Proceedings of the
Adolescent Sexual Health Symposium

February 3-4, 2009
Cornell Club, New York City

June 2009

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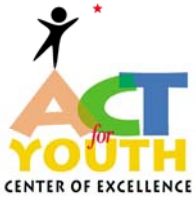

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"Young people – who are the living message we send forward to a time we will not see – are human capital, our rescue plan going forward. As we form new approaches based on better technology, we must never lose sight what young people look like – or who he or she is. This work is about serving youth." – *Michael Carrera*

Introduction

The ACT for Youth Center of Excellence convened a symposium of leading experts and stakeholders in the field of adolescent sexual health on February 3-4, 2009, at the Cornell Club in New York City. The purpose of the symposium was to gather information to assist the New York State Department of Health (NYS DOH) plan for the future direction of its adolescent sexual health initiatives. A panel of leading researchers in the field of adolescent sexual health shared perspectives and engaged in dialogue with a group of stakeholders representing a broad range of experience. The invited stakeholders included a panel of young people, NYS DOH staff, representatives from federal, state and local government agencies, health care practitioners, representatives from youth-serving programs, and adolescent health advocates. The expert panelists were: Claire Brindis, Sarah Brown, Michael Carrera, Alwyn Cohall, Angela Diaz, Ralph DiClemente, Douglas Kirby, Jonathan Klein, Deborah Levine, Guillermo Prado, and John Santelli.

The symposium was designed not to achieve consensus, but to raise critical issues and generate a range of ideas and comments that will aid the NYS DOH in planning the future of adolescent sexual health initiatives. Themes discussed included trends in adolescent sexual behavior; disparities in access to adolescent sexual health services, information, and education; ecological approaches to promoting adolescent sexual health; and new information and communication technologies. Participants were also asked to generate ideas for the design of a comprehensive sexual health initiative, working on focused topic areas in small groups.

This report highlights issues raised, selected comments by experts, stakeholders, and youth, and resources that were offered at the event. A future publication will focus on approaches to address racial and ethnic disparities in sexual health outcomes for young people. The promotion of adolescent sexual health is a complex issue; therefore, the commentary presented here does not address every factor that influences sexual health for young people. It is our hope, however, that the event and proceedings will provide a significant contribution to the broad base of information and expert opinion from which the New York State Department of Health will plan future initiatives.

Featured Speakers

Claire D. Brindis, Dr. P.H., is Professor of Pediatrics and Health Policy, Department of Pediatrics and the Department of Obstetrics, Gynecology and Reproductive Health Sciences at the University of California, San Francisco. She is interim Director of the Philip R. Lee Institute for Health Policy Studies, and the Executive Director of the National Adolescent Health Information Center and Director of the Bixby Center for Global Reproductive Health. Dr. Brindis' research focuses on adolescent and child health policy, adolescent pregnancy and pregnancy prevention, and school-based health services. She has led a multidisciplinary evaluation of the California Office of Family Planning's Family PACT (Planning, Access, Care and Treatment) program, finding that for every dollar spent on the program, an estimated savings of $5.53 in medical and social costs is realized through the prevention of unintended pregnancies. Other research projects include evaluations of California's Community Challenge Grant, a comprehensive teenage pregnancy prevention program, as well as two evaluations of policy coalitions devoted to environmental health and asthma and community clinics.

Sarah Brown, M.P.H., is the CEO of the National Campaign to Prevent Teen and Unplanned Pregnancy, a private and independent non-profit organization working to promote values, behavior, and policies that reduce both teen pregnancy and unplanned pregnancy among young adults. Before helping to found the Campaign, Brown was a senior study director at the Institute of Medicine, where she directed numerous studies in the broad field of maternal and child health. Her last major report there resulted in the landmark book *The Best Intentions: Unintended Pregnancy and the Well-being of Children and Families.* She has served on advisory boards of many national organizations, including the Guttmacher Institute, the Population Advisory Board of the David and Lucile Packard Foundation, the American College of Obstetricians and Gynecologists, the DC Mayor's Committee on Reducing Teenage Pregnancies and Out-of Wedlock Births, and *Teen People* magazine. She holds an undergraduate degree from Stanford University and a Masters in Public Health from the University of North Carolina.

Michael A. Carrera, Ph.D., is Professor Emeritus of Health Sciences at Hunter College of the City University of New York, and Adjunct Professor of Community Medicine at Mount Sinai Medical Center in New York. He directs the Adolescent Sexuality and Pregnancy Prevention Programs for the Children's Aid Society in New York. Dr. Carrera has served as President of the Board of Directors of the Sexuality Information and Education Council of the U.S. and as President of the American Association of Sex Educators, Counselors, and Therapists. He has designed and helped implement 50 long-term, holistic, adolescent pregnancy prevention programs in twenty states throughout the country. His approach, which centers on developing a multi-dimensional, community-based parallel family system program, is serving as a model to increasing numbers of family and youth service organizations. Dr. Carrera's first book, *Sex, The Facts, The Acts and Your Feelings*, has been translated into 17 languages. His most recent book is *Working With Teens When The Topic Is Hope - Lessons For Lifeguards*.

Alwyn Cohall, M.D., is Director of the Harlem Health Promotion Center, one of 33 national Prevention Research Centers established by the Centers for Disease Control to build bridges between academia and vulnerable communities. Dr. Cohall's areas of research interest include: reproductive health; access to health care, particularly for

young men of color; and use of media and technology to enhance health communication/health promotion. In addition to his research interests, Dr. Cohall is board-certified in both pediatrics and adolescent medicine, and maintains a private practice in adolescent health. Further, Dr. Cohall serves as the director of Project Stay (Services to Assist Youth), which is a New York State Department of Health funded program that provides confidential health services to young people affected by or infected with HIV/AIDS. He is also the Project Director for the "EC as 1,2,3" initiative, a social marketing campaign designed to increase adolescent awareness about emergency contraception.

Angela Diaz, M.D., M.P.H., is the Jean C. and James W. Crystal Professor of Pediatrics and Community Medicine at Mount Sinai School of Medicine and Director of the Mount Sinai Adolescent Health Center, a unique program of free, integrated, interdisciplinary primary care, reproductive health, mental health, and health education for teens. She is President of the Children's Aid Society. Dr. Diaz has been a White House Fellow, a member of the FDA and a member of the Board of the New York City Department of Health and Mental Hygiene. She reviews grants and serves on advisory panels for the NIH and the CDC and has received several NIH grants. In 2003, she chaired the National Advisory Committee on Children and Terrorism. In 2008, she was elected to the Institute of Medicine. Dr. Diaz is active in public policy and advocacy and has conducted many international health projects in Asia, Central and South America, Europe, and Africa.

Ralph DiClemente, Ph.D., is Charles Howard Candler Professor of Public Health, Emory University and Associate Director, Center for AIDS Research. He holds concurrent appointments as Professor in the School of Medicine, the Department of Pediatrics, in the Division of Infectious Diseases, Epidemiology, and Immunology, and the Department of Medicine, in the Division of Infectious Diseases, and the Department of Psychiatry. He is currently President, Georgia Chapter of the Society for Adolescent Medicine, and was most recently Chair, Department of Behavioral Sciences and Health Education at the Rollins School of Public Health, Emory University. He is a member of the Board of Scientific Counselors for the CDC and the National Mental Health Advisory Council of NIH. His research addresses the development and evaluation of HIV/STD prevention programs tailored to African American adolescents and young adults; particularly programs that use peer- and technology-based models of implementation and that are culturally and developmentally appropriate.

Douglas Kirby, Ph.D., is a Senior Research Scientist at ETR Associates in Scotts Valley, California. For 30 years, he has directed state-wide or nation-wide studies of adolescent sexual behavior, abstinence programs, sexuality and STD/HIV education programs, school-based clinics, school condom-availability programs, and youth development programs. Dr. Kirby has identified important behaviors that affect the sexual transmission of STDs, painted a more comprehensive and detailed picture of the risk and protective factors associated with adolescent sexual behavior, contraceptive use, and pregnancy, and identified important common characteristics of effective sexuality education and HIV education programs. His findings have been summarized in such widely recognized volumes as *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* and *Emerging Answers 2007*. While these reviews focused on U.S. studies, he has also completed a review of 83 studies of sex and HIV education around the entire world. Dr. Kirby has also authored or co-authored more than 150 volumes, articles, and chapters on adolescent sexual behavior and programs, including reviews of the field for the National Campaign to Prevent Teen Pregnancy, the Centers

for Disease Control and Prevention, the National Institutes of Health, and the World Health Organization, among others.

Jonathan Klein, M.D., M.P.H. is Acting Chief, Division of Adolescent Medicine, Golisano Children's Hospital at Strong; Professor of Pediatrics, Community and Preventive Medicine, and Family Medicine; and Associate Chair for Community and Government Affairs, Department of Pediatrics, University of Rochester. Dr. Klein is also Director of the Julius B. Richmond Center of Excellence of the American Academy of Pediatrics. Areas of expertise include adolescents' access to health care and their care use patterns, organization and effectiveness of adolescent health services, adolescents' use of interactive communication and implications for health care, children and tobacco, and obesity prevention.

Deborah Levine, M.A., is the Executive Director of Internet Sexuality Information Services (http://isis-inc.org), a nonprofit organization dedicated to developing Internet technologies to enhance the sexual well-being of individuals and communities. Ms. Levine has been working professionally on the Internet for more than 14 years. She was a sex educator at Columbia University where she designed an award-winning online sexual health question-and-answer service, Go Ask Alice! She wrote an online sex advice column, Ask Delilah, for AOL and Time-Warner, and the Sexuality blog on Yahoo! Health in 2005-6. She graduated with a B.S.W. from Cornell University in 1985 and holds a Master's in Experiential Education and Counseling from New York University.

Guillermo Prado, Ph.D., is currently an Associate Professor of Epidemiology and Public Health at the University of Miami Leonard M. Miller School of Medicine. Dr. Prado's research interests are to prevent problem behaviors, including substance use and sexual risk behaviors, among Hispanic youth by (a) understanding the contextual determinants of substance use and sexual risk behaviors and (b) developing, evaluating, and disseminating theory-driven, evidence-based interventions designed to target the determinants of substance use and sexual risk behaviors. Dr. Prado's research has been funded by the National Institutes of Health, the Centers for Disease Control and Prevention, and the Department of Health and Human Services. He is a scientific advisory committee member of several NCMHD Centers of Excellence on Health Disparities, including the Centers of Excellence at Arizona State University, Florida International University, and the University of Miami. Dr. Prado's drug abuse and HIV prevention research has been recognized by numerous professional organizations including the National Hispanic Science Network on Drug Abuse and the Society for Prevention Research.

John Santelli, M.D., M.P.H., is the Harriet and Robert H. Heilbrunn Professor and Chair of the Heilbrunn Department of Population and Family Health at the School of Public Health at Columbia University. He is also a Senior Fellow at the Guttmacher Institute. A pediatrician and adolescent medicine specialist, Dr. Santelli has held a variety of positions at the U.S. Centers for Disease Control and Prevention in the Divisions of Reproductive Health, Adolescent and School Health, and STD/HIV Prevention. He has conducted research on HIV/STD risk behaviors, programs to prevent STD/HIV/unintended pregnancy among adolescents and women, school-based health centers, and research ethics, and has been a national leader in insuring that adolescents are appropriately included in health research and have access to medically accurate, comprehensive sexuality education. Dr. Santelli received his M.D. from the Buffalo School of Medicine in 1982 and his M.P.H. degree from Johns Hopkins University in

1986. He has served on the editorial boards of the Journal of Adolescent Health, Perspectives on Sexual and Reproductive Health and AIDS Education and Prevention.

(Note: Loretta Sweet Jemmott, University of Pennsylvania, was expected; however, she was unfortunately unable to attend.)

Youth Panel

Mathew Agostini, Hetrick-Martin Institute

Tremaine Bradley, Co-Chair of the NYS Department of Health Young Adult Consumer Advisory Committee

Plum Cherry, SPEEK (Sinai Peers Encouraging Empowerment through Knowledge) Peer Educator, Mount Sinai Adolescent Health Center

Rose Dubreuil, Co-Chair of the NYS Department of Health Young Adult Consumer Advisory Committee

Zach Wichter, Steering Committee, ACT Youth Network (state-wide) and member, ACT for Youth of Nassau County

Participants' Organizations

Asian and Pacific Islander Coalition on HIV/AIDS
Association of Maternal and Child Health Programs
Center for Community Health and Education - School of Public Health, Columbia Univ.
Centers for Disease Control and Prevention
Children's Hospital at Montefiore
City University of New York
Community Health Project
Cornell University
Erie County Department of Health
Family Planning Advocates
Guttmacher Institute
Hetrick Martin Institute
Maternal Child Health Block Grant Advisory Council
Mount Sinai Adolescent Health Center
National Alliance of State and Territorial AIDS Directors
Native American Community Services of Erie and Niagara Counties
New York City Department of Health and Mental Hygiene
New York City Department of Juvenile Justice
New York State Association of County Health Officials
New York State Center for School Safety
New York State Council on Adolescent Pregnancy
New York State Department of Health
New York State Office of Alcoholism and Substance Abuse Services
New York State Office of Children and Family Services
New York State Office of Mental Health
North Country Prenatal-Perinatal Council
Phillliber Research Associates
Planned Parenthood of New York City
Schuyler Center for Analysis and Advocacy
Safe Horizon - Streetwork Project Uptown
University at Albany
University of Rochester

Agenda

Adolescent Sexual Health Symposium

February 3-4, 2009
Ivy Room, Cornell Club, NYC

Tuesday, February 3, 2009

6:30 PM Registration

7:00 Welcome from the ACT for Youth Center of Excellence

Welcome from the NYS Department of Health

Presentations:

Changes Observed: Adolescent Sexual Health in New York State
Angela Diaz, Mount Sinai School of Medicine and Mount Sinai Adolescent Health Center

National Policy Overview
Claire Brindis, University of California, San Francisco and National Adolescent Health Information Center

Impact of New Information and Communication Technologies
Deborah Levine, Internet Sexuality Information Services

Response: Presenters and Youth Panel

Response and Dialogue with Stakeholders

9:00 Adjourn

Wednesday, February 4, 2009

8:30 AM Registration and continental breakfast

9:30 Opening remarks
Jonathan Klein, University of Rochester Medical Center and ACT for Youth Center of Excellence

Theme 1: Trends in Adolescent Sexual Behavior Today
Moderator – Jonathan Klein

John Santelli, School of Public Health at Columbia University and Guttmacher Institute

Sarah Brown, National Campaign to Prevent Teen and Unplanned Pregnancy

Response: Presenters and Youth Panel

Response and Dialogue with Stakeholders

11:00 **Theme 2: Disparities in Access to Adolescent Sexual Health Services, Information, and Education**
Moderator – Mary Grenz Jalloh, New York State Center for School Safety and ACT for Youth Center of Excellence

Ralph DiClemente, Rollins School of Public Health, Emory University, and Emory/Atlanta Center for AIDS Research

Alwyn Cohall, Harlem Health Promotion Center and Project Stay (Services to Assist Youth)

Loretta Sweet Jemmott, Center for Health Disparities Research and University of Pennsylvania School of Nursing

Response: Presenters and Youth Panel

Response and Dialogue with Stakeholders

12:30 Lunch.

1:00 **Theme 3: Ecological Perspectives: How Do Environments and Relationships Impact Adolescent Sexual Health?**
Moderator – Jennifer Tiffany, Cornell University and ACT for Youth Center of Excellence

Douglas Kirby, ETR Associates

Guillermo Prado, University of Miami Leonard M. Miller School of Medicine

Michael Carrera, Children's Aid Society and Hunter College of the City University of New York

Response: Presenters and Youth Panel

Response and Dialogue with Stakeholders

2:30 **Theme 4: What Might a Comprehensive Adolescent Sexual Health Initiative for New York State Look Like?**

Moderator - Richard Kreipe, University of Rochester Medical Center and ACT for Youth Center of Excellence

Small groups comprised of presenters, youth panelists, and stakeholders will draft initial recommendations within a given topic.

Brief report-out from groups (recommendations only).

Full group discussion and final thoughts.

4:45 Evaluation

5:00 Adjourn

Summary: Issues Raised

While the Adolescent Sexual Health Symposium did not attempt to achieve consensus and could not be comprehensive, the dialogue generated a host of proposals that appear in this document. Many comments fell under the following summary themes.

Maximize the use of information and communication technologies.

- Technology is a vital element of young people's lives and its potential for public health is exploding. In the area of sexual health, a wide range of applications exist or could be designed to raise awareness, provide accessible information, enhance education, improve clinical services and patient follow-up, and harness the power of peer communications. Innovative use of Internet and cell phone technology can serve—though not replace—the relationships and opportunities that support healthy youth development.
- In urban areas, where use of technology by young people is very high regardless of race, innovative use of technology can support efforts to address racial/ethnic disparities in sexual health outcomes (i.e. STDs, unintended pregnancies, HIV infection).

Take a multi-level, ecological approach that meets young people's developmental needs.

- Sexual health programs for young people can be especially successful in fostering attitudes and skills specifically related to sexual and contraceptive behavior; these beliefs and skills do in fact lead to healthy behaviors. However, programs—even those that are evidence-based—can't do it all; successful curriculum-based programs reduce one or more risky behaviors by about one-third.
- Adolescent risk behaviors are affected by myriad factors beyond the scope of sexual health curricula. Young people grow up in families, schools, neighborhoods, faith communities, and workplaces; in face-to-face and online social networks; their behaviors are impacted by their security, relationships, culture, aspirations, and opportunities. An effective, comprehensive strategy would include programs but would also tap into the richly protective resources offered by adolescents themselves and the adults within their environments. With a focus on growing developmentally supportive relationships and opportunities, such an approach would allow funding and time for planning and evaluation, and would be flexible enough to allow for meaningful decision making by youth and local actors.
- Family-inclusive programming that supports strong parent-child relationships is a critical and fruitful element of a comprehensive, ecological approach, and good models are available. Parent/family education that works in tandem with the family's cultural values is an especially promising approach for reducing racial and ethnic health disparities.
- Youth voice is widely recognized as essential to the success of strategies to improve adolescent sexual health. Youth should be involved as partners at every level: design, implementation, and evaluation.

Take a positive, holistic approach to education and clinical services.

- A positive new approach is needed: a new vision for sexual health that moves beyond a problem focus. While a clear message about avoiding pregnancy, STDs and HIV infection is critical, young people want a broader context: they want to know what constitutes a good relationship and what is a positive sequence of sexual activity within a relationship.
- Young people want and need a full range of services delivered efficiently and accessibly. To this end, clinicians should seek to break down silos, integrate sexual health service delivery and primary care whenever possible, and link to other services (e.g. mental health, substance use). De-fragmentation of services has been identified as one way to address racial/ethnic health disparities.
- Clinicians and educators should address the whole person, seeking to understand as much of the familial and environmental context as possible. To be successful—and particularly to address health disparities experienced by both racial/ethnic groups and sexual/gender minorities—clinical services must take into account the patient's culture, language, confidentiality needs, personal history of abuse and risk behaviors, and the community's level of trust/past history with the health care sector. Similarly, health centers should tailor hours, location, transportation, and cost to their target population.
- The inclusion of young people as partners in all aspects of their health care will improve delivery and outcomes. Clinicians and clinic staff would benefit from better preparation in topics such as youth-friendly service, integrating sexual health into primary care, cultural competence; how to talk to adolescents about sensitive topics; and adolescent mental health.
- Fully explore potential of school-based health centers to promote the sexual health of young people who access their services.
- Make comprehensive sexual health education accessible through schools.
- Make programming and messaging attractive and fun!

Address funding issues.

- Prevention is demonstrably cost-effective, yet innovative programs that seek to connect with hard-to-reach populations typically lack sustained, dependable funding.
- Young people need easier access to insurance through Medicaid/Child Health Plus, presumptive eligibility, automatic enrollment, and the Family Planning Benefit Program. The burden for providing all enrollment documentation should not fall on the adolescent. Address confidentiality issues for youth covered by insurance.

Background: Selected Trends

"Unless we understand and can articulate clearly what is driving these statistics, we won't be able to make a difference." - *Sarah Brown*

"Disparities in adolescent health are not genetic and can't be fully explained by cultural factors. Structural racism – lack of insurance and access, poverty, poor schooling, lack of opportunities, etc.— is behind the difference in outcomes. All of these factors are interwoven and compounded." – *Angela Diaz*

"Persistent and marked racial disparity exists and it will get worse if we don't do something—whether or not we have funding." – *Ralph DiClemente*

Selected Trends: STIs, Pregnancy, and Sexual Activity

- Compared to other industrialized nations, U.S. has high rates of STIs and unplanned pregnancy. *(Santelli)*
- From 1991-2005 the U.S. saw improvements in teen birth rate; approximately 1/3 decrease. In 2006 the trend reversed and there was a slight increase, except in 10-14 year olds. Rates have been primarily dropping since the 1950s, though at that time more adolescents married. *(Santelli)*
- In the 15-19 year old age group African American teens have decreased birth rates/pregnancy rates by 1/2, and younger African Americans by 2/3. *(Santelli)*
- Declines in pregnancy rates are linked to increases in correct and consistent use of contraception. As a result of intensified public education, there have been dramatic increases in contraceptive use at first intercourse in the last several decades. *(Santelli)*
- Hispanic youth have emerged with the highest birth rate and the smallest decline. *(Santelli)*
- Older teens (aged 18-19) have a teen birth rate that is more than twice as high as the rate for younger teens (aged 15-17). *(Santelli)*
- Teen parents are too often left out of the equation. *(Stakeholder, Youth Panelist)*
- In New York State, 42% of high school students report having had sex and 29% report being currently sexually active. *(Diaz)*
- Rates of gonorrhea among African American adolescents are 15 times higher than those among white adolescents. Native Americans have the next highest rate. *(Diaz)*
- Many youth have been abused sexually, physically, and/or emotionally; this frequently leads to depression and poor health outcomes such as smoking, drinking, drugs, eating disorders. Sexual abuse is linked very closely to teen pregnancy, STDs, low self-esteem. *(Diaz)*
- Condom use is relational and contextual. A young man might use a condom with casual partners but not with his long-term girlfriend. *(Stakeholder)*
- There continue to be many myths circulating about contraception; can't assume that young people know about contraception. *(Brown)*

Selected Trends: Media and Communication Technologies

- Today's youth grew up with technology. Technology is now an indispensable aspect of life. (Levine)
- 93% of teenagers are on the Internet (Pew). There is no longer a significant digital divide because of public access (especially through libraries). *(Levine)*
- American youth aged 8-18 average 44.5 hours per week in front of a screen. The only thing they do more is sleep. *(Levine)*
- 70% of 12-14 year olds have their own cell phones. *(Levine)*
- "Don't forget that landlines still play a big role as well. I've known a lot of 13-16 year-olds who are going on chat lines with older people." *(Youth Panelist)*
- Internet has increased the availability of pornography. *(Stakeholder)*
- Phone chat lines are still active, and young people are on them with older people. *(Youth Panelist)*

Resources – Youth and New Media

- National Campaign to Prevent Teen and Unplanned Pregnancy: *Managing the Media Monster.* This report "examines in detail how the media influences - in positive and negative ways - teen sexual knowledge, attitudes, and behavior." http://www.thenationalcampaign.org/resources/monster/
- Digital Youth Project Report: *Living and Learning with New Media*. (2008, November) "New media forms have altered how youth socialize and learn, and raise a new set of issues that educators, parents, and policymakers should consider." http://www.macfound.org/site/c.lkLXJ8MQKrH/b.4773437/k.3CE6/New_Study_Shows_Time_Spent_Online_Important_for_Teen_Development.htm
- *Future of Children* Spring 2008. This issue focuses on children and electronic media, and includes articles "Online Communication and Adolescent Relationships", "Media and Risky Behavior", and more. http://www.futureofchildren.org/pubs-info2825/pubs-info_show.htm?doc_id=674322
- Pew Internet & American Life Project: *Teens and Social Media.* (2007, December) http://www.pewinternet.org/PPF/r/230/report_display.asp
- Kaiser Family Foundation: *Generation M: Media in the Lives of 8-18 Year-olds.* (2005). http://www.kff.org/entmedia/entmedia030905pkg.cfm

I. Clinical Practice and Service Delivery*

"Health plays a central role in adolescents reaching their goals." – *Angela Diaz*

"The time for incremental changes has passed. A bold and innovative initiative is needed. Ultimately, political and public health resolve and leadership to is needed to create an integrated continuum of sexual health services and effective delivery systems to eliminate racial disparities." – *Ralph DiClemente*

Health Systems

Issues

- Outreach without the capacity to deliver services is insufficient. *(Brown)*
- Sexual health services are often siloed. Silos create gaps in services and youth fall through. *(DiClemente)*
    - Typically there are totally different staff in STD and HIV clinics and few referrals between them.
    - Silos create disincentives: multiple visits mean multiple fees, transportation arrangements and costs, risks of parents/others finding out, need to remember appointment, etc.
- Young people want a full range of services. *(DiClemente)*
- Need for greater mental health services in NYS. *(Diaz)*

Comments

- Defragment services. Integrate service delivery systems to facilitate referral and access: a "Sexual Health Service Supermarket." *(DiClemente)*
- Link in alcohol/drug and mental health services. Educate and collaborate with other service-systems and non-traditional partners/providers. Keep reminding other systems of their effect on sexual health. *(DiClemente, Small Group 2)*
- Dispel dualism between treatment and prevention. *(DiClemente)*
- Reassess/define capacity. Need a statewide comprehensive assessment to see what's available. *(Small Group 1)*
- Support training/education for primary care physicians. Reintegrate family planning into primary care. Build accountability by tying performance to reimbursement. *(Small Group 1)*
- Blur the boundaries between adolescent and adult health/health care. *(Kreipe)*

Clinical Practice: General

Issues

- In the typical clinical scenario, multiple opportunities for education and information, targeted screening, and intervention are missed. *(Cohall)*

* **Note: to ensure completeness within each area, comments may appear under more than one heading.**

- Certain changes in clinic protocols have been shown to increase condom and contraceptive use (without increasing sexual activity) and reduce unprotected sex (see comments). *(Kirby)*
- Marketing of "reproductive health" services could shut out part of the gay, lesbian, bisexual, and transgender (GLBT) population. *(Stakeholder in group 3)*
- At least one study has shown that lesbians may be twice as likely to become pregnant as heterosexual adolescents. *(Stakeholder)*
- GLBT adolescents: Clinics need great sensitivity to outing in policy and procedures. *(Stakeholder)*
- Legal issues prevent some immigrant youth from seeking care. *(Stakeholder in group 4)*
- Transportation remains a challenge in rural areas. *(Stakeholder)*
- Location of services is a complex issue. Some want services close; some won't go to clinic in the neighborhood because they want anonymity; some would be better served by service in particular area (e.g. gay males going to Village and not to other areas). *(Stakeholders in group 3)*
- Limited hours of operation prevent young people from obtaining services. *(Stakeholder)*
- There is a gap in health services as young people transition to adulthood. Some parents feel their responsibility is over when young people enter high school, and/or communication diminishes. No public health requirements get adolescents in the health care provider's door. *(Stakeholder in group 5)*

Comments

- Adolescents need to be included as partners in involving all aspects of their health care, including shaping policy. *(Diaz, Cohall)*
- Tailor services to target population: hours, location, transportation, culture, language, anonymity, etc. *(DiClemente, Stakeholders, Small Group 3)*
- There are so many disparities: avoid any one-size-fits-all solution. *(Stakeholder in group 4)*
- Tobacco, obesity, etc., are taken seriously but there is not much interest out there in sexual and reproductive health. *(Brindis)*
- Support expansion of clinic hours of operation. *(Stakeholder)*
- Engage communities to enhance local input, and promote community oversight to reduce deep-seated distrust. *(DiClemente)*
- Reimburse client transportation costs. *(Stakeholder in small group 3)*
- Take care with exterior signage (youth feel stigmatized when entering clinic with a large "HIV" sign). *(Youth Panelist, Cohall)*
- There is a need for more integrated approaches that address multiple antecedents. *(Stakeholder)*
- Change clinic protocol for working with adolescents. According to evaluations, the most effective clinic programs: a) provided more than routine information, b) asked questions about adolescents' sexual behavior and barriers to abstaining from sex / using protection, c) did role plays on refusing sex or using condoms and d) gave a clear message about avoiding unprotected sex. *(Kirby)*
- The best outreach is high quality service. *(Brown)*

- Require regular, routine screening for every youth, possibly using vaccination as a vehicle to get youth in for screening. *(Stakeholder in small group 5).*
- Comprehensive initiative must address history of childhood sexual abuse. *(Diaz)*
- Create a tiered service approach that recognizes limited resources and varying degrees of need (e.g. Does teen need therapy or counseling?). *(Stakeholder, group 2)*

Clinical Practice: Assessment

Issues

- In the typical clinical scenario, opportunities for targeted screening are missed. *(Cohall)*
- Most STIs are silent infections. If appropriate questions aren't offered, tests aren't offered. *(Cohall)*
- Some youth are reluctant to bring up sensitive subjects unless they are asked. *(Diaz)*
- Adolescents often also believe that one blood test will give all information – and that doctors have x-ray vision. *(Cohall)*

Comments

- Focus on behavior, not identity. Especially important with GLBT youth. Be very careful with language and labeling. *(Stakeholder)*
- In every setting when history is taken, ask about abuse. If you don't ask directly and sensitively, they will not tell you. *(Diaz)*
- Use technology as an ally, tailored to be culturally appropriate. *(DiClemente, Cohall, Levine)*
- Ask questions about adolescents' sexual behavior and barriers to abstaining from sex or using protection. *(Kirby)*
- Use Audio Computer Assisted Self Interview (ACASI) to elicit information about sexual history/other sensitive subjects. Provider then reviews risk-assessment, verifies information, orders appropriate screenings/follow-up as indicated. *(Cohall)*
- Link ACASI to electronic medical records. *(Cohall)*
- Address what happens during visit: are all adolescents screened appropriately or are some missing tests that they should receive? *(Stakeholder in small group 3)*

Clinical Practice: Information and Education

Issues

- In the typical clinical scenario, multiple opportunities for education and information are missed. *(Cohall)*

Comments

- Use technology as an ally, tailored to be culturally appropriate. *(DiClemente, Cohall, Levine)*

- Transform “waiting time” into “preparation time.” Offer presentations or videos, preferably with staff or students. Could include information about what the visit will entail. *(Cohall, DiClemente, Youth Panelist)*
- Provide targeted education via video/computer while patient is waiting for results of rapid assay for HIV/STDs. *(Cohall)*
- Change clinic protocol for working with adolescents. According to evaluations, the most effective clinic programs: a) provided more than routine information, b) asked questions about adolescents’ sexual behavior and barriers to abstaining from sex or using protection, c) did role plays on refusing sex / using condoms and d) gave a clear message about avoiding unprotected sex. *(Kirby)*
- Encourage young clients to text reputable sexual health links to sexual partners, friends. (Example: young male who had unprotected intercourse 48 hours ago texts girlfriend link for information about EC right from health center.) *(Cohall)*

Clinical Practice: Care

Comments

- Connect young people who have been abused with the right services. Ensure that young men who have been abused have access to services that are appropriate for them. *(Diaz, Stakeholder)*
- Use rapid assays for HIV and STDs; one visit for risk assessment, screening, diagnosis, initial education/counseling. *(Cohall, DiClemente)*
- Address adolescent fears about contraception, such as weight gain. *(Brown)*
- Provide advance emergency contraception to sexually active adolescent girls. *(Kirby)*
- Text appointment reminders to young clients (securely). *(Cohall)*
- Text daily reminders for oral contraceptive pills. *(Cohall)* One youth panelist called text reminders for appointments, etc., "an awesome idea."
- Establish services such as InSpot throughout state to enable anonymous emails informing partners of STD/HIV exposure. Currently available in NYC. *(Levine, Cohall)* http://www.inspot.org/gateway.aspx
- Encourage use of secure email system for better communication between provider and client. *(Cohall)* http://www.relayhealth.com/

New and Different Models for Service Delivery

Comments

- Explore different and innovative service models. *(Small Group 1)*
- Offer satellite teen centers mapped onto high prevalence STD communities, staffed to reflect the community. *(DiClemente, Small Group 1)*
- Create mobile service centers (vans) that bring services to communities. Van can go to youth programs, schools, detention facilities on a regular schedule. *(DiClemente, Youth Panelist)*
- Create centers of excellence for comprehensive services for teens. *(Stakeholders, group 2)* The state needs to be creative with funding integrated services for adolescence. *(Stakeholder, group 3)*

- Fully explore the potential of school-based health centers. *(Multiple stakeholders, Group 3)*
- Don't JUST fund pilots. The Department of Health (DOH) should go to scale. *(Klein)*

Training / Preparation of Clinicians and Clinical Staff

Issues

- Most clinicians are inadequately prepared for taking care of adolescents. *(Cohall)*
- Many clinicians don't even want adolescents in their practice. *(Cohall)*
- Many doctors are not equipped to talk to youth/patients about sex and also drug use. *(Stakeholder in group 2)*
- Providers may be entrenched in what they're doing now, philosophically and otherwise. Trying new models creates fear of litigation. *(DiClemente)*
- Providers don't see the Department of Health as their primary source of information. They do listen to their professional organizations. *(Stakeholder)*
- Clinicians are not always aware that confidentiality is the law in NYS. *(Stakeholder)*
- Confidentiality is critical to young people. *(DiClemente)*
- Young people are sensitive to attitudes of staff. *(DiClemente, Cohall, Youth Panelist)*

Comments

- Train clinicians to get comfortable with asking about abuse. *(Diaz, Stakeholder)*
- Educate clinicians regarding talking to adolescents about a range of risk behaviors. *(Stakeholder)*
- Enhance cultural competence of staff. *(DiClemente, Stakeholders)*
- Sensitize all staff—front office, primary providers—to provide youth-friendly services. Hire staff who value young people. One youth panelist pointed out "If I'm dealing with a bad attitude toward me at the front desk I don't even want to know what's behind [in the exam room]." Another added "It's ridiculously important that young people are comfortable with service providers." Carrera stated "Young people see their worth in that worker's eyes." *(Carrera, Cohall, Kreipe)*
- Provide more training and education for primary care providers. This is very important *(Brown, Kreipe)*. The goal is not to sell contraception to providers but to reacquaint them with different methods *(Brown).* Also to reintegrate contraceptive care so providers see it as being part of care *(Stakeholder).*
- Provide cultural competence training in medical school*. (Stakeholder in small group 3)*
- Make better links with professional groups; get message out to providers through these groups. *(Stakeholder)*
- Create online educational module; offer CME credits online. *(Stakeholder)*
- Ensure that all staff who work with youth have basic education in mental health. *(Stakeholder)*

Needs of Sexual Minority Youth

Issues

- At least one study has shown that lesbians may be twice as likely to become pregnant as heterosexual adolescents. *(Stakeholder)*
- GLBT youth are disproportionately represented within the adolescent homeless population. *(Stakeholder)*
- YRBS data is likely missing many GLBT youth because many are not in school. *(Stakeholder)*
- Family rejection of GLBTQ kids is main predictor of poor outcomes. *(Stakeholder in group 2)*

Comments

- Use great sensitivity to outing (involuntary disclosure of sexual orientation) in all policy and procedures. *(Stakeholder)*
- Focus on behavior, not identity, in prevention and health care. *(Stakeholder)*
- Be very careful with language and labeling. *(Stakeholder)*
- Remember that the symptoms are the same, but the roots are different: messaging and issues are not the same for heterosexual, lesbian, gay, bisexual, and transgender groups. *(Stakeholder)*
- For GLBT immigrant youth, "you need an alternate method than parents." *(Stakeholder in group 4)*

Using Technology for Service Delivery

"Use of media and technology has potential for improving access to health information, facilitating access to care, strengthening client-provider interactions, and enhancing adherence to medication. It's time that we examine every possible resource to provide young people with information and support." – Alwyn Cohall

"Digital media are a gift to public health." – Sarah Brown

Comments

- Establish an ongoing cross-program task force to focus on the use of technology for adolescent sexual health promotion. This recommendation applies to information/training as well. *(Small Group 7)*
- Fund pilots/models prior to scale-up. Need to address issues such as security/confidentiality with new technologies, sustainable funding. *(Brown, Cohall, DiClemente, Stakeholders)*
- Don't JUST fund pilots. The Department of Health should go to scale. *(Klein)*
- Use technology strategically for vastly improved service and outcomes. Dr. Cohall compared a typical visit (resulting in the completion of a physical and college form) to a hypothetical technology-enhanced visit (resulting in completion of physical and

college form, risk assessment, additional screening, diagnosis, and treatment for patient and partners; potential pregnancy averted, multiple opportunities for health education utilized, and additional youth engaged in care.) *(Cohall)*

- Transform "waiting time" into "preparation time." Offer presentations or videos, preferably with staff or students. Could include information about what the visit will entail *(Cohall, DiClemente).* "Videos are really effective. It also helps to have someone there to help process the information, because the videos raise a lot of questions." *(Youth Panelist)*
- "Make them want to ask about their bodies by using videos in the waiting room…Especially upstate, because we don't see a lot of things that you see in here [in NYC]." *(Youth Panelist)*
- Use Audio Computer Assisted Self Interview (ACASI) to elicit information about sexual history/other sensitive subjects. *(Cohall)*
- Link ACASI to electronic medical records. *(Cohall)*
- Provide targeted education via video/computer while patient is waiting for results of rapid assay for HIV/STDs. *(Cohall)*
- Encourage young clients to text reputable sexual health links to sexual partners, friends. *(Cohall)*
- Text appointment reminders to young clients (securely). *(Cohall)*
- Text daily reminders for oral contraceptive pills. *(Cohall)*
- Ensure that relationships are the cornerstone of effort, and that tech is used to enhance, not replace, those relationships (Cohall). Technology cannot replace a relationship that's trustful and engaging with youth *(Stakeholder*).
- Establish services such as InSpot throughout state to enable anonymous emails informing partners of STD/HIV exposure. Currently available in NYC. *(Levine, Cohall)* http://www.inspot.org/gateway.aspx
- Encourage use of secure email system for better communication between provider and client. *(Cohall)* http://www.relayhealth.com/

Fees / Reimbursement / Insurance

Issues

- Lack of insurance a persistent and growing issue. *(Brindis)*
- Latinos are 300% more likely to be uninsured. *(Diaz)*
- Homeless youth can't get insurance; lack of access to documentation. *(Stakeholder in group 3)*
- Reimbursement / payment codes for innovative use of technology are either absent or generate so little revenue that a lot of people don't do it. *(Brown)*
- Young people fear losing their confidentiality when they use insurance. *(Stakeholder)*
- There is a polarization between what we know about best models and our ability to sustain or make those changes over time. *(Stakeholder)*

- Public dollars don't even come close to offsetting the care that is uncompensated by insurance. We need a funding mechanism that is sustainable over time. *(Stakeholder)*
- Siloed services create multiple visits and multiple fees. *(DiClemente)*

Comments

- "We're going to have to be creative. Financing is critical but there isn't a lot there. In the absence of those funds I don't think we do nothing. Persistent and marked racial disparity exists and it will get worse if we don't do something—funding or not." *(DiClemente)*
- Must always remember to address funding. "Keep talking about money." *(Brown)*
- Address issues related to confidentiality and insurance. *(Brown)*
- Federal policy requiring citizenship documentation has impacted states' ability to do family planning waivers. *(Stakeholder)*
- Improve Medicaid funding; consistent reimbursement for transportation; reimburse services such as nutritionist. *(Stakeholders in small group 3)*
- Work with insurance companies so that information about confidential services does not appear on explanation of benefits. *(Stakeholder in group 3)*
- Make links to other sources of funding. For example, when we talk about teen pregnancy we should also be talking about drugs/alcohol. There is funding for HIV prevention. *(Prado)*
- Increase access to insurance *(Small Group 3)*
    - Medicaid – Child Health Plus revamp
    - Presumptive eligibility
    - Automatic enrollment
    - Family Planning Benefit Program (need to resolve issues with documentation, especially for immigrant and homeless youth)
    - Package reimbursement – comprehensive adolescent services
    - Burden cannot fall on the adolescent

Resources, Best Practices, Examples

- The HOTT (Health Outreach to Teens) van is a project of Callen Lorde Community Health Center. The medical van travels to areas in lower and mid-Manhattan in the afternoons and evenings where youth are known to hang out in order to provide confidential services such as HIV counseling and testing. http://www.callen-lorde.org/services/hott.html
- Atlanta has satellite services around city for adolescents. These are the de facto medical homes for these adolescents, right in their community. *(DiClemente)*
- Atlanta has a program now through churches. Personnel rotate through church on a weekly basis. Also do this at jails/detention services. *(DiClemente)*
- At the Young Men's Clinic at Columbia (which provides both primary care and sexual health services) PowerPoint® health education is conducted by Public Health students during waiting time. If students are not available, the presentation is looped with audio. Great resources are available through the Scenarios USA website: http://scenariosusa.org/index.html) *(Cohall)*

- "Safe in the City" video-based intervention recommended: http://www.safeinthecity.org/ *(DiClemente)*
- AAP toolkit is available to help providers with service delivery issues such as confidentiality, screening questionnaire, coding strategies for effective and confidential billing (had input from Jonathan Klein). *(Stakeholder)*
- inSpot: STD online partner notification. http://www.isis-inc.org/inspot.php
- Veteran's Telemental health: http://www.carecoordination.va.gov/telehealth/ccgt/tmh/index.asp

"We need a new vision for sexual health in America…" – *John Santelli*

Curriculum-Based Programming

Issues

- When replicated with fidelity, programs are quite robust; they are effective with multiple groups and have the potential to reach large number of youth. Those that incorporate the 17 characteristics for effectiveness are the most successful. *(Kirby: see also Emerging Answers 2007: http://www.thenationalcampaign.org/EA2007/)*
- However, programs can't do it alone. More effective curriculum-based programs reduce one or more risky behaviors by about one-third. *(Kirby)*
- Sex ed is not addressed consistently in schools. The HIV prevention education mandate is not monitored by the State Education Department; no other sex ed mandate exists in NYS. *(Stakeholders)*
- "We need to learn skill sets, not just sexual stuff—skills like decision making, communicating with others, etc." *(Youth Panelist)*
- Teachers and principals are often uncomfortable with sex ed curricula. *(Stakeholder)*
- Although much is now known about effectiveness and there are a number of models that could be replicated, providers a) don't know about the models, b) can't afford to buy curricula or can't afford the training, and/or c) take pieces from here and there, "hacking up well-tested models." *(Stakeholder)*
- Currently only three behaviors are frequently addressed in sex education: abstaining, condom use, and contraceptive use. In fact, there are 10 behaviors that have an impact on transmission. *(Kirby)*
- Funding silos, timing, trends in policy, politics have a complex impact; create obstacles to integrated approach to sexual health and education. *(Stakeholder)*
- Youth are bored by same curriculum year after year. *(Stakeholder in group 4)*

Comments

- Keep in mind the 17 characteristics of most effective programs. In evaluations, the most effective: a) emphasized risk of pregnancy or STD, b) emphasized ways to reduce risk (e.g., not having sex, condoms, and occasionally having fewer partners), c) gave a clear message about avoiding unprotected sex and d) involved youth interactively so that they personalized the message. *(Kirby)*
- "It has to be fun. Activities make it better because they are fun and then we remember." *(Youth Panelist)*
- Work for better alignment between education and public health. *(Stakeholder)*
- Include more content regarding relationships and values within curricula. Young people want to know what constitutes a good relationship and what is a positive sequence regarding their sexual experience within a relationship *(Kirby).* Don't jump to specific contraceptive methods, etc., ahead of young people *(Brown).* Make the context broad and youth-friendly (positive relationships, positive behaviors), but don't lose the very clear message. *(Stakeholder in group 4)*
- Develop sex positive curricula for sexually active older teens and young adults. This is a current project of ETR, focusing on college-age youth. *(Kirby)*

- Focus on helping young people make decisions that fit their lives. The condoms vs. abstinence polarization is artificial. *(Stakeholder)*
- Ten behaviors have significant impact on STI and pregnancy but only three are typically addressed. Focusing on condoms and abstinence is not enough. Look at these ten behaviors systematically: What do we want to change? What are the behaviors? What is our priority? How do we build the message? *(Kirby and Small Group 4).* Then CBOs will likely know the best ways to disseminate the message. *(Stakeholder in group 4)*
- Provide specific guidance to counties on programs/practices/curricula that are appropriate for different local scenarios; fit community profile. *(Small Group 6)*
- When using an evidence-based program, need to implement with fidelity as much as possible; monitor quality. *(Kirby)*
- Ensure that GLBT youth are included in pregnancy prevention programs/education. *(Brindis, Stakeholder)*
- There are so many disparities: avoid any one-size-fits-all solution. *(Stakeholder in group 4)*
- When we talk about teen pregnancy we should also be talking about drugs/alcohol. *(Prado)*
- Make learning about sex as fun and interactive as a) other subjects and b) the anticipation of having sex *(Levine).*
- Link education, outreach, and services. *(Brown)*
- Use peer education models and allow youth to make it their own. *(Stakeholder in group 4).*

Messaging and Outreach Campaigns

Issues

- Many of the billboard campaigns have been effective at getting adult buy-in but may not be teen friendly. *(Stakeholder)*
- Best place to reach teens still remains through schools. Bigger challenge is hard-to-reach populations – homeless, recent immigrants. *(Stakeholders)*
- Many young people don't know their rights (e.g. confidential care). *(Stakeholder in group 4)*
- "I thought if I didn't have a vagina, sex ed didn't apply to me. You need to tell males how to protect themselves and females how to protect themselves." *(Youth Panelist)*

Comments

- Engage youth/target audiences in design, creation, and dissemination of sexual health messages. *(Stakeholder)*
- Attract youth to programs by talking about "better" sex rather than safer sex. *(Stakeholder)*
- Plan and pay for dissemination of effective programs and interventions – make them easy to replicate and implement. *(Stakeholder in group 2)*
- Consider putting out a message about the importance of timing a pregnancy, such as "babies need adult parents." *(Brown, small group discussion)*

- Deliver comprehensive sexual health messages through diverse systems and methods. Utilize community partnerships required by funding streams, medical providers, parents; ensure cultural competency in message delivery. *(Small Group 4)*
- Create a state-level public campaign to increase condom use. *(Stakeholder)*
- Remember that among different populations the symptoms are the same, but the roots are different: messaging and issues are not the same for heterosexual, lesbian, gay, bisexual, and transgender groups. Messaging may need to be radically different. *(Stakeholder in group 4)*
- Focus some messaging on behavior, not identity (e.g., young MSM may not identify with messaging pitched to young gay-identified men). *(Stakeholder)*
- Disseminate messages to let youth know their rights. *(Stakeholder in group 4)*
- Utilize the many different venues where youth spend their time: school, public transportation, hang outs, radio, etc. *(Youth Panelist in group 4)*
- Evidence-based programs are required but need to look at the limitations of evidence-based programs. *(Stakeholder in group 2)*

Using Technology in Education and Outreach

Issues

- Youth are very tech savvy, but, like adults, report difficulty sorting through an overwhelming amount of online information *(Cohall, Levine).* Adolescents want a trustworthy website. There are too many to choose from *(Youth Panelist and Stakeholder in group 7).*
- Among online youth, 75% have used the web to get health information; 39% say they have changed their personal behavior because of health information they got from the Internet. *(Cohall—Kaiser Family Foundation study)*
- Youth use search engines and social networking / word of mouth / "people like me", to cut through the media clutter of information about sex. Ads also break through. *(Levine)*
- Adults believe (falsely) that young people have the knowledge they need because of what's available on the Internet. *(Brindis)*
- Youth are in a constant state of partial attention—multi-taskers. Kids all have their phones under the table. They're listening AND they're doing other things (like texting). *(Levine)*

Comments

- Engage youth/target audiences in design, creation, and dissemination of digital outreach. Use peer influence, audience-generated material. *(Cohall, Small Group 7).* Put together policies and structures to guarantee youth involvement.
- Develop a national model and policy for culturally relevant interactive sex ed using Internet and mobile devices. *(Levine)*
- Explore innovative sex-tech programs. *(Kirby, Cohall, Levine, DiClemente, Stakeholders).* Text messaging is fertile territory for future growth. *(Stakeholder in group 7).*
- Establish an ongoing cross-program task force to focus on the use of technology for adolescent sexual health promotion. This recommendation applies to service delivery as well. *(Small Group 7)*

- Consider interactivity in stand-alone video- and computer-based instruction. "*Interactive* programs can improve knowledge and attitudes about sexuality." Definitive conclusions about behavior change cannot be reached yet. Interactivity may improve results. *(Kirby, Emerging Answers 2007).*
- Set up a website run by teens—could be called www.NewYorkTeensTellTheTruthAboutSex.com *(Brown)*
- Make websites fun and clearly pitched to young people *(Youth Panelist in group 4).* "It has to be fun. Reputable websites look boring, the people are old, and it's not for younger people. We can't identify.*" (Youth Panelist)*
- Rather than attempting interactivity in website, link it to social networks and youth will then go to website for more information. Websites are great for information but need a good search tool within. No point in trying to get a website to be interactive – it's all on social networks. Can contract out for development. *(Levine in group 7)*
- Tie the campaign / website into a particular health issue – use the technologies to spread awareness, link people to care. *(Cohall)*
- Use young people's language. *(Stakeholder in group 7).*
- Hire and keep young people on staff. They keep up with the latest technologies. *(Youth Panelist in group 7)*
- "It's hard to advertise on Facebook—people don't pay attention to ads. But the Department of Health could have its own Facebook profile." *(Youth Panelist)*

Resources, Best Practices, Examples

- 15 Programs with Strong Evidence of Behavioral Impact (Kirby 2007) http://www.thenationalcampaign.org/ea2007/postitive_impact.pdf
- Characteristics of Effective Curriculum Based Programs (Kirby 2007) http://www.thenationalcampaign.org/ea2007/characteristics.pdf
- See Kirby's full report, Emerging Answers 2007 http://www.thenationalcampaign.org/ea2007/
- ETR Associates is developing a sex-positive curriculum for college students that could ultimately be adapted for high school students. *(Kirby)*
- ISIS projects *(Levine)*
    - SexTech conference
    - SexInfo is a text message service that allows San Francisco youth to text "sexinfo" to 61827 to access information on a variety of topics via text. http://www.isis-inc.org/projects.php
    - inBrief (with BrickFish): Underwear design contest. "Let your undies have the last word."
- Information Rx: Initiative by National Library of Medicine in conjunction with AMA to encourage providers to "prescribe" legitimate health websites. *(Cohall)*
- Sites for youth *(Cohall)*
    - http://www.teenagehealthfreak.org/homepage/index.asp (England) Started as health information books; recast with emergence of Internet. Includes a "virtual clinic" with general health information and "Ask Dr. Ann" which gives health information via email. Sex (57%), drugs (17%), and body image (12%) are the most common topics.

    - http://www.teenhealthfx.com/
    - http://www.goaskalice.com/
    - http://teenshealth.org/teen/
- Cells in the City *(Cohall – in development)*
  Since young people often say they listen to their peers and also embrace texting as a communication channel, Cohall and partners decided to create a fictionalized vignette in which peers encourage one another to seek help for STIs/HIV and unintended pregnancies. Using computer animation, the story-line is advanced solely through texting with voice-overs. Young people are involved in the writing, developing and animating the vignettes. Additionally, they will be involved in disseminating them "virally" through texting, email, and MySpace.
- NYC Department of Health and Mental Hygiene: "Mind Space" on MySpace offers example of good use of scenarios on social networking site. *(Cohall)*
  http://www.nyc.gov/html/doh/html/pr2008/pr050-08.shtml

III. Positive Youth Development Approach

"Programs will fail unless they are linked to all the things that make young people whole."- *Michael Carrera*

Issues

- Biopsychosocial determinants of adolescent sexual health include: poverty, community, family, religiosity, school, peers, puberty, resiliency, predilection for taking risks, government policies, and prevention programs. *(Santelli – see Appendix A)*
- Relationships with parents, peers, school, and community all impact youth. Family relationships matter; family plays crucial role in HIV prevention and intervention. *(Prado)*
- Systems interact with each other to increase or decrease risk. *(Prado)*
- Youth development approaches are desirable because they are holistic. However, evaluations of existing youth development programs show mixed results. *(Kirby)*
- There is a continuum of individual, peer, family, and community factors that influence our sexuality/behavior/health. *(Santelli)*
- 65% of recovering addicts find success in faith-based or family-based programs/initiatives; engage faith-based institutions and find common ground for this conversation; reach out to medical community; engage families. *(Stakeholder in group 2)*
- Across the globe, the biggest predictor of childbearing is whether or not a young woman can go to school. *(Santelli)*
- Community risk and protective factors include: educational opportunities, life opportunities, socio-economic status, social norms about marriage and childbearing, adult role models. *(Santelli)*
- Adolescents and many of their behaviors are demonized in the media and by adults. *(Stakeholder)*
- Accountability is difficult. Results can't necessarily be shown through communitywide data since not everyone is in a program. Efforts to change community norms are hard to measure. Change is incremental. Indicators of community change are difficult to define. Very little evaluation money is available. *(Stakeholders in group 6)*

Comments

- HIV risk preventive interventions should attend to the: a) multiple contexts adolescents are embedded in and b) developmental needs of adolescents. *(Prado)*
- Implement multiple interventions. Carrera's multi-level intervention is the best example *(Kirby)*. Use a multi-level strategy to reach the tipping point. *(Stakeholder)*
- Engage youth in design, creation, and dissemination of sexual health programs, messages, and materials (including digital materials). *(Stakeholder)*
- For success, there is a need to cater to each population. Know the culture(s) of the people to be reached, and reach them through people they can relate to. *(Stakeholders in group 4)*
- Coordinate with other systems to reach certain populations such as adolescents in foster care, juvenile justice, etc. *(Brown)*

- Conduct more comprehensive assessments of teens to identify issues of importance for teens. *(Stakeholder in group 2)*
- Create a new, positive vision for sexual health. *(Santelli)*
- Fund multi-sector collaboration *(Stakeholder in group 4)*. We share the goal of strong and healthy families with many different sectors. We should reach out, add to our "troop" strength, by reaching out to housing, education, cultural values/religion, justice system, public policy, economic sector, health care system. We need to connect with these sectors and help them understand that we're all pulling in the same direction *(Brown).* Work in schools and communities simultaneously *(Levine).* Work with faith institutions. "We can't be afraid of people who believe in abstinence. Invite other voices to the table—this is not a one-dimensional issue." *(Stakeholder)*
- Create a campaign to show positive attributes of adolescents/adolescence. *(Stakeholder in group 2)*
- Keep focus on the whole person. *(Carrera, Stakeholders)*
- Look at community change approach – identify and build on community strengths. *(Stakeholder in group 2)*

Community-Based Youth Development Programming

- Require and support community assessment and strategic planning. Assess services available. Take a multi-sector approach: include schools, faith-based, etc. Require development of strategic plan for the community (neighborhood, agency, municipality). Require youth voice in the planning process. Build in time and funding for planning and evaluation during the life of the grant funding periods. *(Small Group 6)*
- Promote alignment around sexual health goals: alignment between youth, program staff, families, school, all of young people's environments. Get beyond capacity building. *(Carrera)*
- Promote connectedness with adults: a large body of evidence demonstrates that connectedness with adults (parents, schools, faith communities) has a huge impact. (Connectedness with peers has mixed results). *(Kirby)*
- Engage communities to enhance local input into programming; promote community oversight to reduce deep-seated distrust. *(DiClemente)*
- Assist programs with community input. Clarify purpose of community advisory boards and offer strategies for success. Allow flexibility in the model implemented to achieve goal of input and participation in programs. *(Small Group 6)*
- Targeting priorities should include, among others, Latino youth, 18-19 year olds, foster care youth; youth development settings, juvenile justice and court systems. *(Brown)*
- To deliver comprehensive sexual health messages, utilize the community partnerships required by funding streams, as well as medical providers and parents; ensure cultural competency. *(Small Group 4)*
- Continue to strengthen a youth development approach in DOH sexual health programs. *(Small Group 2)*
- "Programs will fail until they are linked to all of the things that make young people whole." *(Carrera)*

- Provide guidance to programs for promoting youth voice – tools and assistance in getting objective youth voice (including youth outside the program). *(Small Group 6)*
- Provide specific guidance to counties on programs/practices/curricula that are appropriate for different local scenarios; fit community profile. *(Small Group 6)*
- Provide specific guidance to community-based programs on how to measure and evaluate program effectiveness in improving the sexual health of young people. *(Small Group 6)*
- Consider certain service-learning programs that have strong evidence for reducing teen pregnancy. Effective service-learning programs included volunteer service in community and small group discussions. For service-learning (unlike all other programs) curriculum content about sexuality appears to be less important or unimportant *(Kirby).* Critical elements appear to be: volunteer work that is considered valuable, youth voice *(Stakeholder).*
- For strong impact among girls, consider intensive, comprehensive approach such as the Children's Aid Society Carrera program. However, results have not always been replicated. *(Kirby)*

Families

Issues

- Family-inclusive programming has been difficult to fund; current bias is that families are the problem. *(Stakeholder)*
- Family rejection of GLBTQ kids is main predictor of poor outcomes (Stakeholder in group 2). For GLBT immigrant youth in particular, "you need an alternate method than parents." *(Stakeholder in group 4)*
- Most youth can identify at least one person who is a positive role model in a family context. *(Santelli)*
- "Parents need education too, especially immigrant parents" (*Youth Panelist).* "We do listen to adults, especially if there's that one cool adult… It starts in 5th grade—what are we doing to reach parents in time?" *(Youth Panelist)*
- Many parents have a history of sexual and substance abuse; parents' personal experiences sometimes block their ability to support their children effectively/in a healthy way. *(Youth Panelist in group 2)*

Comments

- Adapt and disseminate research-based family programs. Promote family-inclusive programming. Good models are available. *(Prado, Small Group 2, Small Group 5)* Programs for families can be effective: "Studies of seven programs for parents of teens indicate that these programs sometimes reduce teens' sexual risk-taking, particularly if the programs include components for teens that incorporate many of the 17 characteristics of effective curriculum-based programs for teens. Programs to increase parental involvement and monitoring may also have a positive impact, but the evidence is still weak." *(Kirby, quote from* Emerging Answers 2007*)*
- Offer parent/family education that is evidence-based and culturally and developmentally specific in a variety of settings (community-based organizations, clinical settings, etc.). *(Small Group 5)*
- Implement evidence-based family interventions. Train public health professionals and/or physicians that are interacting with at-risk families. Those families that are communicating regularly will benefit most. Target families that are at risk with brief

communication measures. Identify target sites based on levels of communication, levels of parent involvement and adolescent risky behavior. *(Prado in small group 5)*

- Point of controversy: target at-risk families, or all families? *(Small group 5)*
- Utilize self-selected populations of frequently engaged parents such as PTAs, and other parents groups that might be interested in training using curricula such as "Strengthening Families" and "Familias Unidas." Strengthening Families curricula provide an opportunity to get youth perspective to parents and vice versa. *(Stakeholder in group 5)*
- Provide routine screenings that will identify family strengths and risks. *(Small Group 5)*
- Interventions are also needed around issues such as drugs and alcohol. *(Small Group 5)*
- Consider immigration issues such as Americanization of adolescents and the tension that can create with parents. *(Stakeholder in group 5).*
- Provide help for family as a whole. *(Stakeholder in group 2, Youth Panelist)*
- Prepare youth to teach parents. *(Stakeholder in group 5)*
- Disseminate information about parent resources (linking to 211 or 311). *(Small Group 5)*
- Create accessible resources for 1) parents to inform themselves and 2) parents to use with adolescents. *(Stakeholder in group 5)*
- Get beyond information: help build relationships and communication within families between parent/child, parent/parent. *(Stakeholder in group 5)*
- Offer interactive programming for parents using multi-media approaches. *(Small Group 7).*
- Develop a family-based program that maximizes teens' potential, looks at how parents/families help adolescents become adults. *(Stakeholder in group 2)*
- Redefine/expand definition of family to include positive role models in family context *(Santelli).* Possible definitions: "a network of extended kinship" *(Prado);* "sustained mutual commitment" *(Tiffany).* Educate family members, not only parents *(Stakeholder in group 5).*
- To build trust with families, work with programs that are already established and trusted in the community (such as Big Brothers Big Sisters). *(Stakeholder in group 5)*
- Ensure that men are included in parenting education programs. Hold classes in fatherhood. *(Stakeholder in group 5)*
- Include adolescent parents in parenting education. *(Stakeholder in group 5)*
- Consider different family structures, including parents with multiple/serial partners. *(Stakeholder in group 5)*
- Address influence of media, which provides opportunities for discussion between parents and children. *(Stakeholder in group 5)*
- Use the Internet for culturally competent parent education. *(Stakeholder in group 7)*
- Use tech: create modules to foster dialogue between parents and youth. *(Cohall)*
- Focus on skills for parents. *(Stakeholder in group 7)*

Schools

- Expand school-based / school-linked health services. Provide comprehensive package of adolescent health services with accessible hours and location, especially in areas with highest immigrant population *(Small Group 3).* In school-based clinics, include a focus on prevention with clear messages about reducing sexual risk and avoiding pregnancy in addition to providing contraceptives. *(Kirby)*
- School-based clinics should offer the full range of contraceptives, including long-acting contraceptives. *(Stakeholder)*
- Gay-Straight Alliances have a positive role. *(Stakeholder)*
- Best place to reach most teens still remains through schools. *(Stakeholder)* However, with NCLB there isn't enough time in the day. *(Brown)*
- Schools also become battlegrounds. Go to other systems where youth are. *(Brown)*
- Many, many adults in this country continue to think that knowledge is dangerous, and that if we teach adolescents about sex it will drive them to have sex. *(Brindis)*
- Identify financing base for sex education: dedicated funds or general education budget funds? *(Brown)*

Resources, Best Practices, Examples

- Familias Unidas, a 17-year-old program for Hispanic recent immigrants, is a 12-week parenting intervention, HIV prevention, health promotion. *(Prado)*
- Children's Aid Society is working with parents and grandparents, and it transforms relationships. *(Diaz)*
- Children's Aid Society works with males in Big Brothers Big Sisters to enhance communication and sexual health for teens. Working with a long-established, trusted program provider (BBBS) helps parental acceptance of sexual health information.
- Service-Learning programs cited in Kirby's *Emerging Answers 2007*: "Reach for Health Community Youth Service Learning" and "Teen Outreach Program."
- Plain Talk/Hablando Claro (Annie E. Casey Foundation): works to create consensus among parents and adults about the need to protect sexually active youth through contraceptive use; gives parents and community adults the information and skills to communicate effectively with teens; improves adolescent access to reproductive health care. Components include community mapping, outreach, and mobilization. http://www.plaintalk.org/

IV. Research

Issues

- Technology moves more quickly than research. Once a project is tested, it may well be out-dated. *(Levine)*
- Some of our data collection systems need to be updated (e.g., YRBS). *(Stakeholders)*
- Some groups are not well-represented in research data: for example, Native Americans, homeless, GLBT, military families, teen parents, etc. *(multiple Stakeholders)*

Comments

- Be creative in research and talk to the community. Hire young people to work with you. *(Levine)*
- For research on fast-moving tech, move from traditional journals to PlusMedicine: open source, quick turnaround. *(Levine)*
- Need to examine other healthy communities and compare/examine how to achieve in NYS/US. *(Stakeholder)*
- Need GLBT data collected as part of YRBS. (NYC version does ask some of these questions.) *(Stakeholder)*
- YRBS should define sex. *(Stakeholder)*
- YRBS should ask about specific contraceptive methods. *(Stakeholder)*
- Support better connections between researchers and communities. *(Prado)*

V. Advocacy

"Health care is a civil rights issue." – *Angela Diaz*

Comments

- Engage young people as partners in advocacy efforts. *(Stakeholder)*
- Need to consider overall context – including policies, politics, and resources that impact on ability of DOH to address other risky behaviors. *(Stakeholder in group 2)*
- Think about how to package information in order to overcome fear. *(Brindis)*
- Need to acknowledge the role of policymakers as barriers or facilitators of developing integrated approach. *(Stakeholder in group 2)*
- Use every opportunity to champion adolescent sexual health. For example, the health reform house parties organized by incoming administration in December. *(Brindis)*
- We share the goal of strong and healthy families with many different sectors. We should reach out, add to our "troop" strength, by reaching out to housing, education, cultural values/religion, justice system, public policy, economic sector, health care system. We need to connect with these sectors and help them understand that we're all pulling in the same direction. *(Brown)*
- Continue to bring the facts to policymakers. *(Brindis)*
- Mandate comprehensive sexual health education in New York State. *(Group 4, Stakeholders)*
- Government agencies funding programs should have an interdepartmental focus in their RFA, etc. *(Stakeholder)*
- Use qualitative data when making the case for funding and changes in policy. *(Brown, Stakeholder)*
- Communicate the facts that reducing teen pregnancy reduces poverty; reducing teen pregnancy saves money; family planning saves money. *(Brown)*
- Remember the role of activism at all levels: researchers, practitioners, etc., to promote integrated services. *(Stakeholder in group 2)*
- Create mandate for adolescent multi-problem center. *(Stakeholder in group 2)*
- Approach private sector, foundations for funding. *(Stakeholder in group 2)*
- Advocate for greater emphasis on adolescence at national level. *(Stakeholder in group 3)*

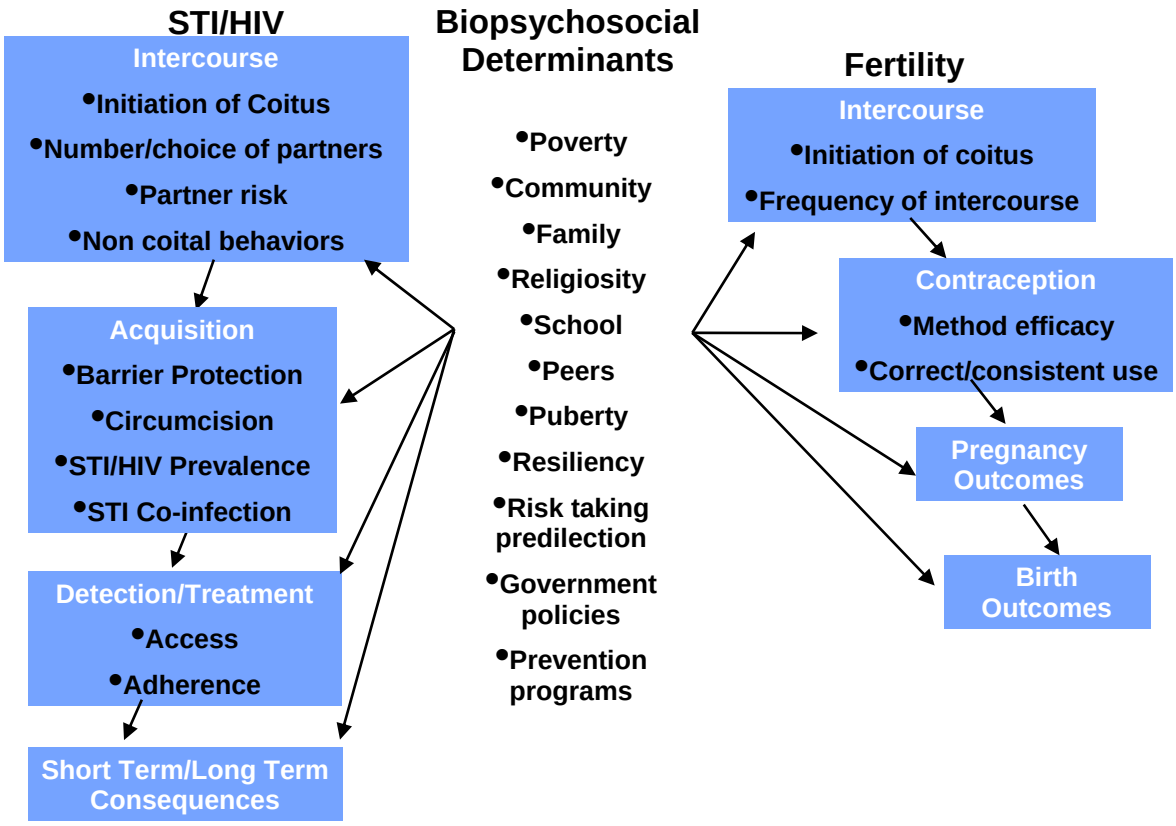
Resources, Best Practices, Examples

- Funding fact sheets available from The National Campaign to Prevent Teen and Unplanned Pregnancy:
  - The Direct Medical Costs of Unplanned Pregnancy and Cost Effectiveness of Preventing Unplanned Pregnancy http://www.thenationalcampaign.org/resources/pdf/FastFacts_DirectCosts_UnplPreg.pdf
  - By the Numbers: The Public Costs of Teen Childbearing in New York http://www.thenationalcampaign.org/costs/pdf/states/newyork/fact-sheet.pdf

Appendix A: Integrated Risk Factor Model (Dr. John Santelli)

An Integrated Risk Factor Model for Adolescent Reproductive Health Outcomes

Presented at the 2009 Adolescent Sexual Health Symposium by Dr. John Santelli



Appendix B: Selected Readings (Expert Panel)

Where available, DOI number is included to enable quick access to articles through a DOI resolver such as http://www.doi.org/

Claire Brindis

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Houck, C. D., Lescano, C. M., Brown, L. K., Tolou Shams, M., Thompson, J., DiClemente, R., et al. (2006). "Islands of risk": Subgroups of adolescents at risk for HIV. *Journal of Pediatric Psychology, 31*(6), 619-629. doi:10.1093/jpepsy/jsj067

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