Sexually Transmitted Diseases

MICHIGAN ASSOCIATION OF SCHOOL NURSES SEXUALLY TRANSMITTED DISEASES

Original Date of Issue: 2016
Foreword

These guidelines contain current best practice recommendations for the health service topic addressed. The guidelines have been reviewed by the School Nurse Practice Subcommittee of the Michigan Statewide School Nurse Task Force as a means to provide consistent and safe care to students. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines. There is no guarantee that the use of guidance in this document will lead to any particular result or outcome. The information in this document was researched in June, 2016.

Purpose

This document will provide guidelines and resources for preventing sexually transmitted diseases (STD) in youth and protecting students at risk for sexually transmitted diseases. This document uses the term STD, however it is interchangeable with sexually transmitted infections (STI).

Overview

The Centers for Disease Control and Prevention (CDC) (2015a) reported that sexually transmitted diseases (STDs) affect individuals of all ages but take a heavy toll on young people. The CDC (2015a) estimates that youth ages 15-24 make up just over one quarter of the sexually active population, but account for half of the 20 million new sexually transmitted diseases that occur in the United States each year. By age 25, half of all youth will have acquired one or more STDs which is more than 9 million youth with a sexually transmitted disease (American Sexual Health Association, 2016). Each of these infections is a potential threat to an individual’s immediate and long-term health and well-being (Lane, 2016). In addition to increasing a person’s risk for acquiring and transmitting HIV infection, STDs can lead to severe reproductive health complications, such as infertility and ectopic pregnancy. The reported rates of chlamydia and gonorrhea are highest among females during their adolescent and young adult years, and many persons acquire HPV infection at this time as well (CDC, 2015a).

Factors contributing to this increased risk during adolescence include having multiple sexual partners concurrently, having sequential sexual partnerships of limited duration, failing to use barrier protection consistently and correctly, having increased biologic susceptibility to infection, and facing multiple obstacles to accessing health care (CDC, 2015a). When non-viral sexually transmitted diseases (chlamydia, gonorrhea, syphilis) are detected and treated early, transmission to others can be eliminated, and sequelae can be averted (American Academy of Pediatrics [AAP] Committee on Adolescence and Society for Adolescent Health and Medicine, 2014).

A high quality sex education program can help eliminate some health disparities while reducing sexual risk behaviors and promoting positive child-parent communication. The Community Preventive Services Task Force from the CDC (2012) recommends group-based comprehensive risk-reduction interventions delivered to adolescents, in schools or communities, to promote behaviors that prevent or reduce the risk for HIV, other STDs, and pregnancy in grades 6-12. Addressing multiple risk behaviors and promoting protective factors by enhancing family interaction and the school environment have been found to be the most effective interventions (Kao and Manczak, 2013; Vivancos, Abubakar, Phillips-Howard, and
Hunter, 2013). Kirby’s (2008) study demonstrated that comprehensive sexual health education programs show strong evidence for positively affecting young people’s sexual behavior, including both delaying initiation of sex and increasing condom and contraceptive use among youth. In Michigan, 78% of parents indicated sex education should be taught in schools (Michigan Department of Education [MDE], 2016a). The 2004 survey results can be retrieved at http://www.michigan.gov/documents/mde/Sex-Ed-Survey_258531_7.pdf.

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1. Michigan and National Data

The 2013 Michigan Youth Risk Behavior Survey (YRBS) (MDE, 2013a) trend data showed the following risk behaviors for Michigan students compared to the national 2013 YRBS data from the CDC (2015d): 38.1% of Michigan high school students have ever had sexual intercourse (47% nationally) and of those, 26.9% had sexual intercourse with one or more people during the past three months (34% nationally). Among students who had sexual intercourse, 61% used a condom (59% nationally).

Although the rates of HIV diagnoses remained stable in 2009-2013, teens most likely to be diagnosed were black males who have sex with males (Michigan Department of Health and Human Services [MDHHS], 2015). The CDC (2013) reported that nationally 1 in 4 new HIV infections occur in youth ages 13 to 24 years. Furthermore, about 60% of all youth with HIV do not know they are infected, are not getting treated, and can unknowingly pass the virus on to others.

In Michigan, the combined number of chlamydia, gonorrhea, and syphilis cases in 2010 – 2014 for youth less than 15 was 3290 (MDHHS, 2015). For youth between the ages of 15 – 19 the number was 85,602. Chlamydia is the most commonly reported STD, gonorrhea was the second, followed by syphilis (MDHHS, 2015). Retrieved from http://www.mdch.state.mi.us/pha/osr/STD/STDCasesByAgeSexObject.asp.
Michigan data (MDE, 2016b) shows that 8.7% of students identify as lesbian, gay, or bisexual and/or have engaged in same sex sexual behavior (sexual minority youth). These students are 3 times more likely to be threatened or injured with a weapon on school property (18% versus 6%); 2.7 times more likely to not go to school because they felt unsafe (16% versus 6%); and 4.6 times more likely than other students to actually attempt suicide (32% versus 7%) (MDE, 2016b). Sexual minority youth often face harassment, abuse, and violence in school settings that put them at greater risk for serious problems, such as substance abuse, HIV, suicide, as well as school failure and dropout. Retrieved from http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_59543-367599--00.html.

2. Legal Framework for Preventing Sexually Transmitted Diseases and Protecting Students at Risk for Sexually Transmitted Diseases

Federal Law

<table>
<thead>
<tr>
<th>Protection of Pupil Rights Amendment</th>
<th>Surveys may be subject to the Protection of Pupil Rights Amendment.</th>
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<tbody>
<tr>
<td><a href="http://familypolicy.ed.gov/ppra">http://familypolicy.ed.gov/ppra</a></td>
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<tr>
<th>Title X Agencies: Family Planning</th>
<th>Parental consent not required for services provided by Title X funded agencies.</th>
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<tbody>
<tr>
<td>42 CFR Part 59</td>
<td>Title X Agencies: Family planning agencies funded under Title X of the Public Health Service Act must provide family planning and related services without regard to age or marital status, 42 CFR 59.5.</td>
</tr>
<tr>
<td><a href="http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-guidelines/42-cfr-59-attachment-b.html">http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-guidelines/42-cfr-59-attachment-b.html</a></td>
<td>Provider discretion applies for providers not funded by Title X or Title XIX. • There are no specific MI statutes on this issue.</td>
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Michigan Law

<table>
<thead>
<tr>
<th>Minor Consent</th>
<th>Venereal Disease or HIV - a minor who professes to be infected may seek medical or surgical treatment or services by a hospital, clinic or physician without the consent of a parent, guardian, or person in loco parentis. For medical reasons the treating physician or another health professional (on the advice of the treating physician) may withhold or provide information regarding the minor to the parent, guardian, or person in loco</th>
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<td>MCL 333.5127</td>
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Michigan Law – Sex Education


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<tr>
<th>Family Planning Device Distribution</th>
<th>§380.1507</th>
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<tr>
<td>(7) A person shall not dispense or otherwise distribute in a public school or on public school property a family planning drug or device.</td>
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<tr>
<td>(8) As used in this section, “family planning” means the use of a range of methods of fertility regulation to help individuals or couples avoid unplanned pregnancies; bring about wanted births; regulate the intervals between pregnancies; and plan the time at which births occur in relation to the age of parents. It may include the study of fetology. It may include marital and genetic information. Clinical abortion shall not be considered a method of family planning, nor shall abortion be taught as a method of reproductive health.</td>
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| MCL 380.1169 | Dangerous communicable diseases; human immunodeficiency virus infection and acquired immunodeficiency virus infection; teacher training; teaching materials; curricula; teaching of abstinence from sex. |
| http://www.michiganlegislature.org/mileg.asp?page=getObject&objName=mcl-380-1169 |

| MCL 380.1506 | Program of instruction in reproductive health; supervision; request to excuse pupil from attendance; “reproductive health” defined. |
| http://www.michiganlegislature.org/mileg.asp?page=getObject&objName=mcl-380-1506 |
The National Association of School Nurses (NASN) believes that promotion of immunizations is central to the public health focus of school nursing practice (NASN, 2015). Public health provides the foundation for the specialty practice of school nursing and is one of the five principles of the Framework for 21st Century School Nursing Practice (NASN, 2016). Key tenets and responsibilities of public health practiced by school nurses include surveillance, outreach, population-based care, levels of prevention, social determinants of health and health equity (Maughan, Bobo, Butler, Schantz, & Schoessler, 2015; NASN, 2016). These principles provide guidance for school nurses when preventing and managing infectious diseases in the school setting. The school nurse observes trends and conditions and help in the prevention of infectious disease outbreaks. School nurses can prevent outbreaks by supporting immunization compliance and promoting influenza vaccination (Maughan et al., 2015).

### 3. School Nurse Role/ Recommendations for Practice

The Michigan Association of School Nurses Sexually Transmitted Diseases (NASN) believes that promotion of immunizations is central to the public health focus of school nursing practice (NASN, 2015). Public health provides the foundation for the specialty practice of school nursing and is one of the five principles of the Framework for 21st Century School Nursing Practice (NASN, 2016). Key tenets and responsibilities of public health practiced by school nurses include surveillance, outreach, population-based care, levels of prevention, social determinants of health and health equity (Maughan, Bobo, Butler, Schantz, & Schoessler, 2015; NASN, 2016). These principles provide guidance for school nurses when preventing and managing infectious diseases in the school setting. The school nurse observes trends and conditions and help in the prevention of infectious disease outbreaks. School nurses can prevent outbreaks by supporting immunization compliance and promoting influenza vaccination (Maughan et al., 2015).
NASN (2012) believes the school nurse plays a vital role in the development and implementation of instructional programs that utilize evidence-based strategies to prevent unintended pregnancies and sexually transmitted diseases, including HIV. Public health provides the foundation for the specialty practice of school nursing and is one of the five principles of the *Framework for 21st Century School Nursing Practice* (NASN, 2016). Key tenets and responsibilities of public health practiced by school nurses include surveillance, outreach, population-based care, levels of prevention, social determinants of health and health equity (Maughan, Bobo, Butler, Schantz, & Schoessler, 2015; NASN, 2016). These principles provide guidance for school nurses helping student to prevent sexually transmitted diseases as well as assisting youth to access health care services (Maughan et al., 2015).

The school nurse office can create an atmosphere that fosters open communication. It is important that the school nurse office has a private space to talk to students (Lane, 2016). Jackson (2011) recommended having pamphlets and information on pregnancy, sexually transmitted diseases and treatment, refusal skills and other sexual health topics readily available in the middle and high school health office (Jackson, 2011). Other recommendations included bulletin boards and posters to display health information. School nurses can offer support and provide resources (Lane, 2016).

Schools can provide services onsite through school-based health centers or create referral systems to teen-friendly clinics (Van Handel et al., 2016).

**Surveillance/Evidence-Based Screening Practices**

1. Be aware of the CDC screening recommendations for adolescents. Routine laboratory screening for common STDs is indicated for sexually active adolescents. (CDC, 2015a). The CDC provides specific screening guidelines for adolescents. The information below highlights the screening recommendations:
   - Routine screening for chlamydia (*C. trachomatis*) on an annual basis is recommended for all sexually active females aged <25 years. Evidence is insufficient to recommend routine screening for chlamydia (*C. trachomatis*) in sexually active young men based on efficacy and cost-effectiveness.
   - Routine screening for gonorrhea (*N. gonorrhoeae*) on an annual basis is recommended for all sexually active females <25 years of age. Gonococcal infection is concentrated in specific geographic locations and communities. Clinicians should consider the communities they serve and might choose to consult local public health authorities for guidance on identifying groups that are at increased risk.
   - HIV screening should be discussed and offered to all adolescents. Frequency of repeat screenings of those who are at risk for HIV infection should be based on level of risk.
   - Annual chlamydia screening of all sexually active women younger than 25 years.
   - Screening at least once a year for syphilis, chlamydia, and gonorrhea for all sexually active gay, bisexual, and other men who have sex with men (MSM).
   - The routine screening of adolescents who are asymptomatic for certain STDs (e.g., syphilis, trichomoniasis, bacterial vaginosis, genital herpes, Human Papillomavirus, Hepatitis A virus, Hepatitis B virus) is not generally recommended.
   - Guidelines from USPSTF, ACOG, and ACS recommend that cervical cancer screening begin at age 21 years.
Note:

- The AAP Committee on Adolescence and Society for Adolescent Health and Medicine (2014) recommends routine laboratory screening for non-viral sexually transmitted diseases (chlamydia, gonorrhea, trichomoniasis) for sexually active adolescents.
- The CDC recommends routine HIV screening for Americans aged 13-64, yet 50% of adolescents and young adults with HIV remain undiagnosed (Van Handel, Kann, Olsen, & Dietz, 2016).
- Van Handel et al. (2016) analyzed the National Youth Risk Behavior Survey and Behavioral Risk Factor Surveillance System to assess HIV testing prevalence among high school students and young adults. HIV testing prevalence was found to be low among high school students (25%) and young adults (33%).

2. Provide students and parents with sufficient HPV vaccine information and guide them to make an informed decision to obtain the vaccine (Ratanasiripong, 2014). The CDC (2015a) recommends the following schedule:

- The HPV vaccine, bivalent, quadrivalent, or 9-valent, is recommended routinely for females aged 11 and 12 years and can be administered beginning at 9 years of age. [http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html). Vaccination is also recommended for females aged 13–26 years who have not yet received all doses or completed the vaccine series.
- The quadrivalent or 9-valent HPV vaccine is recommended routinely for males aged 11 and 12 years and also can be administered beginning at 9 years of age. Vaccination with quadrivalent or the 9-valent HPV vaccine is recommended for males aged 13–21 years who have not yet received all doses or completed the vaccine series, although males aged 22–26 years also can be vaccinated.

3. Understand the vaccination recommendations for HBV and HAV. The CDC (2015a) provides the following guidelines:

- The HBV vaccination series is recommended for all adolescents and young adults who have not previously received the hepatitis B vaccine.
- The HAV vaccination series should be offered to adolescents and young adults who have not previously received the HAV vaccine series.

4. Be familiar and understand state laws about allowing teens to access medical care without parental consent for health issues such as pregnancy and sexually transmitted diseases (Lane, 2016). It is important for teens to be able to access confidential services (services provided without parental involvement) in either the delivery or payment of services (Van Handel et al., 2016).

Data Informed Services

1. Advocate for the implementation of the Michigan Profile for Healthy Youth (MiPHY) to gather specific local data about the health risks (including sexual behavior) and needs of their students. The MiPHY is administered to grades 7, 9 and 11. Schools and districts register and survey via an on-line system. More information about the MiPHY can be retrieved at [http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_44681---,00.html](http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_44681---,00.html).
2. Utilize state and local data to plan, implement and evaluate sex education programming. The MDE (2016) provides information on how to obtain the latest data pertaining to sexual risk behaviors and health outcomes such as HIV and other STDs that can be retrieved at http://www.michigan.gov/documents/mde/Data_on_Adolescent_Sexual_Risk_Behaviors_373267_7.pdf.

School nurses can find STD rankings by county and local health department at http://www.mdch.state.mi.us/pha/osr/index.asp?id=12.

**Outreach/Stakeholder Engagement**

1. Involve young people in the planning, establishing, and development of school-based health centers (Hayter, Owen, & Cooke, 2012) and sex education advisory boards (Brewin, Koren, Morgan, Shipley, and Hardy, 2014). Smart, Parker, Lampert, and Sulo (2012) found students identified the need for accessible, high quality, and relevant information. Preferences ranged from two-way communication with individuals in a personalized way to one-way communication such as static web pages, television, lectures and print.

2. Consider a parent survey to assess parents view about sex education in their child’s school, specific topics to be taught and when they should be introduced (Michigan State Board of Education, 2003). The MDE (2016) provides a sample parent survey that can be retrieved at http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_74638---,00.html.

3. Engage a variety of staff members that have shown a willingness to talk about sensitive topics to reach youth, particularly sexual minority youth, in order to design and implement programs in ways that can best serve those youth (Rasberry, Morris, Lesesne, Kroupa, Topete, Carver, & Robin, 2015). The MDE (2016b) provides resources for creating safe schools for sexual minority youth at http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_59543-367599--.00.html.

4. Champion for healthy teen relationships in your school or community (Freeman, Rosenbluth, & Cotton, 2013). A safe school environment, increased teacher support, and positive peer networks are beneficial to adolescent health (Lane, 2016).

5. Explore the CDC (2016a) Whole School, Whole Community, Whole Child (WSCC) model that expands beyond the Coordinated School Health Components and emphasizes a unified and collaborative approach to learning and health. Schools may consider developing a WSCC team that would include parents, students, staff and community members to address reproductive health issues as well as other student health issues.

**Population-Based Care**

1. Identify community resources such as teen clinics that offer contraception counseling, pregnancy, STD screening, support groups and services for LGBTQ teens (Lane, 2016).

2. Advocate for School-Based Health Centers as one model of a system of health care delivery that provides a health care “safety net” for children who are uninsured or underinsured or represent special populations who do not regularly access health care. Support access to services that include confidential reproductive health services. (AAP Council on School Health, 2012). Information about the Michigan Department of Health and Human Services [MDHHS] (2016a) Child and Adolescent Health Center Program (CAHC) can be found at http://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4912_44686---,00.html.
3. Become familiar with the school’s curriculum about sexual health, STD’s and pregnancy prevention (Lane, 2016). School policies provide critical support for implementation of comprehensive HIV, other STD, and pregnancy prevention education. In Michigan, school districts can choose to provide sex education. Based upon local and state data, MiPHY data, and parent surveys school nurses may consider advocating for research-based sex education to school administrators or supporting existing sex education programs. The data can help guide decisions about content and grade level interventions.

4. Collaborate with school administrators, school staff and other community members to develop and/or sustain sex education programming. The MDE provides specific guidance to help school districts develop and sustain a sex education advisory board. Information can be retrieved at http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_29803---,00.html and http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_29803-204637--,00.html

5. Support delivery of research based sex education programs that encourage parent-child communication on teenage relationships, abstinence, and sexual decision making. Incorporating influences derived from parents and families reduces sexual risk taking behaviors (Kao & Manczk, 2013).

6. Be aware of the local school policy related to handling information obtained through student conversations related to sensitive issues. FERPA allows parents to view all educational records (Freeman et al., 2013).

7. Be aware that Michigan’s model health education curriculum, the Michigan Model for Health® (MDHHS, 2016b) is used by a majority of school districts in Michigan. The curriculum includes model lessons on HIV/STI prevention for Grades 4 and 5, 7-8, and 9-12. Districts can choose to adopt, adapt, or disregard the model curriculum and implement commercially or locally developed curricula. More information can be found at http://www.michigan.gov/mmh.

8. Middle school health curricula should incorporate sexting and its potential legal, social, emotional, and behavioral consequences (Rice, Gibbs, Winetrobe, Rhoades, Plant, Montoya, & Kordic, 2014).

9. Advocate for children with special needs to be included in sex education programming. Teaching efforts for children with special needs should be done in small concrete steps, using repetition, practice and frequent review over time. Content should not be limited to sexual facts, but should include the development of social skills and relationship training (Sweeney, 2008). Using concrete examples of pictures or models can be helpful in conversations with adolescents who have a cognitive delay (Tullock and Kaufman, 2013).

Note: In Michigan, curricula, materials, and methods used as a part of HIV/STI or sex education instruction offered by a school district must go through the formal approval process, including two public hearings and school board approval ($380.1169, §380.1507). School nurses should collaborate with the sex education supervisor and health teachers to obtain approval for materials distributed or posted for students. Below are resources for fact sheets about sexually transmitted diseases.

- Girlshealth.gov provides reliable information for girls on their health and well-being. Girlshealth.gov was created in 2002 by the Office of Women’s Health, a part of the U.S.
Health Equity and Disproportionately Impacted Populations

1. Health equity is when everyone has an equal chance to be healthy regardless of their background. This includes a person’s race, ethnicity, income, gender, religion, sexual identity, and disability (CDC, 2014). The CDC continues to emphasize that research shows there is a higher rate of STDs among some racial or ethnic minority groups compared to whites but that these higher rates are not caused by color or heritage, but by social conditions that are more likely to affect minorities. Factors such as poverty, large gaps between the rich and the poor, few jobs, and low education levels can make it more difficult for people to stay sexually healthy. Some populations that experience STDs at a disproportionate rate include: adolescents, females, gay men, and communities of color, particularly African-Americans.

2. Ensure health equity for all youth by addressing the needs of youth who are at higher risk for targeted problems through education and youth development strategies. School nurses need to analyze state and local data to help determine who are the youth with the greatest risk for STIs/HIV:
   - Lesbian, gay, bisexual, transgender and questioning youth are of disproportionate risk for HIV and other STIs. Retrieved from [http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_29803-367152--367152-,00.html](http://www.michigan.gov/mde/0,4615,7-140-74638_74639_29233_29803-367152--367152-,00.html)

Adolescents
   - Understand that youth are at disproportionate risk for sexually transmitted diseases. Youth have confidentiality concerns regarding disclosing pertinent information and risky behaviors to parents and health care providers. Health insurance, inability to pay for health care services and lack of access to transportation needed to obtain preventive health care services are other barriers to accessing health care (Lane, 2016).
   - Persons who initiate sex early in adolescence are at higher risk for STDs, along with adolescents residing in detention facilities, those who use injection drugs, adolescents attending STD clinics, and young men who have sex with men (YMSM) (CDC, 2015a).

Females
   - Young women face the most serious long-term health consequences from STDs. It is estimated that undiagnosed STDs cause more than 20,000 women to become infertile each year (CDC, 2015b). [http://www.cdc.gov/std/stats14/std-trends-508.pdf](http://www.cdc.gov/std/stats14/std-trends-508.pdf).

Gay men
   - Trend data show rates of syphilis are increasing at an alarming rate (15.1 percent in 2014). While rates have increased among both men and women, men account for more than 90 percent of all
primary and secondary syphilis cases. Men who have sex with men (MSM) account for 83 percent of male cases where the sex of the sex partner is known. Primary and secondary syphilis are the most infectious stages of the disease, and if not adequately treated, can lead to long-term infection which can cause visual impairment and stroke. Syphilis infection can also place a person at increased risk for acquiring or transmitting HIV infection (CDC, 2015b).


Communities of Color

- Advocate for sex education programs in school populations that have a high proportion of communities of color to encourage skill building and knowledge acquisition. Help students access the care needed for a healthy life.

3. Consider using translators for providing reproductive health information (sex education programming, access to youth services) when the school community has diverse languages and cultures. Translation of parent information is helpful to non-English speaking parents and caregivers.

**Red Flags for Preventing Sexually Transmitted Diseases and Protecting Students at Risk for Sexually Transmitted Diseases**

1. Children who are sexually exploited or trafficked may seek medical attention for sexually transmitted infections. Potential indicators of commercial sexual exploitation include being accompanied by an unrelated adult or one who doesn’t allow the child to answer questions, history of abuse, involvement of child protective services or juvenile justice authorities, substance abuse and a withdrawn or fearful demeanor. Youth who are at risk for being sexually exploited may have a history of running away, sexually transmitted diseases, substance use, or involvement with Children’s Protective Services or the Juvenile Justice System. Make a formal report suspected exploitation to law enforcement and child protective services (Junco, 2015).

2. All age groups are susceptible to Zika viral infection, including children. Although Zika virus infection mosquito-borne transmission is the main route of exposure of Zika virus, it has been reported to occur through sexual transmission (Kawasaki, et al., 2016). Condoms can reduce the chance of getting Zika from sex if used appropriately (CDC, 2016b).

3. Early sexual debut is correlated with higher rates of sexually transmitted diseases and teen pregnancies. Rice et al. (2014) found that students who sent and received sexts were more likely to
report sexual activity. In consultation with health teachers, school nurses can advocate for increased awareness for students and parents/caregivers about the risks associated with sexting. Van Otsell, Wayleave, Punned, & Heiman (2015) recommended questions about sexting should be included when school safety surveys or health assessments are conducted to help measure the prevalence of sexting within the school community.

4. Teen dating abuse is associated with higher levels of drug and alcohol abuse, unplanned pregnancy, sexually transmitted diseases, depression and anxiety (Freeman et al., 2013).

5. There are many obstacles to healthy sexuality and a particular tension between healthy sexuality and personal safety for youth with disabilities (Sweeney, 2008). Benefits to providing human sexuality education to children with intellectual disabilities include improved social skills, assertiveness and independence, positive changes in behavior and reduced risk for sexual abuse, sexually transmitted diseases, and unintended pregnancy (Sweeney, 2008).


7. School districts are required to teach about dangerous communicable diseases, including, but not limited to, HIV/AIDS. Instruction must be offered at least once a year at every building level (elementary, middle/junior, and senior high).

8. Each person who teaches K-12 pupils about HIV/AIDS shall have training in HIV/AIDS education for young people.

9. Parents and legal guardians must be notified of HIV and sex education instruction and their right to exclude their child without penalty.

10. Curricula, materials, and methods used as a part of HIV/STI or sex education instruction offered by a school district must go through the formal approval process, including two public hearings and school board approval.

References


