Youth Health Education to Empower and Protect
United States of America
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Schools, as nonpartisan entities, are primary avenues for unbiased, non-politicized health education. Additionally, schools reach students from all socioeconomic and ethnic/racial backgrounds. In understanding the educational, income, and partisan divides in childhood vaccination and public health attitudes, the necessity of increasing access to education regarding such information through school systems has become more pronounced. Peace, as interpreted as a state of security provided by the wellbeing and good health of the community, comes with a communal understanding of oneself as an integral determinant of the health of themselves and their peers, all bound by the same illness and diseases that trump one's socioeconomic, ethnic/racial, and political backgrounds and affiliations.

Parents in households making less than $25,000 per year, parents without a college degree, and Republican parents have become more resistant to vaccinating their children. Race also plays a role in attitudes towards vaccinating children for COVID-19. Whereas resistance rates among Asian Americans stood at 8%, resistance rates among Hispanic and Black parents all remained around 20%; such racial disparities has led to a discrepancy in mortality amongst children where 78% of children who died were children of color and 45% were Hispanic (NPR). In understanding the demographics of California, where over 48% of children are Hispanic –and with Hispanics making up the greatest racial/ethnic group in numerous California counties like Riverside and San Bernardino (which make up the Inland Empire)–, we can better realize the exigence of the matter. Further, these facts contribute heavily to the significant disparities we see in COVID-19 vaccination rates between different age groups with only 60% of 12-17 year olds in California being vaccinated, in comparison to 71% for 18-49 year olds (New York Times), emphasizing the need for more health education and empowerment of youth. Beyond COVID-19 vaccinations, many children missed routine vaccines, with diphtheria, tetanus, and pertussis (DTP) vaccination rates falling by nearly 10% during the COVID-19 pandemic. In many states, a resurgence of measles, meningitis, and polio cases has become apparent and is likely due to the decrease in immunizations.

Our children, and by proxy our community, must be protected. Education systems must serve to empower children to make informed decisions, free from political biases and backed by science, whilst working to mitigate distrust in the health community. Thus, there is a need to incorporate public health education into school districts, including but not limited to by means of an addendum to California Department of Education's (CDE) current K-12 Health Education Framework. The curriculum, added to the "Health Framework for California Public Schools" by the Instructional Quality Commission, may include information regarding public health terminology, common means of transmission of diseases and best practices on how to minimize rates of spread, identification of risk factors and consequences of contracting diseases, how to seek and access assistance from healthcare professionals, current disparities and inequities, the prevalence of misinformation and disinformation and how to identify and mitigate these, and the connections between health (including mental health) and academic success.

Being heavily involved in the primary and higher education policy circuits in California through the organizations California Association of Student Councils –established by the California Department of Education– and GenerationUP, I have developed lasting relations with major youth advocacy groups and passionate students with capacity to mobilize and advocate for bills pertaining to youth empowerment, superintendents and teachers across over fifty districts in the Inland Empire, and Senators and Assemblymembers across the state. Further, as a future physician studying Human Biology and Data Science and a student researcher working in infectious diseases and immunology, I have a deep understanding of the importance of public health education –especially for adolescents– and have ties within the medical and science communities. My passions for both policy, public health, and protecting my community –as someone who grew up in the Inland Empire– merge together with this proposal. I have extensive experience with the process, from writing proposals and preparing presentations, connecting with Legislative Councils to get official language, pitching unbacked bill language to Assemblymember / Senator offices, and giving testimonies in front of the Assembly Higher Education Committee and the Senate Education Committee. The bill language for this proposal has already been drafted, and, starting the next legislative cycle with an established framework curriculum after this project, I aim to pitch the bill to legislators involved in health and education. However, with that being said, I still

have much to learn about curriculum development and budgeting –as publicly available fiscal analyses for such projects are limited– and will seek guidance from Senator Anthony Portantino's office (passed SB 224, explained below) and former-Assemblymember Jose Medina (passed AB 101, mandating ethnic studies as a graduation requirement in California, with which I was heavily and publicly involved with).

Creating a task force of health professionals, epidemiologists, pedagogists, and stakeholders including teachers and students –on a heavily volunteer basis with stipends of $300 for up to 12 people as compensation–, I will work to lead us to create model curriculum that has been field-tested to establish a strong foundation for the vitality and need for such an education program that can later be invested in and scaled to span the state of California –and perhaps, in the future, the US.

With an aim to create a 4-hour training program that can be easily implemented over a week of class time, there will be an upper estimate of 100 hours of development time. As recommended by the National Institute of Corrections, curriculum development –including creating content focuses, instructional strategies, gathering data, and preparing materials– can be set in accordance with five steps: "1) needs assessment, 2) the planning session, 3) content development, 4) pilot delivery and revision, and 5) the completed curriculum package." I have allotted $1000 for the development of material; most will be in digital forms but may require utilizing out-sourced platforms.

After an estimated two-three weeks of content development in the beginning of June, the remaining weeks of the month will be spent designing and coordinating logistics to implement a pilot of the original program over summer school health sessions in the month of July. This includes working with school districts to fund and integrate new modules into the current curriculum. One target school district will include Corona-Norco Unified School (CNUSD) district –the largest school district in Riverside County and the tenth largest district in California– which has summer health sessions including one spanning the month of July. Based on the fiscal analysis of SB 224 –a bill that creates "a distinct category on mental health instruction to educate pupils about all aspects of mental health," similar to this proposal's focus on adding a public health instruction category, that passed in 2022 in California–, there is a lower end estimated cost of $1000 and an upper end of $5000 for each school to train local educational agencies. Thus, with an aim of implementing the mere 4-hour long pilot in at least two to three schools spanning school districts in the Inland Empire –a region that is predominantly Republican-voting, Hispanic, and has a significantly higher poverty rate than the country–, we may allot an overestimate of around $5000 on the training and pilot program for the condensed summer curriculums. Based on feedback and observations, further time can be spent on revisions of the pilot.

As part of the pilot, we will start with an anonymous survey –for which I have allotted an upper estimate $50 for myself $200 for four other members to get any additional necessary trainings regarding privacy to conduct such work– collecting information on students' demographics (including socioeconomic status, race/ethnicity, political affiliations, etc) and vaccination statuses and their current understandings of public health issues and infrastructure. Additionally, questions will aim to reveal students' understood relationships between health and practices and political affiliations and understood roles in promoting the health of their communities. At the end of the program –around a day or school week of content, depending on course pace–, students will take a similar survey, including an assessment of the curriculum content and again addressing their understandings of self and politics in the context of public health, that will allow for direct comparison of learned knowledge and shifts in self and health paradigms. The survey results will be calculated in terms of accuracy regarding content and tabulated based on a number scale for non-discrete questions, thus allowing us to run analysis based on the data from the three schools, aggregated by socioeconomic status, race/ethnicity, and political affiliation –alongside other prevalent factors that may emerge– in early August. Such results will inform the program's outcomes and can guide revisions for later pilots and amendments.

The material from the program may be offered as resources for youth and distributed by teachers in schools, coordinators of leadership programs, pediatricians, families, and beyond to increase availability and accessibility to such information in a condensed and digestible format –though without any supplement instruction– after the program.

With the amendment to add public health education within school district, county office of education, state special school, and charter school that offers one or more courses in health education to pupils in middle school or high schools, the proposal would promote the mutualistic relationship between school and health, leveraging education as a means to promote health empowerment and keep schools and communities safe and. With bettered wellbeing and health and a commitment to protect ourselves and our community, we can push towards peace.