department of Health and Human Services (DHHS) has a history of strong ties to its community. As a result, the City of Stamford DHHS has carried out school-based HIV prevention activities for the past several years. The City of Stamford DHHS Frisky Business program targeted local middle and high schools and included activities such as the following:

- Providing sexuality counseling and age-appropriate educational materials for all students who present at school-based clinics for physicals, sexually transmitted infections (STIs), or pregnancy tests;
- Risk-reduction sessions for students referred for high-risk sexual behavior;
- Classroom lessons in prevention strategies for high-risk sexual behavior;
- On-site confidential HIV testing with a minimum of two counseling sessions in high school clinics; and
- An eight-week risk reduction group session addressing substance abuse, HIV, and other STIs.

NATURE OF COLLABORATION WITH SCHOOLS

Schools hosted the LHD's educational programs about HIV/STI prevention, and school-based health centers worked with the LHD to provide HIV, STI, and pregnancy screening for students.

DESCRIPTION OF PROGRAM

Stamford's Frisky Business project was established in 2005 and was awarded funding from NACCHO as a demonstration site in funding year 2005–2006.

The Frisky Business project supports three key HIV program components:

- To expand on-site HIV testing to Stamford's technical/vocational high school;
- To expand HIV risk reduction services offered to students at the technical/vocational high school and one middle school through an intensive HIV risk reduction group; and
- To assess HIV risk among a minimum of 150 high school students.

PROGRAM DEVELOPMENT

Once HIV program staff at the City of Stamford DHHS and key school personnel agreed upon the program, the staff focused on methods to market the services and find noninvasive ways to implement a survey to assess students' sexual risk behavior.

Key components of the initiative included the following:

- Disseminating flyers and displaying posters in schools to promote HIV services;
- Recruiting students at the technical/vocational high school and the middle school to be interviewed and to participate in a sexuality education and risk reduction program;
- Scheduling and providing HIV counseling and testing on-site at the technical/vocational school;
- Organizing weekly multi-session groups on HIV, substance use, anatomy, self-esteem, self-image, relationships, communications skills, STIs, and pregnancy; and
- Distributing and scoring the Frisky Business surveys to assess students' HIV risk.

Students were surveyed on their awareness of sexual risk behavior by use of the Frisky Business survey, a 10-question self-administered survey designed by high school peer educators. Students chose one of four responses to a specific scenario for each question asked. Each response is coded by the risk associated with it. A response with a rating of 1 is for no risk, 2 for low risk, 3 for moderate risk, and 4 for high risk. Students read a paragraph about their risk according to their scores, which were based on the Frisky Business Scale. Scores of 10–17 were identified as "Frisky Free," 18–25 were "Flirting with Friskiness," 26–32 were "Frisky Features," and 33–39 were "Far Too Frisky." On the basis of the level of risk, students were referred for HIV prevention services.

The City of Stamford DHHS targeted students who frequented the school-based clinics for physicals, STI visits, or pregnancy tests. Students who presented evidence of high-risk sexual

behavior would be referred to three different program interventions. Students could attend an eight-week risk reduction group session addressing substance abuse, HIV, and other STIs; undergo on-site confidential HIV testing and counseling services in the school clinics; and attend classroom sessions focused on prevention strategies for high-risk sexual behavior. The staff provided students with shopping mall gift certificates for participating in the group sessions and offering feedback on HIV initiatives.

COMMUNICATING WITH THE SCHOOL/COMMUNITY

Stamford's HIV program has had a long relationship with schools, a relationship that made implementing Frisky Business an easy task. Because the program was targeted toward middle and high school students, the Department of Education was a key stakeholder in its success. The City of Stamford DHHS carefully planned how to approach non-supporters and how to build a case for the need to have this program in the schools. The planning process was also easy as a result of gaining community buy-in from parents, students, healthcare providers, and related community agencies. In fact, HIV testing in schools was brought about by a legislative campaign in 1992 led by a group of students who wanted to be offered HIV testing without needing parental consent. The public education that went along with this legislative campaign laid the groundwork for the City of Stamford DHHS school-based HIV prevention program.

The City of Stamford DHHS realized that the most effective way to partner with schools would be through flexibility and compromise. The City of Stamford DHHS and schools agreed that the LHD would not distribute condoms in schools; however, staff could test for HIV and talk to students in detail about risk reduction. Staff conducted several faculty trainings and discussions in order to address concerns about confidentiality and discretion.

The City of Stamford DHHS also noted that an important part of its success was the result of having school-based health centers on-site at the schools; the existence of these centers made access to HIV programs easier for students. At the same time, the City of Stamford DHHS had established connections with the school that made it easier to access students within a classroom setting and to identify students for health education and risk reduction activities. If HIV counseling and testing is offered by an LHD on-site at a school but not in partnership with an existing school-based health center, the system for referrals, appointments, and assuring confidentiality may be more difficult.

PROGRAM OUTCOMES

The results of the Frisky Business survey provided a useful overview of how well the program targeted students and assessed risk behavior. Staff recruited 162 students to complete the survey, a number that went beyond the initial target of 150.

Seventy-eight percent of students identified themselves as being "low risk" to "no risk," and 22 percent classified their risk as "moderate risk" to "high risk." The survey revealed that the majority of the youth sampled have some knowledge of ways to reduce risky behavior. It is important to note that this was a self-reported survey. The results of this survey showed that the health department should continue to support students' knowledge and reinforce behavior choices through education and health promotion.

BARRIERS AND CHALLENGES

The Frisky Business project faced many challenges during implementation, both with the students and with the schools; these challenges related to confidentiality, fear, lack of awareness, and sensitivity about HIV risk behaviors in adolescents. Although the Frisky Business project was school-based, the location also posed a barrier because the City of Stamford DHHS needed to conform to the culture and norms of the school. Students initially resisted the testing and counseling services offered, largely because of confidentiality concerns.

FUTURE PLANS

The City of Stamford DHHS will continue to provide HIV counseling and testing services and HIV groups through the school-based health centers. While additional funding is sought, these services will remain the core services of the adolescent HIV prevention program. An evaluation of these services is also planned for the future.

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Baltimore City Health Department

Sexual Health and Responsible Peers (S.H.A.R.P.) Project

LOCATION

Baltimore, MD

POPULATION

608,481

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

30.2% White, 2.3% Hispanic or Latino (of any race), 65.2% Black or African-American, 1.6% Asian, 0.4% American Indian and Alaska Native, 0% Native Hawaiian and Other Pacific Islander, 1.6% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$32,456

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

Adolescent and young adult males aged 18 years and older have the lowest healthcare use rates and are the highest uninsured population in Baltimore.

The male reproductive health services provided by the Baltimore City Health Department (BCHD) include culturally appropriate health information, education, and healthcare. The goal of providing these services is to decrease the rate of both unintended pregnancy and STIs. Clinical services are currently available to adolescent males through the Healthy Teens and Young Adults Center (HTYA), a Baltimore City Health Department Title X-supported facility. The availability of services, however, does not always translate into use, as evidenced by data from this program. Males represent only 10 percent of clients seen at HTYA.

NATURE OF COLLABORATION WITH SCHOOLS

The LHD invited school participation on LHD-led community coalition and program planning initiatives, and schools hosted the LHD's educational programs about HIV/STI prevention.

DESCRIPTION OF PROGRAM

The Sexual Health and Responsible Peers (S.H.A.R.P.) project is a collaboration of the BCHD Bureau of Adolescent and Reproductive Health, Johns Hopkins University, Morgan State University, two Baltimore City public schools, and community-based organizations. The purpose of this project is to develop, implement, and evaluate a reproductive health education and

outreach program targeting adolescent and young adult males ages 11–29 through their involvement in existing community-based organizations and schools across Baltimore City. The ultimate goal of the project is to increase knowledge of male reproductive health and use of clinical services through health fairs and health education curriculum sessions at community agencies in order to increase knowledge and awareness of the need for reproductive health services among males ages 11–29.

PROGRAM DEVELOPMENT

S.H.A.R.P. developed as a collaborative effort in October 2003 among BCHD Bureau of Adolescent and Reproductive Health, local universities, and community-based organizations. The program aimed to increase male reproductive health education and use of clinical services. Individual representatives from the partner organizations participated in a community advisory board, which was responsible for refining all project activities, completing and organizing project survey materials, project implementation, institutional review board approval, amendments, and reapplication, and the development of outcome measures to assess knowledge, attitudes, and behavior change among program participants.



COMMUNICATING WITH THE SCHOOL/COMMUNITY

Two public high schools became involved in the planning, implementation, and evaluation process during the fall of 2005, joining the other community organizations and local universities that had been involved in these processes from the very beginning.

The professional relationships established with the community-based organizations and personnel of the Baltimore City public schools have been a key factor in maintaining community involvement and have continued to move the project toward achieving its goals and objectives.

PROGRAM OUTCOMES

Morgan State University's Prevention Sciences Research Center and Center for Health Disparities Solutions led the team of evaluators collaborating on S.H.A.R.P. The evaluation has assessed changes in knowledge, attitudes, and behaviors among the targeted population across the life of the project. Survey instruments were informed by focus group responses and surveys administered at baseline to all participants of health fairs, students attending school health classes using the Wise Guys/Dare to Be King curriculum, and young men using specific health clinics. Those taking part in Wise Guys/Dare to Be King completed a post-test during the final session and six months following. Other activities included evaluation of the ad campaign, tracking use of clinical services, and numerous process measures of project activities. Evaluation findings have demonstrated a positive relationship with project interventions and use of clinical services.

FUTURE PLANS

S.H.A.R.P. was notified of approval to implement project activities at the first high school in October 2006. A second high school was approved in December 2006. Local school participation has been excellent. S.H.A.R.P. believes that the schools will provide a consistent environment for core intervention activities and will benefit its student population.

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Philadelphia Department of Public Health, Division of Disease Control

High-School-Based Screening for Chlamydia and Gonorrhea

LOCATION

Philadelphia, PA

POPULATION

1,406,415

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

42.1% White, 44.7% Black or African-American, 10.4% Hispanic or Latino (of any race), 5.2% Asian, 0.2% American Indian and Alaska Native, 0% Native Hawaiian and Other Pacific Islander, 6.3% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$32,573

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

The Philadelphia Department of Public Health serves residents of the City of Philadelphia (approximately 1.4 million). In addition to providing services for disease prevention, the LHD oversees eight neighborhood district health centers, which provide city residents with medical care regardless of their ability to pay.⁹ The Philadelphia Department of Public Health STD Control Program maintains the city's STD clinics and prevention activities. In 2000, levels of gonorrhea and chlamydia infection among adolescents were determined to be of an epidemic proportion.

NATURE OF COLLABORATION WITH SCHOOLS

Schools hosted the LHD's HIV, STI, and pregnancy screening for students.

DESCRIPTION OF PROGRAM

The Philadelphia Department of Public Health STD Control Program, in collaboration with the School District of Philadelphia, implemented a citywide high-school-based screening program to address epidemic levels of chlamydia and gonorrhea infections in public high school students, grades 9–12. The goal of the program is to educate Philadelphia's public high school students on the risks of STIs and prevention methods, and to offer screening for sexually active students. In 2005, Philadelphia's "High-School Based Screening for Chlamydia and Gonorrhea" project was recognized as a NACCHO Model Practice as an example for outstanding local public health practice.

PROGRAM DEVELOPMENT

In 2000, chlamydia infections among females ages 15–19 were reported at a rate of 8,224/100,000 in Philadelphia. This rate was more than six times the rate among females of all ages citywide and 3.5 times the national rate for females in this age group. Case infections among males were 1,645/100,000. Because infection is often asymptomatic, LHD staff found that implementing an active screening program among high school students would best serve the need to reach students with infections that would otherwise go undetected. Ultimately, identification and treatment of individuals who test positive would reduce the spread of STIs.

The program targeted all students in grades 9–12 attending public high schools. The program included an educational component in which LHD staff gave presentations to students on the asymptomatic nature of many STIs, along with the importance of testing for STIs. The presentations encouraged students who were sexually active to modify their behavior, and they reinforced abstinence as the only 100 percent effective way to prevent STI infection.

During the planning phase of the project, the LHD took the following actions:

- Assembled a planning team to develop the project protocol;
- Conducted a needs assessment with students and launched a pilot program in two schools using information from reports of chlamydia and gonorrhea morbidity among adolescents;
- Identified key public school staff and lobbied for endorsement from school and health officials;
- Met with key school staff to begin implementation;
- Sought support from the Home and School Council (a parents' association) and students;
- Made agreements to get financial support for laboratory testing; specimen acquisition, handling, and transport; medication; and staff to provide treatment, partner notification services, and screenings; and
- Received assistance from the school nursing staff to conduct confidential treatment and follow-up counseling for students.

COMMUNICATING WITH THE SCHOOL/COMMUNITY

The LHD credits the success of this program to constant communication among administrators, school officials, and staff working on the project. The LHD provided the programmatic elements of this project, while the school district coordinated the scheduling of students for testing, the availability of space

within the schools, and access to students after testing, as necessary. In 2004, the Medicaid Managed Care Providers in Philadelphia agreed to reimburse the Philadelphia Department of Public Health for tests provided to students who were enrolled as members in their plans. To date, they have provided over \$100,000 in reimbursements for this program.

PROGRAM OUTCOMES

During the first full year of implementation (2002–2003), 19,713 students were tested. Staff reported 1,052 students infected with either chlamydia or gonorrhea, and 1,051 (99.9%) were treated. In the 2003–2004 school year, 17,019 were tested, 813 infected, and 807 (99.3%) treated.

This program represents an unprecedented collaboration between an LHD and a metropolitan school district to address the epidemic of STIs among adolescents. It demonstrated that STI testing programs can be implemented, and those programs can be accepted by parents, students, and school faculty. This program also made it clear that testing can be done in schools while protecting the confidentiality of those seeking testing and those who test positive.

UNIQUE COMPONENTS OF THE PROGRAM

This program was innovative in its wide scope and in its effort to test males as well as females. It was implemented on a city-wide basis and included 54 high schools with an overall enrollment of more than 50,000 students. Each year, the program successfully reaches more than 30,000 students in small groups (approximately 60 students per group) with an STI presentation. The program also offers urine-based, non-invasive screening immediately following each presentation, with more than 60 percent of the students volunteering to be tested.

BARRIERS AND CHALLENGES

Cost has been a major challenge in maintaining the high-school-based screening program in Philadelphia. Aside from in-kind contributions, the cost of performing laboratory-based testing totals approximately \$500,000 a year. Although LHD staff has had success in targeting more than 30,000 students through this initiative, the staff is always challenged by the task of maintaining enthusiasm and interest of students and school staff to continue the program from year to year. High staff turnover has also been a major problem.

FUTURE PLANS

The high school-based screening program in Philadelphia continues to work to reduce the spread of STI among adolescents throughout its 54 public high schools. Since

the program's implementation in 2002, more than 50,000 students have participated in the program. Other cities have used Philadelphia's program as a model to implement similar programs in their schools.

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City of Portland Health and Human Services Department, Public Health Division

HIV Prevention in School Program

LOCATION

Portland, Maine

POPULATION

64,249

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

91.3% White, 2.6% Black or African-American, 1.5% Hispanic or Latino (of any race), 3.1% Asian, 0.5% American Indian and Alaska Native, 0.1% Native Hawaiian and Other Pacific Islander, 0.7% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$35,650

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

The Public Health Division is one of four sectors within Portland Health and Human Services. The HIV/STI Prevention Program, a program of the Public Health Division, serves students in Portland and the greater metropolitan areas largely through its six student health centers. Residents of Portland describe their community as being richly diverse with regard to race, gender, and sexual orientation. Over 40 different languages and dialects are spoken among students attending Portland's public schools. Portland has the highest HIV infection rate in the state of Maine. The HIV Prevention in School program was awarded funding as a NACCHO demonstration site for funding year 2004–2005.

NATURE OF COLLABORATION WITH SCHOOLS

Schools hosted the LHD's educational programs about HIV/STI prevention, and school-based health centers worked with the LHD to provide HIV, STI, and pregnancy screening for students.

PROGRAM DEVELOPMENT

Portland's HIV/STI Prevention Program emphasizes a "mission-driven" approach to developing its programs. The idea to implement HIV Prevention in School came from increasing cases of chlamydia and gonorrhea among adolescents ages 14–17. HIV/STI Prevention Program staff recognized that raising awareness about HIV/STI prevention through student health centers would be an effective method to reduce the rate of HIV among students. Staff believed that, if students knew about these services, students would be more likely to inquire about other healthcare services.

The HIV Prevention in School program set out to raise awareness

about HIV prevention through several activities, including the following:

- Conducting an HIV/STI prevention needs assessment of the school and community in collaboration with community coalitions;
- Offering screenings for high-risk behaviors and one-on-one follow-up for high-risk students;
- HIV testing at four targeted schools;
- HIV testing at three community partner sites;
- Dissemination of prevention materials, including condoms, available to all students in the student health centers;
- Presenting curricula approved by the Centers for Disease Control and Prevention in each of four targeted schools;
- Hiring HIV/STI prevention staff, including one middle school prevention educator;
- Disseminating prevention materials from the LHD through community partners;
- Distributing 150 posters and 2,500 flyers for schools and community sites, with written translations in the eight major languages spoken in the community;
- Holding World AIDS Day and HIV Testing Day events in collaboration with community partners;
- Serving as primary sponsoring agency for the Teen Convention, a communitywide youth health fair; and
- Participating in the Northeast Regional Minority Health Conference.

COLLABORATIONS WITH THE SCHOOL/COMMUNITY

The LHD learned that establishing trust and productive relationships with the schools and community partners was essential for implementing this project. The LHD has always had a strong relationship with the school system, and this relationship made it feasible to address sensitive issues and potentially controversial activities that this project would perform. The staff was fortunate to have multiple partners to assist with implementing and maintaining the project—including school nurses, social workers, and other community agencies. Staff also made certain that school principals and staff were receptive to the activities proposed, and staff addressed concerns in an unbiased manner. Staff also helped non-supporters to understand the rationale for providing activities in order to gain support for the program.

Staff learned to compromise with certain aspects of the program to gain support from schools and the community. Schools and



community members urged LHD staff to present more abstinence-based education in middle schools in order to accommodate and respect students' diversity of cultural and religious backgrounds and beliefs.

PROGRAM OUTCOMES

During the 2004–2005 school year, 95 percent of students using one of the four targeted student health centers were screened by use of a health risk questionnaire. At the beginning of the 2005–2006 school year, 96 percent of students had been screened. The project successfully completed 72 HIV tests. Thirty-seven of these were in school-based health centers, and 35 were at teen community sites. A total of 103 teens and 37 community partners participated in the Teen Convention that was held in April 2005.

BARRIERS AND CHALLENGES

Many students who may have been sexually active did not identify themselves as such because of the social stigma around adolescent sexual behavior, which made it difficult to reach students who would be considered high risk. Many of the students who identified themselves as sexually active refused to be tested. Some parents also opted out of enrolling their children in the program, which also made it difficult to reach students potentially at risk.

School policies also presented a challenge to implementing the program. Some school policies require students to visit the nurse's office before going to the health center, adding an

additional step that students must go through to participate in the program. Some students might have refused to participate in the program because they did not want to go through what they saw as an unnecessary process.

Time constraints were also an obstacle. Because the project's funding term was short, the goals of the programs had to be based on resources and time available. Ordering and receiving necessary educational materials, having staff attend state HIV certification trainings, and pre-planning required a significant amount of lead time. Connecting with key stakeholders and coordinating schedules was also time-consuming. In addition, school breaks, summer vacations, and start-up time limited the amount of time in which to implement the programs. Assessing program outcomes was also difficult because of having only one year of funding.

FUTURE PLANS

HIV Prevention in School has done a great job in reaching many students. In 2005–2006, the program reached out to 1,300 students, and staff members feel encouraged that the number will increase in the future. Staff have continued to do outreach through peer education and training sessions targeted to families and students to provide them with accurate information about HIV prevention. Staff will continue to provide HIV and STI curricula in the classroom, an activity that was not a part of the program initially. The staff has leveraged family planning funds to offset the cost of providing OraSure testing, in addition to in-kind services from the student health centers and high school and middle school personnel.

Because of the success of the Teen Convention, LHD staff held similar events. The HIV/STI Prevention Program has taken the lead on this endeavor, but staff from HIV Prevention in School have also been involved. Staff have also received training on motivational interviewing, offered through funding from the Maine State Public Health Office. This method allows staff to acknowledge and accommodate students' readiness for change and to help students make and sustain lifestyle changes.

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Metro Public Health Department of Nashville/Davidson County

Youth Advisory Board

LOCATION

Nashville, TN

POPULATION

549,110

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

64.4% White, 28.6% Black or African-American, 7.2% Hispanic or Latino (of any race), 3.2% Asian, 0.3% American Indian and Alaska Native, 2.5% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$40,214

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

The 550 staff members of the Metro Public Health Department (MPHD) of Nashville/Davidson County provide health protection and promotion services and information to 600,000 documented residents in Nashville and nearly one million individuals who travel through Davidson County daily. The MPHD is governed by the Metropolitan Board of Health and operates on a contractual basis with the Tennessee State Department of Health.

NATURE OF COLLABORATION WITH SCHOOLS

The LHD invited school participation on LHD-led community coalition and program planning initiatives, and schools assisted with recruitment of students for the LHD's programs.

DESCRIPTION OF THE PROGRAM

The Youth Advisory Board (YAB) allows youth to provide input on priority issues that affect them, such as tobacco, teen pregnancy, drugs and alcohol, crime, and school dropout rates. Project ASK: Adolescents Seeking Knowledge was created by and composed of first-year YAB members. Project ASK provides innovative approaches to address tobacco, teen pregnancy, drugs and alcohol, crime, and school dropout rates, as well as other issues. The YAB received national accolades for its local contribution in Washington, DC, at the 2004 American Public Health Association Conference.

The YAB participates in biweekly presentations from the LHD's executive management team, other public health officials, and Project ASK. Additionally, YAB members are provided support for becoming future public health leaders by working as ambassadors for health.

PROGRAM DEVELOPMENT

The motivation to start the YAB came from the leadership of the LHD. The 30-member YAB was created by executive order of the Director of Health, Dr. Stephanie Bailey, in March 1998 to provide ongoing input regarding public health issues in general—particularly as they pertained to youth—to MPHD, the Director of Health, and the broad Nashville community. Additionally, the YAB was designed as a public health asset-based youth engagement strategy to improve the health of adolescents and the overall Nashville community.

When the YAB was started, the projected costs included a \$5,000 annual operating budget for food and meeting supplies for the youth board. However, as the YAB's activities have grown more extensively, the real program costs include the \$5,000 operating budget for food and meeting supplies as well as the allocation of a salary for one full-time employee. The YAB has also engaged in fundraising activities to support members' travel to conferences and events.

COMMUNICATING WITH THE SCHOOL/COMMUNITY

The YAB was convened through initial communication with the Metro Nashville Public School Administration and youth-serving organizations who aided in the solicitation of the charter members. The school health nurses and high school principals served as the educational contacts to integrate the program into the school culture. YAB was the premier youth advisory board of the metropolitan government and was sought after for consultation to other boards and community groups for vetting of youth-related issues.

The LHD has used the YAB to leverage community resources, including community grants to conduct research and educational activities and receive in-kind contributions from community coalitions and foundations. The YAB has also managed to gain national recognition.

PROGRAM OUTCOMES

The YAB's process measures include program evaluations for educational activities and events. Outcome measures include longitudinal analysis of pre- and post-leadership assessment of YAB members as well as longitudinal tracking of post-YAB academic and professional public health activities. A collateral measure was the increased interest in and number of students applying for admission to the program.

Since 1998, 100 percent of all YAB members have demonstrated increased knowledge in regard to public health functions, essential services, and research. Two of the research projects have been accepted for poster presentation at the American Public Health Association, and one was accepted as an oral presentation. Another research project was accepted for presentation at a NACCHO annual conference.

Some unanticipated positive outcomes of the program include the local recognition of the YAB as the model program for youth development within Metro government, as evidenced by the exponential growth of other youth boards within Nashville since 1998. Additionally, the youth engagement opportunities within the LHD have grown to include Project ASK, which has continually received accolades and invitations to present at local and national public health conferences since its inception in 2003. Another outcome of the YAB is the Youth Leadership Summer Institute, implemented in 2006, which is the public health career pipeline summer program for high school students to explore public health careers.

BARRIERS AND CHALLENGES

One initial barrier that the LHD encountered when starting the YAB included communicating to internal and external public health partners about the youth engagement model and managing the subsequent paradigm shift that would have to take place among public health professionals. The YAB model faced some resistance by those who may have viewed youth as having a less knowledgeable and less valuable perspective on public health issues.

FUTURE PLANS

The YAB is looking forward to connecting more strongly with the Centers for Disease Control and Prevention in terms of the development of public health youth engagement models. The YAB plans to work with other national youth groups and organizations. Locally, the YAB is a recognized model program with the capacity for replication to LHDs across the state of Tennessee and other health departments across the nation.

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St. Lucie County Health Department

Mobilizing for Action through Planning and Partnerships (MAPP)

LOCATION

Port St. Lucie, FL

POPULATION

238,575

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

77.7% White, 16.3% Black or African-American, 12.5% Hispanic or Latino, 1.4% Asian, 0.1% Native American or Alaska Native, 3.5% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$42,847

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

The St. Lucie County Health Department is dedicated to providing leadership in health promotion, disease prevention and control, and environmental protection for all residents and visitors in St. Lucie County. St. Lucie County is positioned on the Atlantic coast of Florida, halfway between Fort Lauderdale and Orlando. Although not a major tourist epicenter like neighboring counties north and south, St. Lucie has attracted families and retirees. St. Lucie County is one of the fastest growing counties in the state of Florida. One-half of the county residents live in either Fort Pierce or Port St. Lucie, the two largest towns. According to the 2005 U.S. Census Bureau's American Community Survey, Blacks and African-Americans make up 16.3 percent of the population. Many of these residents are either long-term county residents or recent Haitian immigrants. In 2006, the Florida State Department of Health released *Silence is Death: The Crisis of HIV/AIDS in Florida's Black Communities*, a report stating that one in every 35 Black or African-American residents in St. Lucie County had been diagnosed with HIV. St. Lucie County holds the highest HIV rate among Blacks in the entire state, a rate 20 times higher than the rate for White residents.

NATURE OF COLLABORATION WITH SCHOOLS

The LHD invited school participation on LHD-led community coalition and program planning initiatives.

DESCRIPTION OF THE PROGRAM

Mobilizing for Action through Planning and Partnerships (MAPP) is a public health planning tool that is based on community involvement and support. MAPP consists of six

phases: Organize for Success/Partnership Development, Visioning, the Four MAPP Assessments, Identify Strategic Issues, Formulate Goals and Strategies, and the Action Cycle. MAPP provides a strategic direction to local public health founded on community input and buy-in. The central tenet of MAPP is that community participation in the strategic planning process yields more effective and better supported programs.

PROGRAM DEVELOPMENT

St. Lucie produced a solid strategic plan following a one-year planning process that took place from 2003–2004. At the conclusion of this process, St. Lucie created an Office of Strategic Planning in 2005. Directly thereafter, St. Lucie began the MAPP process in February 2005. MAPP begins with the engagement of local agencies that serve as partners of the LHD. Public health partners included local hospitals, the Florida Community Health Center, the American Cancer Society, New Horizons (a mental health agency), law enforcement, the United Way, the Indian River Community College nursing program, retail pharmacies, community service agencies, the public school board, Friends of St. Lucie (a non-profit organization that sponsors local health events), and local public health coalitions. In 2005, facilitator-led consensus meetings were held with local partner agencies. One outcome of these meetings was the identification of five strategic themes: reducing HIV/AIDS, reducing teen pregnancy, improving access to healthcare, improving mental health services, and enhancing health education and promoting healthy behaviors.

Once the five strategic themes were identified, subcommittees were created for the expansion of each theme. Subcommittees were granted complete autonomy and met separately from the others, along with theme area experts. Upon working more closely on one theme, members of the subcommittees began to realize the interrelationship among all five themes. As a result, stronger partnerships, as well as training and funding priorities, emerged. The subcommittees met individually from January through May 2006 and then met together in June 2006 to finalize a Community-Based Health Improvement Plan.

Some of the results of the planning process included plans to do the following:

- Create an executive steering committee;
- Initiate the creation of a healthcare taxing district;
- Improve marketing and communications of the plan to engage more community partners; and
- Allocate new funding to support additional school nurses by the St. Lucie Board of Commissioners.

COMMUNICATING WITH THE SCHOOL/COMMUNITY

The St. Lucie MAPP effectively identified 54 potential partner agencies, 30 of which participated in the planning process. Although many of these agencies had different priorities at the start of MAPP, most realized their commonalities during the planning process, which led to the formation of new partnerships and coalitions. For instance, the teen pregnancy subcommittee realized that it could better perform its role if it worked in conjunction with the HIV/AIDS subcommittee. By the end of the MAPP process, several community-based organizations created a coalition named the Teen Intervention for Pregnancy Prevention (TIPPS). TIPPS then developed its own strategic plan, which included targeting the same at-risk youth who are recipients of HIV/AIDS prevention programs.

PROGRAM OUTCOMES

St. Lucie County earned the distinction of being recognized by NACCHO's Project Public Health Ready in 2006 after the completion of MAPP. In late 2006, when MAPP was completed, St. Lucie offered three awards of up to \$25,000 each to local community-based organizations to provide HIV/AIDS prevention services for minorities.

BARRIERS AND CHALLENGES

Securing funding to meet the priorities identified in the strategic planning process was a common challenge. St. Lucie needed to identify enough potential funding to meet the five strategic issues that came about through MAPP.

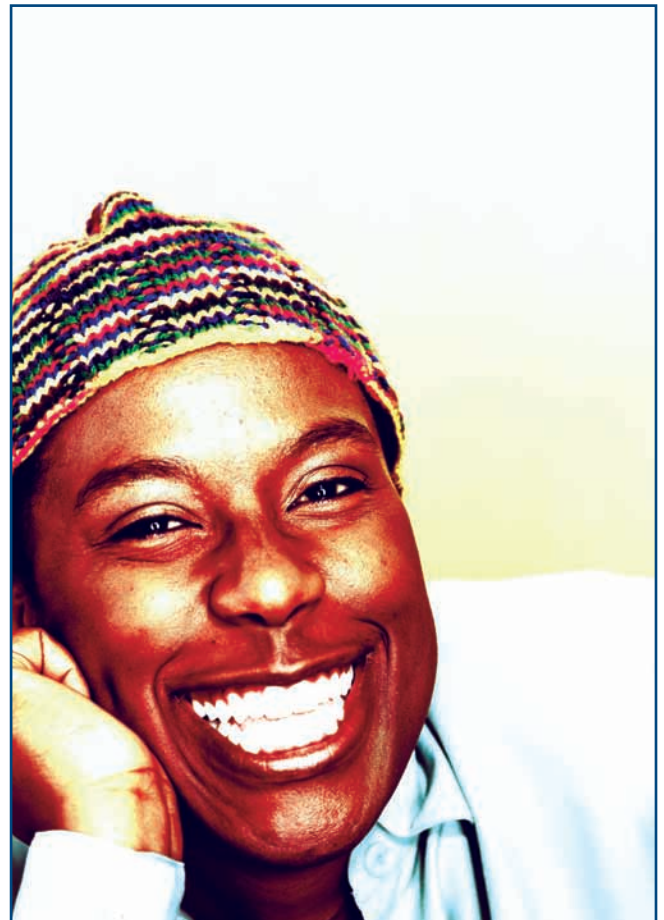
FUTURE PLANS

St. Lucie will continue to address health inequities among Black and African-American residents, particularly in the area of HIV/AIDS. Funding initiatives for community-based organizations are one way that St. Lucie is prioritizing this population.

Additionally, St. Lucie is working on improving its structural systems to better carry out the community-supported strategic plan. The creation of an executive steering committee and a healthcare taxing district, as well as consistently building new partnerships through improved marketing and communications, will better leverage resources to meet the needs that were prioritized in the planning process.

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Multnomah County Health Department

Action Research Project

LOCATION

Portland, OR

POPULATION

656,146

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

80.5% White, 9.7% Hispanic or Latino (of any race), 5.7% Black or African-American, 6.3% Asian, 1.2% American Indian and Alaska Native, 0.4% Native Hawaiian and Other Pacific Islander, 2.0% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$46,242

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

Multnomah County is the largest county in Oregon and also houses the most populous metropolitan area in the state. Jurisdictions served by the Multnomah County Health Department include Portland, Fairview, and Gresham. Multnomah County is home to the largest African-American population in Oregon, and it also has the fastest growing Latino population in the state.

Multnomah County has six school districts, one of which is located in the city of Portland. The Multnomah County Health Department provides each of the six school districts with school-based health centers, dental services, and education in sexuality, nutrition, and tobacco.

NATURE OF COLLABORATION WITH SCHOOLS

Schools assisted with recruitment of students for the LHD's programs.

DESCRIPTION OF THE PROGRAM

The Oregon Action Research Project is a community-based participatory research project aimed at obtaining input from adolescents in order to inform the LHD's prevention programs. The project not only focuses on gaining insight and participation in programs from adolescents, but it also has the goal of training adolescents to become community leaders. The Action Research Project took place at three sites within Oregon, including Deschutes County, Jackson County, and Multnomah County. The project began by recruiting adolescent participants and training them in community research methods. During the training period, the participants were led through a series of exercises that identify a priority issue, and then reframe the issue as the research question. Adolescents are responsible for designing and implementing their research strategy, including logistics, surveying, coding, and interpreting the data. After the research is complete, adolescents present their data to the community and develop plans for the implementation of proposed changes. Throughout the project, a team that includes a researcher and

LHD staff is available to provide feedback and assistance to the adolescent participants

PROGRAM DEVELOPMENT

Motivation for the Oregon Action Research Project came from the 2002 update to the Governor's Action Agenda. As part of the action agenda, a statewide committee was convened to improve community input in public health programs. The committee recognized that state and local governments were not only in need of statewide and county data on adolescent health but also needed to improve adolescent engagement in program development in order to increase program buy-in across the state. Additionally, LHD officials wanted to use a model that would result in action, rather than producing research that would sit on a shelf without follow-up. LHD officials also recognized that taking students out of class for one half-day planning session would not be sufficient to meet these goals. Shortly thereafter, the State of Oregon Department of Health and Human Services began working with Youth Infusion, a youth involvement consultant service, in order to get the Action Research Project underway.

Youth Infusion developed a curriculum to provide adolescent participants with the skills and information necessary to carry out their own participatory research project. Youth Infusion developed a 15-session Action Research curriculum, which was then revised and made into 12 sessions by the Multnomah County Health Department's Action Research Project staff. Each Action Research Project received a grant of \$5,000 from the state, which was used for student stipends and food costs for after-school meetings.

Multnomah County began its Action Research Project by recruiting eight students from a local charter school to participate in and carry out the Action Research Project. After all eight students were recruited, the students were trained using the newly developed Action Research curriculum. During the training process, the participants prioritized sexuality education as a major issue in their schools and developed their research strategy, survey questions, and protocol to elicit more information from students to gain their perspectives on sexuality education in school. In the spring, participants set up meetings with school administrators and English teachers in four high schools in order to carry out their research. Participants chose to go into English classes to conduct the research because English is the only course required for all high school students every year in Multnomah County. Participants collected 859 four-page, self-administered sexuality education surveys by the fall of the following school year. One participant was responsible for entering all data, and all eight participants collaborated on the coding and analysis of open-ended survey questions. One of the main findings as a result of the research was that sexuality education in schools varied widely among teachers, grade level, and high school. The data indicated a need for more consistent comprehensive sexuality education.

After all survey data were entered, coded, and analyzed, participants developed a PowerPoint presentation to be used at community forums when presenting the data. Seven community

forums were conducted across the state, with four having Action Research components. Adolescent participation in the community forums was extremely important to LHD staff and was very successful—the community forum held in Bend, OR, had 50 percent adolescent participation.

As of July 2007, two of the participants were finishing focus groups to supplement the data gathered through the surveys. Additionally, these students were working, along with LHD staff, to bring their sexuality education objectives to school administrators to develop a plan of action to address the needs brought up in the Action Research surveys. Participants in the Action Research Project have also presented their work at several meetings outside of the project.

COMMUNICATING WITH THE SCHOOL/COMMUNITY

Multnomah County began recruiting students for the Action Research Project by approaching one specific public high school with which the county had had a 12-year working relationship. However, administrators at this school were hesitant to participate in the Action Research Project because they were concerned about adolescents conducting the research and the types of potentially sensitive or controversial questions that students would be asked. This public school then referred Multnomah County staff to a local charter school, which had a very diverse student body and had entry criteria that went beyond grades and academic achievement. Students attending this charter school attend one of four home high schools as well as the charter school, alternating daily. Through this mechanism, charter school participants were able to engage not only the charter school student body but also the student body of their home high school, thereby increasing the number of students involved in the Action Research Project. The charter school was very supportive of the Action Research Project and worked with Multnomah County to recruit students and support their participation in the project. Staff at the charter school also supported two participants in using Action Research Project work as their senior capstone project. These students are working directly with the charter school principal to address the needs of students that were elicited through the Action Research.

PROGRAM OUTCOMES

The Action Research Project was successful in engaging a group of students in the Action Research process. Student participants carried out the majority of the research activities with little reliance on project staff. Additionally, the Action Research Project was able to engage school administrators in the process and in planning to meet the needs identified by students. Finally, the Action Research Project was able to engage adolescents throughout the state through community forums and conferences. Adolescent participation in the statewide community forums was tremendous, as demonstrated by 50 percent adolescent attendance at the forum in Bend, OR.

BARRIERS AND CHALLENGES

Being a cutting-edge youth involvement program, the Action Research Project certainly faced some challenges. Overall, the project was given an original timeline beginning in February and ending in June, which was far too short to accomplish all the tasks necessary to carry out such an organic program. At

first, the project was delayed because the curriculum needed to be developed and then revised to be shorter and more user-friendly for student participants. Developing the curriculum took one month. Second, having to approach two different schools was a barrier to getting the Action Research Project started in a timely manner. As can be an issue in most community-based participatory research projects, the use of adolescents as researchers and consumers of programs was a challenging adjustment. For instance, Multnomah County staff had to adjust to adolescents leading the project, and adolescents needed to adjust to being the leaders, with project staff being their assistants. The same adjustment was necessary for school officials who supported the Action Research Project. As a result of the strict timeline, project activities extended into the fall of the following school year, since the summer break interfered with continuing data collection. Action Research Project staff learned a very valuable lesson about how time-consuming this type of work can be, and in the future the staff will plan for project activities to begin in September and end in June. Along with learning to realign the project timeline with the academic year, LHD staff also learned that it is important to engage younger grade levels in the Action Research Project for long-term sustainability. Since all eight students who participated in the Action Research Project were juniors and they finished in the fall of their senior year, their ability to devote time to the project was limited by factors such as college applications, taking SATs, and undertaking career development. Because six of the eight students who were involved in the Action Research Project have moved on to college, follow-through with the agenda outlined in the research has been left to LHD staff.

Each of the three Action Research Projects was awarded only a \$5,000 grant to carry out the work, and no LHD staff salaries were budgeted. Financial constraints continue to be a barrier to carrying out more Action Research Projects in other schools and communities across Oregon.

FUTURE PLANS

One additional motivation for the inception of the Action Research Project was to pilot a project that could be replicated in other Oregon communities. Specifically, the Multnomah County Action Research Project would like to carry out other projects within the county and in minority communities. Since Action Research is focused on the unique experiences of a small community, Multnomah County realizes that what has come out of this project may not be generalized to other high schools. As such, the outcomes of this project are applied only to the schools that were involved. Pending additional funding, Multnomah County will continue to carry out Action Research Projects in other schools and communities.

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State of California STD Community Interventions Program (SCIP)

State of California Education Code Section 51934 specifies that all students in grades 7–12, inclusive, are to be provided HIV/AIDS instruction at least once per school year. Section 51934 does not specify who is responsible for HIV education; as such, the language in the code leaves room for consultants or other health educators to instruct students on HIV/AIDS.¹⁰ Specifically, Section 51934 states that students shall be provided information on HIV/AIDS and how it affects the body, HIV transmission and risk, risk reduction (including condom use and safer needle use), where to obtain HIV services and HIV testing, decision-making and negotiation, and stigma and society's views on people living with HIV.¹¹

On October 1, 2003, the 11 codes pertaining to HIV/AIDS education in schools were combined into Senate Bill (SB) 71, which passed and was put into effect on January 1, 2004.¹² SB 71 includes a mandate for comprehensive sexual health education for students in grades 7–12. Finally, SB 71, Article 4, states that school districts are required to provide training for school district staff who will be delivering the comprehensive sexual health education.¹³ In response to this legislation, county LHDs partnered with local education departments to provide schools the support they needed in order to follow the SB 71 guidelines. Each of the following three county LHDs approached SB 71 in a slightly different way.

COUNTY OF TULARE HEALTH AND HUMAN SERVICES AGENCY

POPULATION

410,874

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

70.9% White, 55.5% Hispanic or Latino (of any race), 3.7% Asian, 1.3% Black or African-American, 0.9% American Indian and Alaska Native, 0.1% Native Hawaiian and Other Pacific Islander, 20.3% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$38,722

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

Tulare County is a geographically diverse region located in Central California. Although it has several incorporated medium-sized cities, the county is primarily comprised of small, geographically isolated communities. Tulare County has become the second-leading producer of agricultural commodities in the United States, largely because of its extensively rich and cultivated agriculture. The Tulare County Health and Human Services Agency offers six healthcare centers throughout the

county. Many volunteers participate in the county's programs and initiatives. Chlamydia is the highest reported sexually transmitted disease among individuals aged 15–19 years (incidence rate of 3,405 per 100,000).¹⁴

NATURE OF COLLABORATION WITH SCHOOLS

School health teachers received continuing education in HIV/STIs from the LHD.

DESCRIPTION OF THE PROGRAM

The Tulare County Teacher Forums, a series of trainings, are a joint effort among the Tulare County Health and Human Services Agency STD Community Interventions Program (SCIP), the Tulare County Office of Education, School Health Programs, and the State of California Department of Health Services STD Control Branch. The forums are held each spring for teachers, school nurses, health educators, outreach workers, and anyone else who is responsible for the provision of HIV and STI education. The goals of the forums, which satisfy the SB 71 mandate, are to:

- Increase knowledge of STIs;
- Provide a uniform STI curriculum and related prevention resources; and
- Improve collaborations among youth-serving organizations in Tulare County.

PROGRAM DEVELOPMENT

In 2000, Tulare County's School Health Program lost funding for its yearly HIV Prevention Education Workshops. The program conducted an informal survey of school districts and found that teachers, nurses, and health educators wanted and needed yearly HIV and STI training to be kept informed about updated information and to meet mandates that require that students be provided HIV and STI education in school.

Later that year, Tulare County received funding from SCIP to investigate the capacity of youth-serving organizations to integrate STI prevention into existing programs and services. The Tulare County Health and Human Services Agency found this to be a unique opportunity to partner with the Tulare County Office of Education and the STD Control Branch of the California Department of Health Services.

In 2001, SCIP conducted its first training, "STI Overview for Non-Clinicians" The purpose of this training was to introduce SCIP and to build school personnel capacity to conduct effective STI prevention education. Seventeen teachers and other school staff participated in the first training.

In 2002–2003, the California Department of Health Services conducted a statewide survey to examine the extent to which public high schools were providing specific instruction on STIs. Teachers stated that they would like more innovative ways to improve STI prevention education capacity through training opportunities beyond text and the Internet. Survey findings also indicated that teachers wanted up-to-date, comprehensive,

evidence-based STI curricula as a way to help ensure the quality of their instruction. The California Department of Health Services found that, in order to better understand STI-specific prevention education and target resources for training and technical assistance, LHDs should consider implementing the school survey in mainstream and alternative high schools. Tulare County conducted the survey in its high schools and then incorporated the data gathered into trainings.

COMMUNICATING WITH THE SCHOOL/COMMUNITY

Tulare County Health and Human Services Agency has assisted county school districts by providing trainings on current research-based interactive STI curricula and STI morbidity. The trainings have also helped districts to comply with SB 71.

The program has leveraged community resources in a very unique way. The cost to attend the training is approximately \$40 per person, sufficiently affordable that substitute teachers could also be trained. LHD staff and staff from community-based organizations participate in cross-training teachers, which cuts down on costs and enables more teachers to be trained.

PROGRAM OUTCOMES

The number of educators who have participated in the Tulare County Teacher Forums has gone from 17 (in 2001) to 396 (in 2006). On average, 70 educators participate in each forum.

The most valuable part of Tulare's partnership with county school districts and the California Department of Human Services has been access to resources, current information, research, and the development of supportive partnerships.

The forums have succeeded in helping local educators meet SB 71 requirements. The forums have also provided participants a research-based curriculum on HIV and STIs that is comprehensive, interactive, and affordable.

BARRIERS AND CHALLENGES

One initial challenge to starting the program was getting teachers and other staff to embrace the idea of building their capacity to do effective STI prevention education. It was also difficult to unite agencies that provide sexuality education in Tulare County. Tulare County Health and Human Services Agency staff had a difficult time engaging school personnel and youth-serving organizations as active stakeholders in the program. Over time, ongoing communication and effective leadership from SCIP helped to overcome these barriers and strengthen relationships with the Tulare County Office of Education School Health Program and community organizations.

Another challenge was staff turnover, which makes maintaining collaboration difficult. The additional expense of having to pay substitute teachers to fill in for teachers attending the trainings was also a barrier. At times, it was also difficult to find substitute teachers to fill in, preventing teachers from being able to attend the trainings.



FUTURE PLANS

Tulare County continues to provide up-to-date STI education to teachers by conducting local trainings, workshops, in-services, and other technical assistance to teachers and school personnel. Regional health education coordinators from the California STD Control Branch and local peer educators assist by providing additional trainings. Resources such as the following are also provided to educators as references following the trainings:

- Making the Connection Between HIV and STIs Curriculum;
- "STD 101 for Teens" PowerPoint teen presentation; and
- SWAP—a free, downloadable Web site for STI/HIV materials (www.stdhivtraining.org/SWAP).

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State of California STD Community Interventions Program (SCIP)

CONTINUED

CONTRA COSTA HEALTH SERVICES

LOCATION

Martinez, CA

POPULATION

1,006,486

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

60.6% White, 21.2% Hispanic or Latino (of any race), 9.3% Black or African-American, 13.3% Asian, 0.4% American Indian and Alaska Native, 0.3% Native Hawaiian and Other Pacific Islander, 12.0% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$69,487

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

Contra Costa Health Services (CCHS) cares for and improves the health of all people in Contra Costa County, with special attention to those who are most vulnerable to health problems. Contra Costa County is located approximately 15 miles northeast of San Francisco, and it includes major urban, suburban, and rural centers. Contra Costa County has the ninth largest population of all California counties, with an estimated population of 1,004,886. The Family, Maternal and Child Health Program, under which the TeenAge Program (TAP) is located, has identified eight key zip codes in the county for special focus as having multiple poor health outcomes, high levels of poverty, and low educational attainment. Within these zip codes, the TAP partners with the three largest school districts that serve a majority of the youth in these communities.

NATURE OF COLLABORATION WITH SCHOOLS

School health teachers received continuing education in HIV/STIs from the LHD, and schools hosted the LHD's educational programs about HIV/STI prevention

DESCRIPTION OF THE PROGRAM

TAP was established in 1977 to provide comprehensive, one-stop health services to middle school and high school students to help them overcome the barriers to accessing healthcare. TAP provides comprehensive sexual health and HIV/AIDS education, coordinates training for teachers and other youth-serving providers, facilitates youth empowerment, youth organizing, and mentorship programs, and helps young people access health services through a school-based health clinic and a Teen Navigator project, all of which help to ensure that young people have access to youth-friendly health services.

The goals for TAP's HIV/AIDS and comprehensive sexual health education and training are to do the following:

- Ensure that all students in partner districts have access to high-quality HIV/AIDS instruction;
- Ensure that all comprehensive sexual health and HIV/AIDS education in partner districts meets the mandates outlined in SB 71; and
- Increase knowledge and skills of teachers to provide comprehensive sexual health and HIV/AIDS education in partner districts.

PROGRAM DEVELOPMENT

While TAP has provided classroom health education for several years, the focus has been on providing HIV/AIDS education, comprehensive sexual health education, and teacher trainings to help schools comply with SB 71. In response, many school districts began searching for partners to provide direct health education and teacher training. Because of the long-standing relationship between TAP and local school districts, districts felt confident in seeking TAP's support in providing direct health education to students, teacher training, and helping build SB 71-compliant curriculum resources.

The need for HIV/AIDS and comprehensive sexual health education was assessed by looking at local statistics (e.g., teen birth and STI rates), gathering information about challenges local clinics described about the difficulty regarding teen follow-through for scheduled reproductive health appointments, and compiling other information from the schools and districts that were asking for support in these areas.



Following the establishment of SB 71, the Bay Area Communities for Health Education (BACHE), in partnership with the American Civil Liberties Union, assumed the role of ensuring that county school districts remained in compliance with the mandated HIV/AIDS education and followed the guidelines for comprehensive sexual health education. BACHE quickly identified that most school districts did not have a clear understanding of SB 71 and that portions of classroom instruction often violated this new mandate. As BACHE served in a “watch-dog” role, school districts began scrambling to identify allies who could partner with them to address the compliance gap. In the districts where TAP already had strong relationships, BACHE approached TAP for help.

COMMUNICATING WITH THE SCHOOL/COMMUNITY

CCHS collaborates closely with school district administrators in charge of curriculum and instruction, district administrators in charge of comprehensive school health, and teachers, principals, and vice-principals. Collaboration at the district level has included the development of HIV and STI curriculum standards, the selection of district-approved texts, and the implementation of district-wide teacher trainings. CCHS has also worked with district-level administrators to strategize ways to ensure school-level compliance with district-level mandates. CCHS has found that HIV/AIDS and comprehensive sexual health is often added on to an existing administrator’s responsibilities and that the administrator often lacks the expertise or experience in this specific area. By working in partnership, CCHS is able to bring its specific expertise on HIV/AIDS and comprehensive sexual health, while administrators contribute their expertise in overall curriculum development and the district policies. Together, a comprehensive, SB 71-compliant curriculum can be created. CCHS has also worked on potential ways to respond to parent or teacher complaints about HIV/AIDS and comprehensive sexual health instruction.

At the school level, CCHS has worked with teachers to implement HIV/AIDS and comprehensive sexual health education in their classrooms. When resources permit, CCHS provides educators the opportunity to conduct the classroom sessions directly. This offers a valuable training opportunity because teachers are able to observe a skilled facilitator working with their students on this sensitive topic. In addition to providing instruction, CCHS works with teachers to build their capacity to take on these components of the curriculum for future classes.

CCHS also works closely with Planned Parenthood and other local health educators to share resources and strategies and to eliminate duplication of efforts. Because many agencies provide adolescent HIV/AIDS and comprehensive sexual health education, and all are working with limited resources, CCHS maintains close communication with these partners in order to determine which agencies provide instruction and support to which schools. In addition, some agencies have specific expertise on a specific topic (e.g., sexual orientation and interpersonal violence). To avoid duplication of efforts, CCHS has developed inter-agency instructional packages to incorporate these different

niches of expertise and related resources and curricula. This collaboration has strengthened the educational strategies of each of the individual agencies. CCHS also partners with these agencies to provide teacher training when appropriate.

PROGRAM OUTCOMES

To evaluate the effectiveness of the teacher trainings and classroom health education, CCHS uses a retrospective post-test assessment to determine change in knowledge and skills. For the teacher trainings, evaluations have shown that training participants have increased knowledge about (1) what they and their districts need to do to be in compliance with SB 71; (2) ways to address HIV/AIDS and other sensitive topics in their classroom; and (3) how to provide accurate, objective health education. As a part of the classroom health education, youth have demonstrated increased knowledge in (1) existing health services; (2) making healthy and safe sex choices; (3) recognizing the characteristics of a healthy relationship; and (4) HIV/AIDS and other STIs.

To evaluate the effectiveness of the district-level support, CCHS tracked the development and implementation of HIV/AIDS and comprehensive sexual health education. At this time, one of the districts has a new, school-board-approved high school health education curriculum that includes comprehensive sexual health and HIV/AIDS education. This curriculum will be implemented in all district high schools beginning in fall 2007. In two of the partner districts, middle school and high school teachers have adopted a standard set of HIV/AIDS lessons, developed by TAP, that complies with the SB 71 mandates. CCHS continues to collect documentation of the progress that districts have made to ensure SB 71 compliance.

CCHS fostered relationships by emphasizing the need for and benefits of information and resource sharing. CCHS emphasized the need to work together to achieve common goals.

BARRIERS AND CHALLENGES

One major challenge associated with mandated HIV/AIDS education is that teachers often feel pressure to prioritize state examination performance over other requirements, making HIV/AIDS education a lesser priority. Adding the HIV module into an already full science or other curriculum often felt impossible for teachers. As a result, CCHS worked closely with teachers to look at how HIV/AIDS instruction could be integrated into the existing curriculum standards and could enhance existing requirements, rather than competing against them.

Additionally, CCHS found that schools and districts planning HIV/AIDS and comprehensive sexual health curricula struggled with ensuring that the information was accessible and inclusive for students of all races, ethnicities, genders, sexual orientations, cultural backgrounds, and abilities. Making HIV/AIDS education appropriate for students of all sexual orientations posed particular challenges; that task required CCHS to work extensively with teachers and administrators to address sexual orientation appropriately.

State of California STD Community Interventions Program (SCIP)

CONTINUED

CONTRA COSTA HEALTH SERVICES *CONTINUED*

Another challenge CCHS experienced was that schools and districts were often wary about accepting assistance in the development of HIV/AIDS and comprehensive sexual health curricula for fear that they would face opposition from parents and other community members. In response, CCHS spent time building trust among teachers and administrators by working with them on less sensitive public health topics before tackling the HIV/AIDS curricula.

An ongoing challenge that this initiative faced was frequent staff change within school districts, change that required constantly building new relationships. Fortunately, districts now identify TAP as an ally in providing comprehensive sexual health and HIV/AIDS education, and because of this history, new staff are generally open to the support.

Finally, CCHS is challenged continually to seek and secure financial resources to support the continuation of this work.

FUTURE PLANS

CCHS will continue to offer the program components described above. In addition, CCHS plans to develop a comprehensive, multi-subject HIV/AIDS curriculum, matched to SB 71 subject standards, for the use of teachers in their classrooms. This curriculum would allow teachers to provide HIV/AIDS education through the use of literature, statistics, history, and science and would ensure that the curriculum supported the teachers in meeting instruction mandates.

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State of California STD Community Interventions Program (SCIP)

CONTINUED

COUNTY OF ORANGE HEALTH CARE AGENCY

LOCATION

Santa Ana, CA

POPULATION

2,944,537

Source: U.S. Census Bureau, 2005 American Community Survey

ETHNIC COMPOSITION

62.5% White, 32.7% Hispanic or Latino (of any race), 1.6% Black or African-American, 16.1% Asian, 0.5% American Indian and Alaska Native, 0.3% Native Hawaiian and Other Pacific Islander, 16.6% Other race

Source: U.S. Census Bureau, 2005 American Community Survey

AVERAGE INCOME

Median household income of \$65,953

Source: U.S. Census Bureau, 2005 American Community Survey

COMMUNITY DYNAMICS

Orange County is the second largest county in the State of California, with a total population of approximately three million residents. It is an affluent county, with the median family income at approximately \$75,000 and the median home price at \$617,000. Eight point eight percent (8.8%) of the residents report incomes below the poverty level, with an unemployment rate at 5.5%.

Orange County ranked 19th in its overall proportion of chlamydia rates among the state's 19 local health jurisdictions. The highest rates of chlamydia in Orange County are among youth and young adults aged 15–24 years.



NATURE OF COLLABORATION WITH SCHOOLS

School health teachers received continuing education in HIV/STIs from the LHD.

DESCRIPTION OF THE PROGRAM

The Comprehensive Sexuality Education in Schools initiative strives to strengthen community collaboration among the Orange County Department of Education (OCDE), Orange County Health Care Agency (OCHCA) STD Community Interventions Program (SCIP), and other Orange County reproductive health agencies to ensure that important reproductive health resources, education, and services are disseminated and made available to teachers throughout Orange County school districts.

The LHD works with youth-serving organizations to integrate STI prevention by having teachers do the following:

- Collaborate with other agencies to present some of the content and methods of their lessons for youth at the OCDE Annual HIV Teacher Update workshops. OCDE serves over 27 school districts and has provided HIV/AIDS Education Updates to staff for over 15 years. The workshops provide an opportunity for teachers to share resources and discuss programs; and
- Conduct peer trainings where teachers and community agency staff implement what they learn about issues related to sexual health among youth. These trainings enhance the skills and knowledge of teachers to more effectively conduct comprehensive sexuality education in their classrooms and to demonstrate that community-based agencies (e.g., Girls Inc., OCHCA Maternal, Child and Adolescent Health program, Planned Parenthood) can provide additional support to teachers inside and outside of the classroom.

PROGRAM DEVELOPMENT

A statewide assessment of STI programs in LHDs in 1998 revealed that most LHDs had little funding dedicated to the primary prevention of chlamydia and other STIs. To address this gap, the California Department of Health Services, STD Control Branch, founded local SCIP collaboratives in 2000 to assist 55 LHDs to focus on ways to address STI prevention.

The California STD Control Branch conducted a statewide survey in 2002–2003 to determine the extent to which public high schools were providing specific instruction on STIs. Every county had at least one district sampled, including Orange County. Results from this survey showed that the following:

- Only six percent of the schools surveyed had purchased

State of California STD Community Interventions Program (SCIP)

CONTINUED

COUNTY OF ORANGE HEALTH CARE AGENCY *CONTINUED*

a curriculum on STIs; and

- Fewer than 50 percent of teachers reported having been trained on STIs.

Middle and high school teachers in Orange County, as well as others across the state, expressed that they wanted easily accessible STI curricula and effective training on STIs and other reproductive health information. As an outcome of this survey, SCIP developed and disseminated two publications throughout the state for teachers to use: (1) Making the Connection between HIV and STDs: A Supplemental Guide to STD Education (2004); and (2) STD 101 for Teens PowerPoint Presentation and Educator Guide (2006).

COMMUNICATING WITH THE SCHOOL/COMMUNITY

The Orange County SCIP and the OCDE have had to work in partnership to implement SB 71. The Orange County SCIP has since broadened its partnership to include other collaborative agencies currently conducting comprehensive sexuality education and teen pregnancy prevention programs with youth. Most of the communication among the LHD, school districts, and community-based organizations are through planning meetings and training preparation.

Aside from staff salaries, the trainings conducted are low-cost. The agencies have capitalized on the experience and expertise of staff within their collaboration to conduct the presentations for the training. Through the peer trainings, teachers and community agencies have been able to enhance their programs by reaching out to more youth, service providers, and the greater community. They have also been able to deliver consistent messages about STI prevention to youth.

PROGRAM OUTCOMES

Since the start of the program, local agencies have been able to address a variety of components of sexuality education, including the following:

- Masculinity and Negotiating Manhood: Boys and Violence (Girls Inc.);
- Media Literacy and Sexuality (Planned Parenthood);
- Addressing Difficult Questions and Issues in Sex Education (Campfire USA);
- Pregnancy Prevention Methods (OCHCA Maternal, Child and Adolescent Health program);

- The Basics of STIs (OCHCA SCIP); and
- Distribution of Making the Connections between HIV and STDs—A Supplemental Guide to STD Education

BARRIERS AND CHALLENGES

One challenge that Orange County faced was maintaining the commitment of all partner agencies to participate in future teacher trainings and projects. Many local professionals in this field are already stretched thin and do not have the time or resources to commit to projects that are considered outside their normal scope of work. Staff turnover within these partner agencies also increases the difficulty of maintaining these collaborations.

Since Orange County has a fairly conservative political climate, many school districts have strict policies and regulations as to what can be taught in the classroom. OCHCA and its community-based partner organizations continue to have problems gaining entry into school districts to conduct comprehensive sexuality education.



FUTURE PLANS

The Orange County Department of Education conducted three HIV/AIDS Update workshops, and partner agencies were invited to participate in all of them. Short presentations were conducted on teen sexuality topics, and a resource showcase was offered during the lunch break. A PowerPoint presentation, "STD 101 for Teens," developed by the California Department of Human Services STD Control Branch, will be featured and disseminated to teachers who attend the HIV/AIDS Update workshops. Additionally, a "STD Update for Educators" course took place in March 2007.

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End Notes

- 1 CDC, HRSA, and National Adolescent Health Information Center, University of California, San Francisco. (2004). Improving the health of adolescents & young adults: A guide for states and communities. Atlanta, GA.
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NACCHO is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

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