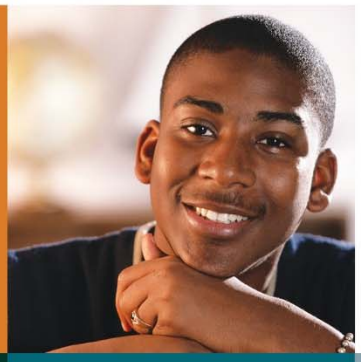
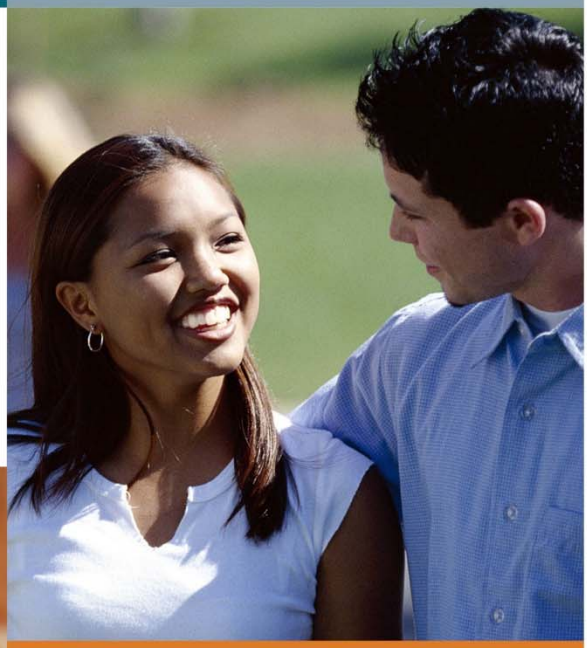


CDC DIVISION OF ADOLESCENT AND SCHOOL HEALTH

DASH | STRATEGIC PLAN

For Fiscal Years 2015-2020



MAY 2016

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

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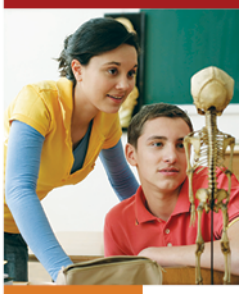

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1.0 Introduction

1.1 History of the Division of Adolescent and School Health

The Centers for Disease Control and Prevention's (CDC) Division of Adolescent and School Health (DASH) was created in 1988 with resources from CDC's human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) budget authority. Initially, DASH was located in the National Center for Chronic Disease Prevention and Health Promotion to ensure application of widespread HIV/AIDS prevention education for school-aged youth within a broad approach to school health programs. In January 2012, DASH was relocated organizationally to the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). DASH's research and programmatic activities were refocused on reducing adolescent sexual risk behaviors and preventing HIV/AIDS, sexually transmitted disease (STD), and pregnancy among teens. DASH also continues to serve as the platform for CDC's school-based surveillance systems and areas of research and research translation for adolescent and school health.

DASH is one of five divisions within NCHHSTP (Figure 1.1). Whereas the other four divisions focus on specific infectious diseases, DASH has focused on the antecedent sexual behaviors that create risk for HIV, STDs, and hepatitis among adolescents. Because some of these antecedent behaviors also perpetuate risk for teen pregnancy, DASH monitors the impact of its work on this outcome as well. Sexual maturation and development occur during adolescence, making this a crucial opportunity for both health promotion and disease prevention efforts.

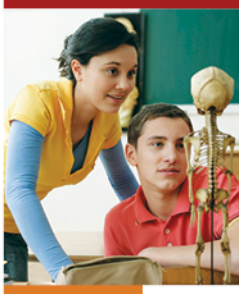
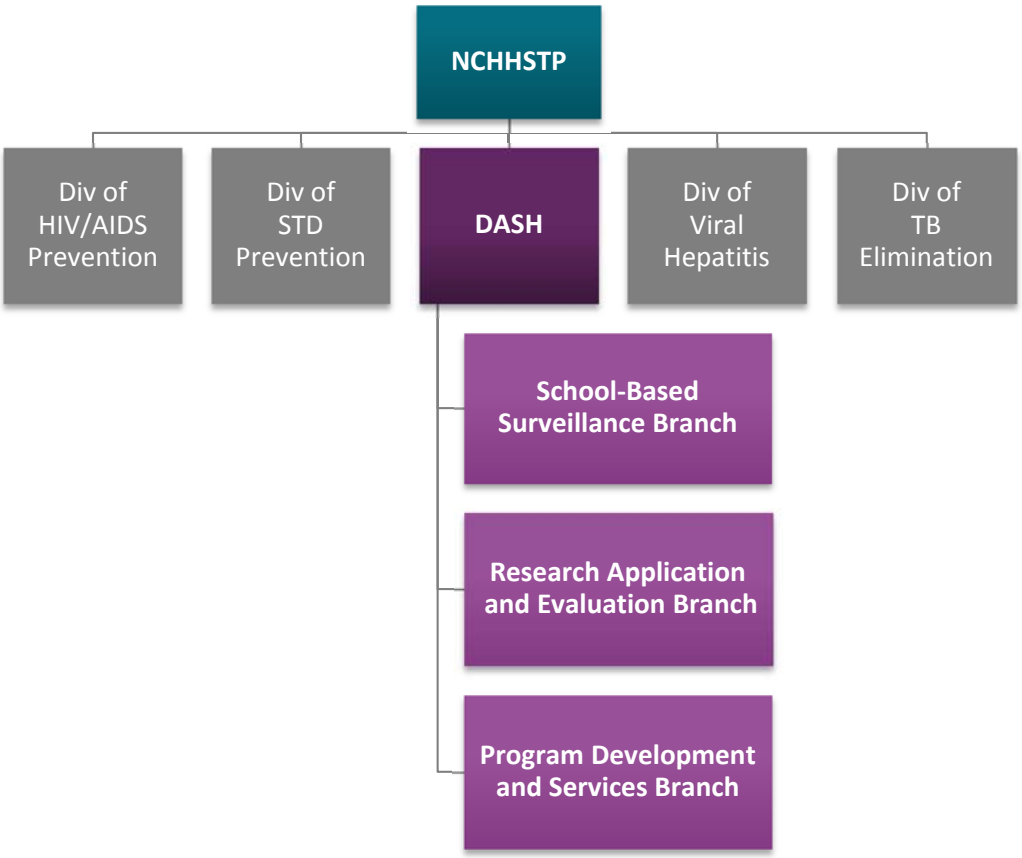


Figure 1.1 Organization of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention



In addition to expertise in adolescent development and behavior, DASH staff are experts in school health policies and practices. DASH plays a key role in working with state and local education agencies to ensure that health and education policies support adolescent health, development, and learning. In particular, DASH focuses on ways to create safe and supportive environments so that all young people have the opportunity to learn and be healthy.

DASH works closely with other Federal programs to assure coordinated and complementary approaches to adolescent health. Within the Department of Health and Human Services, DASH partners with the Office of Adolescent Health, the Administration on Children, Youth and Families, the Health Services and Resources Administration, the Substance Use and Mental Health Services Administration, and the National Institutes of Health. At CDC, DASH serves as a population-focused program within CDC that complements other subject-matter focused activities throughout the agency.

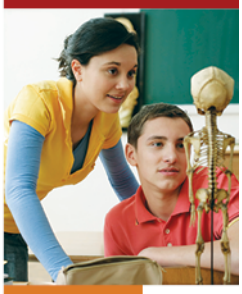
1.2 Adolescent Health

Adolescence is a developmental stage during which profound physical, intellectual, emotional, psychological, and sexual change occurs. Adolescence corresponds to the preteen and teenage years, the middle and high school years, and the years during which puberty and maturation occur, but a specific age range is not defined. Because DASH works predominantly with and through schools, our work focuses on persons of middle and high school age (typically, ages 13–18 years). However, some DASH work also occurs with younger children (ages 10–12 years), older teens who might have graduated already (ages 18–19 years), and teenagers not enrolled in school. In this strategic plan, the term *teens* is used to describe the population with which we work. To the extent possible, we avoid using less-specific terms (e.g., *adolescents*, *youth*, and *young people*).

Teens are a healthy population overall, but they experience certain important preventable causes of mortality and morbidity. Injuries and violence are the leading causes of death among teens, but chronic diseases (e.g., asthma and diabetes) are frequent causes of morbidity, school absenteeism, and health care usage. STDs also occur frequently among sexually active teens and young adults with approximately 10 million new STD infections every year among people age 15-24. Teen pregnancy rates have declined consistently during the past 25 years, reflecting successful public health interventions that encourage delayed sexual initiation and contraception use; however, prevalence of teens giving birth still remains high in the United States.

Risk behaviors in all categories have steadily improved since behavioral surveillance among middle and high school students was initiated in 1991. However, prevalence of certain behaviors still remains high and contributes to ongoing risk for each successive cohort of teens. Regarding HIV, STD, and pregnancy risk, sexual risk behaviors and substance use behaviors are of greatest relevance. Stable rates of sexual experience (47%) and current sexual activity (34%) during the past decade reflect adolescence as the period of sexual development. Rates of risky sexual behaviors (e.g., >4 lifetime partners, 15%; sexual initiation before age 13 years, 5.6%; failure to use condoms, 41%; and low rates of long-acting reversible contraception use, 1.6%) reflect ongoing risk for HIV, STDs, and pregnancy among teens. Although injecting drugs remains low for teens overall (<2%), among sexual minority youth, rates of injecting drugs are up to seven times higher. Additionally, alcohol, marijuana, and some prescription drugs (e.g., opiates) might increase risky sexual behavior, and rates remain high among teens (47%, 27%, and 18% respectively). Certain substance use also might serve as a gateway to injecting drug use behavior later, with an associated risk for HIV and hepatitis.

Exploration and establishment of health behaviors—both risky and protective—also occur during adolescence. Combined with teens' overall state of good health, adolescence is thus also an ideal time to influence the development of healthy behaviors, including overall health behaviors, sexual behaviors, substance use, and health care-seeking behaviors. Focusing on public health action that influences



teens' health behaviors provides the opportunity to improve immediate health (e.g., reduce STDs and teen pregnancy) and prepare teens to better protect themselves during young adulthood when many will face increased risks (e.g., when HIV incidence peaks).

1.3 Schools as a Venue for Health Promotion and Disease Prevention among Teens

The vast majority of teens are enrolled in school, thus making both school-based surveillance and school-based programs practical for disease prevention and health promotion purposes. School health education, physical education, provision of safe and healthy physical and social environments, and provision of or linkage to health services all contribute to disease prevention and health promotion efforts and have a direct impact on teens' health. Schools also serve as a key link to parents and other community health and social services.

The term *coordinated school health* is used to describe a comprehensive approach for meeting students' health and education needs. It uses a socioecological approach to address the policy, environment, educational, and behavioral challenges that affect health outcomes and educational attainment. It does not, however, imply that all work occurs within the school setting. Rather, it accounts for schools as an integral part of the community with links to crucial community-based health, educational, and social services. DASH led the development and evolution of this approach and continues to use this model to practice its approach to adolescent health. Also of note, DASH is an active participant with other parts of CDC and with ASCD, a school leadership, curriculum, and professional development organization (formerly the Association for Supervision and Curriculum Development), in an initiative to expand and evolve the coordinated school health approach into the Whole School, Whole Community, Whole Child model (see www.cdc.gov/healthyyouth/wscc/index.htm for additional information).

A Final Note Regarding Terminology: Throughout this strategic plan, we refer frequently to *parents*. We acknowledge that many teens are being raised and cared for by adults other than their parents, including grandparents, other family members, foster parents, friends' parents, or others. Our use of the term *parents* is for simplicity and should always be construed to include all types of caregivers.

2.0 Strategic Framework

2.1 Mission

As each new cohort of young people enters adolescence, we as a nation have a collective responsibility for ensuring that they have the information and skills they need to be healthy throughout their lifetime. Thus, DASH is committed to its mission to:

> ***Promote environments where teens can gain fundamental health knowledge and skills, establish healthy behaviors for a lifetime, connect to health services, and avoid becoming pregnant or infected with HIV or STDs.***

DASH is a public health organization and thus achieves its mission by conducting its work through the core functions of public health (Box 2.1).

Box 2.1 Core Functions of Public Health

Assessment

- Provide the platform for school-based surveillance at CDC.
- Study trends in teen risk behaviors and school health policies and practices.
- Study risk and protective factors—and interventions to affect them—associated with sexual behavior among teens.

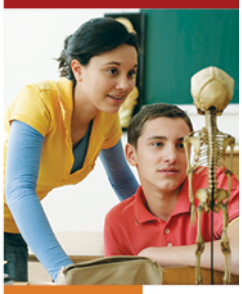
Policy Development

- Provide critical resources and information to education agencies, teachers, parents, teens, and partner organizations.
- Establish, maintain, and leverage associations with partner organizations that have expertise in education, health, and HIV/STD prevention.
- Understand and operate within the national and state health and education policy environments.

Assurance

- Study system-related challenges (e.g., health care, school, or community) to determine how best to affect the environment in which teens live, study, and play.
- Fund state and local education agencies to implement effective disease prevention and health promotion strategies.
- Fund nongovernmental organizations to provide expertise in education, health services, and school climate.
- Establish evaluation protocols and systems and assist funded partners in evaluating programs that address teen sexual behavior.

Institute of Medicine. 1988. *The Future of Public Health*. Consensus, Institute of Medicine, Washington, DC: National Academy Press.



2.1.1 Core Values

DASH shares the core values of NCHHSTP that guide how we think, collaborate, serve our communities, make decisions, and determine our priorities. Those values include the following:

- **Accountability:** Be a diligent steward of the use of funds to achieve NCHHSTP's public health mission.
- **Respect:** Treat persons with dignity and honesty; value diversity and differences of opinion.
- **Integrity:** Be accurate, consistent, and honest.
- **Excellence:** Achieve the highest standard of performance in public health science, program, and policy.
- **Diversity:** Maintain a highly trained, inclusive, and professional workforce.
- **Transparency:** Keep the public, partners, and staff informed about our programs, policy, and science.
- **Equity:** Work to achieve optimal health for the populations we serve.
- **Innovation:** Create an environment that encourages and values new ideas.

2.1.2 Strengths

DASH brings four principal, long-standing strengths to its work.

1. We base our work on timely science, rigorous evaluation, and ongoing disease, risk factor, and policy surveillance.
2. We emphasize high-impact prevention that focuses resources and effort on the most effective activities where they will have the greatest impact.
3. We collaborate effectively to improve multiple health outcomes.
4. We effectively occupy a unique niche that connects the education and health sectors through our surveillance, research and programmatic work.

2.2 The DASH Approach

DASH approaches its work in three ways. Each is of equal importance toward achieving our mission to create environments that support healthy teen development. DASH's primary programmatic approach is directed toward HIV and STD prevention. DASH also serves as a platform for a public health approach to working with schools as a venue for health promotion and disease prevention. Finally, DASH ensures that its internal operations are as effective and efficient as possible through an organizational excellence approach. Each approach is described in the next sections, including a brief summary of ongoing DASH activities and potential opportunities to accelerate progress.

2.2.1 HIV/STD Prevention Approach

Since joining the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) in 2012, DASH has focused on reducing sexual risks for infection with HIV and STD. Based on long-standing expertise in school-based and

school-linked interventions, DASH developed an approach that addresses the spectrum of sexual risk-taking by adolescents. The approach combines segmenting the population of adolescents by risk, and applying appropriate interventions at the right time.

Teen cognitive, psychological, and sexual development occurs at different rates for different individuals. As teens mature, their sexual behaviors might increase, with some of those behaviors imposing risk for HIV or STD infection or pregnancy. While some teens remain sexually abstinent, others become sexually active with increasing rates of sexual activity through the later teen years. Some of this latter group take additional risks including not using condoms, not using contraception, and drug or alcohol use prior to sexual activity.

To ensure that all teens are prepared for eventual sexual activity at some point in their lives, DASH works with state and local education and health agencies, national organizations, parents, and teens to meet the healthy sexual development needs of all teens. These needs include functional knowledge and skills development, an understanding of the health care system to meet sexual health care needs, and safe and supportive environments in which to learn, grow, and develop.

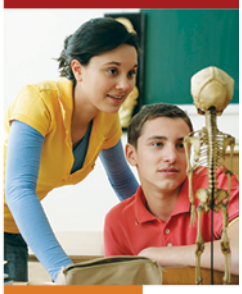
In addition, two subsets of teens are at higher risk of HIV, STD and pregnancy: those who are sexually active and sexual and gender minority teens. DASH has identified these subsets as priority populations to assure that we are addressing all teens with the right interventions in the right way and at the right time.

In addition to identifying priority populations, DASH has also articulated six technical areas required to improve adolescent sexual health. These are defined as follows:

- **Sexual Health Education**—Sexual health education is intended to promote health and prevent health problems, including HIV, STDs, and teen pregnancy. It has two components, defined as follows:

  Curricula—educational plans incorporating a structured, developmentally appropriate series of intended learning outcomes and associated learning experiences for students, organized as a related combination or series of school-based materials, content, and events.

  Sexual health education curricula are further defined by several criteria: they must meet the needs of all students including those who are not sexually active, those who are, those who are engaging in high risk sexual activities, and sexual and gender minority students. They must be medically accurate, developmentally and culturally appropriate, and consistent with scientific research regarding effectiveness. Furthermore, they should enable students to meet the following health behavior outcomes:



- Establish and maintain healthy relationships;
- Be sexually abstinent;
- Engage in behaviors that prevent or reduce STDs including HIV infection;
- Engage in behaviors that prevent or reduce unintended pregnancy;
- Avoid pressuring others to engage in sexual behaviors;
- Support others to avoid or reduce sexual risk behaviors;
- Treat others with courtesy and respect without regard to their sexuality;
- Use appropriate health services to promote sexual health.

Instruction/Instructor—the method and strategies used to deliver the health education curriculum and the characteristics of the instructor (e.g., teacher qualification and training).

To meet the needs of all students, sexual health education instructors should be qualified in sexual health education, knowledgeable of effective strategies, cognizant of and understand relevant laws and policies, comfortable and confident, able to create a comfortable learning environment, able to assess students' learning outcomes, and able to use active learning techniques.

- **Sexual Health Services**—Recommended sexual health services include HIV testing and treatment, STD testing and treatment, contraceptive services, pregnancy testing, condom provision, human papillomavirus (HPV) vaccines and anticipatory guidance and health counseling.

- **Safe and Supportive Environments**—Safe and supportive environments are part of a positive social and emotional school climate (i.e., the psychosocial aspects of students' educational experience that influence their social and emotional development). The social and emotional climate of a school can affect student engagement in school activities; relationships with other students, staff, family, and community; and academic performance. A positive social and emotional school climate is conducive to effective teaching and learning. Such climates promote health, growth, and development by providing a safe and supportive learning environment.

- **Policy Analysis**—"Policy" is a law, regulation or standard that determines the required, permitted, or prohibited elements of sexual health education, sexual health services for teens, and safe and supportive environments within schools in the covered jurisdictions. "Policy analysis" refers to the review and assessment of the current policy landscape which allows for a better understanding of its association with health outcomes.

- **Health Messaging**—Separate from the curriculum-based approach of school health education, public health communication is a principal intervention approach that is tailored for a specific population to achieve increases in knowledge, behavior change, or other actions. It is a modality

that uses formative audience-based information gathering, message development and testing, and use of audience-specific channels and media to achieve results.

- **Research, Evaluation, and Analysis**—Research is lacking regarding teens' sexual and substance use behaviors, information sources, health care seeking and usage, and other aspects crucial in preventing HIV, STDs, and pregnancy. Filling gaps in the research is essential to effective public health action.

To provide a continuum of supports for all three teen groups (all teens, sexually active teens, and sexual and gender minority teens), DASH tailors the technical approach to each population group. The following sections describe how DASH combines and tailors the technical approach to meet the needs of all teens, sexually active teens, and sexual and gender minority teens.

2.2.1.1 Support the Healthy Sexual Development of All Teens

Teens with healthy sexual development:

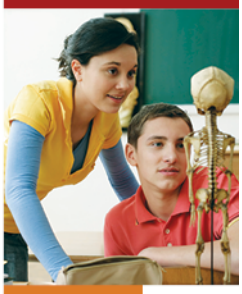
- apply fundamental knowledge and functional skills to enhance their health;
- know how to create and sustain healthy relationships;
- learn healthy behaviors and establish them for a lifetime;
- know when and how to access health services and information; and
- avoid becoming pregnant or infected with HIV or STDs.

These positive characteristics of teen sexual health can be addressed through public health approaches that reach all young people whether at school, with parents or peers, in health care settings, or in other community settings.

With respect to healthy sexual development, the average age of onset of physical sexual maturation for males and females occurs at ages 9–10 years; females experience menarche at approximately age 12. The average age of first sexual intercourse for females and males is age 17. Supporting teens' healthy sexual development means providing them with the information, skills, and support they need throughout the development process and especially before sexual activity begins.

Clinical preventive services for sexual health are also recommended both before and after the onset of sexual activity. In particular, vaccination for HPV is recommended for both males and females at age 11, long before sexual activity is initiated for the majority of persons, to best protect them from infection and the risk for associated cancers. In addition, family planning services are recommended before initiation of sexual activity to protect from unintended pregnancy and sexually transmitted infections.

DASH conducts work to address the healthy sexual development of all teens through such major activities as:



- providing funding, guidance, and technical assistance to 19 state and 17 local education agencies to assess policies and implement programs for sexual health education, referral systems for sexual health services, and safe and supportive school environments;
- developing messages for parents to help them talk with their teens about sex;
- assessing the national, state, and local policy and practice environment pertaining to sexual health education; and
- monitoring and reporting trends in teen sexual risk behaviors.

Many opportunities exist to advance the healthy sexual development of all teens. These actions could be undertaken at many levels and by many types of organizations and serve as a springboard for strategic planning for DASH and our partners. Examples include:

a. Increasing access to quality sexual health education through:

- Clear articulation of up-to-date scientific evidence supporting effective sexual health education.
- Articulation of effective, evidence-based sexual health education policies.
- Development of technical materials to assist school systems in improving sexual health education.

b. Increasing teens' and parents' awareness of and willingness to use sexual health services through:

- Introduction of concepts related to clinical preventive services, including sexual health services, within health education.
- Educating parents about and supporting their teens' access to recommended services.
- Teaching teens and their parents about state and local confidentiality and consent laws, the availability of services in their community, and how to pay for such services.
- Development of school-based referral-to-community-provider systems, parent education, school nurse professional development programs, and school-based service delivery, as appropriate.

c. Improving the school environment so that it is safe and supportive for all students through:

- Development of a school environment free of bullying and sexual harassment.
- Active engagement of parents and students with their schools.
- Partnering with the U.S. Department of Education, to focus on safe school environments.

d. Determining the policy landscape regarding teen sexual health education through:

- Analysis of state and local sexual health education policies, school practices and teen behaviors.

e. Establishing messages and dissemination mechanisms for all teens, parents, and teachers through:

- Development of message content and identification of appropriate dissemination channels for teens, parents, and teachers.

f. Expanding the evidence base regarding teen sexual activity and school-based interventions through:

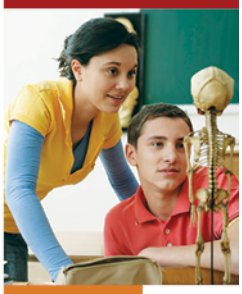
- Research regarding teens' sexual activity, risk and protective factors, and school-based and other interventions designed to reduce risk and promote health.

2.2.1.2 Ensure Sexually Active Teens Can Avoid Becoming Pregnant or Infected with HIV or STDs

As teens become sexually active, their need increases for information, tools, and sexual health services with which to prevent, diagnose, and treat HIV, STDs, or pregnancy. However, young people might experience challenges when trying to access and use health services. For example, although federal Title X clinics must provide confidential sexual health services, other clinical settings might not offer such protections, depending on the state. For teens who need to keep sexual health services confidential, payment for services under parental insurance is not feasible if an explanation-of-benefits statement reveals the receipt of services to parents; other teens might not have the means to pay for such services. In addition, young people might not have transportation to services or the ability to get to services that are only open during hours that would require missing school. Schools can be an ally for teens by either providing services at onsite or nearby clinics or by creating referral systems to clinics that have been assessed for their teen-friendly nature and accessibility. It is important for parents, teens, school staff, and health care personnel to know and understand the confidentiality policies in their local or state jurisdiction.

DASH works to protect sexually active teens in a variety of ways, including:

- funding 19 state and 17 local education agencies to
  - provide targeted curriculum-based or clinic-based programs for sexually active teens to ensure they are aware of and can access needed sexual health services; and
  - create school-based or school-linked referral systems for students to learn about, access, and use sexual health services;



- assessing the national, state, and local policy and practice environment pertaining to sexual health services provision through School Health Profiles and the School Health Policies and Practices Study (SHPPS); and
- monitoring and reporting trends in teen HIV testing.

Many opportunities exist to advance the healthy sexual development of all teens. These actions could be undertaken at many levels and by many types of organizations and serve as a springboard for strategic planning for DASH and our partners. Examples include:

a. Improving teens' health care-seeking skills through:

- Identification of effective ways to interact with teens about sexual health in classrooms, school-based health centers, and community-based health care settings.
- Developing models to assess the effectiveness of a range of school-based risk-reduction programs to identify those of greatest benefit singly or in combination.

b. Increasing access and addressing barriers to health services for teens through:

- Broad dissemination of practical guides for teens, parents, schools, and clinicians to help teens navigate complex health services.
- Provision of clear guidance pertaining to school-located health services and referrals to community-based health services.
- Provision of information about new or emerging clinical services applicable to teens.
- Engagement with partner organizations to leverage existing organizational structures, networks, and communication platforms to increase teen access to and use of health services.
- Development of tailored health communication messages for health providers, community organizations, schools, and others who can increase condom availability.

c. Reducing bullying and improving health care-seeking behavior of sexually active teens through:

- Improvements in sexual health education to address stigmatizing issues.
- Establishment of anti-bullying policies and procedures.
- Shifts in social norms toward addressing teen sexual activity and accessing or using sexual health services.
- Identification or creation of teen-friendly clinical environments to encourage teens to access and use sexual health and substance use services.

d. Assessing the policy landscape regarding teen sexual health services through:

- Analysis of state and local sexual health services policies, school practices and teen behaviors.
- Analysis of the effect of different types of anti-bullying policies.
- Analysis of the effect of confidentiality, consent and billing policies.

e. Increasing demand for HIV and STD testing, availability of condoms, and substance use treatment (if needed) for sexually active teens through:

- Development, dissemination, and evaluation of messages directed to teens, and black and Hispanic/Latino teens specifically, to increase their knowledge about, and ultimately their demand for sexual health and substance use services.

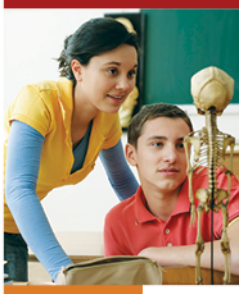
f. Building the evidence base and implementing interventions to increase sexual health services through:

- Determination of where and how sexually active teens want to receive sexual health services.
- Creation of models to determine whether HIV testing at the youngest end of the recommended age range is cost-effective.
- Identification of the types of messages and dissemination channels that will result in increased demand by sexually active teens for sexual health services.
- Development of a better understanding of the declining trend in condom use among different population groups, identification of modifiable risk factors, and development and testing of interventions to increase condom use among teens.

2.2.1.3 Address the Unique Needs of Sexual and Gender Minority Teens

HIV, STDs, and pregnancy disproportionately affect sexual and gender minority teens (i.e., those who identify as gay, lesbian, bisexual, queer, questioning, transgender, intersex, asexual, two-spirit, and others). In particular, black sexual minority males and black transgender females are at increased risk for HIV and STDs. Sexual and gender minority teens are also at increased risk for an array of other health problems. Sexual and gender minority teens are subject to higher rates of bullying and violence, leading to school absenteeism and potentially to higher drop-out rates. Sexual and gender minority students report that sexual health education and sexual health services do not address their unique questions and concerns, and thus, do not provide them with the information they need for healthy living.

DASH has begun developing a comprehensive approach for addressing the sexual health and substance use challenges facing sexual and gender minority teens. This



approach includes all elements of surveillance, research, program, and evaluation. Key activities include:

- adding questions to the Youth Risk Behavior Survey (YRBS) regarding sexual identity and the sex of sexual contacts;
- analyzing and reporting YRBS substance use data among sexual minority teens;
- funding 19 state and 17 local education agencies to assess and improve anti-bullying and anti-harassment policies, improve parent engagement with schools, and enhance student connectedness to schools, especially to promote sexual and gender minority teen inclusiveness;
- funding 3 local education agencies as innovation sites to specifically address the needs of Hispanic/Latino and black young men who have sex with men; and
- providing guidance to funded state and local education agencies regarding creation of safe and supportive environments for all students, especially sexual and gender minority students.

Many opportunities exist to advance the healthy sexual development of all teens. These actions could be undertaken at many levels and by many types of organizations and serve as a springboard for strategic planning for DASH and our partners. Examples include:

a. Improving sexual health education to ensure applicability to sexual and gender minority teens through:

- Improvements to sexual health education curricula and instruction to be inclusive, nonshaming, and applicable to the needs of all students.
- Development and provision of guidance to state and local education agencies regarding curricula and teacher professional development to ensure the applicability of sexual health education curricula to sexual and gender minority teens.

b. Increasing access and addressing the barriers to health services for sexual and gender minority teens through:

- Development and dissemination of practical information and guidance for younger teens, their parents, and clinicians regarding risk assessment, medications and monitoring, medication adherence, parental consent requirements, payment options, barriers to use of new technologies and creating clinical environments friendly to sexual and gender minority teens.

c. Creating safe and supportive school environments for sexual and gender minority teens through:

- Emphasis on anti-bullying and sexual harassment policies and procedures.
- Employment of positive youth-development programs, gay-straight alliances, safe spaces, and visible allies that are intended to support sexual and gender minority teens.

d. Assessing the policy landscape regarding schools' safe and supportive environments through:

- Analysis of anti-bullying policies specific to sexual and gender minority teens.
- Analysis of bathroom and other gender-based policies that affect school connectedness.
- Analysis of changes in national and state policy regarding their effect on school climate and risk behaviors of sexual and gender minority teens.

e. Providing direct messages to sexual and gender minority teens regarding their health concerns through:

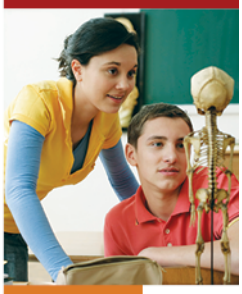
- Development, testing and dissemination of public health messages for sexual and gender minority teens regarding health risk behaviors, prevention, and health promotion.

f. Expanding the evidence base regarding sexual and gender minority teen health through:

- Analysis of new national data and additional state and city data from YRBS regarding associations between sexual minority status and priority sexual risk behaviors.
- Provision of data and analyses to spur further research regarding risk and protective behaviors of sexual and gender minority teens.
- Research regarding protective factors for sexual and gender minority teens in terms of both health and educational outcomes.
- Design of positive, strength-based interventions to reduce sexual risk behaviors and poor health outcomes.
- Evaluation of funded innovation projects to build the evidence base for how to identify and work with sexual and gender minority teens to reduce their disproportionate risk for HIV, STDs, and pregnancy.

g. Identifying and leveraging federal programs that reach sexual and gender minority teens at highest risk through:

- Identification of existing mechanism to reach sexual and gender minority teens who are homeless, in foster care, incarcerated, or in alternative school settings.
- Development of innovative strategies that leverage associations across other federal, state and local agencies and organizations that work with these populations.



2.2.2 Platform Approach

At CDC, the term *platform* is used to describe a system or program designed for one purpose that can be efficiently leveraged to serve the needs of other parts of the agency. DASH serves as CDC's platform for a public health approach to school-based health promotion and disease prevention in three ways (Box 2.2).

Box 2.2 CDC's Public Health Approach to School-Based Health Promotion and Disease Prevention

1. DASH maintains and provides expertise regarding the U.S. educational system by tracking and analyzing federal, state, and local educational policies; engaging with education agencies and schools; conducting program evaluation and evaluation research with schools; and collaborating with professional and policy organizations that represent educational agencies, schools, and educators.
2. DASH maintains and provides expertise in school health education, including educational standards, curricula, instructional delivery, policy, and educator professional development.
3. DASH implements three school-based surveillance systems, each of which serves as a platform for program-specific data collection. The three systems are the Youth Risk Behavior Surveillance System (YRBSS), itself consisting of the national, state and city surveys (YRBS), School Health Profiles, and the School Health Policies and Practices Study (SHPPS). The YRBSS provides the infrastructure in which the National and State Youth Tobacco Surveys (managed by CDC's Office on Smoking and Health) and the Global School Health Surveys (managed by the World Health Organization [WHO]) are implemented. Additional information about these systems can be found in the Appendix.

The following section describes how DASH works to assure that the health and educational needs of teens are being met through a public health approach to school-based health promotion and disease prevention.

2.2.2.1 Maintain the Platform for CDC's Work with the Educational System, School Health Education, and School-Based Surveillance

Serving as the platform for surveillance, research, tool development, and programmatic activities that pertain to adolescent health and conducting public health work within school settings requires collaboration to maintain and build services that will be useful to programs across CDC. DASH staff perform this function at a high level by organizing and maintaining the School-Based Surveillance Advisory Group, the School-Based Surveillance Governance Council, and the CDC-wide School Networking Group and by serving as subject matter

experts on agencywide committees. The tangible products of these collaborations include practical tools (e.g., CDC's Health Education Curriculum Analysis Tool, available at www.cdc.gov/healthyyouth/HECAT/) and school-based surveillance systems (i.e., YRBSS, School Health Profiles, and SHPPS).

Many opportunities exist to advance the healthy sexual development of all teens. These actions could be undertaken at many levels and by many types of organizations and serve as a springboard for strategic planning for DASH and our partners. Examples include:

a. Improving school-based surveillance platforms through:

- Secure resources to maintain robust school-based surveillance systems that monitor changes in youth risk behaviors and school health practices and policies.
- Establishment of a plan and implementation of a comprehensive assessment to ensure that all of DASH's school-based surveillance systems are of the highest quality and continue to meet stakeholders' needs.
- Secure additional resources to increase base funding to the states and expand DASH's capacity to manage collection of increased sample sizes to produce local area estimates of surveillance data.

b. Increasing public access to school-based surveillance data through:

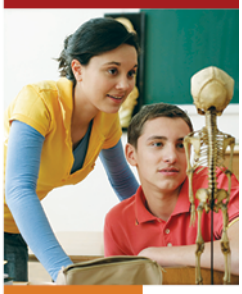
- Enhancements to Youth Online (nccd.cdc.gov/YouthOnline/App/Default.aspx) for data syndication and inclusion of new variables and functionality.
- Provision of easier access for states and cities to their own data.
- Creation of more timely and dynamic data releases for the School Health Profiles.
- Improvements to the production and presentation of YRBS data in *Morbidity and Mortality Weekly Report Surveillance Summaries*.

c. Increasing the value and visibility of DASH's expertise in school-based surveillance through:

- Determination of the best balance of analytic work in subject areas other than those directly relating to DASH's primary mission of preventing HIV, STDs, and pregnancy.
- Improvements in communicating the value of school-based surveillance to other CDC programs and their constituents.

d. Increasing the value and visibility of DASH's expertise in the U.S. educational system and school health education through:

- Expansion of the coordinated school health approach into the Whole School, Whole Community, Whole Child model.
- Broader dissemination and expansion of the Health Education Curriculum Analysis Tool.



- Development of tools for preservice education and professional development for health educators and other school health professionals.
- Establishment of a mechanism to reach the major education organizations (e.g., those that represent educators, school administrators, and school-based health professionals) crucial to achieving CDC's school-, child-, and adolescent-focused programs.

DASH has concentrated its role in HIV, STD, and pregnancy prevention among teens by focusing on sexual development, sexual risk and protective behaviors, and the factors that affect those behaviors. The role of substance use in both increasing sexual risk behaviors and incurring risk for bloodborne pathogens (e.g., HIV and hepatitis B and C) has reemerged as a priority. Thus, the DASH platform could also be improved by:

e. Expanding the applicability of DASH's teen sexual health approach to teen substance use prevention through:

- Analysis and dissemination of current data regarding teen substance use and school policies and practices regarding substance use prevention.
- Cultivation of partnerships with other CDC divisions, other federal agencies, and external partner organizations that focus on teen substance use.
- Identification of effective interventions to prevent or address teen substance use.

2.2.3 Organizational Approach

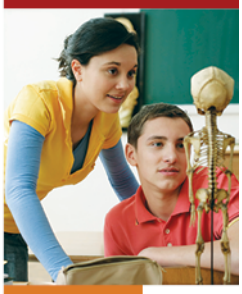
DASH is an excellent place to work. Year after year, DASH staff consistently report through the U.S. Office of Personnel Management's nationwide Employee Viewpoint Survey (EVS) high levels of job and organizational satisfaction. DASH staff have high levels of commitment to the mission and a deep sense of responsibility to the youth we serve.

Employee satisfaction, effective and efficient systems, and productivity are inextricably entwined. DASH's organizational approach focuses on each of these components individually and in combination through:

- ongoing monitoring of employee satisfaction through the EVS, the NCHHSTP Pulse Check Survey, and a DASH suggestion box;
- establishing an EVS Response Working Group that developed and is implementing an EVS action plan; and
- training DASH leaders to improve leadership and management skills, communication, and decision-making.

DASH will continue to be an organization of excellence through continuous attention to:

- Internal transparency and communication
- Workforce planning
- Priority setting and active management
- Partner engagement and collaboration
- Clear messaging, branding, and marketing of our products and services



3.0 Strategic Plan

On the basis of its mission, overall approach (i.e., the HIV/STD prevention approach, the platform approach, and the organizational approach), and the aforementioned opportunities to advance progress in healthy teen development and HIV/STD prevention, DASH has established a strategic plan for Fiscal Years (FY) 2016–2020.

3.1 Vision for 2020: Healthy Teens. Successful Futures.

We envision that by 2020 we can increase the likelihood that the majority of teens in the U.S. will have the knowledge, skills, and resources to avoid becoming pregnant or infected with HIV or STDs. That is, they will be healthy now and well-prepared for a successful future.

3.2 Goals

DASH has aligned its goals to the NCHHSTP Center-wide goals with a focus on HIV and STD prevention, specifically:

- Decrease incidence and prevalence of HIV and STDs;
- Decrease morbidity and mortality from HIV and STDs; and
- Reduce disparities in health outcomes and risk behaviors.

DASH's mission and expertise is focused on primary prevention, thus our work concentrates most on the first of these Center-wide goals (decreasing incidence), although we also work to increase health-seeking behaviors (goal 2), and reduce risk behaviors among sexual and gender minority teens who have disparate risks of HIV and STDs and some risk behaviors (e.g., substance use).

Given our mission, expertise, and vision for the future, DASH's overall goal for this strategic plan is to maximize the opportunities for primary prevention of HIV/STD and pregnancy among teens. We will do this through a combination of strategies that maintain and improve our core business, and address four strategic imperatives to accelerate progress.

3.3 Core Business

As a very small division, DASH's first priority must be to maintain and improve the functions articulated in its official organizational mission statement. We have identified five core business areas addressing these official functions, within which we will focus on high priority activities during the next five years. The core business areas and 2016 priority activities are:

3.3.1 DASH Organizational Excellence:

- Track and respond to employee satisfaction survey results
- Build internal capacity and develop succession plans for key roles
- Develop criteria and mechanisms for promoting relevant partner-developed tools

3.3.2 DASH Visibility:

- Align and prioritize conference exhibits and scientific presentations to our strategic imperatives
- Complete and rollout the DASH Messaging Implementation Guide for staff

3.3.3 DASH Strategy:

- Nurture partnerships that will best support our strategic imperatives
- Initiate development of a framework for the next DASH funding program that aligns to our strategic imperatives
- Launch a new funding program with key partner organizations
- Develop proposals and marketing tools for CDC Foundation support

3.3.4 DASH Funding Program Management:

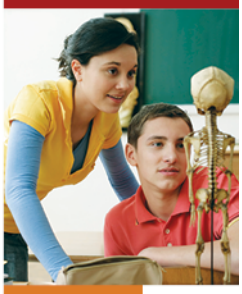
- Monitor grantee performance and provide technical assistance
- Conduct comprehensive program evaluation
- Gather successes and challenges from grantees that can be used to shape activities within our strategic imperatives and core business areas

3.3.5 DASH Surveillance System Management:

- Release the biennial YRBS surveillance summary
- Release a special YRBS surveillance summary regarding sexual minority teens' risk behaviors

3.4 Strategic Imperatives, Objectives and Indicators, Strategies and Activities

With our core business as a foundation, DASH has also identified four strategic imperatives that we must accomplish to accelerate progress toward our vision for 2020 and our goal to maximize opportunities for primary prevention. Criteria for determining the strategic imperatives included DASH's strengths (section 2.1.2), current priorities of NCHHSTP, the National HIV/AIDS Strategy (2015 Update), and input from external partner organizations. DASH also considered current resources and the likely availability of additional resources, although this was not a primary factor in determining priorities. The most critical criterion for selecting strategic imperatives was the likelihood that progress in these areas will drive progress toward our goal.



Within each strategic imperative, we identified the key objective or outcome and the specific indicators (i.e., measures and targets) that we will use to monitor progress. Furthermore, for each strategic imperative we considered the following questions to determine how to define an overarching strategy and action plan.

1. Do we have the evidence we need to take action?
    a. If yes, move to question 2.
    b. If no, develop a research-based strategy to expand the evidence base.
2. Has the evidence been translated into a useful set of tools, or a "technical package" that can be provided to the end-user?
    a. If yes, move to question 3.
    b. If no, develop a tools-development strategy to create the technical package.
3. How do we take the technical package to scale?
    a. Determine the most fitting strategy(ies), including partnership engagement, funding, etc.

STRATEGIC IMPERATIVE 1

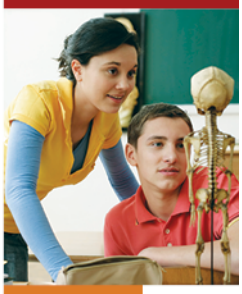
Take Sexual Health Education to Scale Nationally to Assure Teens Have Access to Information and Skills Development

Data from the School Health Policies and Practices Survey 2014 and the School Health Profiles 2014 demonstrates that sexual health education is not well implemented in the United States. In fewer than half of all states do the majority of high schools teach all of the topics identified as critical foundations for sexual health. Middle schools are doing even less. However, sexual health education (as defined in Section 2.2.1 of the DASH Strategic Framework) has been shown to delay sexual initiation and, among teens who are sexually active to reduce sexual risk taking (e.g., not using condoms or other contraception, or having multiple partners). Increasing the proportion of schools that offer sexual health education is an important step in maximizing one aspect of primary prevention of HIV and STDs: assuring that young people have the knowledge and skills they need to be sexually healthy. We will measure progress toward this objective with the measures and targets identified in Table 3.1a.

Table 3.1a: Strategic Imperative 1–Take Sexual Health Education to Scale Nationally

Objective	Indicators	Source	Baseline	2020 Target*
Increase the proportion of schools that offer sexual health education	Increase the median percent of middle schools that taught 8 key HIV, STD and pregnancy prevention topics (grades 6-8)**	Profiles	34.6% (2014)	38.0%
	Increase the median percent of high schools that taught all 12 key HIV, STD and pregnancy prevention topics (grades 9-12)**	Profiles	40.2% (2014)	44.2%
	Increase the median percent of secondary schools that provided curricula/supplementary materials related to LGBTQ youth	Profiles	24.4% (2014)	26.8%
	Increase the percent of 9th grade students nationwide who have never had sexual intercourse **(Budget performance measure; QPR indicator; NCHHSTP indicator)**	YRBS	70.0% (2013)	77.0%
	Increase the percent of currently sexually active high school students nationwide who used a condom during last sexual intercourse **(Budget performance measure; QPR indicator; NCHHSTP indicator)**	YRBS	59.1% (2013)	62.0%***
	Decrease the percent of currently sexually active high school students nationwide who drank alcohol or used drugs before last sexual intercourse	YRBS	22.4% (2013)	20.2%

*Method for calculating the target - 10% (or 5%) change calculated by taking 10% (or 5%) of the baseline and adding it to or subtracting it from the baseline.
** See Appendix B regarding the construction of this indicator.
*** Represents a 5% change (all others are 10%).



For this strategic imperative, sufficient evidence of the effectiveness of sexual health education and the availability of numerous tools and technical guidance allow our strategy to focus on taking these tools to scale. Thus, DASH identified the priority strategies and activities for 2016 to initiate work in this area, shown in Table 3.1b.

Table 3.1b: Strategic Imperative 1–Take Sexual Health Education to Scale Nationally

2016 Primary Strategy	
Pilot a partnership engagement strategy in one high potential awardee state–take that state to scale	Analyze 6 awardee states with state and direct city funding to identify the optimal candidate
	Engage national and state partner organizations to craft and implement a strategy for that state
	Document the strategy and determine next steps
2016 Prerequisite Activities	
Understand and communicate the sexual health education policy landscape	Complete the sexual health education policy database
	Develop a policy landscape report for all 50 states
	Initiate analyses to characterize state laws that are associated with improved school practices
Be prepared to counter arguments that sexual health education is not wanted or necessary	"Parents don't want sex ed" – existing poll data
	"Sex ed doesn't work" – existing effectiveness data
	"Middle school is too early" – existing age of sexual initiation data
Provide a generic technical package for state and local education agencies	Identify relevant existing tools and any required adaptations
	Establish a co-branding protocol for partner-developed tools
	Identify additional tools needed

STRATEGIC IMPERATIVE 2

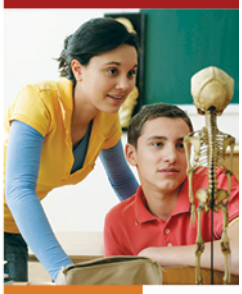
Address Confidentiality Protections for Teens to Increase Their Use of Sexual Health Services

Clinical and public health organizations have recommended specific clinical preventive sexual and reproductive health services for teens, but recent data has shown that these services are not frequently used by teens. One of the most frequently cited reasons for failing to seek sexual and reproductive health services is a fear of a lack of confidentiality. Teens' confidentiality or perceptions of confidentiality can be threatened by several factors—for example, parental consent requirements, confusion about the Health Insurance Portability and Accountability Act (HIPPA) versus the Family Educational Rights and Privacy Act (FERPA) privacy laws, insurance coverage and billing conventions, and even provider competency. Identifying and addressing the key confidentiality concerns of teens will assist in maximizing another avenue for the primary prevention of HIV and STDs: increasing the availability of sexual health services for teens, and ultimately their use of those services. We will measure progress toward this objective with the measures and targets identified in Table 3.2a.

Table 3.2a: Strategic Imperative 2–Address Confidentiality Protections for Teen Sexual Health Services

Objective	Indicators	Source	Baseline	2020 Target*
Increase the availability of sexual health services for teens	Increase the median percent of schools that facilitated access to providers who have experience in providing health services to LGBTQ teens	Profiles	46.3% (2014)	50.9%
	Increase the median percent of schools that provide students with referrals to any organizations or health care professionals not on school property for STD testing	Profiles	46.5% (2014)	51.2%
	Increase the median percent of schools that provided students with referrals to any organizations or health care professionals not on school property for 7 sexual/reproductive health services	Profiles	32.4% (2014)	35.6%
	Increase the median percent of schools that provide referrals for sexual/reproductive health services for which parental consent or notification is not required	Profiles	Pending (2016)	TBD
	Increase the percent of sexually experienced high school students nationwide who have been tested for HIV **(QPR indicator)**	YRBS	22.4% (2013)	23.5%**

*Method for calculating the target - 10% (or 5%) change calculated by taking 10% (or 5%) of the baseline and adding it to or subtracting it from the baseline.
** Represents a 5% change (all others are 10%).



For this strategic imperative, sufficient evidence exists regarding the effectiveness of sexual health services and the failure to maximally deliver these services. Thus, DASH's strategy is to define and develop a comprehensive technical package of informational or procedural tools that can be used by schools, parents, teens, and health care providers. Thus, DASH identified the priority strategies and activities for 2016 to initiate work in this area, shown in Table 3.2b.

Table 3.2b: Strategic Imperative 2–Address Confidentiality Protections for Teen Sexual Health Services

2016 Primary Strategy	
Develop a generic technical package of strategies and resources for state and local education agencies that addresses challenges to confidentiality in access and use of sexual health services	Engage internal and external partners in a process to identify needed resources
	Expand and adapt current grantee guidance regarding sexual health services
	Identify and develop tools based on existing research and evaluation findings
2016 Ongoing Research Activities that are Prerequisites for Additional Tools Development	
Conduct research and research synthesis activities to inform future resource development	Analyze and publish from National Survey of Family Growth (NSFG)
	Analyze and publish from YRBS and SHPPS
Research and evaluate sexual health services access and use related to research agenda, that are related to issues of confidentiality	Conduct systematic literature reviews
	Conduct applied evaluations
	Conduct miscellaneous research activities

STRATEGIC IMPERATIVE 3

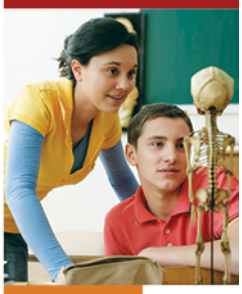
Expand the Evidence Base Regarding Sexual and Gender Minority Teen Health to Develop Methods that Decrease Risk and Increase Protective Factors

Sexual and gender minority (SGM) teens are at increased risk of HIV, STDs and unintended pregnancies among many other health threats. Behavioral risks are also greater among sexual minority teens, but there are no nationally representative data regarding behavioral risks among gender minority teens. Furthermore, recent systematic literature reviews reveal a dearth of evidence regarding risk and protective factors for sexual and gender minority teens. The lack of evidence regarding these factors also means that little evidence exists regarding the effectiveness of interventions to decrease risk and increase protective factors. In order to maximize primary prevention opportunities for these teens, we must expand the evidence base in all of these areas of study in order to eventually develop and evaluate interventions to promote health and prevent disease among sexual and gender minority teens. We will measure progress toward this objective with the measures and targets identified in Table 3.3a.

Table 3.3a: Strategic Imperative 3–Expand the Evidence Base Regarding Sexual and Gender Minority Teen Health

Objective	Indicators	Source	Baseline	2020 Target*
Increase the proportion of schools that are addressing the unique needs of sexual and gender minority teens	Increase the median percent of schools that identify safe spaces for SGM teens	Profiles	61.4% (2014)	**
	Increase the median percent of schools that encourage staff to attend professional development on safe and supportive environments for all students	Profiles	59.0% (2014)	**
	Increase the median percent of schools that have a gay/straight alliance or similar club	Profiles	26.7% (2014)	**
	Decrease the percent of sexual minority male high school students in major urban centers who had sexual intercourse during the past three months with three or more persons or who had sexual intercourse during the past three months and did not use a condom or ever injected any illegal drug **(QPR indicator; NCHHSTP indicator; NHAS indicator)**	YRBS	34.1% (2013)	30.7%

*Method for calculating the target - 10% change calculated by taking 10% of the baseline and adding it to or subtracting it from the baseline.
**Until evidence is strengthened, monitor trends only.



For this strategic imperative, the lack of evidence points to a research-focused strategy. Thus, DASH identified the priority strategies and activities for 2016 to initiate work in this area, shown in Table 3.3b.

Table 3.3b: Strategic Imperative 3–Expand the evidence base regarding sexual and gender minority teen health

2016 Primary Strategy	
Articulate the state of the science and research priorities	Develop clear messages regarding the current state of the science regarding sexual and gender minority teen health
	Work with internal and external partners to identify the highest priority research questions
	Begin developing a research funding strategy to initiate an extramural research program
2016 Ongoing Research Activities	
YRBS: Complete and release the first national surveillance summary of YRBS data regarding sexual minority youth and conduct 7 planned analyses of sexual minority data; continue working with advocates and state/city YRBS coordinators to develop and test a valid/reliable survey question regarding gender identity	
Modeling: Complete 5 planned papers currently underway with Harvard and Emory, and continue ongoing work with modeling collaborators, including planning for additional studies as needed	
Leverage the applied evaluation of 1308 innovation sites to identify future research questions and program planning by collecting and analyzing data from the 3 sites with planned evaluation reports each year	
Formative Research: Complete ARCUS Foundation-funded work related to LGBT health; launch planned qualitative study of protective factors for transgender youth; continue Minority AIDS Initiative-funded research regarding health care preferences of adolescent sexual minority males	

STRATEGIC IMPERATIVE 4

Integrate Substance Use Prevention into HIV/STD Prevention Efforts for Teens

While trends in substance use among teens have decreased or remained stable over the past decades, the current prevalence of use of alcohol, marijuana, prescription drugs for non-prescribed purposes, and other drugs remain high. Substance use can increase the likelihood of risky sexual behavior, and some substance use can serve as a gateway to eventual injecting which carries its own risk for infections such as HIV, HBV or HCV. Limited data also demonstrate that sexual minority teens might be as much as five to seven times more likely to inject drugs than their heterosexual peers. To date, DASH has not directly addressed substance use. However, recent outbreaks of HIV and HCV infections among injecting drug users, the national increase in opiate/opioid addiction, and the move toward legalization of marijuana have highlighted the issue as an important area for primary prevention of HIV and STDs, especially at the intersection of substance use and sexual risk taking. We will measure progress toward this objective with the measures and targets identified in Table 3.4a.

Table 3.4a: Strategic Imperative 4–Integrate Substance Use Prevention into HIV/STD Prevention Efforts for Teens

Objective	Indicators	Source	Baseline	2020 Target
Increase the availability of tools that incorporate substance use prevention into HIV/STD prevention efforts	Increase the number of Profiles questions that address the intersection of sexual risk taking and substance use by teens	DASH Administrative Data	TBD	TBD
	Increase the number of YRBS and Profiles analyses that address the intersection of sexual risk taking and substance use by teens	DASH Administrative Data	TBD	TBD
	Increase the number of program sites that are addressing the intersection of sexual risk taking and substance use by teens	DASH Administrative Data	TBD	TBD

For this strategic imperative, DASH has developed an exploratory strategy to identify the current evidence and evidence gaps regarding all aspects of substance use prevention as it pertains to HIV and STD risk, determine what tools are already available, cultivate new partnerships, and begin learning how states and communities are addressing these issues for teens. Thus, DASH identified the priority strategies and activities for 2016 to initiate work in this area, shown in Table 3.4b.

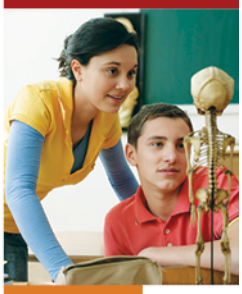


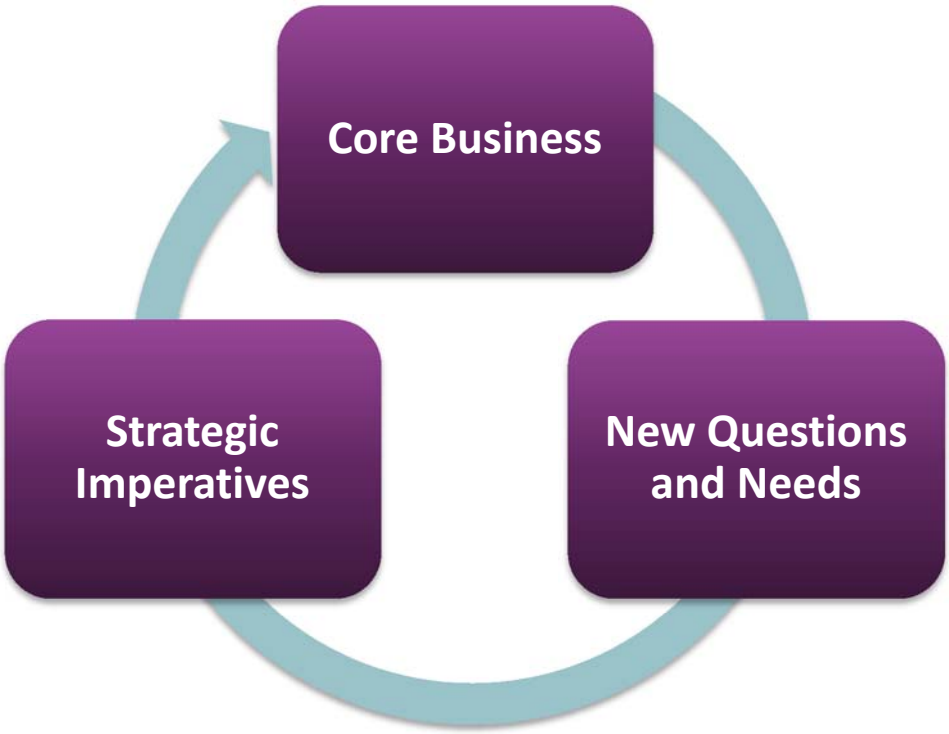
Table 3.4b: Strategic Imperative 4–Integrate Substance Use Prevention into HIV/STD Prevention Efforts for Teens

2016 Priority Strategy	
Conduct a broad range of exploratory activities that inform the development of a justification for an increased budget to support the integration of substance use into DASH's HIV/STD prevention portfolio	
2016 Ongoing and Planned Activities	
Establish a pilot program to determine the utility of DASH's sexual health approach for substance use prevention	Finalize pilot program sites and activities
	Determine appropriate evaluation approach for pilot program
	Launch pilot
Determine YRBS, SHPPS and Profiles analytic priorities	Conduct analyses and provide reports on high priority variables from existing school-based surveillance systems
Determine changes required in existing school-based surveillance	Revise 2017 YRBS questionnaire as required and feasible
	Determine relevant SHPPS questions that should be included in Profiles
Build DASH's identity/role in this subject area	Identify current 1308 grantees work in this subject area
	Develop messages regarding DASH's surveillance, research, and programmatic role
Assess the scientific literature regarding primary prevention of substance use among teens	Initiate development of a logic model and systematic literature review protocol

3.5 Strategic Feedback Loop

DASH's core business routinely generates new questions, identifies needed tools and guidance, elicits new programmatic and policy needs, and highlights communication challenges. These questions and needs generate and feed into DASH's strategic priorities, which in turn shape and remodel the core business activities (Figure 3.1). One way new questions and needs are captured, organized and prioritized is through a research agenda. The research agenda serves as an ongoing reference and tool for tracking research needs, setting priorities, and leveraging opportunities to conduct new research. DASH's current research agenda is included as Appendix C of this Strategic Plan.

Figure 3.1 The DASH Strategic Feedback Loop

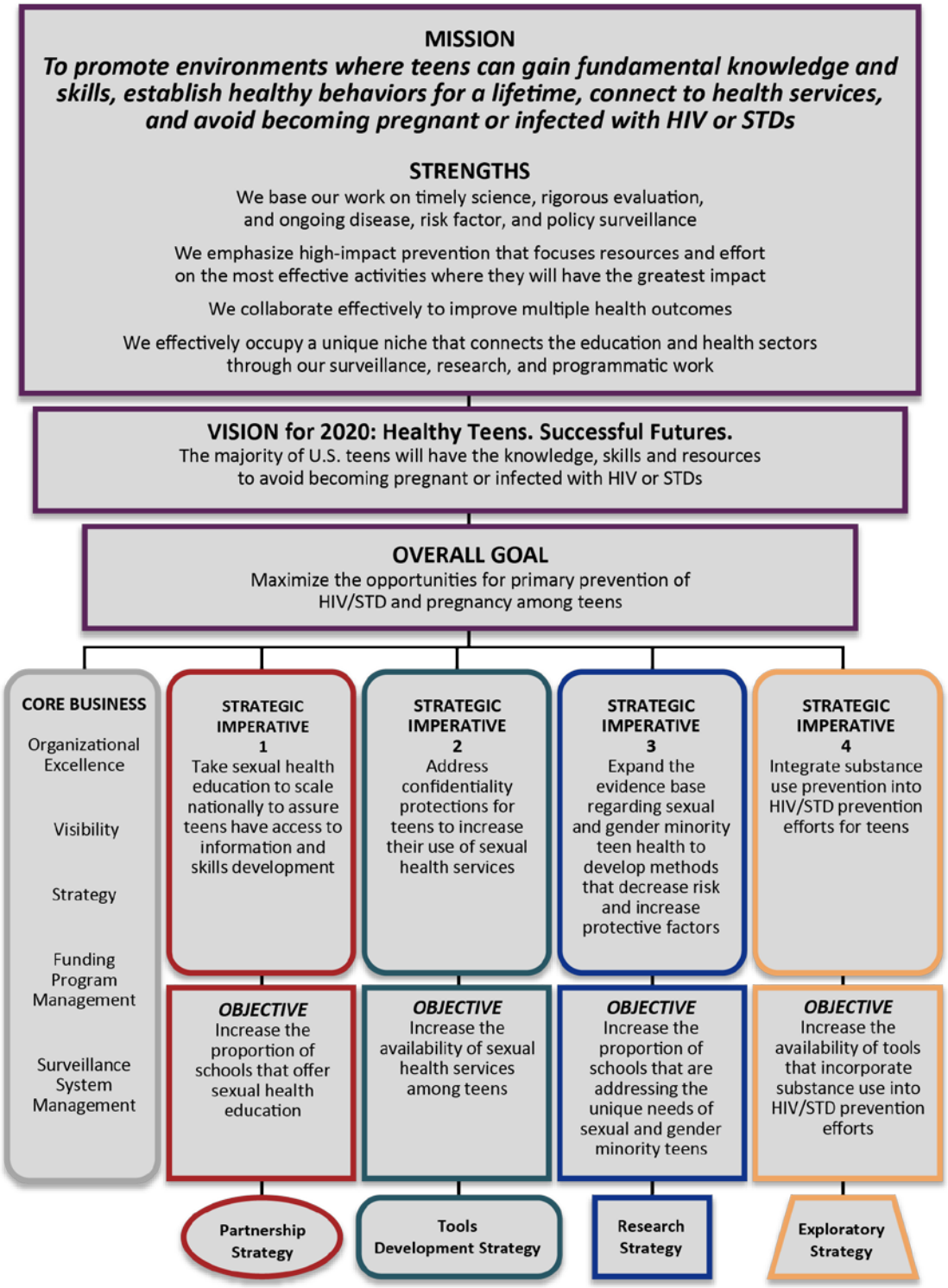


4.0 Summary

DASH has revised and updated its strategic framework to better articulate DASH's overall approach to adolescent health and the behaviors that increase risk for HIV, STD and pregnancy. From this framework, DASH has developed a strategic plan that is aligned with the NCHHSTP-wide goals and responsive to the National HIV/AIDS Strategy (2015 Update). The strategic plan includes attending to our core business priorities and using that foundation to accelerate progress toward a vision of well-prepared teens. We will move toward this vision via four priority strategies that promote adolescent health and healthy sexual development in school, home, and community environments most amenable to working with teens. The DASH strategic plan will guide specific action planning and resource allocation from 2016 through 2020.

DASH's overall strategic plan is best summarized via the strategy map illustrated in Figure 4.1.

Figure 4.1 DASH Strategic Plan, May 2016



Appendix A – School-Based Surveillance Systems

A-1 Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance System (YRBSS) includes national, state, local, territorial, and tribal school-based Youth Risk Behavior Surveys (YRBS) of representative samples of high school students in the United States and national surveys conducted in collaboration with WHO of students ages 13–17 years in low-socioeconomic countries. The YRBSS primarily monitors six categories of priority health risk behaviors in addition to monitoring obesity, asthma, and sexual minority status. The six categories include

- alcohol and other drug use,
- unhealthy dietary behavior,
- injury and violence,
- inadequate physical activity,
- tobacco use, and
- risky sexual behavior.

A-2 School Health Profiles

The School Health Profiles (Profiles) collect data biennially from state and local representative samples of secondary schools to monitor the status of

- school health education requirements and content;
- physical education and physical activity;
- practices related to bullying and sexual harassment;
- school health coordination;
- school health policies related to HIV/AIDS, tobacco-use prevention, and nutrition;
- school-based health services; and
- family and community involvement in school health programs.

A-3 School Health Policies and Practices Study

The School Health Policies and Practices Study (SHPPS) is a national survey periodically conducted to assess school health policies and practices at the district, school, and classroom levels. Questionnaires cover

- health education,
- physical education and physical activity,
- nutrition environment and services,
- counseling and psychological and social services,
- health services,
- social and emotional climate,
- physical environment,
- employee wellness,
- family engagement, and
- community involvement.

Appendix B – Middle and High School Sexual Health Education Topics Indicators

Two indicators for Strategic Imperative 1, "Take Sexual Health Education to Scale" are calculated by combining data from 8-12 individual questions in School Health Profiles. This appendix explains how these indicators are constructed.

Indicators, Baselines, and Targets:

Indicator	Source	Baseline	2020 Target
Increase the median percent of middle schools that taught 8 key sexual health education topics (grades 6-8)	Profiles	(2014)	
Increase the median percent of high schools that taught 12 key sexual health education topics (grades 9-12)	Profiles	(2014)	

Construction of the Indicators:

The indicators are constructed from among School Health Profiles questions posed to lead health education teachers in surveyed schools regarding topics included in teaching about human sexuality, HIV/STD prevention, and pregnancy prevention.

Topic	Included in Middle School Indicator	Included in High School Indicator
How HIV and other STDs are transmitted	M	
Health consequences of HIV, other STDs, and pregnancy	M	
The benefits of being sexually abstinent	M	
How to create and sustain healthy and respectful relationships	M	H
The influences of family, peers, media, technology, and other factors on sexual risk behaviors	M	H
Communication and negotiation skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy	M	H
The importance of using condoms consistently and correctly	M	H
Methods of contraception other than condoms*	M	H
The importance of using a condom at the same time as another form of contraception to prevent both sexually transmitted diseases (STDs) and pregnancy		H
How to obtain condoms		H
How to correctly use a condom		H
Goal-setting and decision-making skills related to eliminating or reducing risk for HIV, other STDs, and pregnancy		H
Preventive care (such as screenings and immunizations) that is necessary to maintain reproductive and sexual health		H
How to access valid and reliable health information, products, and services related to HIV, other STDs, and pregnancy		H
The importance of limiting the number of sexual partners		H

*In 2016, this question replaces a separate set of seven questions regarding a variety of contraceptive methods previously asked only in high schools. This topic is not included in the 2014 baseline for middle schools. The seven previously asked questions are included in the 2014 baseline calculation for high schools, by querying if ANY of the seven contraceptive topics were taught.

Rationale for Topic Selection:

- Alignment to the National Health Education Standards:
  - All topics selected for the middle school indicator, and 9 topics selected for the high school indicator directly align to Standard 1 of the National Health Education Standards, pertaining to knowledge acquisition.
  - The remaining three high school topics (i.e., accessing valid and reliable health information, how to obtain condoms, how to correctly use a condom) directly align to Standard 3 of the National Health Education Standards, pertaining to health-seeking behavior skills.

- Many of the selected topics also relate to one or more of Standards 2-7 of the National Health Education Standards that address other specific skill-building elements of health curricula.

- Alignment to the Health Education Curriculum Analysis Tool (HECAT):
  - The topics selected for inclusion in the indicators align to one or more of the Health Behavior Objectives specified in the HECAT. The HECAT specifies numerous knowledge and skill expectations for each HBO that are fundamental to behaviors pertaining to human sexuality, HIV/STD prevention, or pregnancy prevention.
  - The topics selected for inclusion in the indicators are a small subset of the HECAT knowledge and skills expectations. This subset provides an indication of the general landscape of sexual health education that is being provided in middle and high schools.

- Assignment to the Middle School and/or High School Indicators:
  - Topics included for middle school but not high school indicate that the topic is prerequisite for later lessons, and is ideally taught prior to the initiation of sexual activity in earlier stages of adolescence.
  - Topics included for high school but not middle school indicate that the topic is more appropriate for later developmental stages of adolescence and builds upon content taught earlier.
  - Topics included for both middle and high school indicators are those that are introduced in earlier grades but require important expansion of knowledge and skills in later grades.

Four additional sexual health education topics are included in the School Health Profiles questionnaire, but are not included in the indicators for reasons indicated below. We will continue to use these questions to follow trends in the data.

Influencing and supporting others to avoid or reduce sexual behaviors	Advanced concept for sexual health education that is not likely to be widely taught
Efficacy of condoms, that is, how well condoms work and do not work	Can be answered "yes" under a variety of policies that can lead to different content being taught in different jurisdictions
Sexual orientation	• New questions being tested for the first time in 2016 • Can be answered "yes" under a variety of policies that likely lead to different content being taught in different jurisdictions
Gender roles, gender identity, or gender expression	

Use of the Indicators:

These indicators were developed to monitor progress toward the objective of increasing the delivery of high quality sexual health education in middle and high schools. The selected topics provide an indication of how well sexual health education is being implemented, but do not reflect the entirety of content that should be included in K-12 sexual health education. Schools, school districts, parents, and other policy makers should refer to the National Health Education Standards and the HECAT to review the complete recommended content for high quality sexual health education.

Appendix C – DASH Research Agenda Summary

Introduction

Starting in early 2015, staff in the Division of Adolescent and School Health (DASH) engaged in a systematic process to consider research gaps, partner needs, and division priorities to identify research priorities. The resulting research agenda provides a roadmap for key research activities and priorities in DASH over the next 5 years (2016-2020). It reflects division-wide needs, allowing DASH staff to prioritize existing research activities and make strategic and informed selections about new research projects and funding mechanisms. Research priorities include research needed to (1) support and refine DASH's current scope of work and (2) identify and shape strategies and approaches DASH can use in the future.

Components

The **priority project list** outlines priority research projects that address multiple research questions identified as priorities for DASH. A **contextual overview** outlines the process used to develop the research agenda, describes how the priority projects fit into DASH and NCHHSTP strategic goals, provides the rationale for research areas and questions, and describes other key topics of importance that emerged in the development process. The **action plan** helps DASH staff clarify and plan to address challenges to initiating the priority projects.

Development Process

The research agenda development process gathered input from DASH staff to provide a foundation for setting priorities.

Focus groups with DASH staff. In April 2015, 2 DASH researchers led focus groups with four groups of DASH staff—3 with non-management DASH staff and 1 with DASH management. Focus groups were well-attended and included representation from all branches and DASH's Office of the Director. Approximately 35 staff members (of approximately 55 total) participated in the focus groups.

Focus groups discussed research needs related to DASH's existing program and research focus by considering common questions from funded partners, information needed to inform implementation of key activities, and aspects of our work that are difficult to justify or have an insufficient evidence base. Focus groups also discussed research topics outside of our current scope of work that might be important for improving sexual health outcomes among adolescents.

Participants were asked to identify three research topics/research questions they would like to prioritize for initiation in the next 1-2 years, and 3 they would prioritize for initiation in 3-5 years. This provided a snapshot of key priority topics and research questions for DASH staff.

Prioritization of research topic areas. Notes from each focus group were compiled and organized by key topic area. Focus groups provided ideas with

varying levels of specificity—from overarching topic areas to narrowly defined research questions. This information was compiled into a single document listing 43 possible topic areas. This document was shared back with DASH staff to provide opportunity for any clarifications or additions. Staff were reminded of the workgroup members who would represent them in the prioritization process and were encouraged to share preferences for priorities with them.

Next, the workgroup was given the list of possible research topics and the most recent version of the DASH strategic plan for review. They were also asked to gather input from their respective team/branch/office members. The workgroup then engaged in a prioritization activity that used a rotating, 2-round small group discussion process to identify priority topics.

The group ultimately selected six topics for research priorities:

1. Condom use and availability
2. HIV & sexually transmitted disease (STD) acquisition
3. Pre-exposure prophylaxis (PrEP) for adolescents
4. In-school services implementation
5. Communicating with youth
6. Youth Risk Behavior Survey (YRBS) data

Development of specific research questions. Once the six priority topics were selected, groups of subject matter experts (SME) from across the division developed 1-2 specific research questions for each priority area. In addition, these groups provided 3 key pieces of information: a rationale for selecting the research questions, the proposed timing for addressing each research question, and background or foundational steps necessary to initiate research projects to address the questions.

Development and review of priority project list. The SME groups generated 12 research questions for the 6 priority areas. Across these 12 questions, some SME groups proposed similar approaches. To compile a more distinct and actionable set of research priorities, the information provided by each group was reviewed and organized to create a list of priority projects. Projects were prioritized for initiation in either years 1-2 or years 3-5. The priority project list is ordered to allow foundational activities (such as literature reviews or secondary data analyses) to inform and feed into priority projects for later years. DASH management reviewed and approved the project list in September. Management staff noted the importance of reconciling differences between the evolving strategic plan and the research agenda.

Development of a contextual overview and action plan. The contextual overview and action plan were developed following DASH management approval of the priority project list and build on the rationales, foundational steps, and background information from the agenda development process.

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