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A Grant Proposal to Fund Prevention Education for Teen Pregnancy, HIV, and Other Sexually Transmitted Infections in Targeted High Schools in Gwinnett County, Georgia

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ABSTRACT

A GRANT PROPOSAL TO FUND PREVENTION EDUCATION FOR
TEEN PREGNANCY, HIV, AND OTHER SEXUALLY TRANSMITTED INFECTIONS IN
TARGETED HIGH SCHOOLS IN GWINNETT COUNTY, GEORGIA

by
CONNIE LYNN RUSSELL

November 30, 2016

INTRODUCTION: This capstone project is a grant proposal to provide prevention services to adolescents using a comprehensive risk reduction approach modeled after the federal Personal Responsibility Education Program that supports abstinence and also provides medically accurate information regarding the use of birth control and condoms for the prevention of pregnancy and sexually transmitted infections, including HIV.

NEED: Teen births result in poorer outcomes for babies and mothers and have a negative impact on our economy. There are disparities in teen birth rates among racial and ethnic population groups, with young Hispanic and black girls having rates that are three to four times higher than young white girls. Sexually transmitted infections can lead to premature death and have negative impacts on sexual health. Adolescents and young adults are disproportionately impacted by HIV, as well as other sexually transmitted infections, such as chlamydia, gonorrhea, and syphilis.

PROPOSED PROGRAM: The proposed program consists of four main components, 1) implementation of the *Reducing the Risk* curriculum for all ninth-grade students in the Health Education course, 2) implementation of the *Be Proud! Be Responsible! Be Protective!* curriculum with pregnant and parenting teens, 3) presentation of adult preparation topics, and 4) referral to health services inclusive of family planning and STI/HIV testing as needed.

TARGETED POPULATION: The two targeted high schools serve a high proportion of minority and underserved youth in Gwinnett County. All ninth-grade students will be targeted for the main intervention and additional intervention will be provided for pregnant or parenting teens, as well as youth who have any of the following risk factors: sexual minority, students living in foster care, homelessness, and youth living with HIV/AIDS.

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APPROVAL PAGE

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Author's Statement Page

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Introduction

This capstone project is a grant proposal to provide prevention services to adolescents using a comprehensive risk reduction approach modeled after the federal Personal Responsibility Education Program that supports abstinence and also provides medically accurate information regarding the use of birth control and condoms for the prevention of pregnancy and sexually transmitted infections, including HIV.

Statement of Need

Teen Pregnancy

Teen births result in poorer outcomes for babies, including a higher percentage born with low birth weight and a higher percentage born prematurely (1). These infants are at great risk of death in their first year, as well as longer-term negative health outcomes such as serious illnesses, developmental delays and disabilities (1). Teens who have babies are more likely to drop out of school, resulting in lower educational attainment and greater risk of poverty for both the teen and the child (2). The estimated cost of teen childbearing to national, state, and local taxpayers in the United States was $9.4 billion in the year 2010 alone (3), the most recent year for which an estimate is available. A substantial portion of these costs are related to child welfare, public health care, and incarceration (3).

Reducing teen pregnancy is a national priority in the United States according to Healthy People 2020 (4). There are two Family Planning objectives related to this issue: "FP-8.1 Reduce pregnancies among adolescent females aged 15 to 17 years," and "FP-8.2 Reduce pregnancies among adolescent females aged 18 to 19 years." Other relevant Family Planning objectives include increasing the proportion of adolescents aged 17 years and under who have never had

sexual intercourse (FP-9) and increasing the use of condoms and other contraception to prevent pregnancy and disease among sexually active adolescents (FP-10 and FP-11).

Teen births in the United States reached a peak of 96.3 births per 1000 women aged 15-19 in 1956 and has declined during all but 4 periods (1969-1970, 1979-1980, 1986-1991, and 2005-2007) since that time until 2013 (1). Teen birth rates declined dramatically between 1991 and 2013, dropping 57% overall with only one period of increase from 2005 to 2007 (1). Between 2007 and 2013 the rate dropped 36%, to a low of 26.6 per 1000 (1). The teen birth rate declined further to 24.2 births per 1000 women aged 15-19 in 2014 (5). However, U.S. rates are still higher than those of many other developed countries (1) (6) and the highest among developed countries outside the former Soviet bloc (7). In fact, many developed countries have rates less than half of the U.S. rate for births per 1000 women aged fifteen to nineteen: Austria (9.1), Belgium (9.1), Denmark (4.6), Finland (7.7), France (9.4), Germany (8.2), Greece (9.8), Italy (6.3), Japan (4.5), Netherlands (4.8), Norway (7.1), Spain (9.6), Sweden (5.9), Switzerland (3.4) (7).

In addition, there are disparities in teen birth rates in the United States among racial and ethnic populations groups. While rates for various racial and ethnic groups have declined following a similar pattern to the overall trend in the United States, disparities continue to exist (8). For example, in 2011, the overall teen birth rate was 31.3 per 1000 females aged fifteen to nineteen: Asian females had the lowest rate at 10.2, non-Hispanic white females had the next highest rate at 21.8, American Indian or Alaskan Native females had a birth rate of 36.2, non-Hispanic black and Hispanic females had the highest rates at 47.4 and 49.4, respectively. The largest declines between 2007 and 2011 were seen in the Hispanic teen population at 34% and the black teen population at 24%, compared to white non-Hispanic teens at 20% (8).

Teens who have previously given birth to a child are at risk for additional pregnancies (9). In the United States, almost one in five births to teen mothers (age 15 to 19) is a "repeat birth," the birth of a second (or higher) child prior to the age of 20 years (9). Minority youth are 50% more likely to have repeat births than are non-Hispanic white youth (9). Although most teen mothers use some form of birth control, about 80 percent of teen mothers are not using the most effective types of birth control, such as long acting reversible contraceptives (9). Black teen mothers are about half as likely to use the most effective types of birth control (14%) compared to white (25%) and Hispanic (28%) teen mothers (9).

As of 2014, teen birth rates among states ranged from 10.6 in Massachusetts to 39.5 in Arkansas (10). Georgia ranked thirty-sixth in the nation for teen birth rate at 28.4 births per 1000 compared to the national rate of 24.2 (10). Georgia has one of the highest repeat teen birth percentages (along with 7 other states) at 20% (9). In Georgia, as in the nation as a whole, health disparities in teen birth rates exist, with Hispanic teens at 43.8 per 1000, non-Hispanic black teens at 36 per 1000, and non-Hispanic white teens at 23.3 per 1000 (10). The estimated cost of teen childbearing to taxpayers in 2010 was $395 million (11). As of 2011, the most recent year data is available, the teen pregnancy rate in Georgia was 59 per 1000 females aged fifteen to nineteen (10). In the same year, health disparities in teen pregnancy rate existed, with Hispanic teens at 95 per 1000, non-Hispanic black teens at 78 per 1000, and non-Hispanic white teens at 41 per 1000 (10).

In Gwinnett County, the teen birth rate is 27 per 1000 females aged fifteen to nineteen, slightly lower than the state teen birth rate of 28.4 (12). Disparities in teen births are evident in Gwinnett County: in 2015, the birth rate of Hispanic girls (aged 15 to 19) was at 37.7 per 1000, over four times that of non-Hispanic white girls at 8.9 per 1000, and over three times that of

non-Hispanic black girls at 11.9 per 1000 (13). In 2012, Gwinnett County was identified as being among the "25 persistently low-achieving school districts" that accounted for 20% of the students who dropped out in the U.S. and 16% of the teen births in the nation (2). This report points to teen pregnancy as a contributing factor to low graduation rates (2). Gwinnett was reported to have 1011 teen births within the county and a projected 5366 non-graduates (2).

Human Immunodeficiency Virus (HIV)

Though the incidence of HIV in the United States decreased by 19% between 2005 and 2014, there are still approximately 40,000 new cases diagnosed each year (14). HIV prevention remains a priority for the United States. The *National HIV/AIDS Strategy*, which was published in 2010 by the White House, was updated in 2015 to reflect the most current prevention and intervention research (15). Healthy People 2020 contains two objectives specifically targeting reduction in the number of new HIV infections among adolescents and adults (HIV-2) and reducing the rate of HIV transmission among adolescents and adults (HIV-3) (16).

Racial and ethnic disparities exist in HIV incidence. African Americans have the highest incidence, with 44% of new diagnoses in 2014 occurring in this group that comprises only 12% of the U.S. population (14). The incidence rate for Latino men and women represent 23% of new diagnoses while comprising 17% of the U.S. population (14). The HIV infection rate per 100,000 population of adolescents and adults for African Americans is 54.9, for Hispanics it is 18.7, and for whites it is 6.6 (15). In each of these three categories, men have rates that are at least three times higher than women (15). The incidence rate for African American men is the highest at 105.7 per 100,000, followed by Latino men at 41.8 and white men at 13.8 (15). Death rates (per 1,000) of people living with HIV in 2012 were higher for blacks (20.5) than whites (18.1) and Latinos (13.9) (15).

Adolescents and young adults are disproportionately impacted by HIV. In 2014, 22% of all diagnosed cases of HIV in the United States were in the 13 to 24 year old age range (17). Many of these cases were among men who have sex with men (MSM), 7,828 of the 9,731 cases (17). Young adults aged 18 to 24 years who have HIV are less likely than the overall population living with HIV to be aware of their HIV status, with only 56% aware in 2012 (17). Young people with HIV aged 13 to 24 are also less likely to be linked to care within 3 months of diagnoses compared to other age groups, with only 78% meeting this standard (17).

Gay, bisexual, and other men who have sex with men (MSM), bear a disproportionately high burden of HIV in the U.S. While incidence decreased 18% for white MSM , incidence increased for both Latino and African American MSM, 24% and 22% respectively from 2005 to 2014 (14). The most dramatic increases during this period occurred among MSM aged 13 to 24, with an 87 percent increase for both young black MSM (from 2,094 to 3,923) and young Latino MSM (from 866 to 1,617), and a 56 percent increase for young white MSM (from 756 to 1,179) (14). Death rates (per 1,000) of gay men living with HIV is highest among blacks and Latinos, compared to whites (15).

Regionally, the Southern United States is disproportionately impacted by HIV, with 44% of the U.S. population living with HIV in this area that represents 37% of the U.S. population (14). People living with HIV in most Southern states also have a higher death rate (14). Georgia is one of the top 5 states for HIV infection deaths with an age-adjusted death rate of 3.7 per 100,000 population in 2013 (18). In Georgia, only 81% of individuals who are infected with HIV are aware of their HIV status compared to the national average of 87%, placing Georgia among the top 4 worst performing states on this measure (14).

National patterns of HIV infection are reflected in Gwinnett County data. For example, the national pattern of disproportionate impact in young people holds, with 20 percent of new diagnoses occurring in the 13 to 24 year old age group in 2015 (19). Disparities in racial and ethnic groups also exist in Gwinnett County, with African Americans having the highest percent of new cases (49%), followed by Hispanic (15%) and white (9%) (note: race was unknown for 26% of new cases in 2015) (19).

Sexually Transmitted Infections (Chlamydia, Gonorrhea, and Syphilis)

The same behaviors that put adolescents at risk for pregnancy and HIV infection can lead to transmission of other sexually transmitted infections (STIs), such as chlamydia, gonorrhea, and syphilis. The CDC prioritized the reduction of these three STIs in Healthy People 2020 objectives STD-1,STD-6, and STD-7 (20). These infections can have negative impacts on adolescent and young adult sexual health, such as pelvic inflammatory disease, chronic pelvic pain, and infertility (21). Infection with an STI also increases the risk of acquiring or transmitting HIV (17). In addition, untreated syphilis can lead to stoke and visual impairment (22)

Sexually transmitted infections effect some segments of the population disproportionately. Nationally, gonorrhea and chlamydia impact adolescents and young adults at a higher rate than other age groups (22). Twenty-six percent of chlamydia cases occur in the 15 to 19 year old age group (22). Twenty percent of gonorrhea cases occur in the same age group (22). In the United States, 90% of syphilis cases are in men, with 83% of the cases occurring in MSM (22). Syphilis in the United States increased among gay and bisexual men from 2007 to 2014, with a dramatic increase of 15% from 2013 to 2014 (22).

Infection rates of these three STIs are high in Georgia. In 2013, Georgia had a rate of 514.8 chlamydia infections per 100,000 population and was ranked ninth in the nation for highest infection rate (21). The Georgia rate for women (721.2) was over twice as high as that for men (289.9) (21). During the same year, Georgia's gonorrhea infection rate was 143.7 per 100,000, with a national ranking of eighth highest state infection rate (21). The highest rates among Georgia women for both chlamydia and gonorrhea were in the 15 to 19 and 20 to 24 year old age groups (21).

In 2013, Georgia had the highest rate of syphilis (primary and secondary) in the United States, with 10.3 diagnoses per 100,000 population (21). While the state's ranking dropped to third in 2014, the rate actually increased to 12.3 per 100,000 population (23). In 2014, the Atlanta Metropolitan Statistical Area (MSA), which includes Gwinnett County, had a syphilis rate (all types) of 48.3 per 100,000 population, one of the highest MSA rates in the United States (23). Gwinnett County's syphilis rate (primary and secondary) was 11.2 per 100,000 in 2014 (23).

Consistent with the national data, Gwinnett youth are disproportionately impacted by sexually transmitted infections (24). The highest numbers of cases for chlamydia and gonorrhea are in the 15 to 19 and 20 to 24 age ranges (24). Syphilis numbers are highest in the 20 to 24 and 25 to 29 age ranges (24). Gwinnett county data also reveal racial and ethnic disparities, with blacks and Hispanics disproportionately impacted by all three of these sexually transmitted infections (24).

Targeted Populations

The proposed interventions will be targeted at racial/ethnic minority youth, sexual minority youth, pregnant girls, parenting teens, students living in foster care, homeless youth,

and youth living with HIV, as recommended by the federal Personal Responsibility Education Program (25). Data are not available on all of these indicators by school or school cluster, so the school selection criteria will be limited to percent of racial/ethnic minority students served and willingness of the school administration to support implementation of the intervention. While individual school administrators have the autonomy to implement interventions locally, not all school administrators who serve the most at-risk populations were willing to implement curricula that are different from those used broadly by the school system, apparently due to concerns about the potential controversy of teaching comprehensive risk reduction rather than abstinence-only approaches. This recruitment challenge has been noted previously in one published evaluation study of the *Reducing the Risk* curriculum (26).

The Gwinnett County Public School (GCPS) system, the largest in the state of Georgia, has an enrollment of 178,767 in this current school year 2016-2017 (27). The school system serves a very diverse population, with the overall student population composed of 31.77% black, 29.76% Hispanic, 24.28% white, 10.3% Asian, 3.68% multi-racial, and 0.21% American Indian students (27). Over 54% of the students in GCPS receive free or reduced lunch (28), indicating a fairly high level of poverty. GCPS is divided into 19 school clusters with 19 local cluster high schools, one district-wide STEM-focused high school, and several smaller alternative schools (28). Norcross High School and South Gwinnett High School were selected from among the 19 local cluster and specialty high schools to participate in the proposed interventions based on the high percentage of minority students and the willingness of administrators to support implementation in their schools.

Norcross High School serves the third highest percentage of Hispanic high school students in GCPS (27). The racial/ethnic composition of Norcross High School is 46.54%

Hispanic, 29.72% black, 13.85% white, 6.79% Asian, 2.92% multi-racial, and 0.18% American Indian (27). The free and reduced lunch participation is 67% at Norcross High School (28). Meadowcreek High School, which has the highest percentage of Hispanic students (27), is already participating in the AHYD program under PREP funding. The administration of the high school with the second highest Hispanic student population was not supportive of participation. Currently, 3,799 students attend Norcross High School, with 1139 in the ninth grade (27).

South Gwinnett High School, located in Snellville, serves the highest percentage of black high school students in GCPS (27). The racial/ethnic composition of South Gwinnett High School is 74.88% black, 12.48% Hispanic, 7.04% white, 3.32% multi-racial, 1.96% Asian, and 0.32% American Indian (27). The free and reduced lunch participation is 59.89% at South Gwinnett High School (28). Currently, 2500 students attend South Gwinnett High School, with 647 in the ninth grade (27).

Abstinence-Only Versus Comprehensive Risk Reduction Interventions

When selecting teen pregnancy prevention curricula, there are two main approaches to choose from, those that focus on abstinence-only education (AOE) and those that focus on comprehensive risk reduction (CRR) (29). Abstinence only education promotes abstinence as the best way to prevent pregnancy and may cover birth control and condoms, focusing on failure rates of these methods. Comprehensive risk reduction approaches also support abstinence as the best way to prevent pregnancy, but presents medically accurate information regarding the use of birth control and condoms as important for preventing pregnancy if the teen chooses to be sexually active.

Until 2010, federal funding for teen pregnancy prevention was only available for abstinence only education and the curricula had to meet a stringent list of requirements set forth in Title V Section 510 of the Social Security Act of 1996 (30) as outlined below:

> "(A) Have as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity
> (B) Teach abstinence from sexual activity outside marriage as the expected standard for all school-age children
> (C) Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems
> (D) Teach that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of sexual activity
> (E) Teach that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects
> (F) Teach that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society
> (G) Teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances
> (H) Teach the importance of attaining self-sufficiency before engaging in sexual activity."

Federal funding for comprehensive risk reduction approaches to teen pregnancy prevention was put into place under the Patient Protection and Affordable Care Act of 2010 (31). Funding under the Affordable Care Act supports evidence-based programs that use curriculum-based sexual education or youth development approaches targeting teen pregnancy prevention (29) and includes the Personal Responsibility Education Program (32).

The Affordable Care Act also funded a review of evidence for teen pregnancy prevention approaches (32) which was published in 2012 (29) and led to recommendations (33) that are part of the CDC's Guide to Community Preventive Services (34). Based on this systematic review (29), the Community Preventive Services Task Force recommends "group-based comprehensive risk reduction delivered to adolescents to promote behaviors that prevent or reduce the risk of pregnancy, HIV, and other sexually transmitted infections (STIs). The

recommendation is based on sufficient evidence of effectiveness in: 1) reducing a number of self-reported risk behaviors, including engagement in any sexual activity, frequency of sexual activity, number of sex partners, frequency of unprotected sexual activity; 2) increasing the self-reported use of protection against pregnancy and STIs; and 3) reducing the incidence of self-reported or clinically documented STIs" (33). On the other hand, the Task Force "finds insufficient evidence to determine the effectiveness of group-based abstinence education delivered to adolescents to prevent pregnancy, HIV, and other STIs" (33). Additional studies are underway to further assess group-based abstinence education (32).

Intervention Description

The proposed project will expand the GCHD AHYD program to 2 additional schools in Gwinnett County that have been identified as at-risk for teen pregnancy, HIV infection, and other STIs. These two additional schools are Norcross High School and South Gwinnett High School. The proposed program consists of four main components, 1) implementation of the *Reducing the Risk* curriculum for all ninth-grade students in the Health Education course, 2) implementation of the *Be Proud! Be Responsible! Be Protective!* curriculum with pregnant and parenting teens, 3) presentation of adult preparation topics, and 4) referral to health services inclusive of family planning and STI/HIV testing as needed.

Reducing the Risk

The proposed school-based curriculum to be implemented by the AHYD program is *Reducing the Risk*. The purpose of this curriculum is to prevent pregnancy and STIs, including HIV (35). The curriculum is approved by the current Georgia PREP program (36) and was selected from the Health and Human Services list of "Evidence-Based and Effective Programs" (35). The curriculum is appropriate for the proposed intervention because it is a classroom-

based curriculum that has been shown to be effective with racially and ethnically diverse high school student populations of both males and females (35). The classroom materials are available in both English and Spanish (35). The curriculum is not limited to sexually active teens so is appropriate for all students (35). Since sexual minority youth are a specific target population for the program, the LGBT adaptations provided as a supplement to the *RTR* curriculum will be used to make the curriculum more inclusive of LGBT youth (35). The sixteen-session curriculum of 45 minutes each can be taught as part of a one-semester Health Education course. High school students in the Gwinnett County Public School system are required to take one semester of Health Education. This course is usually taken in the ninth grade. *Reducing the Risk* will replace *Choosing the Best*, an abstinence-only program that is used widely in Gwinnett County Public Schools. Notification of the curriculum and the option to review materials prior to administration will be provided to all parents or guardians of students in the Health Education course and participation will be on an opt-out basis. This is recommended practice for most sexual education curricula, including *RTR*, and is also the practice used by GCPS for all sexual education.

The theoretical basis of *Reducing the Risk* is found in three theories: social learning, social inoculation, and cognitive behavior theory (37). *Reducing the Risk* focuses on teaching two main skills, refusal and postponement (37). Both of these skills can lead to later onset of sexual activity, reduction in number of sexual partners, and greater likelihood of using contraception and protection against sexually transmitted infections. The curriculum begins with teaching knowledge about pregnancy risk and prevention and HIV and other STI risk, prevention, transmission, treatment, and consequences. Teens also learn the consequences of unprotected sex. Abstinence and effective use of birth control are taught, along with skills to

obtain birth control and condoms if the teen decides to be sexually active. Sessions are designed to be interactive, with activities, small group discussions, and role playing for practice of newly forming communication skills. Assignments for two of the sessions encourage teens to talk with a parent or trusted adult about teen sexual activity and birth control.

Three quasi-experimental evaluations of the *Reducing the Risk* curriculum have been published, substantiating its effectiveness. The initial study, conducted in California with primarily white and Latino high school students, demonstrated increases in knowledge about abstinence and contraception, increases in teen communication with parents about abstinence and contraception, delays of onset of sexual intercourse among teens who had not previously had sex, and reduction in unprotected intercourse (38). The second study, conducted in Arkansas with white and black high school students, also revealed that students receiving the intervention communicated more with parents about contraception and protection from STIs, were more likely to delay onset of intercourse, and those who were sexually active were more likely to use condoms (39). More recently, the *Reducing the Risk* curriculum was evaluated in Ohio and Kentucky with a diverse population of high school students and was found to delay the onset of sexual activity, with a stronger impact on black than white students (26).

Be Proud! Be Responsible! Be Protective!

As noted earlier, teens who are pregnant or parenting are at risk for repeat pregnancies and sexually transmitted infections due to a history of unprotected sexual activity. The *Be Proud! Be Responsible! Be Protective!* (*BPBRBP*) curriculum was selected for use with pregnant and parenting teens, as this curriculum is specifically tailored to this population with an emphasis on reducing risky sexual behavior to prevent repeat pregnancy and sexually transmitted infections, including HIV (35). This curriculum is approved by the current Georgia

PREP program (36) and was selected from the Health and Human Services list of "Evidence-Based and Effective Programs" (35). The target age group is fourteen to eighteen (40), which is a good match for the high school age youth in this program. *BPBRBP* consists of eight modules that can be covered in one day or spread over as many as eight days in a community setting with groups of five to fifteen (35). The AHYD program will provide the curriculum once each semester, after school or on a series of Saturday mornings depending on the most convenient time for the participants. Topics include knowledge about and vulnerability to HIV and unplanned repeat pregnancy; attitudes and beliefs about HIV, AIDS, and safer sex; condom use skills; negotiation skills; and refusal skills (35).

The theoretical bases for *BPBRBP* are the social cognitive theory and the theory of reasoned action. The curriculum provides medically accurate information on pregnancy prevention, HIV, and other STIs (35). Outcome expectancies and attitudes are covered, along with building negotiation skills, self-efficacy, and confidence using positive reinforcement and feedback (35). The curriculum is interactive with role playing, facilitator modeling, and demonstrations of skills such as condom use (35).

The *BPBRBP* was evaluated for effectiveness with a population of primarily Latina (78% Latina, 18% black) low-income pregnant or parenting females in four Los Angeles County school districts (41). The study assigned the treatment and control (general health promotion sessions) randomly by school site in order to reduce the risk of treatment contamination and completed surveys with the students prior to and immediately following the intervention then three, six, and 12 months after completion of the intervention (40) (41). The focus of the intervention was HIV prevention with special emphasis on reducing sexual risk behaviors. The evaluation revealed that AIDS knowledge was better at baseline, immediately post-

intervention, and at 6 months post-intervention. Behavioral intentions to use condoms were greater at 12 months post-intervention for the intervention group. The intervention group had a significant decrease in proportion of participants engaging in risky sexual behavior at both 6 months and 12 months post-intervention. A decrease in number of sex partners was also demonstrated at 6 months post-intervention for the intervention group.

Adult Preparation Topics

PREP requires the presentation of at least three of six adult preparation topics as part of a funded program. The six options for adult preparation topics are adolescent development, educational and career success, financial literacy, healthy life skills, healthy relationships, and parent-child communication (25). The AHYD program will cover, at a minimum: parent-child communication, healthy relationships, and educational and career success.

Parent-Child Communication

Parent-child communication was selected as an adult preparation subject because parent-adolescent general communication and sexuality communication can lead to better outcomes for adolescent sexual and reproductive health (42). For example, teens who have talked to a parent about condom use prior to their first sexual intercourse are more likely to use a condom during first intercourse than teens who have not talked to a parent. The *Reducing the Risk* curriculum has been shown to increase parent-child communication about abstinence and birth control through the use of homework assignments (39). Monthly parent-only sessions will cover topics relevant to those being covered in the *Reducing the Risk* curriculum in health education classes. The intention of these parent education sessions is to improve parent knowledge and skills in communicating with their teen about healthy sexual behavior to prevent pregnancy and STIs (43).

Healthy Relationships

The adult preparation subject Healthy Relationships was selected because teens are more likely to delay initiation of sex and recognize situations that lead to coercion to participate in sex with an understanding of the characteristics of healthy and unhealthy relationships (43). The Health Department will enter into an agreement with Gwinnett Partnership Against Domestic Violence to teach two additional sessions of the Health Education course focusing specifically on forming and maintaining healthy relationships. Lessons 6 and 7 of the FLASH curriculum will be used to focus on healthy relationships and the prevention of sexual violence (44). Healthy communication skills, sexual rights, legal issues around sex, and sexual consent are covered in these lessons that aim to build healthy relationships and prevent sexual violence by building healthy social norms (44).

Educational and Career Success

Educational and Career Success was selected as an adult preparation subject because this has been identified as a need in the high schools serving at-risk youth. These youth are not only at-risk for poor sexual health outcomes, but also for poor educational and career outcomes. Case management will be used to address barriers to academic success that may be inclusive of sexual health issues. As with our program at Meadowcreek High School, ninth graders who are at-risk due to disciplinary actions, attendance issues, or academic performance will be referred by school faculty, staff, or administration for a strengths and needs assessment to determine potential supports for the student (43). Health Department staff with youth development training will provide this assessment and coordination of referrals along with ongoing monitoring of the student's achievement of goals.

Health and Social Services Referrals

As part of the case management mentioned above, the need for health services will be assessed and appropriate referrals will be made. The Health Department has three health centers in Gwinnett County that provide preventive health services such as family planning, pregnancy testing, HIV/STI testing and treatment, dental care, and immunizations (including HPV). All of these services are provided at a low cost to teens and the fees may be waived if extreme financial need is demonstrated. The Health Department partners with community agencies for referrals to other health services such as primary care and mental health services. Primary Care is available at two Federally Qualified Health Centers, the Cosmo Health Center and Four Corners Primary Care. Cosmo Health Center specializes in care for limited English proficient clients. Mental Health services are available through Viewpoint Health, a government-funded mental health provider that serves uninsured and underserved residents of Gwinnett County. Viewpoint Health services include a 24-hour access line, behavioral health screening, an adolescent crisis stabilization unit, individual and family counseling, intensive substance use recovery, and care management. Viewpoint Health also partners with Four Corners Primary Care for integrated physical and mental health services. The AHYD staff will document referrals for health services as part of their case management activities.

Participants in the *RTR* curriculum will also be referred for assessment and case management when any of the following risk factors are identified: sexual minority, students living in foster care, homelessness, and youth living with HIV/AIDS. Appropriate support services will be identified and goals will be monitored for these youth based on their voluntary participation. All female participants in the *RTR* curriculum who are pregnant or parenting will

be referred for case management and also recruited for participation in the *BPBRBP* curriculum. Parental consent will be obtained for participation for all students who are minors.

Outcomes Expected

Program Goals

The goals of the Gwinnett County Health Department Adolescent Health and Youth Development Program are to reduce teen pregnancy, reduce HIV infection and reduce other sexually transmitted infections among youth participating in the programs at Norcross High School and South Gwinnett High School.

Objectives

Outcome Objectives

The following outcome objectives will be measured as part of the program evaluation:

1. Students completing the *RTR* or *BPBRBP* curriculum will show an improvement in pregnancy, HIV, and other STD knowledge at the end of the final curriculum session.
2. Students completing the *RTR* or *BPBRBP* curriculum will show an increased intention to abstain from sexual intercourse.
3. Students completing the *RTR* or *BPBRBP* curriculum will delay initiation of first sexual intercourse.
4. Students completing the *RTR* or *BPBRBP* curriculum will decrease number of sexual partners.
5. Students completing the *RTR* or *BPBRBP* curriculum who choose to be sexually active will increase use of effective methods of contraception.
6. Students completing the *RTR* or *BPBRBP* curriculum who choose to be sexually active will increase use of condoms.

(Note: The specifics of these outcome objectives will be determined by baseline measures obtained during the curriculum pre-test and are subject to revision based on input from evaluation stakeholders.)

Process Objectives

The following process objectives will be measured to ensure reach and effectiveness of the proposed intervention:

1. At least 90% of students taking 9th grade Health Education class will participate in the *RTR* curriculum each semester (a total of 1607 students per year, inclusive of both high schools).
2. At least 12 pregnant or parenting students (in any grade) will participate in the *BPBRBP* curriculum each semester at each high school (a total of 48 students per year, inclusive of both high schools).
3. The curricula will be implemented with at least 90% fidelity as indicated on the fidelity forms.
4. At least 90% of participating students will attend at least 75% of sessions (12 of 16 for *RTR* and 6 of 8 for *BPBRBP*).
5. At least 10% of students participating in *RTR* will receive a case management assessment based on referral and identification of at-risk status (such as living in foster care, identifying as a sexual minority, living with HIV/AIDS, homelessness or evidence of need for other health or social services related to sexual health or school success).
6. At least 90% of students participating in *BPBRBP* will receive a case management assessment (as these teens are already identified as being at higher risk for sexual health issues due to past or current pregnancy).

Logic Model

A one-page logic model (see Attachment 1) illustrates the inputs, intervention activities, and expected outcomes of the proposed program.

Inputs

Implementation of the program will require one full-time Program Coordinator and 4 part-time contracted Facilitators. The curricula are *Reducing the Risk* and *Be Proud! Be Responsible! Be Protective!*. Associated materials will include program forms (enrollment, parental consent, session fidelity), sign-in sheets, student workbooks, activity kits, educational pamphlets, and incentives for pregnant and parenting teen participation. Equipment will be limited to a laptop and for each staff person and a mobile phone for the Program Coordinator. The costs of these inputs are provided in the budget and budget narrative.

Intervention Activities

The essential activities of the program are listed in the program Logic Model (see Attachment 1). An overview of program activities is provided in the Intervention Activities document (see Attachment 2). Initial activities will include recruitment of program staff and training of program staff on the curricula, case management requirements, and data collection for the program evaluation. Curricula training will be provided by professionals who are certified to deliver this training and a professional trainer will oversee staff that are facilitating the curricula.

At the beginning of the semester, parents of students in Health Education classes will be sent notification for participation and the option to review *RTR* content. All parental opt-out responses will be tracked and those students will receive alternative health instruction during classes when *RTR* is implemented. Implementation of *RTR* will begin approximately 5 weeks

into the semester, with two or three sessions per week until all 16 sessions are completed. The pre-test will be administered at the beginning of the first RTR session. The post-test will be administered at the last RTR session. Fidelity forms are completed by Facilitators after every session. The two Healthy Relationships sessions will be conducted by the community agency Partnership Against Domestic Violence in two Health Education class periods after the final RTR session and prior to the end of the semester.

Female students who are identified by school or program staff to be pregnant or parenting will be invited to participate in the *BPBRBP* program that will be administered in four two-hour sessions at a time that is convenient for the students. Incentives, such as gift cards to local stores, will be provided to each participant at each session in order to support participation in an activity that takes place outside normal school hours. The *BPBRBP* program will be implemented once each semester. Participants will complete the pre-test at the first session and post-test at the end of the final session. Fidelity forms are completed by Facilitators after every session.

Case management will be ongoing throughout the school year as students are referred. Parents are asked to complete an enrollment form that includes a consent to participate for students who are referred. This process is currently used with students at Meadowcreek High School and has been effective in obtaining consent for participation, as well as gaining some basic information about the student and their family context.

Sexual Health topics will be taught during monthly Saturday morning sessions for parents of students who are participating in any of the components of the GCHD AHYD program at each high school. Program staff will work with school staff to advertise these sessions to parents and promote attendance. This is a popular component of our program at

Meadowcreek High School as many parents are glad to have the opportunity to learn more about supporting responsible sexual health choices.

Outcomes

The anticipated short-term, intermediate, and long-term outcomes of the program are outlined in the program Logic Model and discussed in greater detail earlier in this grant proposal. It is expected that the program will lead to increased knowledge and skills related to prevention of pregnancy, HIV, and other STIs. This in turn will lead to behavior changes that protect against pregnancy, HIV, and other STIs. Ultimately, the long-term outcome is expected to be reduced pregnancy, HIV infection, and other STIs among the participating students.

Evaluation

Data will be collected in order to conduct process and impact evaluations. Details are provided in the Evaluation Matrix (Attachment 3). The process evaluation will document the program activities, reach, dosage, and quality (fidelity) of implementation. The impact evaluation is a pre/post-test evaluation of strategic indicators of knowledge, intent, and behaviors related to prevention of pregnancy, HIV infection, and other STIs. Knowledge will be tested using the proprietary pre/post-test survey provided with the *RTR* curriculum (37). This survey is considered to be part of the curriculum and is covered under the opt-out document that is sent to the students' parent or guardian at the beginning of the school year. Intentions and behaviors will be measured from a subset of questions from two validated instruments: a published RTR evaluation (38) and the *Youth Risk Behavior Survey* (45). A separate notice and opt-in consent will be utilized for this portion of the survey, along with assurances of confidentiality of the students' responses.

Process and outcome indicators will be reported for each semester, at the end of each school year, and in a final project report spanning the three year funding period. Evaluation reports will be utilized to make adjustments to procedures as needed to better meet the objectives of the program. Barriers to evaluation and observed best practices will be noted in the annual and final reports. In addition to these measurements, the program will collect and submit any other data that is required by the funder.

Organizational Capacity

The Gwinnett County Health Department provides prevention-focused healthcare services to the uninsured and underinsured in Gwinnett County, as well as providing other services that protect our community from illness and disease. The mission of the organization is "to protect and improve the health of our community by monitoring and preventing disease; promoting health and wellbeing; and preparing for disasters." The Health Department partners with Gwinnett Medical Center, the Strickland Family Medicine Center, and other community organizations such as Gwinnett County government, Gwinnett Coalition for Health and Human Services, and the United Way to assess the health of the community and plan for initiatives to improve health.

Over 103,000 residents received prevention-focused healthcare services from the Gwinnett County Health Department in 2015. Services provided to the community at the three Health Centers in Lawrenceville, Buford, and Norcross include child and adult immunizations (153,774 vaccinations in 2015), school screenings, breast and cervical cancer screenings, child health exams, dental care for children, international travel vaccinations, family planning, STD testing and treatment, refugee health, DNA tests. The WIC nutrition program focuses on promoting health through nutrition education and healthy foods for pregnant and

breastfeeding mothers, infants, and children to age 5 are provided at these locations, as well as a free standing WIC clinic in Lilburn. Approximately 22,000 women, infants, and children are served each month in the WIC program. Referral and case management programs such as Children First; Early Hearing Detection and Intervention, and Children's Medical Services ensure that children identified in our community to be most at-risk receive the services they need for optimal growth and development, leading to better health, school readiness and success for our children.

Other programs aim to reduce the burden of illness throughout the community, impacting all who live and work in Gwinnett County. For example, the Epidemiology program monitors outbreaks of illness such as tuberculosis and food-related outbreaks and reduces illness through treatment and infection control interventions. Public health surveillance is conducted on more than 50 diseases and conditions. Environmental Health ensures the health of the community through regulation of restaurants and school cafeterias, community pools, body art establishments, and septic systems. This nationally recognized Environmental Health program has received funding to serve as a mentor to other health departments across the nation. The Health Department's Emergency Preparedness program supports community healthcare organizations in preparing for natural and man-made disasters, including regular convening of the Healthcare Emergency Local Planning (HELP) committee.

The Gwinnett County Health Department is part of a tri-county local health district known collectively as the Gwinnett, Newton, and Rockdale County (GNR) Health Departments. The GNR Health Departments employ approximately 320 individuals. The Chief Executive Officer and Medical Director is Lloyd M. Hofer, M.D., M.P.H. Dr. Hofer is a licensed and board certified pediatrician. The AHYD program is under the supervision of Debbie Crowley, APRN,

Deputy District Program Director, who has over 20 years of experience in delivering family planning services to adults and youth. She supervises our Director of Adolescent and School Health, Andre Castro, MPA (see Attachment 4). The composition of the Board of Directors is dictated by Georgia law and consists of both elected officials and appointed positions (see Attachment 5). The Board Chair, Mrs. Louise Radloff, is an elected school board member and strong supporter of youth programs in the community.

The focus of the Gwinnett County Health Department Adolescent Health and Youth Development (GCHD AHYD) program is to promote health and well being among adolescents in our community. The Health Department has always served adolescents in our clinics. In addition, the Health Department has been operating a school-based adolescent health and youth development program at Meadowcreek High School in Norcross, Georgia since 2005 under the leadership of Andre Castro. The program began as an after-school program established with funds provided by the Georgia Department of Public Health to address high teen pregnancy incidence, especially among Latina youth, using an abstinence-only approach. Subsequently, the program was integrated into the school day to maximize impact.

Beginning in 2011, GCHD AHYD received federal Personal Responsibility Education Program (PREP) funds through the Georgia Department of Public Health DPH) via the Georgia Department of Human Services to serve this at-risk population using a comprehensive risk reduction approach to teen pregnancy, HIV, and other STI prevention, with the inclusion of adult preparation subjects. The current PREP grant concluded five years of funding at the end of the 2015-2016 school year. The 2016-2017 school year marks the beginning of another 5-year PREP cycle to be administered at Meadowcreek High School. The program has been recognized by the Georgia DPH as a Program of Excellence that has served more students than

any other PREP-funded health department in the state, illustrating the successful recruitment and administration skills of our program staff.

Funding for the proposed project will allow for the hire of a full-time Project Coordinator and four contracted Program Facilitators (two at each high school). The Project Coordinator will have training and experience in health promotion and youth development and will oversee the implementation and evaluation of the two high school programs. The Program Facilitators will implement the two selected curricula and provide case management to youth who are identified as most at risk.

The Finance Department of the organization follows standard accounting practices and is audited by an independent accounting firm on an annual basis. The reports, which are available upon request, demonstrate a long history of strong financial management. Programmatic reviews are conducted regularly in the form of self-reviews, state program reviews, and federal funder reviews. The Health Department has a strong reputation for programmatic compliance and appropriate expenditure of program funds.

Protection of Sensitive and/or Confidential Information

All student records are handled in compliance with FERPA and HIPAA. Employees receive regular training on HIPAA and confidentiality. All contractors sign a Partner Agreement confirming that they will protect all confidential information. Background investigations of employees and contracted facilitators are stored and managed according to applicable state and federal laws. A recent routine external compliance review resulted in no findings for these procedures.

Third-Party Agreements

A memorandum of understand (MOU) will be signed with each high school delineating the responsibilities of the Gwinnett County Health Department and the high school (see Attachment 6 for MOU template). Program Facilitators are contracted by the Gwinnett County Health Department to implement critical aspects of the AHYD program (see Attachment 7 Program Facilitator contract template).

Letters of Support

Letters of support will be provided by key community partners, including Positive Impact Health Centers, Cosmo Health Center, Four Corners Primary Care Center, Viewpoint Health, and Partnership Against Domestic Violence (see Attachment 8 for letter of support template). Positive Impact Health Centers will provide testing and ongoing treatment for HIV/AIDS for students as needed. Cosmo Health Center and Four Corners Primary Care Center will provide primary care to uninsured and underinsured students as needed. Cosmo specializes in serving populations with limited English proficiency. Viewpoint Health will provide crisis intervention and ongoing mental health services for students as needed. Partnership Against Domestic Violence will teach the Healthy Relationships sessions during Health Education classes and will also provide family support for victims of domestic violence.

Project Budget

The total amount of funds requested under this grant proposal is $516,259 (see Attachment 9 - Project Budget).

Personnel

One Project Coordinator will work full-time for three years to oversee all aspects of the project, including supervision of contracted Program Facilitators. This individual will have a Master of Public Health in Health Promotion and Behavior with at least 3 years of experience working with adolescents in a public health program. The annual salary will be $47,000 and the 3-year total will be $141,000.

Fringe Benefits

Fringe costs for the Program Coordinator include health insurance (30.454%), retirement (24.810%), and FICA (7.65%) for a total of $29,570 annually (62.914% of $47,000). The 3-year total will be $88,710. These are standard percentages for all health department employees determined by the state personnel board.

Travel

The Program Coordinator and one other staff person will travel to the grantee's conference each year for program updates and sharing of best practices. The travel costs will include two round-trip airfares at $155 each ($310) and 3 nights for two people in a hotel at $129 per night (2 x $387 = $774). The total cost for travel to the conference each year will be $1,084.

Additionally, it is expected that the Program Coordinator will travel between the two high schools three times each week for management and implementation of the program. With a reimbursement rate of $.55 per mile, the estimated travel cost per year will be $1,069 (36 weeks x 3 trips per week x 18 miles x $.55 per mile).

Equipment

No equipment (value > $5000) will be purchased with these funds.

Supplies

The Program Coordinator and four Program Facilitators will use lightweight 2-in-1 touchscreen laptops for communications with staff and students, instructional support, and data collection. The selected laptop costs $799 for a total cost of $3,995 (5 x $799).

The Program Coordinator will receive a smart phone for communications with staff and students at an initial purchase price of $400 to be used for the full grant cycle.

The Program Coordinator and each of the four Program Facilitators will have a *Reducing the Risk* Enhanced Set which includes:

- Teacher's Guide
- Student Workbooks (classroom set of 30)
- Activity Kit
- *STD Facts for Teens* pamphlets (50)
- *HIV Facts for Teens* pamphlets (50)
- *Birth Control Facts for Teens* pamphlets (50)
- All materials in the Basic Set
- *STD Facts* laminated poster
- *HIV Facts* laminated poster
- *Birth Control Choices* laminated poster
- *How to Use a Condom* DVD
- *Understanding Self-Identity* LGBTQ supplement

This is a one-time expense of $1750 (5 x $350) at the beginning of the program.

At Norcross High School there will be approximately 38 sections of Health Education each year and at South Gwinnett High School there will be approximately 22 sections (30 students per section). This will require the purchase of additional materials each year, to include 36 sets of 50 (for 1800 students) of *STD Facts for Teens* pamphlets, *HIV Facts for Teens* pamphlets, and *Birth Control Facts for Teens* pamphlets at $.29 each, for an annual total of $1566 and a three-year total of $4698.

Each high school will have a *Be Proud! Be Responsible! Be Protective!* curriculum basic kit at $1290 (2 x $645) as a one-time expense. Each school will serve approximately 24 students each year.

Contractual

The four Program Facilitators will be contracted at $1800/month during each school year (4 x $18,000/month for 10 months) for an annual total of $72,000 and a three-year total of $216,000.

Other

Participants in the program for pregnant and parenting teens will receive incentives for attendance totaling approximately $10 for each 2-hour session attended in the form of gift cards for baby supplies or gas cards for transportation. The program budget will be $1920 annually (48 students/year x $10/session x 4 sessions).

The telecommunications cost for the Program Coordinator's mobile phone service will be $600 annually ($50 per month).

Indirect Charges

The Health Department has an indirect charge of 8.6% for all programs. This rate is determined by the Georgia Department of Public Health per the Gwinnett Cost Allocation Plan. The total indirect charge for the three year funding period will be $44,379.

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Attachments List

Attachment 1 – Logic Model

Attachment 2 – Intervention Activities

Attachment 3 – Evaluation Matrix

Attachment 4 – Organizational Chart

Attachment 5 – Board Composition

Attachment 6 – Memorandum of Understanding (MOU) for Participating High Schools Template

Attachment 7 – Program Facilitator Contract Deliverables

Attachment 8 – Letter of Support Template

Attachment 9 – Project Budget

Attachment 1 – Logic Model

Inputs	Activities	Outcomes		
		Short-Term	**Intermediate**	**Long-Term**
Staff 1 Program Coordinator(PC) (full-time) 4 Facilitators (part-time, 2 for each of 2 high schools) **Materials** Program Enrollment forms Parental Consent forms Session Sign-in sheets Session Fidelity forms Student workbooks Activity Kit Educational pamphlets Incentives for participation (pregnant & parenting teens) **Curricula** • *Reducing the Risk* • *RTR* LGBT Supplement • *Be Proud! Be Responsible! Be Protective!* **Supplies** 5 Laptops for staff 1 mobile phone **Funding** $516,259	Train program staff on: • *RTR* and *BPBRBP* curricula • Case management requirements and documentation • Data collection for program evaluation Facilitators implement the *RTR* Curriculum (16 sessions each semester) as part of the Health Education Class for all 9th Graders PADV implement the Healthy Relationships lessons (2 sessions per semester) as part of Health Education Class for all 9th Graders Facilitator implement the *BPBRBP* Curriculum on weekend or evening (four 2-hour sessions each semester) PC or Facilitator Implement Parent-Only Classes on Sexual Health topics (1 class per month on Saturday morning – 4 classes each semester) Provide assessment and case management: make Health and Social Service Referrals as appropriate. Track student goals. PC implement program evaluation.	Increase knowledge of risk behaviors related to pregnancy, HIV, and other STIs Increase knowledge of contraceptives and their efficacy Increase knowledge of proper condom use Increase intentions to abstain from sexual intercourse Increase intention to use contraceptives if sexually active Increase intention to use condoms if sexually active Increase refusal and postponement skills Increase sexual health communication with parent	Increase abstinence from sexual intercourse Delay initiation of first sexual intercourse Decrease number of sexual partners Increase use of effective methods of contraception by those teens who choose to be sexually active Increase use of condoms by those teens who choose to be sexually active	Reduce teen pregnancy among youth attending high schools identified to be at-risk in Gwinnett County Reduce HIV among youth attending high schools identified to be at-risk in Gwinnett County Reduce other sexually transmitted infections among youth attending high schools identified to be at-risk in Gwinnett County

Attachment 2 – Intervention Activities

	Years 1, 2, & 3											
Activity	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**
Staffing												
Hire/Contract Staff	■											
Train Staff	■											
Recruit Students & Parents												
RTR Notification & Opt-out	■					■						
BPBRBP invitations	■					■						
BPBRBP Consent	■					■						
CM Parent letters	■					■						
CM application/consent	■	■	■	■	■	■	■	■	■	■		
Advertise Parent Seminars	■	■	■	■	■	■	■	■	■	■		
Implement Programs												
RTR (16x/semester)		■	■	■	■		■	■	■	■		
BPBRBP (4x/semester)		■	■	■	■		■	■	■	■		
Case Management	■	■	■	■	■	■	■	■	■	■		
Parent Seminars (1x/mo)		■	■	■	■		■	■	■	■		
Evaluate Programs												
RTR Pre-test		■					■					
RTR Post-test					■					■		
RTR Attendance		■	■	■	■		■	■	■	■		
BPBRBP Pre-test		■					■					
BPBRBP Post-test					■					■		
BPBRBP Attendance		■	■	■	■		■	■	■	■		
Maintain CM Records		■	■	■	■		■	■	■	■		
Parent Eval. of Seminars		■	■	■	■		■	■	■	■		
Update Procedures						■					■	
Reporting												
Write Semester Report						■					■	
Submit Semester Report							■					■
Write Annual Report											■	
Submit Annual Report												■
Report to Stakeholders							■					■

RTR=Reducing the Risk, *BPBRBP=Be Proud! Be Responsible! Be Protective!*, CM=Case Management

Attachment 3 - Evaluation Matrix

Type of Evaluation	Question	Indicators	Data Collection Sources	Methods	Sample	Timing
Process Evaluation	Is the intervention reaching the intended population?	Number of students participating in the RTR curriculum Number of students participating in BPBRBP curriculum Number and risk status (e.g., homeless, LGBT, foster care, HIV) of students participating in case management Number of parents participating in the monthly Sexual Health Seminars	Attendance logs	Document Review	Students enrolled in Health Education classes and BPBRBP Parents of students participating in AHYD programs	Attendance is documented at all sessions
Process Evaluation	Are the curricula being implemented with fidelity?	Fidelity Forms are completed for 100% of RTR sessions At least 90% of RTR sessions meet all fidelity measures fully Fidelity Forms are completed for 100% of BPBRBP sessions At least 90% of BPBRBP sessions meet all fidelity measures fully	RTR Fidelity Forms BPBRBP Fidelity Forms	Document Review	All sessions of the RTR and BPBRBP curricula	Form is completed immediately after each session is conducted
Process Evaluation	Are participants receiving an adequate "dose" of the intervention?	Percent of students attending at least 75% of sessions (12 of 16 RTR) (6 of 8 BPBRBP)	Attendance records (from student sign in sheets)	Document Review	All students enrolled in each curriculum	Student Attendance taken at every session.

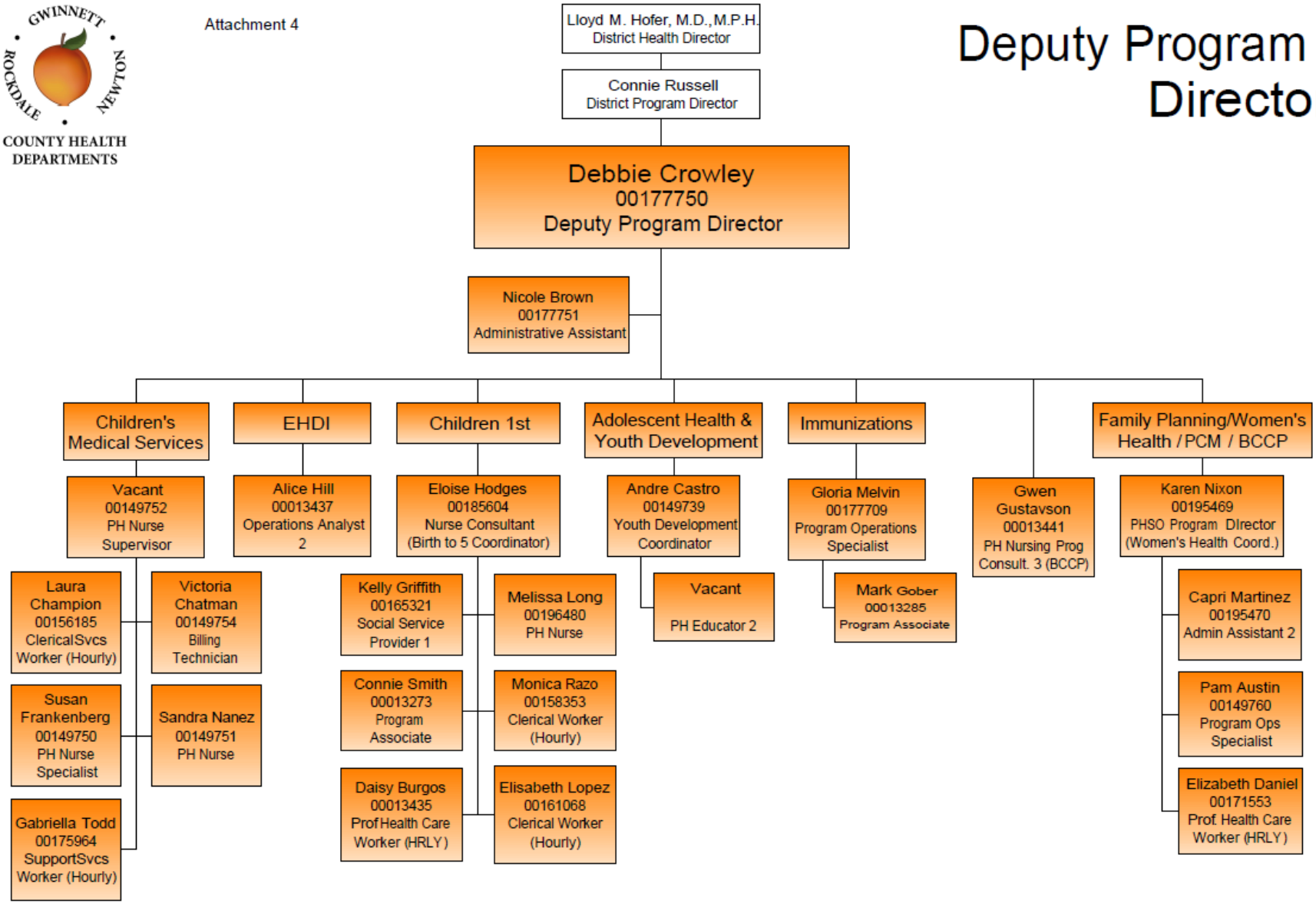
Process Evaluation	Did at least 10% of students receive a case management assessment?	The number of students with a completed case management assessment divided by the number of students taking Health Education Class each semester	Case Management records and Health Education Class enrollment	Document Review	All students enrolled in each curriculum	All case management documented at time of session. Measure evaluated at the end of each semester
Impact Evaluation	Did at least 80% of students completing the curriculum show an improvement in pregnancy, HIV, and other STD knowledge?	The percent of students participating in each curriculum that shows an improvement in pregnancy, HIV, and other STD knowledge, including contraception and condom use	Knowledge-based Pre-test and Post-test	Pre-Test and Post-Test administration	All students enrolled in each curriculum	Knowledge Pre-Test is administered during the first session of each curriculum. Knowledge Post-Test is administered after the last session of each curriculum.
Impact Evaluation	Did students' intentions related to sexual risk behaviors change as a result of the two curricula?	Increase intentions to abstain from sexual intercourse Increase intention to use contraceptives if sexually active Increase intention to use condoms if sexually active Increase refusal and postponement skills	Intention-based Pre-test and Post-test	Pre-Test and Post-Test administration	All students enrolled in each curriculum	Intention-based Pre-Test is administered during the first session of each curriculum. Intention-based Post-Test is administered after the last session of each curriculum.

Impact Evaluation	Did students' sexual risk behaviors change as a result of the two curricula?	Increase abstinence from sexual intercourse Delay initiation of first sexual intercourse Decrease number of sexual partners Increase use of effective methods of contraception by those teens who choose to be sexually active Increase use of condoms by those teens who choose to be sexually active	Behavior-based Pre-test and Post-test	Pre-Test and Post-Test administration	All students enrolled in each curriculum	Behavior-based Pre-Test is administered during the first session of each curriculum. Behavior-based Post-Test is administered after the last session of each curriculum.

GWINNETT ROCKDALE NEWTON
COUNTY HEALTH DEPARTMENTS

Attachment 4

Deputy Program Director



Effective: 11/01/2016
Revised: 10/24/2016

Attachment 5 – Board Composition

COMPOSITION OF THE GWINNETT COUNTY BOARD OF HEALTH

This is to certify that the following persons are members of the **Gwinnett** County Board

of Health, in accordance with the provision of OCGA Sec. 31-3-2.

NAME	APPOINTMENT	TERM
Charlotte J. Nash Commission Chairman Gwinnett Board of Commissioners	Chief Executive Officer of the county's governing authority (or other member designee)	While in Office
Louise Radloff - Chairman	Consumer representing on the Board, the County's consumers of health services Appointed by Governing Authority of County	January 1, 2011- December 31, 2016
Mike Mason – Vice Chair Mayor of Peachtree Corners	Chief Executive Officer of largest municipality in county (or other member designee)	While in Office
Alvin Wilbanks GCPS Superintendent	Superintendent of largest school system	While in Office
Alan Bier, MD Gwinnett Medical Center	Public Health consumer or nurse appointed by Governing Authority of largest municipality of the county	January 1, 2011 – December 31, 2016
Joy Monroe	Consumer member appointed by the Governing Authority of the county to represent the needy, underprivileged, or elderly	March 22, 2016 – December 31, 2021
Earl Grubbs, MD, FACEP	Physician appointed by the Governing Authority of County	January 1, 2012 – December 31, 2017

Attachment 6 – Memorandum of Understanding (MOU) for Participating High Schools Template

Adolescent Health and Youth Development

Memorandum of Understanding (MOU)*

The Gwinnett County Board of Health and _____ High School agree to the following roles and responsibilities in the administration of the school-based Adolescent Health and Youth Development (AHYD) Program.

The AHYD Program will provide in-school adolescent health and youth development services for the participating students at _____ High School during the school day and after-school activities. The program will be based on the AHYD Program deliverables.

The Mission of the Adolescent Health Youth Development Program is to focus on the prevention of at-risk behaviors through education, mentoring, recreation and skill building of adolescents enrolled in public middle and high schools. At-risk behaviors are identified as (but not limited to):

- Involvement in sexual activity
- Pregnant or parenting teen
- School attendance issues
- School academic issues
- Grade retention
- Gang involvement
- Disciplinary issues

Our goal is to collaborate with parents, school and community partners to deliver a coordinated array of services and programs that support the development of adolescents into healthy and productive adults.

This MOU contains three sections:

- Joint responsibilities of the Gwinnett County Board of Health and _____ High School
- Responsibilities of Gwinnett County Board of Health
- Responsibilities of _____ High School

A. Joint Responsibilities of Gwinnett County Board of Health and _____ High School

1. Support and commit to improve the social, emotion and academic competencies of students and focus on prevention and reduction of at risk behaviors. Reduce teen pregnancies in students enrolled in AHYD evidence-based programs. Provide and support parental involvement and education
2. List and disseminate all procedures and regulations for health, fire, safety, parent consents, transportation, food, sport-related health exams, insurance, medical and other emergency procedures in compliance with Gwinnett County Board of Education and Gwinnett County Health Department Program standards when applicable.
3. Structure and facilitate meaningful communication between school and AHYD Program staff. Provide on-going opportunities for school and AHYD Program staff to plan, coordinate, and integrate curricular areas with AHYD Program activities.

4. Hold scheduled monthly meetings between the Youth Development Coordinator (YDC) and School Principal, as well as other appropriate personnel to discuss issues pertaining to the AHYD Program. Issues could include, but not limited to, staff performance, program effectiveness, student development and program evaluation.
5. Develop mechanisms and opportunities to communicate on a regular basis with the Parent Teacher and Student Association (PTSA) and family members of the AHYD Program students (e.g., Parent Center, HS website, PH website)
6. School and AHYD Program staff work collaboratively to recruit, select and enroll student participants in the AHYD Program and disseminate procedural information widely.

B. Responsibilities of the Gwinnett County Board of Health

1. Communicate and provide information to the School about the AHYD Program through scheduled meetings between the YDC and the School Principal.
2. Recruit, hire and train all program staff.
3. All AHYD staff will complete a background check prior to beginning work as per District Policy.
4. Manage the day-to-day operations of the AHYD Program and notify the school of any problems, issues and concerns in a timely fashion.
5. Track student enrollment and attendance and provide that information to the school on a monthly basis.
6. Invite designated school administrator to attend AHYD Program staff meetings.
7. Attend school staff meetings as determined by the school principal.
8. Provide AHYD Program related in-services to school staff as appropriate on request.
9. Respect school property and keep spaces designated for the AHYD Program clean while in use.
10. Follow established protocol for emergency notification of parents and /or guardians.
11. Provide Department of Public Health AHYD Program with all monthly, quarterly and annual reports as specified in Program requirements.
12. Maintain with fidelity to evidence-based program models as determined by AHYD Program guidelines.
13. Work cooperatively with the research and evaluation component of the AHYD Program.

C. Responsibilities of _____ High School

1. Provide the Youth Development Coordinator with office space equipped with a telephone and computer, access to the copy machine, fax and other equipment related to program administration.
2. Provide a clean office space for the AHYD program as well as access to the commons area, auditorium, library, and computer lab. Provide office space during the summer for the AHYD Programs and camps within the school cluster.
3. Provide adequate and appropriate secured storage space for AHYD Program materials and equipment.
4. Work cooperatively with the research and evaluation component of the AHYD and after-school programs to provide agreed-upon information. This may include but not limited to, sharing school profiles and all relevant data available in the public domain. Additionally test scores, grades attendance date will be provided with full protection of the rights of students and within school system regulations.
5. Provide clean spaces for the after-school programs in an adequate number of classrooms, as well as the commons area, auditorium, library, computer lab, gymnasium, dance studio, art studio and any other relevant space.
6. Facilitate the provision of full custodial services at no cost to the GCBOH.

Correspondence related to this contract should be addressed to:

Contractor	**Board**
High School Name	Gwinnett County Board of Health
Address Line 1	P.O. Box 897
Address Line 2	2570 Riverside Parkway
Address Line 3	Lawrenceville, GA 30046-0897

Authorized Administrator Signature	Authorized Administrator Signature
Print Administrator's Name	Print Administrator's Name
Date	Date

*Note: MOU adapted from existing high school MOU utilized by Gwinnett County Health Department

Attachment 7 – Program Facilitator Contract Deliverables

AHYD Program Facilitator Responsibilities:

1. Implement and facilitate with fidelity the following selected AHYD Program evidence-based curricula: *Reducing the Risk* (up to 12 sessions per week in classes of 30 to 35 students) and *Be Proud! Be Responsible! Be Protective!* (full implementation at least once per semester with up to 12 students).

2. Provide case management and referral to appropriate health services, which may include preventive health, family planning, HIV/STD testing, and mental health services. Documentation of referral and outcome will be done on the AHYD log for referrals and in the individual student case notes.

3. Assist in the data collection process, including Session Attendance, Fidelity Monitoring Forms, and Pre- and Post-Test Surveys. These forms are used to document services provided to registered youth and measure participant's progress in the program.

4. Coordinate with the Program Coordinator, school administrators, teachers, counselors and faculty to actively recruit students to participate in the Adolescent Health Youth Development Program.

5. Attend weekly AHYD staff meetings, and staff trainings as required by Program Coordinator. Attend all required AHYD Program meetings and trainings required by program funders.

6. Facilitate monthly Parent Seminars on sexual health topics as designated by the AHYD program.

7. Fidelity and attendance forms with Contractor signature must be submitted weekly to the Program Coordinator or his designee. Submit monthly and quarterly needs assessments and case management activities reports to Youth Development Coordinator by the first (1st) of each month.

8. Works with Youth Development Coordinator; to coordinate work activities, meet deadlines, and provide support where needed.

9. Invoice for payment must be signed by Youth Development Coordinator and submitted on the 15th of each month.

Attachment 8 – Letter of Support Template

(Place on Organization Letterhead.)

Date

Funder Contact
Funder Address

Dear Grant Proposal Review Committee:

The *organization name* is pleased to support the Gwinnett County Health Department's grant proposal to fund the expansion of the Adolescent Health and Youth Development (AHYD) program to two additional schools in Gwinnett County. Teen pregnancy and sexually transmitted infections threaten the health and economic wellbeing of our youth and our community.

As a community partner committed to supporting the mission of the AHYD program, the *organization name* will support the program by (describe organization's intended contribution, such as taking referrals to provide health services).

The Health Department has a proven record of effective intervention in teen pregnancy and HIV/STD prevention at the Meadowcreek High School. Our organization enthusiastically supports the expansion of the program to other high schools in the county.

Sincerely,

Name
Title

Attachment 9 – Project Budget

Project Budget: Gwinnett Adolescent Health and Youth Development Program				
Budget Categories	Year 1	Year 2	Year 3	Total
a. Personnel (salary)	$47,000	$47,000	$47,000	$141,000
b. Fringe Benefits	$29,570	$29,570	$29,570	$88,710
c. Travel	$2,153	$2,153	$2,153	$6,459
d. Equipment	$0	$0	$0	$0
e. Supplies	$9,001	$1,566	$1,566	$12,133
f. Contractual	$72,000	$72,000	$72,000	$216,000
g. Construction	$0	$0	$0	$0
h. Other	$2,520	$2,520	$2,520	$7,560
i. Total Direct (sum a-h)	$162,244	$154,809	$154,809	$471,862
j. Indirect Charges	$15,265	$14,566	$14,566	$44,397
K. TOTALS (sum I and j)	$177,509	$169,375	$169,375	$516,259