Introduction

Unintended pregnancy, sexually transmitted diseases (STDs), and the human immunodeficiency virus (HIV) are among the issues identified as crucial concerns for adolescents. The majority (63.1%) of 12th graders in U.S. schools report having had sexual intercourse, with 14.3 percent of adolescent students in grades 9–12 reporting intercourse with four or more partners. Of 9th-through 12th-grade students who reported having sex, 62.8 percent had used a condom at last intercourse. The number of adolescent males that reported having used a condom at last intercourse was 70 percent, while the number of adolescent females who reported having used a condom was 55.9 percent.

Unintended pregnancy is another area of concern for sexually active adolescents. Teen pregnancy can result in lower educational attainment for the mother and a higher likelihood of financial struggle. Teen mothers are more likely to smoke cigarettes during their pregnancy, are more likely to be infected with an STD, and are less likely to receive regular prenatal care, which results in a greater number of low birthweight babies. Although unintended pregnancy rates have declined within the last few years, unintended pregnancy is still an issue for adolescents. In 2000, the unintended pregnancy rate was 75 per thousand females aged 15–19 years, down from a 1990 high of 117 per thousand. The majority (77 percent) of this decline among 15- to 17-year-olds can be attributed to improved contraceptive use; a smaller portion of the decline can be attributed to teens choosing to delay sexual intercourse.

Other outcomes associated with unprotected sexual behavior among adolescents include rates of STDs that far exceed those of any other age group in the U.S. Roughly nine million new STDs are diagnosed among 15- to 19-year-olds in the U.S. each year. Female rates of chlamydia and gonorrhea are higher among 15- to 19-year-olds than among any other age group. STDs often go undetected and can result in serious complications, including adverse pregnancy outcomes and pelvic inflammatory disease (PID). Untreated PID can cause chronic pelvic pain, involuntary infertility, and ectopic pregnancy. Nationally, 75 percent of females have no identified symptoms of chlamydia infection, and 50 percent of men are also asymptomatic.

HIV also poses a significant risk to sexually active adolescents (defined for HIV prevalence as ages 13–24 years). It is likely that most HIV-infected adolescents in the U.S. have not been identified and are therefore unaware of their infection. In 2005, 5,172 adolescents were diagnosed with HIV. As of 2005, a total of 40,764 adolescents had been given an AIDS diagnosis. Existing data on annual HIV diagnoses in the 33 U.S. areas with confidential name-based HIV reporting demonstrate an increase in incidence of HIV infection among adolescent males from approximately 1,200 in 1999 to approximately 1,800 in 2003, with the most common mode of exposure being male-to-male sex. Adolescent females’ incidence of HIV infection, most commonly transmitted via heterosexual contact, has remained between 1,200 and 1,400 per year during the same time period. African American adolescents, both male and female, bear a disproportionate burden of HIV infection. While these data are compelling, actual adolescent HIV-infection prevalence is likely to be higher than indicated, given that (1) data from large portions of the country have not been collected long enough to provide accurate estimates; (2) few adolescents have been infected long enough for their HIV infection to be identified through an AIDS diagnosis; (3) behavioral surveillance indicates high-risk sexual behavior among youth to be relatively common; and (4) even high-risk adolescents are unlikely to be tested for HIV.

Since the earliest days of the HIV epidemic in the U.S., 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. In order to understand these relationships better, particularly those involved in adolescent HIV, STD, and unintended pregnancy prevention, staff at the National Association of County and City Health Officials (NACCHO) conducted two sets of key informant interviews.
interviews assessing the barriers and facilitators to LHDs’ engaging in adolescent-focused HIV, STD, and unintended pregnancy prevention in their communities. The first set of interviewees was selected from a purposeful sample of 30 LHDs between 2005 and 2006, including individuals from LHDs in areas of high AIDS prevalence and with a mixture of LHDs serving primarily urban areas spread throughout the country. The second set of interviewees was selected from another purposeful sample of about 30 LHDs, generally smaller and serving less urban areas. With few exceptions, the HIV prevention program manager or equivalent was identified and was the primary respondent on behalf of the LHD. In larger LHDs, this individual was primarily or solely focused on HIV prevention. In smaller LHDs, one person was more likely to have had multiple LHD responsibilities, including oversight of HIV prevention. During many interviews, more than one respondent was included, with as many as four people providing responses specific to their particular responsibilities within the LHD. Interviews, lasting about one hour, were conducted via telephone using an interview guide that was sent to participants prior to the agreed-upon interview time. HIV-prevention managers from 19 larger LHDs and 21 smaller LHDs were ultimately interviewed.

This document begins with a summary of findings. Following the summary are highlights from the interviews, particularly around barriers and facilitators primarily regarding adolescent HIV prevention but also addressing STD and unintended pregnancy prevention. In addition, the document provides examples of the types of adolescent-specific HIV prevention successes LHDs have achieved. It concludes with related practice and policy implications that may strengthen LHDs’ adolescent HIV-prevention efforts.

Summary of Findings

- The degree to which adolescents are viewed by the LHD as an HIV-prevention priority varies. Low HIV prevalence rates among youth, budget constraints, and resource limitations contribute to the challenge of LHDs making adolescents a prevention priority. LHDs that have justified positioning adolescents as a high priority have used behavioral data, local STD data, or unintended pregnancy data to do so.

- Schools are viewed as an important setting in which to reach adolescents, but few LHDs have established strategic and ongoing relationships with them. A number of LHDs reported that the strength of their relationships with local schools or school systems depended on the strength of interpersonal rather than organizational ties. The focus on academic achievement and abstinence-only-until-marriage educational policies was cited as a barrier to providing or ensuring HIV-prevention education in schools.

- Parents are viewed as a potentially valuable audience, but they are not often targets of LHDs’ prevention activities. Only a handful of respondents reported targeting parents as a secondary audience, and those who did most often used ad hoc strategies. LHDs that did engage families in prevention activities typically did so through presentations at parent-teacher association meetings or by holding health fairs or conferences with youth and parents. Establishing partnerships with community organizations that serve parents is an alternative to working through schools to reach parents.

- Collaborating with youth-serving community partners is seen as a successful way to reach youth at high risk of infection. Respondents reported conducting adolescent HIV/STD-prevention outreach activities with the help of community-based organizations (CBOs) and partners and in a variety of venues. Larger LHDs reported that they often contracted out adolescent HIV-prevention services to youth-serving organizations to more effectively and efficiently reach adolescents in their communities.

- Conducting HIV-prevention activities through on- and off-site health clinics is considered a successful way to reach adolescents. While LHDs did not often intentionally use health clinics to target adolescents, most LHDs reported using on- and off-site health clinics, including school-based health clinics, to conduct HIV prevention, HIV testing, STD screening, and related sexual health promotion with adolescents.
SUMMARY OF IMPLICATIONS FOR PRACTICE
Findings from the key informant interviews led to the following potential implications for LHDs’ practices:

- Identify stakeholders and the unique contribution of LHDs to adolescent HIV prevention
- Use LHD data, including behavioral and STD data, to advocate for adolescents as a prevention priority
- Build more systematic relationships with schools
- Work with community partners to identify and reach youth at highest risk
- Work within the LHD to identify and leverage adolescent resources
- Involve youth in the planning and implementation of efforts intended to reach them

SUMMARY OF IMPLICATIONS FOR POLICY
Findings from the key informant interviews led to the following potential implications for LHDs’ policies:

- Improve surveillance systems to allow disaggregation of data for local use
- Support evidence-based unintended pregnancy, STD, and HIV prevention in schools and community settings
- Provide funding that is flexible enough to permit localities to address their unique priorities

The Experiences of Select LHDs

MAKING ADOLESCENTS A PRIORITY
Several of the large LHDs that participate directly in the community planning process to allocate HIV-prevention dollars described youth as being either a lower or an ad hoc priority after established HIV/AIDS adult priority groups. The push for increased accountability in terms of data-driven decision-making and evidence-based programming is at play in many of these determinations.

When an increase in morbidity is identified in a certain demographic segment of the population, that is where programmatic efforts are focused.

While respondents agreed that data should drive public health practice, many described how various interpretations of data-driven practice had negatively affected the degree to which adolescents were targeted for HIV prevention. This is particularly a problem because youth prevalence rates of diagnosed HIV infection are relatively low, despite high rates of unprotected sexual behavior, unintended pregnancy, and STD infections.

[We don’t work with youth] as much any more… When the budget was cut, youth [prevention services] were reduced. Positivity rates among youth aren’t very high...

We’ve prioritized away from [adolescents] because of resources. Case-finding is connected to funding.

…[We’re] not able to have a clear understanding of what the actual numbers are. The providers claim there are a lot of youth at risk or infected, [but] the numbers don’t really reflect that youth are at great risk.

Some respondents reported focusing on non-age-specific risk categories and focusing on youth through them:

If [youth are] MSM [men who have sex with men], they’re in the picture.

We try to incorporate youth into already existing programs.

Still other respondents justified their focus on youth with data on other related risk behaviors.

We have significant numbers of AIDS cases in their 20s. We justify our youth focus by every survey conducted showing tremendous risk factors even if they don’t have HIV—alcohol use, drug experimentation, and many sexual partners.

We are working with the school board and the PTAs. They know from the unintended pregnancy rate that kids are having sex. We give a lot of stats of teens with chlamydia.

…We’re trying to work with the CPG [community planning group] to modify the way that they prioritize populations, because in the past they’ve used surveillance that won’t find youth. We’re assisting them in using STD surveillance and other types of data...

Other LHDs reported youth to be a high priority for their prevention efforts or were actively working to identify ways to address these needs better. More often than not, these LHDs had fewer restricted local or other dollars.

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Although they are not a specific priority group established by the CPG, youth are a major priority for our program, not only in schools, but also on the streets and in youth-serving organizations.

Several respondents cited empirical and anecdotal community data that clearly underscored the need for targeting adolescents in their community. Most often reasons for not doing so more were related to resource limitations and the multiple responsibilities of the staff who oversee these services.

Many respondents reported targeting adolescents through clinics, often through reproductive health clinics. In these cases, female participation was generally higher than male participation. One respondent described efforts to make adolescent health a priority in everyday programs after a “community conversation” concluded with the designation of youth as the number-one priority for the community. To the extent that respondents talked about having a youth or adolescent health focus, they usually emphasized HIV/STD and unintended pregnancy as foci of their efforts.

Resources
Funding is a key barrier to improving adolescent HIV-prevention activities. In a public health environment in which categorical funding drives much of the work of LHDs, discrete funding streams for adolescent HIV prevention from sources other than local funds are rare, and STD-prevention dollars for primary prevention rarer still. In addition, use of dollars that do support HIV prevention are rarely at the discretion of the LHD to direct toward identified and closely HIV-prevention-related local problems, such as STD prevention.

Some larger LHDs reported using funds targeted for adolescents in their reproductive health, health education, and chronic disease health grants to address adolescent risk behavior more broadly. Less frequently, respondents reported dedicating portions of their HIV/AIDS or STD funding to adolescents, either for direct program and service provision or through collaborations or subcontracts with CBOs. Generally, smaller LHDs, especially “second tier” jurisdictions with relatively high HIV/AIDS prevalence but no direct funding from the Centers for Disease Control and Prevention (CDC), perceived that funding priorities favor larger population centers and leave them without sufficient resources to support HIV/STD prevention overall, let alone to target adolescents.

Those who did have programs commonly described episodic efforts in place “when they had X grant.” Some related comments included:

We feel very limited in our ability to target youth. Funding comes from [the administration] for the entire state. There is a review of priorities, and it is decided for the whole state who receives funding for what. We participate in the [planning groups], but we are only one voice of many.

We used to have mini-grants that we could give to CBOs, but we don’t have that funding anymore.

LHDs’ Relationships with Schools
Respondents almost universally recognized schools as critical venues through which to reach adolescents. However, the depth and quality of school relationships varied widely. On the whole, school-LHD relationships, at least within the HIV units of the LHDs interviewed, were largely determined by individual rather than organizational relationships and were often described as occasional presentations by LHD staff in classrooms at the request of individual teachers. Systematic, collaborative, ongoing relationships were not commonly reported.

Abstinence-Only-Until-Marriage Policies
Almost universally, respondents who did report attempting to work with schools found abstinence-only-until-marriage policies to be a major barrier to reaching youth at risk. Because most of the respondents were directly responsible or had oversight of HIV/STD surveillance or STD or other clinics—both on-site and in satellite locations, including in schools—they were only too aware of the fact that youth in the community were engaging in unprotected sexual activity. The vast majority of respondents expressed frustration at not being able to provide adolescents with comprehensive HIV, STD, and pregnancy-prevention information in school settings.

Our major challenge is that they want to stick to a strictly [abstinence-only] program—[many youth are] abstaining from vaginal sex but are still participating in oral and anal sex. In the middle and high school you have to tell the kids like it is…

…They want to talk abstinence, but our stats say there is a lot of sexual activity. Their own surveys [Youth Risk Behavior Surveillance] talk about the risk behaviors of their students….

Schools need to meet us half-way, at least in regard to the curriculum…

In many cases, the barriers created by such policies were perceived as so substantial as to shift the focus of the LHD away from schools.
In some cases, the policies were unclear or were inconsistently enforced within a given school system.

*It is class-by-class in terms of what is allowed….We can talk about condoms sometimes…*

**School-Based Health Clinics**

School-based health clinics are not particularly common. Only 6.5 percent of schools nationwide have at least one school-based health center. However, where school-based health clinics exist, they can provide the opportunity to educate as well as to provide screening for HIV, STDs, and pregnancy. LHDs often administer or staff these clinics. However, while education is common within the clinic, external connections, such as from clinic to classroom, are less common.

*School-based health clinics* are satellite health departments in the schools, but there is not a lot of relationship with the school infrastructure.

In several schools we do urine-based STD screening, but we don’t actually do education there. There is not much relationship with the school infrastructure.

Another potential point of intervention for LHDs in schools is through curriculum development or adoption. However, few respondents reported involvement with schools in these areas. The most frequently cited reasons for LHDs not being involved in school curriculum development were because of school policies not supporting the input of outside organizations or supporting abstinence-only education.

**Gaining Entrée into Schools**

Several respondents reported more success at working with teachers, nurses, and other individual allies within the educational system than with their attempts to work with school system administration.

*The relationship is really very good with the school nurses and teachers. The struggle is with the administration—to allow open sharing of information…*

School nurses have a contract with the health department and are very involved in setting up prevention programs, but it seems to be at the discretion of the principal.

We’ve tried very hard, but the school board always turns us down. We have a lot of interaction with school nurses and the superintendent—both are interested but can’t allow it.

Respondents commonly cited relationships with teachers and nurses as their entrée to the schools. This was particularly true in what were described as conservative communities.

We work through teachers and nurses. [We] cannot go through the administration….we cannot do it on a broad basis.

Individuals would like to be involved [with the health department], but the [school] system doesn’t….There is more of a collaborative relationship with the charter schools.

We have to go on an individual level; you need an individual relationship. [The schools] have funding for HIV prevention, but they don’t look to the health department for prevention. It’s school by school….

There is a nurse from the health department at the schools who asks if representatives could sit in on the health curriculum meetings, but no schools have accepted the offer.

**Untapped Potential**

Some LHDs indicated that they had other opportunities to gain access to schools, which they had not yet pursued.

*I’m not sure what the schools do….I guess I should make that my business to get in there and find out. I talked to a teacher and she didn’t even know that we provide confidential teen services.*

*…There is an HIV specialist in the schools….but I have not met with them. We have the means and the outlets, but we need to do that…*

**School Performance Pressures as a Barrier to Health Education in the Classroom**

Increased emphasis on academic achievement and school performance measures was cited as another barrier to greater collaboration between schools and LHDs.

*It is not that the schools are not necessarily receptive, but they are so focused on [academic] testing that they cannot think about taking on anything more.*

Where respondents reported having the opportunity for more extended access to students, they often also reported a lack of staff resources to meet the demand for in-class presentations.

**Curricula**

Other respondents reported being involved in curriculum development. One large LHD reported helping the educational
development. One large LHD reported helping the educational agency review the HIV-prevention curriculum to make it more responsive to youth, with CBOs doing the same from their perspectives. The LHD described the process of working with teachers and administrators around issues of epidemiology, citing principles of health education such as “you want them to get there independently rather than try to get them to do what you want them to do.”

Because LHDs have access to the data that can support the need for addressing sexual risk behavior, they can be instrumental in helping communities understand the need for and importance of adolescent HIV, STD, and unintended pregnancy prevention. However, depending on the political and other realities of the community, advocating for these issues can be perceived as not the best use of limited resources as illustrated by this respondent:

**Successes**

Despite the many challenges described by participants, there were also success stories, which were often supported by policies permitting or encouraging comprehensive approaches to addressing sexual risk behavior:

[Our relationship with the schools] is exceptional. Not perfect but way better than other jurisdictions. The health department provides the health program—school staff are health department employees, fully supported by the schools. [We have the] flexibility to do things that the schools can’t. We can freely refer kids to STD and other related programs…

The health department is working more closely with the schools and recently took over all school-based health clinics. Once a year there is a training for teachers for STD and HIV testing and [the health department] updates them on new statistics [so that they can] then try to include it in their curriculum.

**REACHING YOUTH IN COMMUNITY AND HOME SETTINGS**

Respondents routinely acknowledged that parents, as a secondary audience for reducing sexual risk behavior, were a valuable and critical resource, but only a few LHDs reported any systematic means by which they target parents. One-time presentations at parent-teacher association meetings were the most commonly cited means by which parents were targeted. One LHD worked through churches to reach parents. Another worked with a local youth task force to host an annual teen health summit at which there are specific parent-centered groups. Some of the largest LHDs mentioned that agencies that they fund have worked with parents, but few described programs or initiatives with parents as a primary focus. Others were not at all connected with parents:

We haven’t [targeted parents], but that doesn’t mean it’s not happening [elsewhere in the community]….We don’t have the resources.

Parents were not always seen as allies in HIV/STD prevention. Several respondents reported that parents who oppose more comprehensive approaches to sex education or who do not agree with adolescent confidentiality laws were substantial barriers.

…[Some] parents still believe that when you provide children too much information about sex, you stimulate their curiosity and some may start thinking about experimenting with it now that you have it on their minds…

**REACHING YOUTH IN THE BROADER COMMUNITY—COLLABORATIONS AND PARTNERSHIPS**

A common strategy for HIV/STD prevention was collaboration with community partners and coalitions. An overarching theme of these community efforts was epidemiologic data that drove prevention efforts to populations or areas at highest risk.

Respondents from the largest LHDs often reported that they contracted out youth outreach services to CBOs whose focus was HIV prevention or youth. LHDs directly involved in adolescent HIV prevention—more often the smaller of what are still relatively large LHDs—reported a variety of venues through which they reached youth, including the following:

- CBOs, through collaborations or contracting
- Faith-based groups
- Runaway teen groups and shelters
- Churches and faith-based organizations
- Local and state legislative boards
- Teen clinics
- Children’s centers
- After-school programs
- Juvenile detention centers
- Sororities and fraternities of local universities
- Teen health programs
- Alternatives-to-incarceration programs
- Street outreach via mobile vans or on-foot (sometimes with peer outreach workers)
- Rural nursing programs
Of the above-listed venues for reaching youth, juvenile justice facilities, alternatives-to-incarceration programs, and drug treatment centers were the most frequently cited. Some LHDs reported difficulty gaining entry into some of these programs, due to perceptions of competing priorities, lack of trust, or a lack of a solid relationship with corrections-systems gatekeepers. The following response was typical of large, urban LHDs:

*We still fund a fair amount of non-positive stuff for youth. We try to look at all of the resources and fill the gaps where the resources aren’t.*

*We work with the juvenile detention center…working to do OraQuick with them but find it difficult to find folks to be supportive and helpful in that system.*

Respondents whose LHDs were directly engaged in youth HIV-prevention activities often acknowledged their sensitivity to the needs of youth, emphasizing their use of non-invasive STD and HIV screening methods and the use of peer interventions.

A few respondents described reaching youth through social channels, including malls, movie theatres, billboards, radio, and popular “hang-out spots.” Respondents used such channels to distribute condoms and pamphlets and to conduct interviews to get a sense of adolescents’ awareness of HIV/STD prevention. Other respondents noted working with the student-body representatives to discuss the dangers of risky behaviors during prom season, targeting seniors during the spring semester. Peer educators were often reported to be an integral part of these efforts, with some youth even riding along with staff in mobile outreach vans.

**REACHING YOUTH THROUGH ON- AND OFF-SITE CLINICAL SERVICES**

Another means by which LHDs reach adolescents is through their HIV, STD, or reproductive health clinics, either in their own facilities or, less frequently, through school-based health clinics. Confidential and free services for adolescents were almost uniformly considered essential to reaching adolescents in this manner. More often than not, respondents reported that their HIV, STD, and reproductive health services were integrated or that their clinic staff was cross-trained to ensure comprehensive services for both adolescents and adults.

In addition, LHDs in states that permit confidential HIV testing of minors reported that this was a valuable prevention tool. In one LHD, the HIV test is in high demand among both middle and high school students, despite a relatively low prevalence rate of HIV among youth. The pre- and post-test counseling sessions provided an opportunity for young people to get information that they believed they did not get in a classroom setting or at home. These visits to clinical settings were reported to be very dependent upon word-of-mouth and other less formal communication from young person to young person.

**Implications for Practice**

The following recommendations are based on the report findings and subsequent discussion with NACCHO’s HIV and STD Prevention Workgroup members.

- **Identify Stakeholders and the Unique Contribution of LHDs to Adolescent HIV Prevention**

While LHDs have a set of general responsibilities, each LHD has a unique role to play within the broader local public health system. Identifying community stakeholders and partners for adolescent HIV, STD, and unintended pregnancy prevention is central to defining what might be the optimal role and unique contribution of the LHD within this system. Stakeholders can include CBOs, faith-based organizations, youth groups, and parent-teacher associations.

- **Use LHD Data, Including Behavioral and STD Data, to Advocate for Adolescents as a Prevention Priority**

Data collection and dissemination is one unique contribution of LHDs in most communities. Through data, LHDs can describe the problem of adolescent HIV, STD, and unintended pregnancy rates in their local jurisdictions and provide stakeholders with valuable information to advocate for financial or other resources to be dedicated to prevention.

- **Build More Systematic Relationships with Schools**

Schools are where most youth are and can have a broad impact on the vast majority of the adolescent population. While it is not realistic for many LHDs to target youth at highest risk in these settings, building relationships at an organizational rather than interpersonal level can help both entities find common ground for providing important prevention information to students. This could be achieved through LHDs’ participation in school health advisory councils and schools’ participation in LHDs’ planning groups and coalitions, collaboration on classroom curricula, participation in parent-teacher associations, collaboration with school nurses or school-based clinic staff, or through the infusing of HIV prevention and related information into other subject areas. Schools may also be reached through
collaboration with school boards and individual members. If significant barriers to establishing new and systematic relationships with schools exist, LHDs might consider other cost-neutral efforts, such as attendance at community meetings to meet stakeholders within the education system to attempt to identify common ground.

Local school boards are one critical point of intervention within this system, and they can often be motivated by compelling data. Other points of intervention in schools include supporting efforts to establish or expand school-based health clinics and participating in school health advisory councils.

The CDC’s Division of Adolescent and School Health funds several local education agencies (LEAs) for HIV prevention. LHDs in jurisdictions with funded LEAs can look to their LEAs to learn how they are using these funds and explore areas for potential collaboration. The list of funded LEAs is available at www.cdc.gov/HealthyYouth/.

• Work with Community Partners to Identify and Reach Youth at Highest Risk

Define what is meant by “youth at highest risk” in a given community and target them directly or through partnerships with other government agencies and community organizations. Examples include alternative schools, juvenile detention centers, substance abuse treatment centers, youth homeless shelters, and other related human service or youth-serving agencies. Working in coalition with these partners can enhance both efficiency and creativity in programming.

• Work within the LHD to Identify and Leverage Resources

Identify and work strategically with all the stakeholders within the LHD. Host a meeting of those whose responsibilities do or could relate to adolescent health or adolescent HIV prevention, e.g., HIV prevention, STD prevention, reproductive health, health education, family health, school-based clinic staff, and school nurses. In an organized meeting of these individuals, discuss opportunities for leveraging resources and for communicating a unified message when working directly with or ensuring services for youth. Consider developing a strategic plan for collaboration and related activities. (See NACCHO’s Adolescent HIV Prevention demonstration sites for strategic planning models.)

• Involve Youth in the Planning and Implementation of Efforts Intended to Reach Them

One way to better ensure that programs and services are appropriate for and will be likely to reach youth in a given community is to engage them actively to the extent possible in all aspects of planning, implementation, and evaluation of services. One tool LHDs can use to assess the degree to which adolescents are involved in the programs is the Ladder of Youth Participation. The Ladder of Youth Participation begins with degrees of non-participation and moves up to youth being equal decision-makers alongside adults. The Ladder of Youth Participation consists of the following eight levels:

1. Youth are manipulated
2. Youth are decoration
3. Youth are tokenized
4. Youth are assigned and informed
5. Youth are consulted and informed
6. Adult-initiated, shared decisions with youth
7. Youth lead and initiate action
8. Youth and adults share decision-making

Optimally, adolescent participation in prevention-program design should be as high up on the ladder as possible. Forming partnerships with schools and other youth-serving agencies can help gain access to adolescents and eventually build relationships with them. Youth-serving agencies that already engage adolescent participation in their programs may be able to provide sound advice and guidance to LHDs.
Implications for Policy

The following recommendations are based on the report findings and subsequent discussion with NACCHO’s HIV and STD Prevention Workgroup members.

• **Improve HIV and STD Surveillance Systems to Improve the Ability of LHDs to Identify and Disaggregate Accurate Local-Level Data**

LHDs are often forced to rely on state HIV and STD data, which limits their ability to quantify accurately the extent of HIV and STD infection in their local jurisdictions or in specific areas (e.g., school district, zip code, or census tract) within a jurisdiction. The ability to disaggregate data by census tract, zip code, local jurisdiction, and region would greatly enhance the ability of LHDs to identify areas of need and justify committing scarce resources to those areas. This is particularly important given the limited data on HIV-infected youth.

Additionally, data must be collected on specific risk behaviors among adolescents. Prevalence of unintended pregnancy, STDs, and HIV lends only a narrow view into how adolescents are at risk. Improved surveillance systems for prevalence and risk behaviors among adolescents enable LHDs to pinpoint prevention efforts to specific high-risk subpopulations. LHDs in communities in which the Youth Risk Behavior Surveillance Survey is not conducted regularly in schools can help advocate for its administration.

• **Provide Support for Evidence-Based Unintended Pregnancy, STD, and HIV Prevention in Schools and Community Settings**

Policies and funding support for evidence-based comprehensive sex education could have a significant positive impact on the ability of LHDs to partner effectively with schools and community partners to reduce the avoidable negative outcomes of adolescent sexual behavior. Abstinence-only-until-marriage programs have little evidence of effectiveness and pose some challenging moral dilemmas. Unintended pregnancy, STD, and HIV-prevention education emphasizing abstinence but providing information on condom and contraceptive use do have evidence of effectiveness in both delaying the onset of sexual activity and reducing high-risk behavior and are supported by a wide array of medical, public health, and educational organizations, as well as by parents and the public at large.

• **Provide Funding to Support Comprehensive Adolescent HIV, STD, and Unintended Prevention, Particularly for Youth at High Risk of Infection**

More flexible funding or dedicated streams of funding for adolescent HIV prevention would address many of the funding-related barriers to adolescent HIV prevention raised by respondents. For example, flexibility to use HIV-prevention dollars to address STD prevention among youth might lessen the existing barriers to addressing adolescent sexual risk, both across the health department and in the community.
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FOR MORE INFORMATION, PLEASE CONTACT:

Jennifer Joseph, PhD, MEd
Program Manager
National Association of County & City Health Officials

P (202) 783 5550, Ext. 243
F (202) 783 1583
jjoseph@naccho.org