

MCHB/EMSC Webcast

Eliminating Adolescent Health Disparities and Achieving Equity: Capacity Building Interventions for Communities

April 2, 2009

CHAD ABRESCH: Good afternoon. I'm Chad Abresch I'm and the facilitator today.

Welcome to the webcast "Eliminating Adolescent Health Disparities and Achieving Equity: Capacity Building Interventions for Communities". We have three excellent speakers including Kimberly Ross, Shameeka Jelenewicz and Claude Gilmore.

Today's webcast is part of a three webcast series brought to you by NIA, the national initiative to improve adolescent health. The workgroup on adolescent health and safety equity has come together to deliver these webcasts. The series began on March 11th of this year by providing participants with a framework for considering adolescent health equity. The webcast has been archived at mchcom.com And you can find it under recent events. Look for the webcast titled "Eliminating Adolescent Health Disparities and Achieving Equity: Capacity Building Interventions for Communities". The second and current webcast will advance the issue to explore local capacity building interventions and on Wednesday, April 29, 2009, we'll offer eliminating health disparities and achieving equity/empowering youth. This third webcast, the final in our series, is now available for registration at the same address, mchcom.com.

By way of housekeeping, you should know that slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You don't need to do anything to advance the slides. You may need to

adjust the timing on the side to match the audio by using the slide delay control at the top of the messaging window.

We will have a question and answer on today's webcast following the presentations of our speakers and I encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the right -- in the white message window on the right of the interface. Select question for speaker from the dropdown menu and hit send. Please include your state or organization in the message so that we can know where you are participating from. The questions will be relayed on to the speakers periodically throughout this broadcast. If we don't have the opportunity to respond to your questions during the broadcast, we will email you afterwards. Again, we encourage you to submit questions at any time during the broadcast.

Also, on the left of the interface is the video window. You can adjust the volume of the audio using the control slider. Which you can access by clicking on the loudspeaker icon. Those of you who selected accessibility features when you registered will see the text captioning underneath the video window.

At the end of the broadcast, following our question and answer, the interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple of minutes to complete this evaluation. Your responses will help us to plan future broadcasts in this series and improve our technical support.

Our first speakers are Kimberly Ross and Shameeka Jelenewicz, they're both research assistance at CARTA. She is currently enrolled in the doctoral program at Epsilon University. Kimberly co-facilitates the technical assistance and training services of various

projects related to parent/family engagement. Racial/ethnic disparities. She plays a role in the applied research and evaluation work at CARTA. Shameeka Jelenewicz has been a research associate for CARTA for the past 3 1/2 years. She holds a Bachelor of Arts degree in sociology from the University of Maryland college parks and a University of arts degree from the University of Maryland, Baltimore County. At CARTA she -- community based youth engagement and youth activism. A published author Shameeka also contributed to a study for age appropriate male reproductive health services information. Education and clinical services among adolescents and young adult males in Baltimore city. Together Kimberly and Shameeka will discuss the unity project, for racial equity and social justice. Kimberly will get us started. I hand it over to you.

KIMBERLY ROSS: Thank you, Chad. In today's presentation we will discuss background info on why unity was created. Goals and outcomes for this work, project activities, highlight each partner site that has participated in the unity project. Discussion the lessons learned and present recommendations for others who may want to do this work.

Next slide. In 2005, the Ford Foundation funded CARTA to look at racial/ethnic disparity in adolescent, reproductive and sexual health across the United States. We looked at birth rates, pregnancy rates and rates of sexually transmitted infections and found some interesting patterns. States with high rates on multiple indicators are located primarily in the south, particularly the Gulf Coast region and southwest. States such as Texas, Louisiana, Mississippi, Arizona and New Mexico. Also, these states have significant racial/ethnic disparities in sexual health outcomes. There is between a two and four-fold gap for teen births and pregnancy rates for non-whites relative to whites. Texas has a two-fold difference in birth rates between Blacks and whites and a 2.6 fold difference between

Spanish and whites. I do want to pause for a moment and explain when we say a threefold difference we're referred to a rate ratio so that for every one white teen who gets pregnant three Hispanic teens get pregnant. When we say a ratio we're talking about the rate for the Hispanics divided by the rate in this case whites. If birth weights for Hispanic females for 83.4 and for white females 21.5. The ratio would be 21.5 divided by 83.4. Hispanic girls have a teen birth rate approximately three times higher than that of white girls of the same age. On to another interesting point. Disparities are even more striking in states with overall lower rates on sexual health indicators. States like Wisconsin, Minnesota and Connecticut show disparities in teen birth rates that range between a five fold difference between Blacks and whites in Wisconsin and a six fold difference between Hispanics and whites in Connecticut.

Next slide. Why in sites that seem to be doing well are people of color doing worse? It may mean not everyone is benefiting from what is going on. In states that are struggling it is expected that everybody should be doing poorly, yet youth of color continue to have significantly higher rates of negative sexual health outcomes so place matters. We need to find out what is going on. We need to examine the inequality, social, economic could be Texas well as the program and policy contexts where people live. These next compare high and low birth rate states on equality measure. The first is the percent of children living in poverty. As you can see disadvantaged is significantly higher in the high birth rate states with a quarter of children in Mississippi and New Mexico living in poverty and over a quarter children in Louisiana as compared to only 10% of children living in poverty in most of the low teen birth rate states.

Next slide, please. We see that educational attainment is lower in high teen birth rate states with most of the high teen birth rate states hovering around a quarter of the adults 25 years or older do not have a high school diploma as compared to the majority of the low teen birth rate states having less than 20% of adults with low educational attainment.

Next slide. On this slide we examine residential segregation and measure the dissimilarity index. Now the dissimilarity -- a score of 0 means complete integration and a score of 100 means complete segregation. So if a city's white black index was 65, that would mean that 65% of white people or 65% of Blacks would need to move to another neighborhood to make whites and Blacks evenly distributed across all neighborhoods.

Next slide. We see the residential segregation is a problem across major cities in both low and high rate states. It is interesting that for the major cities highlighted in the low teen birth rate states they have an index for Blacks to Whites that is above the moderate level of 50. We went on to put out a local example for Milwaukee, Wisconsin. As you'll see the state teen birth rate is 20.8 per 1,000. Yet the city teen birth rate of Milwaukee for African-Americans is 103.9 per 1,000 and for Hispanics 106 per 1,000. The city's overall unemployment rate is 5.4% but unemployment rates for African-American and Hispanic males are much higher.

Next slide. Another bit of data not shown here is residential segregation where the black/white dissimilarity index is very different. What is the causation of racial/ethnic disparities in teen sexual health outcomes? While there are many things that may elevate negative outcomes of youth of color we examine trends in adolescent health suggest one of the most critical reasons for these differences is unequal access to opportunities and support systems. This lack of access can be linked directly to structural racism.

Next slide. Structural racism goes beyond individual acts of bias, discrimination or domination. It includes policies such as money for public education and practices such as racial profiling that contribute to disparities, assumptions and stereo types about people based on how they look, act or where they live. The theory based on the work of Dr. Jones suggests a structural racism works on three different levels. The institutionalized racism. Difference to access according to race. Prejudice and discrimination by individuals against others based on their racial or ethnic background, and internalized racism acceptance of members of a stigmatized racial/ethnic group of the negative messages about their own abilities and values. Our model shows there are three critical elements for adolescent development. We believe they consist of identity, developing a positive sense of self-, intimacy and trust, learning how to love and establish healthy relationships with family, other adults and friends. And industry, discovering something that you are good at and developing skills and talents to contribute to society. And when present, these factors help youth delay sexual activity or use protection if they become sexually active. But structural racism has a negative effect on each of these factors. For example, for identity formation structural racism contributes to an individual's negative opinion of oneself and negative views of ones racial/ethnic group starting at an early age. Negative media messages can further the impact of stereo types and promote misconceptions of youth of color. For intimacy structural racism -- residential segregation often leads to mistrust and false perceptions of others. Groups who live far apart tend to interact less with each other and are more likely to draw conclusions based on stereo types and here say. And for industry structural racism can challenge a young person's ability to develop new skills and contribute to his or her community by reducing their identity for work, education and career and limiting their connections to academic and career opportunities. Structural racism creates a barrier to healthy youth development which puts young people of color into

unhealthy situation that increase their odds of engaging in sexual activity and lowers their ability to avoid sexual situations. Studies suggest that structural racism intensifies the levels of mental and emotional conflict young people experience in puberty so it promotes unhealthy emotional responses such as anger and resentment, desire to control or need to feel love and wanted and inability or unwillingness to trust. And these responses make youth more likely to be open to sexual risk taking which increases their involvement in negative peer groups, seeing sex and risk taking as a right of passage and tolerance of multiple partners or risky sex.

Next slide. In addition to examining the social and economic context of these states we examined the policy and program context as well. And we found that high teen birth rate states had limited state level prevention efforts addressing family planning and contraceptive access and sexuality education was dominated by abstinence only. Limited coalition efforts or lack of critical mass of grassroots efforts to address teen pregnancy prevention and sexual health strategies. While the low birth rate states had increased state level prevention and strategic planning, multiple organizations and coalitions targeting teen health, grassroots efforts were more progressive and they had broad access to sexual health information and reproductive health services, as well as comprehensive sexual health education.

Next slide. Based on our findings, it was evident to Carter that communities could benefit from capacity building support which focuses on engaging and growing local grassroots involvement in comprehensive approaches to teen pregnancy prevention and sexual health. Additionally, communities would need assistance developing an action plan that responds to the economic and social context driving conditions that influence disparities in teen sexual health in their community. And so the unity project was developed. The initial

goals of the unity project were long term and short term. For long term it's to see a social movement within the field of adolescent reproductive and sexual health to address structural racism. We hope to add more sites but understand that we need to find out what works well in the ones we're in before we can cause a complete social movement. Short term goals include we want to increase awareness and understanding of reproductive health and youth development organization of structural racism and social injustice and its influence on arch disparities and want them to respond to local conditions contributing to structural racism through community based action planning.

Next slide. We want unity sites to be able to do the following. We want them to have increased knowledge and understanding of ARSH disparities, structural racism and social justice. People should be comfortable talking about these issues. We also want constituency building. We want them to bring other stakeholders to the table and increase their understanding of the issues as well. We want them to engage these constituents in action planning to help them develop a sustained response to the problems in their community. Develop this action plan but also make sure that you identify funding, expertise needed to carry out the task and people who will participate and lead this work. And disseminate the action plan and mobilize people to action.

Next slide. Carter proposes that the way to achieve adolescent reproductive and sexual health equity is by using a place-based strategy of capacity building and community engagement around structural racism, social justice and disparities in youth and young adult health. Based on the work of the national community development corporation, also known as NCDI, Carter's organizational capacity for social change model is designed to specifically address structural racism and ARSH disparities. A key aspect of CARTA's capacity building process is the inclusion of youth adult partnerships. Promoting youth as

social change agent should be a core element of youth development and reproductive health practice. Self-awareness efforts can enable young people not only to celebrate their racial and ethnic identity but also to understand how a positive sense of self-can empower them to make better choices. Young people can be encouraged to address community problems through analysis of the causes of inequality. Identifications of solutions and involvement in making change. Our organizational capacity for social change model consists of four elements designed to build the capacity of organizations around the work of structural racism and disparities. The four elements are strengthening the organization, community ownership and sustainability. Community vision and action planning of the organization and community mobilization.

Next slide. Note that the model is circular and not linear meaning that as you proceed through one element you may need to go back to a previous one or you can work on elements simultaneously. So in order for an organization to move through the elements of our organizational capacity for social change process, they must achieve competency in five areas. One is organizational capacity. They must show readiness to lead the work, have human and financial resources sufficient to support and sustain this work.

Knowledge and awareness, ability to understand structural racism and to articulate its connection to adolescent reproductive and sexual health disparities. They must also be able to galvanize support for the work. The third is data. They must be able to access, analyze and translate data to gain support on this issue. Fourth is funding. They must be able to identify and secure external funding. And fifth, which is key aspect of our work, youth adult partnerships. We want to ensure that young people are seen as an asset. That they're active participants in planning and mobilizing for this work.

Next slide. The ultimate goal is to equip organizations to engage that your communitying both youth and adult residents to change social and institutional policies to change structural condition and individual behavior change resulting in adolescent reproductive and sexual health equity. So our activities with the sites included cross site meetings, and the cross site meeting we allow representatives from all three unity sites to come and connect with CARTA members and facilitation team. The purpose of this event was to provide site participants with more information on racial ethnic despair east and further explain CARTA's structural racism framework and our capacity building process as well as we had in depth conversations and present a plan for the site visit beginning as early as fall 2007. Now, this meeting was co-hosted by the people's institute for survival and beyond which did training exploring the history of racism in the United States and strategies for overcoming it. We have had a second cross site meeting held last fall to check in with the sites about their accomplishments thus far. We've also had tailored facilitation and support. Given the extent of needs of the partner sites, CARTA secures partnership with several organizations to provide a range of technical assistance and support resources to the unity sites. These organizations include the People's Institute which presented their racism workshop at the first meeting. It included the National Community Development Institute. They are a technical assistance and training organization that works to build capacity in communities of color and other low income communities and they focus on organizational development and community mobilization with the sites. We had an independent consultant who served as a facilitation partner and worked with all three partner sites over time to help them develop an action plan. We had the services of the innovation Center for community and youth development which is an organization dedicated to unleashing the potential of youth, adults, organizations and communities to engage together in creating a just and equitable society. And they focused

on the developing youth adult partnerships and making sure that our site organizations really had young people as decision makers and not just as place holders at the table.

And then -- next slide. We had phone-based technical assistance. Staff conducted a series of phone TA sessions to help sites form their core planning teams, identify stakeholders, identify strategies to explain unity to the community and secure site buy-in and to plan each site stakeholder's meeting. There was tool development. We found the need to develop tools to assist partners. We had to help them understand who all should be involved as a stakeholder. We also included a Google group for sites to cross share information without always having to go through us. Then we had the on site stakeholder meeting. The purpose of this meeting was to connect the goals of unity with local stakeholders and identify the most critical issues impacting adolescent reproductive and sexual health on their local level. We did this by using a series of activities. We had the dance for your generation where participants were grouped together by decade in which they were teenagers and perform the most popular dance during that time. It allows people to laugh at each other and begin to bond as a group. Then we moved onto the mine field exercise and this provided participants with various mind or obstacles that young people might encounter or try to navigate life in their own community. We went on to talk about our structural racism framework. We had the decade com line where participants were asked to walk around and indicate for each decade they live in their respective city what were the issues that impacted adolescent reproductive or sexual health outcomes as well as the individual groups and events that helped to diffuse these issues. We went from the 1960s to the current decade. Then we had a brain map where we took the issues that were identified in this decade time line and asked participants to discuss specific details of each issue. For example, if crime was an issue, the specific detail might be increased homicides among young males of color. Then we moved to

issue priority sayings where participants looked at the issues identified in the time line and further explored in the brain and voted on the issues that are most important to them. The top four issues were extracted and in small groups the participants discussed how these issues impacted adolescent reproductive sexual health outcomes and developed possible strategies to influence change.

Next slide. Now I'm going to pass it off to Shameeka who will tell us more about the partner sites and the on the ground work.

SHAMEEKA JELENWICZ: Thanks, Kimberly. As Kimberly just walked us through the conceptualization of this work and our capacity building activities, for the remainder of CARTA's presentation I'll talk about how these capacity-building activities looked on the ground for each of our partner sites.

Next slide, please. At the start of this initiative, CARTA sent a request for proposal to a select number of organizations located in the cities where communities experienced an overlap in teen birth, pregnancy and sexually transmitted infections. And were exhibiting significant racial and ethnic disparities in teen sexual health and characterized by high rates of poverty and social inequality. In addition to having a concentration of high rates as a criteria, CARTA looked for organizations that had some level of existing activity and potential to support this work. In order to achieve meaningful results within the time and resources allotted for the unity project, which was 18 months, may 2007 to October 2008. A total of 26 organizations were identified from seven states. We had a total of 11 proposals submitted. The review committee consisted of three CARTA program staffers.

The review process consisted of staffers rating on a scale from one, not at all, to five, excellent on how well the organization addressed a number of items. We were looking for defining target community. So the community -- so the target community's racial and ethnic composition was aligned with the focus of the unity project. We were looking that the sites had an understanding of disparities, that they were able to describe the racial/ethnic disparities in adolescent and reproductive sexual health and their target community identified. They demonstrated knowledge of the issue of racism and inequality and disparity. We were looking for readiness for change. Looking for organizations that identified strengths and opportunities for addressing disparities in ARSH and the target community. We were looking for organizations that were able to engage youth as partners and organizations that had a track record of collaboration in their community. That they were able to connect with others in the local efforts. From our review we then selected three organizations that we felt had the most promising proposals to serve as partnering organizations or partner sites.

Next slide, please. The organizations that were selected to serve in this role were from Albuquerque, New Mexico, the New Mexico Teen Pregnancy Coalition. The New Mexico Teen Pregnancy Coalition located in Albuquerque, New Mexico was established in 1989. They are a leading private non-profit statewide organization dedicated to reducing teen pregnancy and the negative consequences of this and related issues in New Mexico. In NMTC is committed to provide the state with the most accurate information on all issues related to teen pregnancy advocating for efforts and promoting solutions to -- this also provide training, networking opportunities, resources, technical assistance so adults working on the front lines with New Mexico youth. NMTPC's ability to drive on grassroots leadership made them ideal for the unity project. Here we've just put at a glance of some ARSH indicators that are occurring in Albuquerque, New Mexico. For example, in 2004 we

see that in regards to teen pregnancy rates the percentage of all births that occurred in Albuquerque was lower than the percent of births to teens in the State of New Mexico regardless of race.

Next slide, please. Our second selected partner site was breaking the cycle located in Hartford, Connecticut. Breaking the cycle is a city-wide campaign established in 1995 to reduce Hartford's high rate of teen births. In the 2006 breaking the cycle partnered with the city's Office of Youth Services. The Office of Youth Services was created to engage the lives of young people through programming and positive alternatives hoping young people make good choices. While breaking the cycle has a solid record of reducing the birth rate among teens in Hartford, the unity project offered an opportunity for the organization to use a fresh approach to address and overcome their existing barriers to success. Breaking the cycle and the Office of Youth Services joined forces to create a community collaboration that increases youth and adult capacity to address racial and ethnic disparities in ARSH in Hartford. Here is just some examples of ARSH disparities in Hartford, Connecticut. Hispanic teens were four times more likely to report higher rates of gonorrhea than white teens. Hispanics teens were two times more likely to report rates of Chlamydia. Black teens were ten times more likely to report higher rates of gonorrhea than white teens and black teens were four times more likely to report higher rates of Chlamydia than white teens.

Next slide, please. Our third but not least slide was the urban underground who comes to us from Milwaukee, Wisconsin. It's a grassroots organization founded in 2000 working for the educational and social advancement of youth ages 14-21 from low income backgrounds. Through initiatives Urban Underground provides opportunities for youth to develop skills in community leadership and engages teens in developing their personal

career-orientated and leadership skills. They have an established solid foundation and reputation in the Milwaukee community. Urban Underground viewed the unity project as an opportunity to work collectively with other like-minded individuals and groups in the Milwaukee area, something that they had not previously done in the past. Here is just some examples of the adolescent reproductive sexual health disparities occurring in Milwaukee. For example, teen pregnancy rates in 2004. Hispanic and non-Hispanic black teens were three times more likely to get pregnant than non-Hispanic white teens. Differences are smaller in Milwaukee than for the overall state. Looking at sexually transmitted infections in 2006, Milwaukee was rated ten times -- ranked 10th highest in the nations among cities of Chlamydia, gonorrhea and syphilis. 30% of STDs occur among youth under the age of 20. The next part of the presentation will highlight for each partner their on-site stakeholder meeting. What issues came out of these meetings as well as their action plans, goals and outcomes.

Next slide, please. The New Mexico Teen Pregnancy Coalition group had their on site stakeholder meeting at a local community center in March of 2008. They had approximately 15 participants. The majority of the attendees were youth from a number of the Albuquerque public schools. They also had local members from the plain talk initiative, a national effort developed by the Casey foundation to help communities protect their youth are from the consequences of early sexual activities. Participants from the local Planned Parenthood. Their meeting was smaller in the comparison to the other two sites which gave us an opportunity to have a real intimate discussion with attendees. The New Mexico Teen Pregnancy Coalition and their stakeholders identified or prioritized four main issues. That they felt impacted adolescent reproductive sexual health disparities in their community. These issues included the lack of knowledge and access to reproductive sexual health information and services. They said that amongst Albuquerque teens, HIV is

still seen as a gay health issue. Disparities in the level of sex education at schools occurs. That is, that the districts, the school districts act anonymously. There is a lack of knowledge of where to access information and there are still a lot of stereotypes about not having sex. Their second issue was drugs followed by the lack of self-identity and I awareness among youth. This lack of self-identity and awareness as the young people spoke in the meeting was due to the lack of historical context or knowledge of where they come from. They have issues of Chicano, versus Mexican. Their last issue was environmental and economic justice. Geographic locations of liquor stores in their communities. Environmental factors they thought had an effect on health. Pregnant females living near toxic waste dumps. Economic factors affecting their access to education and services. The fact that they had a lack of transportation to get to the doctor or no health insurance. These were the issues that were prioritized by their stakeholders. As with all the partner sites, the New Mexico Teen Pregnancy Coalition core leadership team worked with our unity facilitation partner, Jamie Hart, to take these prioritized issues and formulate an action strategy. Jamie had each team not only look at the issues from their on-site meeting but also to think about where they were as a group in their capacity to move this work forward. As well as to reflect on their current project work and try to incorporate these prioritized risk issues into their existing platforms. The New Mexico Teen Pregnancy Coalition came up with the following goals and outcomes. The first goal was to gain funding for programs and increase awareness and create buy-in in policy change. New Mexico Teen Pregnancy Coalition wanted to focus on assisting with expert testimony to the legislative body in New Mexico. They felt that the issue of sexual racism and adolescent reproductive sexual health is something that needed to be added to the agenda of the teen pregnancy subcommittee to the health council and to collaborate with existing and new partners who focused on adolescent reproductive sexual health and/or structural racism to help in testimony. There are a lot of local groups. The male

involvement project and the teen outreach program and others who all go and testify on various issues in New Mexico. And they wanted to increase these groups' awareness of exactly how structural racism impacts the sexual health. Their other goal was to disseminate information and increase awareness. They wanted to develop tools and materials help trainers know their audience and tailor their approach and messages. They wanted to develop presentations specific to structural racism to work with school partners, detention centers and probation officers. They want to review and revise their plain talk work, the young fathers curriculum to incorporate language about the connection between structural racism and adolescent reproductive sexual health. They were looking to review and revise presentations as well. And they also wanted to increase outreach to Native American populations. Their last action plan, goal, was to engage youth in discussions of structural racism and sexual health to ensure young people's voices are integrated and heard in activities. They wanted to train peer mediators, conducting trainings on how to clarify and make explicit discussions of structural racism and adolescent reproductive sexual health.

Next slide, please. Breaking the cycle. Help their local on site stakeholders meetings in January 2008 they had 25 participants. The majority of their attendees were youth from Hartford, Connecticut public schools with adult participants coming from an array of organizations such as the Hispanic health council, the institute for community research and MIKASA family service. Their issues included education, parent/family engagement and sexual education, employment and racism. Breaking the cycle came up with the following goals and outcomes as their action plan. They wanted youth workers to address their own personal radiated and internalized racism and be able to work with other youth on this issue and built discussions on the effect of structural racism on youth development in Hartford, Connecticut. They're looking at short term outcomes for youth that have been

involved in the project up to this point to continue to conduct meaningful conversations with youth, to continue to raise awareness on these issues and to provide opportunities for youth to create ongoing communication.

Next slide, please. Urban underground had their meeting at a local YWCA of greater Milwaukee in January of 2008. A total of 22 participants attended their on-site meeting. It was a mix of participants. Basically evenly divided between adults and youth. Youth stakeholders from various organizations throughout the greater Milwaukee area. The prioritized issues that came out of their on-site stakeholder meeting included health, education, employment and incarceration. Urban Underground decided that they would like to focus on their organizational development, to help them incorporate a clear definition of structural racism and adolescent reproductive and sexual health into their mission and goals. To develop this clear definition between the relationship between structural racism and ARSH and looking to continue to work the CARTA to help define this. Their second area was to inform and educate people in order to reduce the negative impact structural racism has on ARSH outcomes in Milwaukee. Currently youth and Urban Underground run summer workshops that talk about such topics like teen pregnancy, sexually transmitted infections, healthy relationships, teen domestic violence and sexism. And they would like to revisit these curriculums and somehow incorporate structural racism and its impact on ARSH outcomes. They would also like to develop and evaluation to look at change in knowledge, attitudes and behaviors of teens that engage in their summer workshops. And are very interested in engaging stakeholders in other organizations in workshops throughout the city. And last but not least on their list, of course, is to look for continuous funding to do this work.

Next slide, please. As well all initiatives, there are some challenges that we -- CARTA incurred challenges while implementing this work. Some of these challenges are specific to partner sites and their readiness for this project. Other challenges reflect a level of being naive on the part of CARTA -- partner sites not being fully prepared organizationally to do this work. Challenges with leadership and limited ability to create vision for unity in their communities.

As we look specifically at the sites -- I'm sorry, I forgot to say next slide, please. As we look specifically at the challenges in which our on-site partners had, when we look at the New Mexico Teen Pregnancy Coalition they had a kind of unique challenge. The New Mexico Teen Pregnancy Coalition is a coalition. Because they're a coalition they have members from various organizations and it was a challenge to do this work in such an environment. They chose to engage two individuals from their membership organization to serve on the unity core leadership team and at times it was a challenge to allow these individuals to have concentrated time to move this work forward. So the New Mexico Teen Pregnancy Coalition continues to work out how exactly do you do this work in such a larger group context. Their other issue was they continued to struggle with inclusion of all communities of color. CARTA recognized a lack of diversity on the New Mexico pregnancy teen coalition leadership team as well as the stakeholders invited to their on-site meeting. While the African-American community in New Mexico is small, less than 5% their voices should be represented. There is also a large Native American population that is struggling as well with adolescent reproductive sexual health disparities and are not adequately represented. This lack of engagement with these communities specifically with African-Americans was an ongoing challenge for them. In past work that CARTA has done in the Albuquerque region, we have heard the frustrations of the health providers of color in this area. These providers have been dissatisfied with the lack of inclusion and so CARTA

urged the New Mexico Teen Pregnancy Coalition to think about how they can integrate partners from other communities as they move their work forward.

Next slide, please. Breaking the cycle. Breaking the cycle had a number of challenges as well. Their first one was navigating newly formed relationships with the offices of youth services trying to figure out how do you start a new partnership and take on new work at the same time. They struggled collectively with structural racism framework and connecting it to ARSH outcomes. Without their core leadership team having the knowledge and understanding of the structural racism and how it impacts collectively -- I heard a beep, I'm sorry. The group continued to struggle in making and framing this work for their constituents. Our next organization Urban Underground had three areas in which we felt were challenging for them. In the midst of doing this work, they had a shift in leadership in their organization where their executive director departed as this work took off and so it took the new executive director time to balance taking on a new organization and handling such a large project as unity. They also struggled collectively as breaking the cycle did with their knowledge and understanding of structural racism and its impact on adolescent reproductive and sexual health. Last, but not least, they were limited in their networks with other community-based organizations and adult leaders. Urban Underground has a strong youth partnership. They are a household name when it comes to youth in Milwaukee and are truly a youth-run organization. However, adults throughout the community are unaware of Urban Underground and the work that they do. And at times this presented a challenge.

So as we close out, just to -- next slide, please. Just to recap some lessons learned on CARTA's behalf. Time and funding, while it seems like a no-brainer we all recognize that we propose and desire from funders may be difficult to obtain. The unity project was

initially proposed at a four-year effort with funding for two years. CARTA viewed this as a great opportunity to launch the work and agreed to the shortened time frame but we acknowledge it was unrealistic for achieving the initial project goals. Realistically this is a five-year effort at minimum, two years for team and organizational development work to action planning and three years for implementation. Another lesson learned is increasing knowledge of the social movement process for the lead organization and for the community partners. While CARTA has a general understanding of the process of building social movements, we were not as intentional as we should have been regarding this goal. Our third point is staff stability. This project needs a dedicated staffer. It takes a lot of time and energy to provide technical assistance to your partner sites. Organizational selection process and criteria as well. Partner organizations capacity to launch this work was more limited than we anticipated and the community context was unclear or different than what organizations indicated initially in that request for proposal submitted. CARTA needed a better way to assess the organization's readiness for the unity project as part of the final selection of partner organizations.

Next slide, please. So where are we going? CARTA's initial vision for this work was to increase awareness and understanding of the structural racism and social injustices appeared their influence on adolescent disparities and respond to local conditions being a social movement. As CARTA took a moment to step back and assess where our partner sites were and where we frankly were as an organization doing this work, we decided that we needed to shift where we were going with our partner sites based on both factors. We decided to concentrate on increasing the knowledge and awareness of each of our partner sites around structural racism and its impacts on adolescent reproductive sexual health outcomes. This lack of understanding and confidence among our leadership teams hampered their ability to engage others in their community and so we felt that it was

necessary to really concentrate on this area. And we did this in a number of ways. We hosted webinars, we talked about where team members felt they struggled in understanding the framework and then where they struggle on explaining it to others. We received great feedback from them on how we could make it clearer, which allowed us to develop a more lay person's one-pager that outlines the framework. I'm happy to report that all of our sites have done a wonderful job in increasing their knowledge and awareness on this very difficult topic to understand. We also decided that based on our lessons, we weren't ready for a social movement. Rather, we were ready for our teams to take their prioritized issues and develop these great action strategies I discussed earlier.

Next slide, please. So the next step for CARTA in this work is we're looking to secure continuous funding. We're finalizing the development of our capacity-building toolkit which will be used as part of our roadmap to do this work. Partner sites existing and those that we look to bring on in the future will use this toolkit as a guide as they move through the various steps of our capacity-building process, along with our expert facilitation partners. And last but not least, CARTA continues to provide technical assistance to our current partners as they move their action priorities and plans forward.

Next slide, please. In providing recommendations for organizations that are interested in doing this work, we just want to highlight that you ensure enough time and resources to this work. As they say, Rome was not built in a day. Eliminating inequalities isn't going to happen overnight. It is going to take time. Make sure you have a dedicated staffer who can attend meetings, who can cross reference and discuss issues not only with facilitation partners but other stakeholders in the community. Make sure you have a roadmap and a clear understanding of what you're looking to do as an organization. That you involve partners in the beginning so that everybody has a clear understanding of their roles and

responsibilities. And an important point is that everybody has a clear knowledge and understanding of structural racism and how it impact adolescent reproductive and sexual health outcomes for your community. And that would wrap up CARTA's presentation.

Next slide. The last slide is our contact information if anybody is interested in learning more about our framework, learning more about the unity project, please feel free to visit our website or you can contact Kimberly Ross or myself, thank you.

>> Thank you, Kimberly and Shameeka. Great presentation. As a reminder to our audience, please submit questions for the speakers using the message center on the lower right-hand side of your screen. Select question for the speaker and designate which speaker should answer the question. Our next speaker is Claude Gilmore. Claude holds a master of science in social work and a master of health services administration. He serves as Youth Policy Director for the Wisconsin Department of Health Services/Division of Public Health. Claude will discuss how Wisconsin is using data to address youth sexual behavior, drawing upon the 1993-2007 Wisconsin youth sexual behavior and outcomes data report. He will also discuss how Wisconsin and Milwaukee have formed a partnership, the Milwaukee adolescent pregnancy prevention partnership to reduce teen births and sexually transmitted diseases. Claude.

CLAUDE GILMORE: Thank you, Chad, appreciate it. Good afternoon. As Chad indicated, I'll be addressing the issue of the impact of this data that we've collected in Wisconsin to inform us around policy and recommendations, as well as a unique organized collaborative in Milwaukee that we have put together to reduce unintended pregnancy and STDs in our largest urban city.

Next slide. The key focus of this is a report that we put together as part of a partnership between the Department of public instruction, our education agency, and our Department of Health Services and our local Bureau of health information and policy. This is trend data from the youth risk behavior survey collected by our Department of public instruction, as well as other data looking at teen birth rates, STD and HIV rates in Wisconsin. And this data information and how to locate it in more detail we will provide at the end of the report.

Next slide. The first slide we want to highlight for you is the sexual behavior data information from our youth risk behavior survey. Looking at the information from 1993 to 2007, you would note that in the years of 1993 to 2003 we had a decline in percent of high school students who reported having had sexual intercourse. We have seen a slight uptick in the 2007 to 45%. We're looking to see if the trend continues in 2009. The slide is not here but we have looked at the condom use. That has been fairly high but it has dropped down in the last review period in 2007.

Next slide. Another item area we've looked at. This is fairly new, is looking at the reports of students who reported any sexual contact amongst same sex partners. And here we have a note that about 8% reported that in the last survey that was done through the Department of public instruction this information is fairly new. It is looking at the population that we consider to have some risks associated with it so we do not have any trend data at this particular point. But an area that we're looking at as we go forward.

Next slide. This slide focuses on the Milwaukee STD rates and it is from CDC looking in 2006 and expands upon the information that my colleagues presented earlier. The information does not present a very positive picture for our largest urban city. It is noted here that Milwaukee has the highest STD rate for Chlamydia, gonorrhea and syphilis for

the 50 -- and our respective area in a different lower level. So it's an area of concern for our state.

Next slide. This slide looks at the issue of disparities around the increase of STD rates among African-Americans since 1997. You can see the different color across the graph, the red being the African-American population and the green being the representative of the white population. This side represents a clear disparity looking at the overall rate of selected STD for teens age 15-19 by race and ethnicity. There is a significant disparity, 18 times difference in this. This is an area we have significant concern about and continue to try to address it as we go through this presentation to show you what we're trying to do about it. But it gives you a clear graphic illustration.

Next slide. In the area of HIV, among people age 15-24 you can see for the adjusted number of cases of the reported HIV among this population by risk exposure you have men who have sex with men, including those who inject drugs, you have the injection drug users and heterosexual contact. As you can see there has been an alarming increase in this population toward the latter years of 2004 to 2007. An area for significant concern. However, there has been a decline in the cases of transmission attributed to heterosexual contact and injection drug use. This is an area of particular concern for our state and public health and that we want to continue to address.

Next slide. This gives a more particular view of Milwaukee's metropolitan statistical area. Those outside the central City of Milwaukee and surrounding areas indicates for the African-American population men who have sex with men for the ages 13 to 19 you can see a tripling impact from 2000 to 2008 for the African-American population as compared to the white population. An area also reinforced in the numbers I showed you earlier on

the 18 fold difference you can see a lot of it is driven by this particular data that is coming out of Milwaukee. And the final data slide is regarding teen births. Here we have some good news as well as some not so good news. The good news is that looking at the period from 1993 to 2007 you can see there has been a significant decline in the African-American teen birth rate. As a matter of fact, this particular rate has declined significantly in the Milwaukee area, which has experienced its lowest teen birth rate in 2007. We are looking to see what the good news contributed to this decline and will be working on that with our partners on this area. However, the news about the disparities still remains significant. The five fold difference for African-Americans, the five fold difference for Hispanics and 4 fold difference for Native Americans remain an area of concern.

Go to the next slide. What does the data tell us? As I indicated earlier the area we're looking at now is the 2009 Wisconsin youth risk behavior survey. Hope you'll be able to tell us whether the trend regarding high school students reporting sexual intercourse will go back to being declining or whether it continues to increase. There has been an increase amongst activity nationwide. We hope that the trend has -- will be abated but we'll know more later on this year. We also will know more about the trend regarding the sexual contact for same sex behavior. We'll see how that reports out but that gives you a sense of the snapshot. Our Department of public instruction has done an excellent job in collecting this data. They have a large sample, a good sample of high schools who participate in this and this is very important data for us to understand the trends. In the area of STD it was pretty clear from the data I showed you earlier that there is a one in eight African-American teens contracting STD between 2003 and 2007. And that is compared to one in 145 white teens. Thus reflect being the 18 fold difference. You can see that has lasted for a while and definitely an area of concern. In terms of the data that tells about HIV, we're significantly alarms us about the rate of the cases. Looking at male

to male sexual contact encounters for 73% of the cases of HIV reported among youth between 2004 and 2007. When you look at that snapshot further in terms of the African-American population which represents 8% of the Wisconsin male population, between the age of 15 and 24 it accounted for 43% of the HIV cases attributed to male to male sexual contact between the same time period. That is an alarming trend. The African-American MS population in the metropolitan area tripled. In teen births the data tells us as I shared earlier we remain to have disparities but we're showing a trend in the African-American population of a decline. That is an area that we are pleased to see. There are a lot of efforts going on in Milwaukee which I'll share with you in this presentation that I think are providing some assistance in that area, but we remain concerned. For Milwaukee I think this is good news in the 15 to 17-year-old girls that the teen birth rate did drop to the lowest level in 28 years in 2007 to 50 per 1,000 girls. So that's what the data tells us.

Now, as to -- next slide. As to what it says about policy, what direction should we be going in, we've had some discussions about this. And one of the areas that we are emphasizing is to promote the use and access to dual protection services. This is a services that will provide simultaneous information of providing information and supplies to reduce the risk of STD and unintended pregnancy. We're looking at that in our family planning program. Programs providing teen parent services, a whole range of areas and evidence indicates that this is an effective approach. Second recommendation we're looking at is we've been promoting and working in the area of healthy birth outcomes. Specifically trying to address infant mortality but within that context we also looking at teen pregnancy. The efforts around healthy birth outcomes is focusing on eliminating racial and ethnic disparities and looking at a social marketing effort trying to attract the STD situation and promoting quality healthcare to African-American youths which I think is a central piece of this. The third area is an area of testing and promoting the norm of testing annual testing for HIV and

STD especially with men who have sex with men. This includes that younger population we talked about in terms of 15 to age 24. The fourth recommendation we think is important and we've worked closely with our educational counterparts around this and we think we need to continue to support the efforts to implement human growth and development curriculum. An important part of the process of getting this information to youth at an earlier age. The last recommendation we're looking at because of the risk issues it has improved the health needs. LGBT and sexual minority youth populations especially in light of this data. Data is important, it tells us a lot about what the information indicates the risks are and disparities and it also helps us inform some policy recommendations. Now we'll shift to the second part of the presentation which involves a program in Milwaukee.

Go to the next slide. This is an effort began by the state Division of Public Health. We worked in close cooperation with a lot of our partners. The goal here was to establish Milwaukee partnership and we did this by working across sectors with other funding sources to pull us together and I'll get to that later. Four agencies ended up receiving the contract. The lead agency in Milwaukee was the medical college of Wisconsin, a large medical education agency. Has a Milwaukee adolescent health program that's been in existence for a long time located in the central City of Milwaukee doing work in adolescent health. The City of Milwaukee health department operates the Keenan clinic located in the city and provides assistance services for those in need of STD treatment and intervention. The third agency is a community health agency focusing on -- in the central city and it operates lots of different services for a very population in need. So this is a community health center which is vitally important. The fourth agency which is a community-based agency is new concepts development center incorporated and they have been in the business for well over 30 years. They operate 18 pregnancy prevention and community

case management type of program and do a lot of work with teen parents and those in need of services. That represents the partnership.

Next slide. The overarching department strategy here for our area looks at implementing evidence-based dual goal strategy. There are two prongs to this. The first prong is encouraging and promoting delayed sexual activity among sexually abstinent adolescent. For those who cannot delay and are able to do this we provide access to contraceptives, reproductive health services to prevent unintended pregnancies and STDI among sexually activity adolescents. Under this overarching goal, , we have formulated two goals for the Milwaukee partnership collaborative. One we really want to laser beam focus around developing a Milwaukee-driven community based partnership focused on reducing -- age 15 to 19. Second goal here ties to a Medicaid family planning waiver program that's operated through our Medicaid division. Want to increase that in Milwaukee. This Medicaid waiver program is designed to help low income women age 15 to 44 who are at or below the 185% of the federal poverty level to help them avoid unintended pregnancy and obtain family planning care services at no charge. We think this is a very important strategy and really put our emphasis on that.

Next slide. Looking at the partner agencies in a little more detail. The Milwaukee adolescent health program operated under the medical college of Wisconsin has three local sites. It has a downtown health clinic that operates Monday through Friday and Saturday with a physician on call 24 hours seven days a week. And it also operates as juvenile detention program reproductive health clinic in the juvenile detention center. This is where a very high risk population is housed and they provide excellent services there and in terms of getting services to this population that probably would not receive it without Milwaukee being present. There is also a school health clinic located in the lady

Pittz Custer high school in Milwaukee. It's a clinic that has been in place for a number of years and services will be provided to adolescents right on-site within that school building.

Next slide. To give you a picture on some of the -- data collected from September of last year 2007 to June of 2008, you get a picture of some of the characteristics. They reached out to 235 females, as you can see the largest population was African-American 65%. They did serve other populations but they were lower numbers in terms of percentages. 80% of them were of the age group of 15 to 19. Small percent but not, you know, 20 percent were age 12 to 14. 90% were sexually active. There is a correlation with the alcohol and drug use and looking at the insurance status, large numbers were on Medicaid and some did not know their insurance. This gives you a picture of a snapshot of the population served that included those at the downtown health center as well as the juvenile detention center.

Next slide. Another key partner is our city health department. This is the largest health department in Wisconsin. And it is located in central City of downtown Milwaukee. It operates a STD clinic that is operational Monday through Friday and offers free services. This partner is critical because it serves a large number of clients and provides a feeder for some of the other partner agencies. We go to the

it gives a picture of an initiative that we've established with this clinic in Milwaukee. This is an effort to get dual protection in sort of a different way. We've taken this within the confines of the STD clinic. The goal is to educate the patients there. Offer condoms plus the emergency contraception. We encourage and enroll the clients into the family planning waiver at any and all manner and shape of getting it done. We provide a feeder referral and the medical home to those that do not have a medical home to enter the agencies I

mentioned earlier and also we stress the importance of getting reimbursement through Medicaid for the STD reproductive health services. This allows the agency or services the clinic within the local health department to get some additional revenue by servicing those who qualify for the family planning waiver.

Next slide. Looking at the available partner services through the new concepts development center, I think this is a very important one. Have a local community based organization who has been on the ground for well over 30 years doing this work as a vital partner. They're housed in a Martin Luther King Offices in the central part of the city. Very active in the program for plain talkers initiative that was mentioned earlier to address the issue of getting information to parents about educating them about teens and sexual activity. They operate a education at the juvenile detention center which is vitally important. They provide training around the waiver but most importantly they do an excellent job around case management. These are cases that are intense and require a lot of follow-up and I think the key goal here is to reduce subsequent pregnancy.

The next slide talks about new concepts and accomplishments and looks at the services provide. We have 25 sessions conducted. 65 girls they serve. 60 of them African-American with teen moms received individual case management and a picture of some of those. The key things here is the prevention of subsequent pregnancy, encouraging making sure they get a reproductive healthcare home and ensure the girls are in school. Challenges here revolve around baby's grandparents. There is concern around childcare and access to that and prevention of child abuse and neglect. This is a very important service done by this agency.

Next slide. Here we're looking at the Milwaukee health services incorporated. This is the community health center. Having a community health center is vitally important. Especially in light of the changes that will be occurring around the president's proposals to use a lot more resources in community health centers in various cities. They operate two sites, one is right in the heart of Milwaukee, central city. The Martin Luther King heritage center they operate Monday through Friday with Saturday hours. They have specific times for teens and children and they have a site on the north side of Milwaukee called the heritage health center. That's a growing area for Milwaukee's African-American population.

Next slide. Here we'll share a little bit about the nurse midwife accomplishments. The data they collect. They see a large number of clients and this data reflects some of the characteristics of those. Relative to STI, STD treatment as you can see here the data indicates that the Chlamydia infections were the largest number at 42%. For pregnant teens as you can see the age 18 to 19 is a significantly increase of 59%. Smaller percentage for the population age 16 to 17. However, these are numbers to be concerned about if we go forward in terms of whether or not that will continue to increase. They do sign people up for the waiver working in a health center is an important -- it's important that you engage people around benefits coordination, customer service. Understand how to do the actual signup so the teens get the information and the services before they walk out of the door. That gives you a little bit about the characteristics and makeup of the organizations that are part of this partnership. I want to shift to the operational structure in terms of how this has been done just as my colleagues talked about the things that they did on the ground relating to the CARTA project and the unity project they shared with you. We've done similar work in the area of Milwaukee but it may not be as visible. A lot of the footprints are becoming to become clear. The Milwaukee adolescent partnership initiative I just shared with you has recently merged with an initiative called the Milwaukee

alliance for sexual health. The Milwaukee alliance for sexual health was begun many years ago by our Division of Public Health as an effort to address the growing STD rate in Milwaukee and to address teen pregnancy. And that effort was also a partnership with the medical college and several other clinic and service-based agencies. They formulated a significant white papers and groups focusing on policy advocacy. Reproductive health services, counseling and testing, school services, curriculum development and youth/peer outreach. We've combined the resources of those two groups together and it is now serviced as a central point as the driver for our efforts on teen pregnancy prevention. United way of greater Milwaukee is also -- has undertaken a very public/private leadership role in trying to get resources to help us help Milwaukee address this problem. The greater Milwaukee teen prevention initiative is what it is called. People can access that through united way Milwaukee.org to take a look at some of the work they're doing. They've taken a leadership role along with the leadership of the Milwaukee journal sentinel, the private foundations for trying to take this issue on in terms of the funding and the things that will be necessary to addressing this. This will take a long-term effort. We'll also partner with an issue called the mill walk -- it's an initiative that began many years ago that linked together many funding sources to address the issue of youth alcohol, teen pregnancy, violence and other youth-related issues and child abuse and neglect was part of it. They represent about 40 agencies in the city that do a lot of work in terms of serving young people so they're part of this partnership and also direct providers in the teen network that are vitally important. This formulates what we call the collaborative group that is working in Milwaukee and we hope to be able to bear more fruit of this as we now go forward.

Next slide. Here just to give you a picture on how this began, one -- a former state health officer, Dr. Harry Johnson, was instrumental in promoting we link several funding streams to try to pull this initiative together. We pull dollars together we get from our state general

purpose revenue here in the -- Title V dollars, federal match dollars to come up with a total funding source of \$121.783. This funding process can be increased if we get additional resources to fund a collaborative. It did have its challenges but it was something that we were able to get done and to get this initiative off the ground.

Next slide. This is part of our public relation effort. I'm very proud of this because young people were instrumental in designing this respect and protect postcard. It had street credibility to it. Kids liked it. We adopted it. It was put together by a group called the youth ambassadors. They provided a lot of the input. As you can see by the design the goal was to get the message out instead of talking about as a family planning waiver we talked about it as respect and protect. Target population, the services, how you can actually get what you need on the first page and the second page talks about how you quality and local agencies they can go to. We have these in post cards around the city and running on an electronic billboard on the buses in the City of Milwaukee getting the message out as part of our effort with a media firm.

Next slide. Here there are lessons learned and as my colleagues noted here, taking these things on are not easy. First lesson learned has to do with we created a funding stream as I indicated. Pulling that together was challenging we had to satisfied several state and federal requirements. Around Medicaid created a little challenge in the fiscal department but we worked it out. It can be done. Second challenge was how do you link programs with similar outcomes, target populations and funding streams and collaborative affiliations? These were a lot of mixed metaphors together and it was like conducting an orchestra trying to figure out how we'll meld this. I had some challenges and we had challenges at the beginning to see if we could make sure the thing worked together. The key was having a lead agency. The third one, the lead agency was a medical college of

Wisconsin which we subcontract to local agency and collected the data but it was really interesting data collected from a community health center, from a CDO and from a local health clinic had different kinds of ways of collecting data. It was challenging but my role was to push the envelope to get them through this process. Lastly it was an advantage to having a centralized contract. We had one provider to work with and now through the collaboration of the two efforts -- initiatives I shared with you we now have one central group that we can go to to address teen pregnancy prevention in Milwaukee. That's sort of a quick and fast on some of the things from my perspective. The last slide you have my contact information that you can follow up with me and a link to the Wisconsin youth sexual behavior data outcomes data website so you can get access to the report. You can download sections, all the trend data and graphs are there. I want to personally acknowledge several of my colleagues. The Department of public instruction were vital to this in terms of their collection of data for the risk behavior survey. We want to knowledge Brian weaver who did a lot of work on this. An HIV consultant at our Division of Public Health. Mike Vaughn from family planning and reproductive health. Brandon from STD consultant in our division and our Bureau of information and policy instrumental in pulling this report together. That's the highlights from my area and hopefully maybe if we don't have time for questions you can follow up with me later on. Thank you.

>> Thank you so much, Claude, excellent material. We are at time on the webcast but I think we can push just a couple more minutes here. I want to thank all three of our speakers for their time and valuable information. We'll see if we have just a few minutes to squeeze in a question or two. We did have a great question come in for Kimberly and Shameeka. Could you please describe what is in the CARTA toolkit? How will organizations and communities be able to access it? How will they be able to use it? Does it contain any materials to help build community's readiness?

>> That is a great question. The elements that are in the toolkit are a number of things. There is a section on organizational capacity to do the work so there is an assessment that an organization would take to assess their readiness to take on the work. There are sections that talk about how to gather data around the issues, around ARSH indicators and how do you present this data in a friendly format for the community? There are tools in -- there are tools in the toolkit that talk about how do you collaborate with other individuals in your community, how do you bring stakeholders together for stakeholder meetings? How do you flush out the issues in your community, prioritize them, develop an action plan and then how do you hit the ground running with the action plan? There are -- there is also a section on youth/adult partnerships. How do you really formalize these partnerships so you don't just have young people sitting around the table we have young people sitting around the table but not engage in the process. There are a number of resources that are incorporated in the toolkit. The way in which people get access to the toolkit is through CARTA. It is not going to be the kind of toolkit that we just put on our website and make available to individuals. Rather, you would sign on to be a part of CARTA's capacity-building work around this issue. And when you sign on as a partner site for this work the toolkit is a part of the services that are provided. So the toolkit is an element of the technical assistance service you get with CARTA and our seasoned facilitation partners.

>> Thank you, so much. And Claude I'll send two quick questions your way. The second one I think can be answered fairly briefly. What are the respect and protect post cards available for other state campaigns -- are they available, I'm sorry, is there a price attached for those? The second question is could you be specific about how Wisconsin as

a state is taking action on its key policy recommendations which have been formulated based on the Wisconsin-specific data?

>> Relative to the first question, that is specifically postcard directed for this campaign so it is not something that we made available sort of to a lot of external partners because it's being tailored to Milwaukee. I'm sure as we go through the process of looking at some of the -- what is working and getting some tweaks on it we can share the information. I think for now if people want to know more about it they can submit some information to me and I can email them the people working on the ground on this. It's not proprietary as much as we want to make sure it works. We're in the second year and we need to do an evaluation on how effective the campaign has gone and it is not complete yet. Relative to the information about forming the policy. Some of this data that I've shared with you today has been presented with our department secretary and there are things that we're looking at what we can do in the current climate in terms of budget and resources, it makes it very difficult. We're looking at ways that we can do things more efficiently and effectively to address some of the outcomes that we have and so our division and folks are looking at things at what we can support legislatively, what we can do programmatically. What's working that we can continue to promote. So obviously if things do improve resource-wise there would be things we would like to do more of obviously. The significant problem we're facing, we know for now it will be a lot harder but data is important. I think it's important to do that because now we've given information to our management and to folks who will be working on this over time, some actual hard evidence of why there is a need. A lot of challenge is what can we do with that.

>> Thank you, Claude. That concludes our webcast for today. I would like to remind you to tune in for the third and final installment in this series. It will be titled eliminating health

disparities and achieving equity/empowering youth. The webcast will take place on Wednesday, April 29, 2009. Registration is now open at www.mchcom.com Again, you can also watch the archived version of the first webcast in this series, it took place on Wednesday, March 11, 2009. It was titled eliminating health disparities and achieving equity/a framework for achieving the health, safety and well-being of adolescents. That webcast is also located at www.mchcom.com. Under recent events. Thank you all for joining us today for this important topic. We look forward to seeing you again virtually on April 29th. Thank you and goodbye.