

# ONLINE APPENDIX

## YOUTH SEXUAL HEALTH IN COLORADO: A CALL TO ACTION

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

**Youth Sexual Health in Colorado: A Call to Action, Online Appendix**

Prepared by Colorado Youth Matter and The Healthy Colorado Youth Alliance

for the

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## Table of Contents

**Bibliography** ..... **2**
Annotated Bibliography – Influencing Factors of Adolescent Sexual Behavior ..... 25
**Topic Summaries** ..... **46**
Academic Achievement ..... 47
Comprehensive Sexuality Education ..... 48
Contraception and Sexual Protection ..... 51
Dating Violence and Sexual Assault ..... 54
Family Planning and Clinical Services ..... 55
Health Inequities and Social Determinants of Health ..... 57
Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) Youth ..... 59
Parental Involvement and Youth-Adult Connectedness ..... 60
Positive Youth Development ..... 62
Sexual Behaviors ..... 63
Sexually Transmitted Infections (STIs), including HIV ..... 66
Teen Pregnancy and Parenting ..... 68
Youth in Foster Care/Youth in Transition/Homeless Youth ..... 70
**Youth Outreach Leaders** ..... **72**
**Community Conversations** ..... **89**
**Informal Focus Groups** ..... **103**
**Statewide Survey** ..... **121**

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The following is a list of all the sources used in the Call to Action, Annotated Bibliography, and Topic Summaries. Sources are listed here alphabetically.


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## Annotated Bibliography: Influencing Factors of Adolescent Sexual Behavior

This section of the appendix is provided to present recent literature about the factors influencing adolescent sexual behavior. Articles were chosen based on their descriptions of factors that change adolescent sexual behavior, as well as being from a peer-reviewed journal. Short summaries for each article are available in this section.

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Cavazos-Rehg, P. A., Krauss, M. J., Spitznagel, E. L., Schootman, M., Bucholz, K. K., Peipert, J. F., Sanders-Thompson, V., Cottler, L. B., & Bierut, L. J. (2009). Age of sexual debut among US adolescents. *Contraception, 80*, 158-162. doi:10.1016/j.contraception.2009.02.014

Data from the Youth Risk Behavior Surveillance (YRBS) was examined to compare sexual debut in adolescents across gender, racial and ethnic groups. The study measured approximately 67,000 students in grades nine to 12 across four major ethnic groups: Caucasians, African Americans, Hispanics, and Asians. There were similar numbers of male and female participants. About half of the survey respondents (47.9%) had not yet experienced their first sexual intercourse and were not eligible to be analyzed in data measuring age of sexual debut.

Some of the major patterns found in the survey results were that African American males experienced sexual debut earlier than all other groups and Asian males and females experienced sexual debut later than all of the other ethnic groups. By participants' 14th birthday, the likelihood of sexual debut was 42% for African American males and 23% for Hispanic males. By the 16th birthday, the likelihood of sexual debut was 72% for African American males, 55% for African American females, 53% for Hispanic males and 41% for Hispanic females. Conversely, the likelihood of sexual debut was less than 40% for Caucasian males and females by the 16th birthday and less than 35% for Asian males and females by their 17th birthday. The increased likelihood of early sexual debut for African American and Hispanic teens may result from lack of communication about sex between families and youth. Adolescents may not know their parents' opinions regarding early sexual behavior. They also may not understand the risks involved with early sexual debut, such as increased risk for STI and HIV transmission and teen pregnancy.

Future sexuality education programs should keep these cultural differences in mind and understand the differences in risk of early sexual debut across racial/ethnic groups.

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Deardorff, J., Tschann, J. M., Flores, E., & Ozer, E. J. (2010). Sexual values and risky sexual behaviors among Latino youths. *Perspectives on Sexual and Reproductive Health, 42*(1), 23-32. doi:10.1363/4202310

This journal article highlights the link between risky sexual behaviors and the sexual values of young Latinos. The study focuses on three sexual values (the importance of female virginity, sexual satisfaction, and comfort with sexual communication) and how these values affect young Latinos' sexual behaviors. Several sexual outcomes are also measured including: age at initiation of intercourse, number of sexual partners over youths' lifetime and in the past year, and frequency of condom use during the first and last month of the current sexual relationship. Overall the study shows that Latinos' sexual values are associated with both protective and risk behaviors. The importance of female virginity is a potential protective factor for young women's number of sexual partners, but is a risk factor for inconsistent or nonuse of condoms in the first month of a sexual relationship. Female virginity does not seem to have any association with age at first intercourse. The importance of satisfying sexual needs among young Latino men is a risk factor associated with age at first intercourse, number of sexual partners, and inconsistent or nonuse of condoms. Conversely, young women who value sexual satisfaction but not virginity are more likely to have used condoms in the last month of their current relationship than young women who highly value virginity. The more comfortable partners feel with sexual communication, the less likely they were to use condoms in the last month compared to their peers who felt less comfortable. Authors believe this could be a result of partners' willingness to talk about their sexual histories and ensure they are safe before engaging in sexual behaviors. Based on these findings, future interventions with young Latinos should involve discussions of the above-mentioned sexual values in addition to any other relevant values that may arise. These values should be integrated into activities to help youth realize how these values are internalized and in turn may affect their behaviors. It is important that young Latinos

understand the cultural contradictions related to sexual norms and cultural values that they may hold.

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DeRosa, C. J., Ethier, K. A., Kim, D. H., Cumberland, W. G., Afifi, A. A., Kotlerman, J., Loya, R. V., & Kerndt, P. R. (2010). Sexual intercourse and oral sex among public middle school students: Prevalence and correlates. *Perspectives on Sexual and Reproductive Health, 42*(3), 197-205. doi:10.1363/4219710

Research often focuses on sexual behaviors of high school students resulting in interventions that target older youth; thus the purpose of this study was to identify the prevalence of oral sex and sexual intercourse in middle school students. The study found that seven percent of sixth graders, eight percent of seventh graders and 18% of eighth graders reported having had oral sex, sexual intercourse, or both. Males and Black youth were more likely than their peers to report having had sexual intercourse. Among youth who had only had oral sex, they expected to have sexual intercourse within the next six months. This expectation of having sex in the future as well as having a romantic partner in middle school was strongly associated with both oral sex and sexual intercourse.

This study shows that sexual behaviors are beginning before high school. While sixth and seventh graders reported lower rates of oral sex and sexual intercourse, the percentage of eighth graders reporting these sexual behaviors more than doubled. It is important that interventions begin to target younger students to decrease their likelihood of engaging in sexual intercourse at an early age.

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Gilliam, M. L., Berlin, A., Kozloski, M., Hernandez, M., & Grundy, M. (2007). Interpersonal and personal factors influencing sexual debut among Mexican-American young women in the United States. *Journal of Adolescent Health, 41*, 495-503.

This study advances the knowledge and research on Latina-specific adolescent sexual behavior and decision-making in order to improve upon existing reproductive health programs and services that target Latino populations. Previous research shows personal factors such as self-esteem, perceived self-efficacy, religiosity, future personal and career goals, and parental attitudes can influence

adolescents' sexual decision-making. Latina-specific research also shows there may be a positive association between acculturation and timing of sexual initiation among Latina youth, and Latina adolescents may be easily influenced in their contraceptive decision-making by the social norms and opinions of those in their social networks. Family norms and values had a significant influence on Latina sexual decision-making according to study survey results. Latina adolescents who perceive that their family values education over marriage and expects them to abstain from sexual activity until marriage are more likely to have older ages of sexual debut. Latina adolescents are also influenced by their mothers' behaviors; the mothers' ages of first pregnancies are significantly related to the age of sexual initiation for the adolescents. Other risk behaviors that mothers engage in such as smoking may have a strong influence on their daughters' sexual decision-making. However, according to the results of this study, the strongest factor in influencing the delay of sexual initiation is having a greater sense of personal control over sexual behaviors. This finding alone may suggest that adolescents' own beliefs regarding the timing of their first sexual intercourse may outweigh the influence of their families and friends. Nonetheless, family values should be considered when approaching sexual health education with Latina adolescents to compromise self-efficacy with their cultural reality.

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Guilamo-Ramos, V., Bouris, A., Jaccard, J., Lesesne, C. A., Gonzalez, B., & Kalogerogiannis, K. (2009). Family mediators of acculturation and adolescent sexual behavior among Latino youth. *Journal of Primary Prevention, 30*, 395-419. doi:10.1007/s10935-009-0180-1

This study shows the relationship between acculturation and adolescent sexual behavior in the context of Latino familial and cultural contexts. The authors recognize the fundamental cultural value of *familismo* that embraces strong relationships, closeness, support and mutuality among family members. Previous studies show that parental orientations toward adolescent dating and sexual behavior have a significant influence on adolescents. Parents who strongly disapprove of adolescent sexual activity are associated with reduced sexual risk, later onset of sexual activity, fewer partners, and decreased sexual activity among their adolescents.

Mothers who embrace the cultural value of *familismo* and are focused on their own family are more likely to disapprove of their adolescent dating. However, the mothers' disapproval only seemed to have an impact on their daughters, not their sons. Latina adolescents who strongly embrace *familismo* are more likely to have mothers who share that value. Girls who are oriented to *familismo* also prefer a romantic partner who embraces the same cultural value, but the relationship again seems to be insignificant for boys regarding romantic partner preferences. Boys that do prefer a romantic partner oriented to *familismo* are less likely to intend to have sexual intercourse in the near future.

Boys who have higher levels of acculturation are less likely to prefer romantic partners who embrace *familismo* and are more likely to have strong intentions to engage in sex in the near future. Conversely, girls who are more acculturated to the United States often perceive their mothers as being less approving of dating so they are less likely to be in a romantic relationship and/or engage in sex in the near future. Parental opinions and cultural values can strongly influence female adolescents but *familismo* does not seem to have a significant effect on adolescent boys' behaviors or intentions. Nonetheless it is important for parents to clearly communicate their values and opinions related to adolescents engaging in sexual behavior and ensure their child has correct perceptions of their parents' opinions.

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Habel, M. A., Dittus, P. J., DeRosa, C. J., Chung, E. Q., & Kerndt, P. R. (2010). Daily participation in sports and students' sexual activity. *Perspectives on Sexual and Reproductive Health, 42*(4), 242-250.

Previous research has shown that participation in sports has had many positive impacts on females in terms of lowering the likelihood of dropping out, receiving better grades in school, promoting higher educational aspirations, lowering drug and alcohol use and lowering rates of sexual activity and pregnancy. Authors of the current study hypothesized daily sports participation is a protective factor against sexual activity for females, middle school students, and students who have positive maternal relationships. Based on survey results from approximately 4,500 middle school student participants and approximately 6,000 high school student participants, students who participate in a daily sport have an elevated risk in engaging in

sexual behaviors compared to students who did not participate in a daily sport. Authors hypothesize this may result from the physical maturity of athletes which may give them access to older and more experienced sexual partners. Authors also conclude that they may have more access to members of the opposite sex than students not participating in a daily sport. Athletes also tend to be leaders among their peers and have elevated social stature in their peer-networks. Other findings show that sports participation is a protective factor for females against oral sex. Athletes are also more likely to report using a condom at last intercourse and in general are more likely to use contraception consistently because of the ramifications pregnancy could have on their athletic career. Middle school athletes are at a higher risk of engaging in sexual behaviors earlier than their non-athlete peers, and should be targeted for an intervention early on to promote sexual risk reduction and healthy norms. Student athletes' satisfaction with their maternal relationships was not associated with adolescents' sexual experiences.

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Kerr, D. C., Leve, L. D., & Chamberlain, P. (2009). Pregnancy rates among juvenile justice girls in two randomized controlled trials of multidimensional treatment foster care. *Journal of Consulting and Clinical Psychology, 77*(3), 588-593. doi:10.1037/a0015289

Past literature has shown that pregnancy rates appear to be much higher among adolescent girls in the foster care system than their peers who are not a part of the foster care system. This study compared two treatment programs, hoping to see Multidimensional Treatment Foster Care (MTFC) as having a greater effect on reducing risky sexual behaviors than the control group which participated in typical foster care group home activities. MTFC is an intensive process that places foster youth with highly trained and supervised foster parents. Foster parents have daily telephone contact with their supervisor and also participate in weekly supervision and support meetings. The female foster youth receives individual therapy, family therapy, close monitoring of her school attendance and performance and access to an on-call staff 24 hours per day. The MTFC model also includes an intervention to target HIV-risk behaviors but did not provide any information about overall reproductive health.

This treatment program has been very effective in reducing delinquency despite the intervention group having much less restriction than their peers who live in group homes. The intervention group can attend public schools and have typical social interactions rather than being segregated in a group home. While MTFC continued to show positive results in reducing delinquency rates, it was not shown to have an impact on the likelihood of pregnancy. Further research needs to be done to evaluate whether MTFC could have a stronger impact on reducing sexual risk behavior among female foster youth than the traditional group home model.

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Kinsella, E. O., Crane, L. A., Ogden, L. G., & Stevens-Simon, C. (2007). Characteristics of adolescent women who stop using contraception after use at first sexual intercourse. *Journal of Pediatric Adolescent Gynecology, 20*, 73-81. doi:10.1016/j.jpag.2007.01.004

This study builds upon previous research that has shown the United States to have higher rates of conception than other Western countries due to ineffective usage of contraception. American teenagers are currently less likely to use contraceptives as they gain sexual experience. This study aims to find out what motivates sexually active adolescent to stop using contraception. The findings suggest that some adolescents may develop doubts about the necessity and desirability of using contraceptives to prevent pregnancy as they get older and gain sexual experience. Study participants who stopped using contraception were less likely to believe that not using contraception would result in pregnancy, were less likely to want to remain non-pregnant and were older or had been sexually active longer than their peers who continued to use contraception. Findings also suggest that the primary factor behind consistent contraceptive use among sexually active young women is the belief that the consequences of not using contraception (e.g. pregnancy) would prevent them from achieving career and life goals. Results of this study suggest that education about contraception should be presented continually in the lives of teenagers, rather than a one-time sexuality education course.

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Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent*

*Health, 42*, 344-351. doi:10.1016/j.jadohealth.2007.08.026

Because the United States has higher teen pregnancy, birth and abortion rates than other developed countries, the present study examined what influence sexuality education has on determining STI and pregnancy risk. This study describes the impact of sexuality education and how the type of sexuality education influences sexual risk behaviors. Results of the study show that abstinence-only programs have no significant impact in delaying the initiation of sexual activity or in reducing the risk of teen pregnancy and/or STIs. Conversely, comprehensive sexuality education programs are significantly associated with the decreased likelihood of becoming pregnant as a teen.

Comprehensive sexuality education programs are marginally associated with the decreased likelihood of a teen becoming sexually active compared to teens who don't receive any sexuality education. However there is no significant difference in the initiation of sexual intercourse between teens who have received abstinence-only education and comprehensive sexuality education. The study also found that teens from intact families are more likely to participate in and have access to comprehensive sexuality education programs than teens from non-intact families. The results of this study show few but significant results in favor of comprehensive sexuality education. Thus, future interventions targeting adolescent pregnancy should encompass comprehensive sexuality education and should be targeted to teens from all family backgrounds.

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Koon-Magnin, S., Kreager, D. A., & Ruback, R. B. (2010). Partner age differences, educational contexts and adolescent female sexual activity. *Perspectives on Sexual and Reproductive Health*, 42(3), 206-213. doi:10.1363/4220610

Many believe that relationships between young adolescent females and older males are inherently predatory and harmful to the young woman due to perceived power imbalances. However this study challenges that assumption and suggests that young women dating older men who attend their same school are less at risk than young women dating men not in secondary school regardless of age. This challenge arises from the arbitrary process of defining the age of consent as well as the legally appropriate age span between partners that

differs across states. The authors argue that dissimilar educational contexts rather than age asymmetries may be an indicative factor in high-risk dating relationships.

The results of the study show that while dating a partner three years or older is associated with a greater risk of sexual intercourse for adolescent females, that risk dissipates if the two partners attend the same school. The authors speculate this is because a 14-year-old and 18-year-old may see each other as peers if they attend the same school even if the law does not recognize them as peers. These results should be closely examined by policy makers regarding statutory rape laws. Social contexts of relationships should be an important element when considering legally appropriate relationships, age of consent laws, and statutory rape laws.

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Manlove, J., Ryan, S., & Franzetta, K. (2007). Contraceptive use patterns across teens' sexual relationships: The role of relationships, partners, and sexual histories. *Demography, 44*(3), 603-621.

This study examines if and how contraceptive use is negotiated between sexual partners based on previous sexual relationships and what role contraceptive method plays in this communication. Authors propose based on previous research that relationship factors such as exclusivity and intimacy with romantic partners, shorter relationship duration, and awkwardness in relationship communication influence contraceptive use. The study sampled 4,383 unmarried and sexually experienced adolescents.

The overall finding of the study is that teens vary their contraceptive use patterns across relationships depending on various factors. Older teens and teens involved in a romantic relationship as opposed to those with casual sex partners tend to be more comfortable negotiating contraceptive use with their partner. Female adolescents who have a partner outside of their social network, a partner of a different race/ethnicity, or a partner who is older than they are may be less comfortable negotiating contraceptive use. Teens with consistent patterns of using contraception are better able to maintain this consistency in subsequent relationships. The authors propose that future efforts surrounding teen pregnancy and STI prevention should have participants role-play these partner negotiations to help them feel

more confident in refusing unprotected sex.

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Manlove, J., Welti, K., Barry, M., Peterson, K., Schelar, E., & Wildsmith, E. (2011). Relationship characteristics and contraceptive use among young adults. *Perspectives on Sexual and Reproductive Health, 43*(2), 119-128. doi:10.1363/4311911

Due to high rates of unintended pregnancy and STIs of young adults in their late teens and early twenties, authors of this study uncover patterns and behaviors of youth related to their relationship characteristics and their contraceptive use. Three theoretical frameworks inform this study. The first is the *Sawtooth hypothesis* which explains that condom use is typically higher in casual relationships and then declines with greater relationship duration, intimacy and commitment between partners. The second is a *communication model*, hypothesizing that overall contraceptive use rises as partners' knowledge of each other, time spent together, and level of intimacy increases. Finally, the *power dynamics model* says that a relationship with conflict and/or violence that results from power differentials between partners is associated with reduced contraceptive use. The current study found that the duration of a relationship is positively associated with the use of a hormonal contraceptive method rather than no method at all, using a condom, or using multiple methods. The authors hypothesize that partners become more focused on pregnancy prevention rather than STI prevention as they become more intimate and their relationship moves beyond casual dating. Conversely, young adults in casual relationships are more likely to engage in more protective behaviors against STIs and pregnancy through using a condom or a dual method. While these findings mentioned above enforce the Sawtooth hypothesis of contraceptive use, the power dynamics model was also shown in to be evident between partners or different races, ethnicities, education levels or ages who often had reduced communication and trust.

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McLeod, J. D., & Knight, S. (2010). The association of socio-emotional problems with early sexual initiation. *Perspectives on Sexual and Reproductive Health, 42*(2), 93-101. doi:10.1363/4209310

Previous research has shown that youth with socio-emotional problems such as antisocial behavior, depression, attention

deficit hyperactivity disorder (ADHD), and low self-esteem tend to initiate sexual intercourse at younger ages than their peers without socio-emotional problems. The current study examined differences between internalizing and externalizing problems and their associations with early sexual initiation. Furthermore, they include gender and race/ethnicity as variables to see if stronger associations exist for particular populations. The authors found that internalizing problems such as depression did not seem to be associated with early sexual initiation. However, externalizing problems such as antisocial behavior and hyperactivity seemed to moderate the relationship between internalizing problems and early sexual initiation. Externalizing problems were associated with early sexual initiation which the authors believe may be due to the poor or impulsive decision-making that often occurs in young adults with ADHD or antisocial behavior. There were no significant associations related to gender or race/ethnicity and their effect on early sexual initiation caused by socio-emotional problems. Further research should be done as all data from this report is from mothers' reporting their children's socio-emotional problems. Because it is easier to visibly see externalizing behaviors in comparison with internalizing behaviors, future research should consider using self-reported data from adolescents themselves. The authors suggest creating population-specific interventions and sexuality education programs that address the internalizing and externalizing behaviors this group exhibits.

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Messer, L. C., Shoe, E., Canady, M., Sheppard, B. K., & Vincus, A. (2011). Reported adolescent sexual norms and the development of a social marketing campaign to correct youth misperceptions. *Journal of Children and Poverty, 17*(1), 45-63.

Previous research has shown that adolescent perceptions of the sexual activity of their peer group have a strong influence on the likelihood of when they will initiate sex. Similar findings have been found related to adolescent perceptions of peer group condom use. Social marketing and media can also have an influence on adolescent behavior. This study analyzes the Taking Responsible Actions in Life (TRAIL) program to see its impacts on middle and high school students' perceptions of sexual behavior norms. The TRAIL program functions by publicly posting school-specific

facts about teen sexually activity in order to dispel myths and misperceptions of current sexual activity in the chosen student body. Analysis of the social marketing campaign showed that students consistently overestimated the unhealthy behaviors of the other students in their schools. Furthermore, results showed a strong correlation between adolescent perceptions of drug and alcohol use among other teens and perceptions of sexual activity of other teens. If an adolescent perceived drug and alcohol use and sexual activity as normative, they were more likely to report already having had sexual intercourse. Interventions to change the perceived norms around drug and alcohol us by teens may indirectly affect adolescent sexual behavior and/or the perceived norms around adolescent sexual behavior.

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Moreno, M. A., Parks, M. R., Zimmerman, F. J., Brito, T. E., & Christakis, D. A. (2009). Display of health risk behaviors on MySpace by adolescents: Prevalence and associations. *Archives of Pediatric and Adolescent Medicine, 163*(1), 27-34.

With the increasing use of social networking sites such as MySpace, adolescents have begun publicly displaying health risk behaviors on their profiles. This has at times led to unwanted online attention from individuals such as cyberbullies or sexual predators. The authors of this study analyzed the prevalence of and content displayed on MySpace web profiles that suggest sexual behavior, substance use, and violence.

Results showed that more than half of 18-year-olds displayed some reference to health risk behaviors. Those who reported a sexual orientation other than straight were more likely to display sexual content on MySpace profiles. Health care providers cannot overlook the increased use of social networking sites and their role in publicly displaying health risk behaviors. Further research can and should be done in order to find more demographic, risk, and protective factors involved with the display of health behaviors on social networking sites.

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Oster, A. M., Dorell, C. G., Mean, L. A., Thomas, P. E., Toledo, C. A., & Heffelfinger, J. D. (2011). HIV risk among young African American men who have sex with men: A case-control study in Mississippi. *American Journal of Public Health, 101*(1), 137-143. doi:10.2105/AJPH.2009.185850

African American men who have sex with men (MSM) account for a disproportionate amount of new HIV infections among the MSM population. The National HIV Behavioral Surveillance Systems estimates that the HIV infection rate for African American MSM ages 18 to 24 is 17%. This study furthers research on this subject with an analysis of African American MSM in Mississippi as there are few studies focused on that region of the country. Participants of this study were African American men ages 16 to 25 who resided in the Jackson, Mississippi area and reported anal sex with a man in the 12 preceding months of the interview and a negative HIV test during the six months preceding the interview. Results showed that having a male sex partner older than age 25 was associated with HIV infection. Unprotected anal intercourse with casual partners was also shown to be an independent risk for HIV infection. Participants who responded as likely to give into their partners' desire for unprotected sex are also more likely to become infected with HIV. Future interventions need to target African American MSM and especially those who live in the southern areas of the United States where this problem may not be readily addressed. Beyond providing education and resources for having protected anal sex, it may also be important to address sexual negotiation and communication in HIV prevention programs as this seems to be a key factor in whether or not participants used protection during sex.

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Ott, M. A., Ofner, S., Tu, W., Katz, B. P., & Fortenberry, J. D. (2010). Characteristics associated with sex after periods of abstinence among sexually experienced young women. *Perspectives on Sexual and Reproductive Health, 42*(1), 43-48. doi:10.1363/4204310

This study examines factors that influence sexual decision making for adolescent females after a period of abstinence. There has historically been very little research and consistency around the definition of abstinence. The study had approximately 350 adolescent women keep daily diary reports of sexual activity; abstinence periods were defined as beginning the day after a diary entry of vaginal sex and ended with a diary report of vaginal sex. These periods were purely defined by behavior and not motivations, attitudes, or moral characteristics. The study revealed three main findings around duration of abstinence periods, relationship characteristics, and

STI characteristics. First, having an STI diagnosed just prior to an abstinence period was associated with reduced likelihood of sex for short abstinence periods, but an elevated likelihood of sex for intermediate abstinence periods. The diaries also measured the moods of adolescents and positive mood was associated with the decision to have sex only after short periods of abstinence. Finally, relationship quality and sexual interest showed associations with an elevated likelihood of sex for short, intermediate, and long abstinence periods. Using this data for future interventions, clinicians should not only be searching for answers about whether or not adolescents are sexually active but also when they last had sex and what influenced their decision-making to have sex.

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Parkes, A., Wight, D., Henderson, M., Stephenson, J., Strange, V. (2009). Contraceptive method at first sexual intercourse and subsequent pregnancy risk: Findings from a secondary analysis of 16-year-old girls from the RIPPLE and SHARE studies. *Journal of Adolescent Health, 44*, 55-63. doi:10.1016/j.jadohealth.2008.06.006

This United Kingdom-based study looked at two sexual education methods, Randomized Intervention of Pupil-Led sex Education (RIPPLE) and Sexual Health and Relationships Education (SHARE) to see whether teenagers using oral contraceptives were more or less protected against unintended pregnancy than those using condoms only. Previous research has shown that condoms have been found to offer less protection against unintended pregnancy than oral contraceptives. Of the approximately 2,000 female adolescents eligible to be included in this dataset, it was found that participants ages 16 years or younger who reported only using oral contraceptives at first intercourse were more likely to become pregnant that those who reported using condoms only. The authors interpreted this finding to mean that young participants who reported only using oral contraception were not using it correctly and therefore it was not effective. The study suggests that condoms may be easier to use during a female adolescent's first sexual experience rather than oral contraception. More research should be done to know how to target young adolescents with education on effective contraceptive use.

Rocca, C. H., Doherty, I., Padian, N. S., Hubbard, A. E., & Minnis, A. M. (2010). Pregnancy intentions and teenage pregnancy among Latinas: A mediation analysis. *Perspectives on Sexual and Reproductive Health, 42*(3), 186-196. doi:10.1363/4218610

Previous research, as shown in the 2002 National Survey of Family Growth, has found that over half of all Latinas in the United States are likely to become pregnant at least once before the age of 20. Latinas are also twice as likely as their non-Latina counterparts to report being "very pleased" about becoming pregnant no matter what their age is. This study takes into account acculturation, *familismo*, collectivity, and traditional roles for women – all themes that typically play a large role in Latina reproductive health - in examining teenage Latinas' intentions in becoming pregnant. Significant results were found in this study related to the themes listed above. Teenagers who are in a romantic relationship and have a serious partner are more likely to look at pregnancy more favorably than do other teenagers. The odds of becoming pregnant were doubled for participants who had any level of desire to become pregnant. If participants had a strong value in *familismo*, this was strongly associated with being happy after becoming pregnant but not with pregnancy wantedness or subsequent pregnancies. Participants who had mothers who had given birth as teenagers had higher pregnancy risk but there was no association with pregnancy happiness or wantedness. There was also a small but significant association between age and pregnancy happiness; Latina teenagers may have increasingly favorable attitudes towards pregnancy as they get older. Interventions with Latina adolescents should take the cultural themes and motivations to become pregnant into account when designing and implementing a curriculum. This provides a culturally relevant sexuality education program while still conveying appropriate data related to sexual risk behaviors and protective factors.

Rosenbaum, J. E. (2009). Patient teenagers? A comparison of the sexual behavior of virginity pledgers and matched nonpledgers. *Pediatrics, 123*, e110-e120. doi:10.1542/peds.2008-0407

This study compared the sexual behaviors between adolescents who make a virginity pledge (an oral or written promise to refrain from sexual activity

until marriage) with matched non-pledgers. Results of abstinence-only sex education (AOSE) programs have been ambivalent and inconsistent. Some research has found that virginity pledgers are just as likely as non-pledgers to acquire an STI within five years of making their pledge and are less likely to use contraception than non-pledgers if they do have sex. On the other hand, some AOSE programs have been correlated with change in adolescent sexual behavior. This study measured the behaviors of groups of virginity pledgers and non-pledgers who were matched on as many characteristics as possible in order to solely measure sexual behavior.

Virginity pledgers in this study were less likely than matched non-pledgers to protect themselves against STIs and pregnancy. Further, over 80% of pledgers had abandoned their pledge after 5 years and claimed to have never made the pledge. Pledgers and non-pledgers had the same number of lifetime partners and the same mean age of sexual initiation. These results show that not only are many outcomes between pledgers and non-pledgers the same, but in certain aspects pledgers are at a higher risk of contracting an STI or becoming pregnant than non-pledgers.

Results from this study show that virginity pledge programs do not change sexual behaviors and do not prepare pledgers with knowledge about health outcomes if they do decide to have sex.

AOSE funds should be shifted to evidence-based sexuality education programs. These programs tend to have much more positive effects on adolescent sexual behavior than AOSE programs. Virginity pledge programs are only measured by how many participants make a virginity pledge, regardless of future behavior. In this study making a virginity pledge was ineffective in protecting against sexual behavior and this should be taken into account by policy-makers.

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Santelli, J. S., Lindberg, L. D., Finer, L. B., & Singh, S. (2007). Explaining recent declines in adolescent pregnancy in the United Sates: The contribution of abstinence and improved contraceptive use. *American Journal of Public Health, 97*(1), 1-7. doi:10.2105/AJPH.2006.089169

Past research has shown that two key behaviors are responsible for the decreasing teenage pregnancy rates in the United States: reduced sexual activity and increased contraceptive use. This

study took a more comprehensive look at the roles each of these two factors play in decreasing teen pregnancy rates. Data from the National Survey of Family Growth from 1995 to 2002 was used to address patterns in sexual behavior of adolescents. The authors found that the number of young women 15 to 19 years old who had ever engaged in sexual intercourse had decreased approximately 10% between 1995 and 2002. During this same time period, there were significant increases in the use of individual contraceptive methods and increases in the use of multiple contraceptive methods. The data also showed an overall pregnancy risk reduction of 38% between 1995 and 2002. Decreased sexual activity was found to be responsible for 23% of the decline of teen pregnancy rates among 15 to 17-year-olds; however this factor had no effect on 18 to 19-year-olds. These results suggest that declining teen pregnancy rates can be mostly attributed to increased contraceptive use (responsible for 77%) rather than abstinence and teens delaying sex. It is important that policies and programs promote accurate information about contraception and increased access to contraceptives. While abstinence programming may be a worthwhile goal for younger adolescents, it is ineffective for older cohorts of adolescents and they should be addressed with evidence-based sexuality education.

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Santelli, J. S., Orr, M., Lindberg, L. D., & Diaz, D. C. (2009). Changing behavioral risk for pregnancy among high school students in the United States, 1991-2007. *Journal of Adolescent Health, 45*, 25-32. doi:10.1016/j.jadohealth.2009.04.017

After a steady decline of teen birth rates in the United States between 1991 and 2005, there was a sudden rise in teen childbearing rates beginning in 2006. The authors of this study used data from the Youth Risk Behavior Surveillance (YRBS) to find behavioral explanations for this unexpected rise. YRBS data from 2003, 2005 and 2007 was used in order to calculate changes in pregnancy risk over the years. Some of the major findings of the study focused on changes in contraceptive use, rather than changes in sexual activity. When authors calculated pregnancy risk, there seemed to be no associations between increased pregnancy risk and sexual activity, only between increased pregnancy risk and contraceptive use. Between 2003 and 2007, there were increases in condom use while fewer adolescents relied on withdrawal or used no method at all.

However, there was a significant decline in hormonal contraception among Hispanic and Black adolescents over this time period. This appeared to be the biggest causal factor of increase in teen birth rates after 2006 based on the YRBS data. The authors of the study also point out other external factors that may affect rising or falling teen birth rates. Previous research has found correlations between poverty rates and teen birth rates in the United States. If poverty rates decline, so do teen birth rates. The authors also hypothesize that rising teen pregnancy and birth rates could be an indirect consequence of weakened HIV prevention efforts among youth. Authors of this study suggest increased HIV prevention efforts to improve condom use and reduce pregnancy risk.

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Scott, M. E., Wildsmith, E., Welti, K., Ryan, S., Schelar, E., & Steward-Streng, N. R. (2011). Risky adolescent sexual behaviors and reproductive health in young adulthood. *Perspectives on Sexual and Reproductive Health, 43*(2), 110-118. doi:10.1363/4311011

This study clarifies the relationships between adolescent sexual risk behaviors and reproductive health outcomes, such as unintended childbearing, STI diagnosis, and number of sex partners in the past year. Some of the risk factors and behaviors identified by the authors are contraceptive inconsistency, age at first intercourse, having an older sexual partner, ability to discuss birth control with partner, number of sexual partners, non-monogamous relationships, and having casual and non-romantic sexual partners.

Results of the study showed that some of the riskiest behaviors for adolescents were having two or more sexual partners, inconsistent contraceptive use, not discussing contraception prior to sex, and having first sex before the age of 16. All of these behaviors put adolescents at a higher risk for unintended pregnancy and STI diagnosis. Future interventions should acknowledge each of these risky behaviors and the potential impacts they may have on adolescents' reproductive health outcomes, whether it is contracting an STI or becoming pregnant unintentionally. These risky behaviors should also be addressed early on during adolescence so that these behaviors do not shape adolescents' future sexual behaviors in adulthood, as risky sexual behaviors can have both short-term and long-term consequences.

Sikkema, K. J., Wilson, P. A., Hansen, N. B., Kochman, A., Neufeld, S., Ghebremichael, M. S., & Kershaw, T. (2008). Effects of a coping intervention on transmission risk behavior among people living with HIV/AIDS and a history of childhood sexual abuse. *Journal of Acquired Immune Deficiency Syndrome, 47*(4), 506-513.

This study compared the results of two interventions created for HIV-positive adults with histories of sexual abuse to see which intervention had a larger effect on this population. The first intervention was Living in the Face of Trauma (LIFT) that focused on coping skills for HIV-positive men and women with extensive histories of childhood sexual abuse. A support group for men and women who are HIV-positive that did not directly address participants' histories of childhood sexual abuse was used as a comparison group. HIV-positive people with histories of childhood sexual abuse often demonstrate significant sexual risk behaviors later on in life suggestion a correlation between the two factors. These behaviors can lead to increased transmission risk behaviors which is an important health issue to be addressed. This study found the LIFT program to be much more effective in reducing transmission risk behaviors than a typical support group. In a 12-month follow-up with LIFT participants, there were fewer instances of unprotected intercourse with all partners in comparison with participants in the support group. LIFT participants had reduced unprotected anal and vaginal sex with all partners by an average of 54%. These findings suggest that addressing trauma in intervention program may help to reduce transmission risk behavior among HIV-positive men and women. Whether the population is facing homelessness, incarceration, sex trade, or a history of sexual abuse, gaining the tools to acknowledge and cope with these life events may produce more effective intervention outcomes than a support group for HIV-positive persons.

Sznitman, S., Stanton, B. F., Vanable, P. A., Carey, M. P., Valois, R. F., Brown, L. K., DiClemente, R., Hennessy, M., Salazar, L. F., & Romer, D. (2011). Long term effects of community-based STI screening and mass media HIV prevention messages on sexual risk behaviors of African American adolescents. *AIDS and Behavior*, 1-9. doi:10.1007/s10461-011-9946-6

The authors of this study hypothesized that a combined intervention of STI screenings and a media campaign would result in decreased sexual risk behaviors among African American youth. Participants completed interviews using audio, computer-assisted technology about their STI status at different points up to 18 months after recruitment and provided urine samples to test for STI presence. A portion of the participants lived in cities with a media campaign about how to respond to sexual risk dilemmas that aired on television and radio. While increasing STI screenings is important because many vulnerable youth may be asymptomatic or unable to afford treatment, authors found that the effects STI screenings had on risk behavior were short-lived. Most adolescents resumed their previous behavior within 6 months of their positive-STI diagnosis. Adolescents who saw the campaign had lower rates of unprotected sex than youth who did not see the media campaign and only had an STI screening. The media campaign was successful in reducing unprotected sex but not in reducing participants' number of sexual partners. Results from this study show that there are many elements that go into addressing risky adolescent sexual behavior. Intensive counseling could accompany STI screenings in order to have a longer-lasting effect. Furthermore, combining many different types of interventions such as screenings, counseling, and media messages will be more effective than one of these interventions on its own.

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Villarruel, A. M., Jemmott, J. B., III., & Jemmott, L. S. (2006). A randomized controlled trial testing an HIV prevention intervention for Latino youth. *Archives of Pediatric and Adolescent Medicine, 160*, 772-777. Retrieved from *archpedi.ama-assn.org/content/vol160/issue8/index.dtl*

This study tested the "¡Cuidaté! (Take Care of Yourself) Latino Youth Health Promotion Program" designed specifically for Latino adolescents to evaluate its effectiveness in reducing HIV sexual risk behaviors. In order to test the program's effectiveness, one group participated in a specific HIV risk reduction intervention while the other group participated in a general health-promotion intervention. The HIV risk reduction intervention not only included specific STI information but also used a culturally relevant model incorporating Latino values such as familism and gender role expectations. The HIV risk reduction intervention led to fewer reports

of sexual intercourse and fewer sexual partners compared to the participants in the general health promotion intervention. The HIV risk reduction program participants also increased their consistent condom use. Future interventions should consider incorporating some of the elements of the "¡Cuidaté!" program, including specific health information that aims to reduce risky behaviors paired with a culturally relevant curriculum to the participants.

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Whittaker, P. G., Merkh, R. D., Henry-Moss, D., & Hock-Long, L. (2010). Withdrawal attitudes and experiences: A qualitative perspective among young urban adults. *Perspectives on Sexual and Reproductive Health, 42*(2), 102-109. doi:10.1363/4210210

This study examined the prevalence and opinions of adolescents around the use of withdrawal as a form of sexual protection. A recent survey of 18 to 24 year olds showed that 43% had ever used withdrawal, 20% consider it a safe-sex behavior, and 12% use withdrawal regularly during sexual intercourse. Participants in the study reported using withdrawal often and saw many benefits to it. Some of the reported benefits were the convenience of withdrawal as a contraceptive method and that it typically allows for greater intimacy than using condoms during sex. The reported drawbacks to using withdrawal during sex are males' lack of self-control and female-reported reduced sexual pleasure. Despite its popularity among the sample, there was an overarching sense of uncertainty about the effectiveness of withdrawal. Similarly, there was uncertainty about the norms and expectations related to withdrawal. Despite the general positive opinion about withdrawal, participants did not think of withdrawal as a legitimate contraceptive method and as a result did not discuss this method with their doctors or health care providers. Information about withdrawal was informally and unreliably passed through social networks. Future research and interventions with adolescents and young adults should address withdrawal as a contraceptive option, providing accurate and non-judgmental information about its use.

## Topic Summaries

This section of the appendix was written to summarize relevant topics related to adolescent sexual health and provide a more comprehensive picture of the different influences among youth regarding their sexual health. These summaries cover the following topics as they pertain to adolescent sexual health:

- Academic Achievement
- Comprehensive Sexuality Education
- Contraception and Sexual Protection
- Dating Violence and Sexual Assault
- Family Planning and Clinical Services
- Health Inequities and Social Determinants of Health
- Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) Youth
- Parental Involvement and Youth-Adult Connectedness
- Positive Youth Development
- Sexual Behaviors
- Sexually Transmitted Infections (STIs), including HIV
- Teen Pregnancy and Parenting
- Youth in Foster Care/Youth in Transition/Homeless Youth

While the sections are not represented as comprehensive, the summaries provide a brief overview of current research related to each topic

## Academic Achievement

It is important to consider health and education together because research has shown that more educated people have fewer health problems as adults. Better educated people are less likely to suffer from hypertension, emphysema or diabetes, and are also less likely to smoke, binge drink, suffer from overweight or obesity or use illegal drugs (Cutler & Lleras-Muney, 2006). They also have increased access to health services, access to jobs with higher salaries, health insurance and safe work environments and access to social networks with financial, physical and emotional support (Bureau of Labor Statistics, 2001; Cutler et al., 2006). As education level increases, levels of self-reported health increase (National Center for Health Statistics [NCHS], 2011). Persons with less than a high school diploma are approximately four times more likely than those with the highest educational level to report having only fair or poor health (NCHS, 2011). Thus it is important that school dropout be framed as a public health issue and measures should be taken to coordinate school health programs, comprehensive sexual health education, HIV prevention, pregnancy prevention programs and special services for pregnant and parenting teens (Freudenberg & Ruglis, 2007).

Research has also shown that academic success and health are positively associated for youth. Students are more likely to succeed academically when their health is taken care of, ranging from correcting a student's vision, providing proper asthma treatment and ensuring students have a proper breakfast to preventing teen pregnancy and mitigating aggressive and violent behavior (Basch, 2010). If any of the above factors are present, students are more likely to drop out of school, hindering academic achievement and impeding future success and access to opportunity.

From 2003 to 2004, the dropout rate for female students in Colorado was 22% (National Women's Law Center [NWLC], 2007). Colorado is seeking to understand why students are dropping out and subsequently keep more students in school through graduation. Research has shown that becoming a teen parent can exponentially increase one's chances of dropping out of school (Basch, 2010). Other students don't see a purpose in attending school and don't have connections to the school community and slowly "fade out," or are "pushed out"

because they are perceived as detrimental to others in the school (Colorado Department of Education [CDE], 2010).

Female participation in sports has been shown to be a protective factor against dropping out, drug and alcohol use, and sexuality activity and pregnancy (Habel, Dittus, DeRosa, Chung, & Kerndt, 2010). Female athletes are also more likely to get better grades in school and have higher educational aspirations than their non-athlete peers (Habel et al., 2010). Some ways to improve dropout rates are to increase school accountability for students who are dropping out, increase access to after-school and athletic programs for boys and girls, increase access to academically rigorous career and technical education for boys and girls, and ensure that high-risk students have a trusted adult at school to hold them accountable for attendance and academic success (NWLC, 2007).

## Comprehensive Sexuality Education

Title V, Section 510 of the Personal Responsibility and Work Opportunity Act of 1996 has provided $50 million of federal funds annually since 1998 to abstinence education programs. Peer-reviewed research and analysis of the programs that have received funding show there are almost no behavioral differences between program participants and their peers who did not receive the abstinence education programs (Trenholm, Devaney, Fortson, Quay, Wheeler & Clark, 2007). Some of the behaviors that were measured were participant's level of abstinence, condom use, age at first intercourse, number of sexual partners, knowledge of sexually transmitted infections and their consequences, knowledge of unprotected sex risks, and perceived effectiveness of condoms and birth control – none of these behaviors were significantly impacted by abstinence education programs (Trenholm et al., 2007).

In comparing outcomes between abstinence-only education and comprehensive sexuality education, studies show that there is no significant difference in adolescents initiating sexual intercourse despite their participation in either program (Kohler, Manhart & Lafferty, 2008). Comprehensive sexuality education programs have shown positive associations with reducing the risk of teen pregnancy (Kohler et al., 2008). Abstinence only-programs have no significant effect in reducing the risk for teen pregnancy or sexually transmitted infections (Kohler

et al., 2008). Another study that evaluated various abstinence-only sexuality education programs that used virginity pledges as part of the program curriculum found that virginity pledgers were just as likely as non-pledgers to have STIs five years after making their pledge, were less likely to use contraception than non-pledgers, have the same average number of lifetime sexual partners and the same mean age of sexual initiation (Rosenbaum, 2009). These programs receive funding based on how many participants make a virginity pledge, regardless of sexual behavior; it may be worthwhile to consider shifting these federal funds to programs that have been demonstrated to affect sexual behaviors (Rosenbaum, 2009).

Effective sexuality education programs spend time assessing the needs of the group and integrating theory and research into the curriculum development to address risk and protective factors (Kirby, 2007). It is also important that programs with non-sexual factors are integrated into youth's lives to promote overall well-being. These could be programs that focus on substance abuse, violence prevention and/or youth development (Kirby, 2007). Abstinence-only education programs have not been shown to have much success in the past; however one particular program based in social cognitive theory, the theory of reasoned action and the theory of planned behavior was shown to have some success (Ball, 2010). Participants in this program were less likely to initiate sex and less likely to have had sex than their peers in the three-month follow-up, although the program was shown to have no effects on condom use (Ball, 2010). If districts are intent on using abstinence–only education in schools, it may be worthwhile to explore theory-based programs that contain medically accurate information and do not portray sex in a negative way (Ball, 2010). Despite having theory-based programs, it is difficult to evaluate success when the implementation process is hindered by a lack of resources, school support and staff turnover which leads to teachers not being properly trained in the curriculum (Sutherland, Araia & Finklestein, 2011).

Many youth report receiving information about sexually transmitted infections, how to prevent HIV/AIDS and how to say no to sex and many youth report learning this information while in middle school (Martinez, Abma & Copen, 2010). The majority of teens (66% male and

80% female) feel they have a trusted adult with whom they can discuss sexuality education topics (Martinez et al., 2010). When youth are asked about their preferences in learning about sex, many say that high school or college health programs have been the best way to learn about sexual and reproductive health, along with family and online searching as sources of education (Levine, 2011). It is important that sexuality education programs are culturally competent and fit in the context of a young person's life. A way to do this may be to integrate different mediums to reach a variety of youth in different ways such as technology, television shows, conversations with trusted adults and medically accurate information all combined together (Levine, 2011). Parents are also supportive of comprehensive sexuality education in schools that includes an abstinence message as well as medically-accurate information on condoms and contraception (Tortolero, Johnson, Peskin, Cuccaro & Markham, 2011). Furthermore, many parents believe this education should begin during middle school (Tortolero et al., 2011).

Some youth are initiating sexual behavior very early; one study cites that by the sixth grade, one in 10 students is sexually experienced (Peskin, Hernandez, Markham, Johnson & Tyrrell, 2011). Thus sexuality education classes should not only be implemented with comprehensive and effective information but also should be initiated earlier in hopes of delaying sexual behavior, improving condom use and reducing teen pregnancy (Peskin et al., 2011). A study of school staff and teachers confirmed the need for comprehensive sexuality education as well as displayed their willingness to implement sexuality education programs in middle schools (Peskin et al., 2011).

The majority of school districts in Colorado have policies on HIV/AIDS prevention education, Sexuality and Family Life education, drug and alcohol prevention education, and mental health treatment and counseling. However, the majority of teachers in these districts are unaware that these policies and resources exist (Colorado Youth Matter, 2010). School districts in other states reported that teachers felt that there was not enough time allowed to teach sexuality education to students, there was not enough training for teachers, there were not enough sexuality education resources available, and there was very little centralized support for the district's

implementation of a sexuality education program (Fagen, Stacks, Hutter & Syster, 2010).

## Contraception and Sexual Protection

Current research attributes declining teen pregnancy rates equally to both teens delaying sex and remaining abstinent longer and improved contraceptive use (Santelli, Lindberg, Finer & Singh, 2007). Both play an important part; however when studied further, it was found that improved contraceptive use was responsible for 77% of the decline in pregnancy risk and abstinence was responsible for 23% of the decline in pregnancy risk (Santelli et al., 2007). Not only is contraception effectively decreasing rates of teen pregnancy and pregnancy risk, but it also is cost effective for society. Any kind of contraception method ranging from vasectomy or tubal ligation to intrauterine systems are more cost effective than no contraceptive method and the health costs associated with giving birth and raising a child (Trussell, Lalla, Doan, Reyes, Pinto & Gricar, 2009).

An increasing number of sexually active adolescents are using contraception and various methods of sexual protection. A national study found that 95% of respondents had use a condom at least once in their sexual history, and almost 80% used any contraceptive method the first time they had sexual intercourse (Abma, Martinez & Copen, 2010). Males especially have increased their regular condom use from 71% in 2002 to 81% in 2008 (Abma et al., 2010).

Studies suggest that while contraceptive use at first sex is increasing, females are showing patterns of tapering off their contraception use after having been sexually active and begin to develop doubts about the necessity and desirability of using contraceptives as they get older and gain more sexual experience (Kinsella, Crane, Ogden & Stevens-Simon, 2007). Other studies suggest that young women may be using oral contraceptives incorrectly, as teenage girls aged 16 years or younger only using oral contraceptives at first sex were more likely to become pregnant than those using condoms only (Parkes, Wight, Henderson, Stephenson & Strange, 2009). Kirby (2007) found that among 15-19 year old girls relying on oral contraceptives, only 17% take a pill every day as they are directed. Because it is medically proven that oral contraceptives are more effective than



condoms at preventing pregnancy if taken correctly, clinicians must consider that condoms may be easier and more effective for younger females to use for their first sexual relationship (Parkes et al., 2009).

While adolescents seem to be aware of how to use condoms and other types of contraception, knowledge about the emergency contraceptive pill is not as pervasive. For those who haven't used an emergency contraception pill, there is a general negative attitude towards those who do take it and a stereotype that those people are "strippers" and "fast life people" (Mollen, Barg, Hayes, Gotcsik, Blades & Schwarz, 2008). However, some sexually active study participants had more sympathetic views towards people who take emergency contraception, such as young students who may get pregnant accidentally (Mollen et al., 2008). Clinicians should present emergency contraception as a viable form of contraception if other methods fail during sex.

Withdrawal during sex is one of the most widely used temporary methods of contraception in the world but there has been a dearth of literature and research on the subject and very little acknowledgement of this as a contraceptive method (Whittaker, Merkh, Henry-Moss & Hock-Long, 2010). Despite youth thinking that withdrawal is a safer sex behavior along with the convenience it allows for, the method creates a sense of uncertainty about its effectiveness and its use is often driven by unreliable peer information (Whittaker et al., 2010). Clinicians and sexuality education programs should be addressing withdrawal as a contraceptive method to provide more knowledge and better understand attitudes and practices surrounding the method (Whittaker et al., 2010).

Relationship factors can also influence contraceptive use. Older teens and those who are in an exclusive romantic relationship may be more comfortable negotiating contraception with a partner, while female adolescents who don't know their partner through usual social networks, who have a partner of a different race/ethnicity, or who have an older sexual partner may be less comfortable with negotiating contraceptive use (Manlove, Ryan & Franzetta, 2007).

Conversely, previous studies have shown condom use is more common between casual sex partners rather than with partners in a serious romantic

relationship (Manlove et al., 2007). Partners in a serious romantic relationship are more likely to use oral contraceptives as focus shifts from STI prevention to pregnancy prevention with partners' knowledge of each other, time together and level of intimacy increase (Manlove, Welti, Barry, Peterson, Schelar & Wildsmith, 2011). Interventions to encourage consistent communication between partners about contraception may focus on practicing saying no to unprotected sex and negotiating contraceptive use through role plays (Manlove et al., 2007).

Some schools across the country have explored condom availability programs in schools in order to assess the impact it would have on decreasing rates of teen pregnancy. These programs were found to be most effective in small schools, alternative schools and programs where condoms were either available in school health centers or had condoms available in bowls or baskets (Kirby & Brown, 1996). Programs that were weaker and did not show significant success in terms of how many condoms were obtained during the school year had elements such as having to ask an adult for a condom or having to pay for condoms through a vending machine (Kirby & Brown, 1996).

Other programs have tried voucher programs, where schools distribute vouchers to students to pick up contraceptives at community clinics at no cost, but an evaluation of the program found that most vouchers went unfilled (Sidebottom, Bimbaum & Nafstad, 2003). The program was adjusted so the school could directly distribute contraceptives to students which was found to be very successful – 99% of students received all requested contraceptives and 100% received requested condoms and birth control (Sidebottom et al., 2003). Another study showed similar results; the rate of follow-up appointments for birth control directly available at a school clinic was much higher than follow-up appointments at a school clinic that gave out referrals to obtain birth control elsewhere (Smith, Novello & Chacko, 2011). Research clearly shows that direct provision of birth control is likely to increase birth control use and is also likely to lower rates of unintended pregnancy within schools (Smith et al., 2011).

## Dating Violence and Sexual Assault

Dating violence is a prevalent issue among adolescents; approximately 25% of eighth- and ninth-grade students have experienced dating violence at some point (Centers for Disease Control and Prevention [CDC], 2000). Dating violence and abuse can encompass a variety of behaviors including physical abuse, psychological and emotional abuse, verbal abuse and sexual abuse (Offenhauer & Buchalter, 2011). Among teens it has been difficult to fully understand dating violence and it has been slow to gain recognition as a public health and policy concern in comparison with adult intimate partner violence and domestic violence (Offenhauer & Buchalter, 2011).

Dating violence has evolved in part because of advances in technology that make it harder to track and recognize. Teens often use cell phones and social networking sites that can facilitate psychological abuse and excess monitoring, and for "sexting," which is sending sexually inappropriate images or words via text message (Offenhauer & Buchalter, 2011). Pressuring a partner to have sex before it is wanted or to have more sex than desired by a partner can be considered sexual abuse (Offenhauer & Buchalter, 2011).

Protective factors against teens experiencing dating violence are adequate parental monitoring for both boys and girls and positive interactions between youth and their parents (Offenhauer & Buchalter, 2011). Risk factors for teens experiencing dating violence are connection to an aggressive peer network, consistent negative interactions between youth and their parents, mental health problems and low academic achievement (Offenhauer & Buchalter, 2011).

Associations have been found between partner violence and unintended pregnancy, making this a significant reproductive health issue (Miller, Decker, McCauley, Tancredi, Leveson, Waldman, Schoenwald & Silverman, 2010). Male partners may coerce their female partners into an unwanted pregnancy through verbal demands, threats and physical violence or by sabotaging women's use of contraception by flushing her birth control pills down the toilet or intentionally breaking condoms (Miller et al., 2010). Women who reported birth control sabotage or pregnancy coercion

were also likely to report partner violence (Miller et al., 2010).

Sexual violence yields significant costs to our country; in 2005 costs were estimated at nearly $8 billion (Minnesota Department of Health [MDH], 2009). As a result, states are designing action plans to prevent sexual violence. Minnesota created a plan with hopes to strengthen social norms about safe and respectful relationships, train leaders across the state to educate people about sexual violence, and strengthen prevention efforts at an individual, community and state level (MDH, 2009). Colorado also has a state plan to address sexual violence by improving the capacities at the state, community and individual levels to plan, implement and evaluate sexual violence prevention programs, enhance data systems to track occurrences of sexual violence and provide support for community-based strategies and programs that seek to prevent sexual violence (McCort & Gagne, 2010).

It is important for professionals who work with survivors of dating and/or domestic violence to receive proper training. Research shows that training on partner violence is positively associated with helpfulness in screening clients (Colarossi, Breitbart & Betancourt, 2010). Professionals felt that in working with survivors of domestic violence, it is important to screen for current violence rather than past incidences of violence and consider the long-term health implications of domestic violence. They should also have the tools and resources to provide clients with appropriate and feasible referrals as well as follow up with survivors after initial screenings (Colarossi et al., 2010). Prevention programs can also be an important tool to change attitudes, perceptions, and behaviors related to dating violence (Advocates for Youth (AFY), 2000).

## Family Planning and Clinical Services

Despite the initial discomfort it may cause, youth tend to have more positive perceptions of their primary care provider when a visit included a discussion of sensitive health topics and these perceptions were positively correlated with the number of sensitive topics covered (Brown & Wissow, 2009). Many primary care clinicians and pediatricians working with youth do not offer counseling or services that can help patients protect their reproductive health, such as sexually transmitted infection screenings and prescriptions for contraceptives

(Ramashwar, 2010). Reasons cited for the lack of services offered were because clinicians were untrained and uninterested in sexually transmitted infection counseling, they feel uncomfortable discussing this topic with their patients, or they were not adequately paid by insurance to fulfill these services (Ramashwar, 2010).

Clinicians such as nurses, nurse-midwives, OB-GYNs and primary care physicians felt that they tried to integrate an abstinence message into their treatment with adolescent patients, although they adapt the relevance of the message for patients who are already sexually active. For example, clinicians broadened the "don't have sex until marriage" message to "wait until you find a partner willing to get tested" or "use contraception to protect against sexually transmitted infections" (Harper, Henderson, Schalet, Becker, Stratton & Raine, 2010). Clinicians also may use abstinence to empower young women in abusive and unhealthy relationships to say no to unwanted sex (Harper et al., 2010). Clinicians feel it is important to include abstinence as an option in comprehensive sexual health education messages with information about sexually transmitted infections prevention and access to contraception (Harper et al., 2010).

School-based health centers are a viable resource for providing reproductive health services to teens as well as general health services. They are an important resource for students without health insurance and can increase students' health knowledge (AFY, 1999b). Research shows that school-based health centers increase follow-through on mental health referrals, increase rates of students seeking substance abuse counseling, increase visits to social workers and counselors, and reduce rates of unintended pregnancies and sexually transmitted infections through the supply of contraceptives and reproductive health education and counseling (Colorado Association for School-Based Health Care [CASBHC], 2009). Studies show that a majority of parents support the reproductive health services provided by school-based health centers because of the positive outcomes that have been associated with them, such as increased grade point averages, increased attendance rates and increased graduation rates (CASBHC, 2009).

Clinics should also make increased efforts to ensure that women who would like follow-up information know how to access or find it. One clinic evaluated the effectiveness of follow-up phone calls to address client concerns after the appointment. It was not found to have any effect on participants' attitudes of clinic effectiveness so other interventions should be tried to address the needs of the specific population and community (Kirby, Raine, Thrush, Yuen, Sokoloff & Potter, 2010). Women with disabilities are likely to receive recommendations and referrals to receive a Pap smear but are less likely to than women without disabilities to follow through in receiving the Pap smear (Drew & Short, 2010). Approximately 30% of women with disabilities who were interviewed cited cost or lack of insurance as the primary reason they had not received a Pap smear. Efforts should be made to reduce inequalities in access to reproductive health care and the needs of women with disabilities should be considered in prevention programs (Drew & Short, 2010).

## Health Inequities and Social Determinants of Health

Social determinants of health are individual factors, structural factors, contextual factors, and environmental factors that can impact a person's health (CDC, 2009). Race, body weight, mental health, socio-economic status, education levels, sexuality, and the neighborhood or community one lives in are all factors that can determine health outcomes. There are four themes of sexual risk and protective factors that should be addressed in comprehensive sexuality education programming. The first theme consists of individual and biological factors such as age and gender that are extremely difficult to change or modify. The second theme is the environments teens live in and includes rates of substance abuse, violence and divorce. The third theme is the sexual values, attitudes and behavior modeled by the parents, peers and romantic partners of teens. The final theme is connected to the adults and organizations in the lives of teens (Kirby, Lepore & Ryan, 2005).

Colorado's four major communities of color (Hispanics/Latinos, African Americans/Blacks, American Indians and Asians/Pacific Islanders) all face significant health disparities such as

child obesity, diabetes mortality, HIV mortality and low-weight births (Palacio, Reynolds, Drisko, Lucero, Hunt & Phi, 2009). Racial and ethnic discrimination can lead to poor adjustment, loneliness, anxiety and somatization that can all influence sexual decision-making and behavior (Juang & Alvarez, 2010). Families can buffer teens' experiences of discrimination by creating a close-knit network of support, or families can exacerbate the problem by not communicating about what the teen is experiencing (Juang & Alvarez, 2010). Structural racism can impede adolescent development, contribute to unhealthy behaviors and lifestyles, and limit exposure to educational, employment and social opportunities (Center for Applied Research and Technical Assistance [CARTA], 2005).

Women of color are more likely than white women to have an unintended birth (Guzman, Wildsmith, Manlove & Franzetta, 2010). Youth of color are less likely than their white peers to report using contraception, and thus have a higher risk of contracting an STI and are more likely to report multiple lifetime sex partners (CARTA, 2005). Latinas specifically aren't having more sex than white females but they have lower rates of contraceptive use due to lack of affordability and poor access to family planning services (Fuentes, Flores & Gonzalez-Roja, 2010). Black men who have sex with other men are one of the highest risk populations for transmitting HIV, often due to unprotected anal intercourse and lack of communication about protection between partners (Oster, Dorell, Mean, Thomas, Toledo & Heffelfinger, 2011).

Latino immigrant youth have fewer resources for healthcare and education and their parents have limited access to information they may need for their children (Fuentes et al., 2010). Policies for obtaining Medicaid or other forms of public assistance have shifted to remove immigrants (documented and undocumented) from eligibility. However, this policy is hindering those who are eligible for services from applying because of the extensive documentation needed to complete the process (Sonfield, 2007). This policy could keep pregnant women from obtaining needed prenatal care while attempting to get proper documentation, further worsening the health conditions and disadvantages of poor women and their babies (Sonfield, 2007).

Obesity and overweight can be risk factors for risky sexual behavior because they are related to poor body image and self-esteem (Boughton, 2010). Overweight and obese adolescent girls are more likely to engage in risky sexual behaviors such as having sex before age 13, having more than 3 lifetime partners and are less likely to use condoms or contraception (Boughton, 2010). Obese women were less likely than their normal weight counterparts to use oral contraceptives and were more likely to have relied on withdrawal during sex (Doskoch, 2010). Obese men have increased odds of having had an STI in the past five year and have increased odds of having erectile dysfunction (Doskoch, 2010). Youth experiencing mental health problems such as antisocial behavior or hyperactivity, are more likely to initiate sexual activity earlier because these specific problems may be associated with poor and impulsive decision making (McLeod & Knight, 2010).

## Lesbian, Gay, Bisexual, Transgender, and Queer/ Questioning (LGBTQ) Youth

The Healthy People 2020 agenda has identified improving the health, safety and well-being of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals as an important objective (Gowen, 2011). As a historically underserved group, this is an important step in increasing support for this population, as they face many adverse health outcomes because of discrimination based on their sexual orientation and/ or gender identity. A study of transgender youth found that between 60 and 70% of female transgendered youth have engaged in sex work and approximately 20% are HIV positive (Gowen, 2011). LGBTQ youth are also more likely to engage in risky sexual behaviors such as early sexual debut, are more likely to be sexually active, have more sexual partners, and be under the influence of alcohol or drugs the last time they had sex in comparison with their heterosexual peers (Gowen, 2011). LGBTQ youth have higher rates of suicidality than their peers (Mustanski, Garofalo & Emerson, 2010).

LGBTQ youth are less likely than their peers to obtain necessary medical services due to negative experiences and compromised confidentiality from medical providers related to their sexual orientation (Clayton, Brindis, Hamor, Raiden-Wright & Fong, 2000). They are more likely to experience dating violence and be physically hurt by their partner

than heterosexual youth, and are more likely to have experienced physical and sexual abuse as a child (Gowen, 2011). LGBTQ youth are also more likely be involved in a pregnancy in comparison to heterosexual youth, possibly as a result of their lower likelihood of using condoms and other contraceptives (Gowen, 2011).

LGBTQ youth experience high rates of verbal and physical harassment and physical assault both in and out of school in comparison to their heterosexual peers (Fisher, Reece, Dodge, Wright, Sherwood-Laughlin & Baldwin, 2010). Historically school-based sexuality education has almost always focused on heterosexuality while excluding other sexual experiences of LGBTQ individuals (Ella & Eliason, 2010). This exclusion often leads to homophobia among school staff and students with little to no resources and positive messaging about LGBTQ issues in school setting that could counter physical and verbal abuse (Ella & Eliason, 2010). In schools that do have gay-sensitive HIV instruction, adolescent sexual and reproductive health outcomes for LGBTQ youth were positively impacted, as youth reported fewer sexual partners, less frequent recent sex, and less substance abuse associate with sex in comparison to LGBTQ youth who do not receive gay-sensitive education and programs in school (Ella & Eliason, 2010).

Potential solutions to mediate these health risks are increased prevalence and support for Gay-Straight Alliances, community support groups and providing LGBTQ-sensitive sexuality education that address specific health outcomes this population of youth faces (Gowen, 2011). More research should also be conducted on this population, as there is still much to be uncovered regarding health disparities among LGBTQ youth. The health of transgender individuals has especially been excluded from what little data exists about the LGBTQ population; a possible solution to this problem is to add transgender measures to population studies (Conron, Scott, Stowell & Landers, 2012). There may also be some openness to having sexual orientation be a part of routine health surveys (VanKim, Padilla, Lee & Goldstein, 2010).

### Parental Involvement and Youth-Adult Connectedness

While there may be an assumption that parents are less involved with their children than in generations past, in reality most parents feel they have open and

trusting relationships with their adolescents (Bostrom, 2001). Parents do have some influence over their adolescents' openness to having sexual intercourse, despite misconceptions that their children don't listen or care what their parents think (Guilamo-Ramos, Bouris, Jaccard, Lesesne, Gonzalez & Kalogerogiannis, 20009).

Parent-child communication is positively associated with increased teen contraceptive use. However, many barriers seem to exist to prevent clear communication about sexual health and behaviors between parents and their children (Akers, Schwarz, Borrero & Corbie-Smith, 2010). Parents tend to help their male adolescent children obtain condoms more than their help their female adolescents, and parents in general had little knowledge of types of contraception and how they are used (Akers et al., 2010). One study showed that many fathers are willing to talk to their children about sex, although they approached sons and daughters differently. Fathers talked to their daughters about waiting to have sex and abstinence while they talked with their sons about their intentions to have sex (Wilson, Dalberth & Koo, 2010). This gender bias resulted due to fathers' discomfort considering their daughters' sexuality and thus approached talking about sex in a protective and restrictive manner while they were more encouraging of their sons (Wilson et al., 2010).

Timing can also be a barrier, as many parents fear their children are too young to understand what sex is (Wilson, Dalberth, Koo & Gard, 2010) and are only willing to discuss contraception and consequences of sexual behavior after they believe their child is sexually active (Beckett, Elliott, Martino, Kanouse, Corona, Klein & Schuster, 2010). This in turn can leave their children unprotected and without knowledge during their first sexual encounters, which tend to yield risky sexual behaviors (Beckett et al., 2010).

It is important that parents honestly and openly share their views and opinions of their adolescent children having sex. Studies show that parental disapproval of adolescent sexual activity is associated with reduced sexual risk, later onset of initial sexual activity, fewer sexual partners and overall decreased sexual activity (Guilamo-Ramos et al., 20009). This finding is especially true in Latino families, where mothers have a strong influence on their daughter's sexual

decision making (Guilamo-Ramos et al., 20009). Latino parents' communication with their adolescents about sexual health is heavily influenced by socio-cultural factors such as immigration, levels of acculturation and gender and family roles (Murphy-Erby, Stauss, Boyas, Bivens, 2011). Adolescents who feel they have a secure relationship with their parents also tend to have positive school attitudes and connections with teachers (AFY, 1999a).

## Positive Youth Development

It is important to begin applying elements of positive youth development to public health through data collection and surveillance, education and technical assistance, programs and services and partnerships and collaborations for healthy youth development (Judd, 2006). Programs that incorporate connectedness, competence, confidence and character outcomes also can help youth develop the motivation, skills and confidence necessary to make healthy decisions that are right for them (Gavin, Catalano & Markham, 2010). These stable and long-lasting programs also have elements of skill-building, enhancing bonding experiences, strengthening family relationships, engaging youth in activities, empowering youth, and communicating expectations (Gavin, Catalano, David-Ferdon, Gloppen & Markham, 2010). Evidence has shown that combining elements of positive youth development programs with age-appropriate, evidence-based sexuality education will improve adolescent sexual and reproductive health outcomes (Gavin, Catalano, David-Ferdon et al., 2010).

Positive youth development is measured by four categories: connectedness, competence, confidence and character (Gavin, Catalano & Markham, 2010). Connectedness is an important element of positive youth development that encompasses connectedness between the youth and their family, peers, partner, school and community, as well as parent-adolescent communication (Markham, Lormand, Gloppen, Peskin, Flores, Low & House, 2010). Markham et al.'s (2010) review of the literature surrounding connectedness outcomes in positive youth development programs shows that family connectedness is a protective factor for ever having had sex, sexual debut, frequency of sex and pregnancy. Parent-adolescent communication (in general and about sex) also has protective associations with ever having had sex and delaying sexual

debut and parental monitoring seems to be a protective factor for increased condom use (Markham et al., 2010). Youth who feel more connected with their school are less likely to participate in high-risk behaviors such as early sexual debut and engaging in sex frequently (Ewalt, Freeman & Poole, 1998; Markham et al., 2010).

Competence relates to cognitive, emotional, social, behavioral and moral constructs that are all necessary for the development of skills to make healthy decisions regarding sex (House, Bates, Markham & Lesesne, 2010). The areas of academic achievement and IQ within the cognitive construct were found to be protective factors for ever having had sex, contraceptive use and pregnancy. Within the social and behavioral constructs, partner sexual communication was positively associated with increased contraceptive use (House et al., 2010).

Confidence is a positive youth development outcome that is measured through youths' belief in the future, self-determination, clear and positive identity and self-efficacy (Gloppen, David-Ferdon & Bates, 2010). In Gloppen et al.'s (2010) review of positive youth development programs, results showed that belief in the future and self-determination were protective factors for adolescent sexual and reproductive health outcomes.

Character is comprised of two positive youth development constructs, prosocial norms and spirituality (House, Mueller, Reininger, Brown & Markham, 2010). These two constructs were found to be protective factors for adolescent sexual and reproductive health outcomes such as the intention to have sex, early sexual debut, ever having had sex, contraceptive and condom use, frequency of sex and pregnancy (House et al., 2010).

## Sexual Behaviors

The National Survey of Family Growth (2006-2008) shows that the while rates of sexual activity among 15 to 19 year old females and males have not significantly changed in recent years, it has steadily declined from the early 1990s (Abma, Martinez, & Copen, 2010). The majority of teenagers have their first sex with someone whom they are going steady (72% of females and 79% of males) while others have their first sex with someone they just met (14% of females and 25% of males) (Abma et al., 2010). Nonetheless, youth are still engaging in risky sexual behaviors. According to 2009 data from the Youth Risk Behavior

Surveillance (YRBS), nearly 40% of adolescents who are sexually active did not use a condom the last time they had sex, and 77% did not use other forms of contraception such as birth control or Depo-Provera the last time they had sex (Banspach, 2011).

Studies have also found interesting data regarding the sexual behaviors of younger adolescents. Approximately 18% of middle school students in one study reported having had oral sex, sexual intercourse, or both (DeRosa, Ethier, Kim, Cumberland, Afifi, Kotlerman, Loya & Kerndt, 2010). For those who hadn't yet had sex, students with oral sex experience expected to have intercourse in the following months at much higher rates than their sexually inexperienced peers (DeRosa et al., 2010). However some programs exist to help middle school youth avoid STIs and pregnancy, such as the program "It's Your Game: Keep It Real," which was found to be successful in lowering rates of sexual initiation by the ninth grade, especially for female and Hispanic participants (Doskoch, 2010).

Significant differences exist across racial and ethnic groups regarding initiation of sexual activity (Cavazos-Rehg, Krauss, Spitznagel, Schootman, Bucholz, Peipert, Sanders-Thompson, Cottler & Bierut, 2009). One study found that African American and Hispanic males were more likely to have their first sexual experience at a younger age, followed by African American and Hispanic females. Conversely, Asian males and females had very low rates of early sexual debut, even by their 17th birthday (Cavazos-Rehg et al., 2009). A study of Latino values and teen sexual behaviors found that the value of *marianismo* (a gender role norm that women should be submissive and chaste) and a high importance of female virginity is a protective factor and negatively associated with young women's number of sexual partners. However, a high value of female virginity is a risk factor that is associated with inconsistent or nonuse of condoms during the first month of a sexual relationship (Deardoff, Tschann, Flores & Ozer, 2010). A protective factor, especially for Latino teens, is when they perceive that their families value education over marriage and expect them to abstain from sexual activity until marriage. These teens are more likely to wait longer to initiate sexual activity than their peers (Gilliam, Berlin, Kozloski, Hernandez & Grundy, 2007).

Sexual minority youth are more likely to engage in risky behavior. The Youth Risk Behavior Surveillance also found a high prevalence of sexual risk behaviors among gay, lesbian and bisexual students, as well as students who had sexual contact with the same sex or both sexes regardless of their sexual orientation compared to heterosexual students and students who only had sexual contact with the opposite sex (CDC, 2011). Data describing 15 to 21 year olds from the National Survey of Family Growth shows that approximately 11% of women and four percent of men reported same-sex sexual experience (McCabe, Brewster & Tillman, 2011). Men and women reporting same-sex sexual experience were more likely to report being gay, lesbian or bisexual; however, women who reported an exclusive attraction to the opposite sex were more likely to have engaged in same-sex sexual activity compared to men who reported an exclusive attraction to the opposite sex (McCabe et al., 2011).

Some risk factors for sexual behavior include youth whose mothers had their first birth as a teen (Gilliam et al., 2007) and youth who did not live with both of their parents at age 14 (CDC, 2010). Also, females who have a younger sexual debut than their peers are more likely to have had higher numbers of total sexual partners (CDC, 2010). Significant age differences between sexual partners is a risk factor (Koon-Magnin, Kreager & Ruback, 2010), although when explored further, one study found that dissimilar educational contexts may be more of a risk than age differences. When both partners are in high school, regardless of age differences, they are at less risk than partners where the female is in high school and the male is not (Koon-Magnin et al., 2010).

Other risk factors include contraceptive inconsistency, multiple sexual partners, non-monogamous relationships, and casual sexual partners (Scott, Wildsmith, Welti, Ryan, Schelar & Steward-Streng, 2011). These risk factors can result in short-term consequences (STI diagnosis) and long-term consequences (unintended pregnancy and childbearing). After periods of abstinence for sexually active females, characteristics that often cause them to have sex are positive mood, partner support and good relationship quality (Ott, Ofner, Tu, Katz & Fortenberry, 2010). Weight also seems to be a factor in the sexual behaviors of female youth. Females who were underweight according to their body mass

index score had reduced odds of having used a condom the last time they had sex (Hollander, 2010a). Females who perceived themselves as overweight were more likely to have had initiated sex before the age of 13 and also were less likely to have reported condom use the last time they had sex (Hollander, 2010a).

### Sexually Transmitted Infections (STIs), including Human Immunodeficiency Virus (HIV)

Social determinants of health, such as socio-economic status, health care access and environmental factors, should all be considered when creating programs to address diseases such as HIV/AIDS, viral hepatitis, STIs and tuberculosis (TB). Prevention programs should comprehensively address health needs where we live, work, learn and play (CDC, 2010). This can be accomplished through a myriad of ways, including expanding public health policies, improving national data systems, creating interagency partnerships to build capacity to more effectively target populations affected by HIV/AIDS, viral hepatitis, STIs and TB and fund more prevention research and evaluation (CDC, April 2009). The direct costs of curable STIs among all sexually active Americans are estimated at $8.4 billion per year (Kirby, 2007).

The Centers for Disease Control and Prevention estimates that approximately one in four young women between the ages of 14 and 19 is infected with at least one STI (Department of Health and Human Services [DHHS], 2008). The two most common STIs are human papilloma virus (HPV) and chlamydia. African American teenage girls are the most severely and disproportionately affected by STIs (DHHS, 2008). Other common types of sexually transmitted infections are trichomonas, herpes simplex virus and bacterial vaginosis (Forhan, Gottlieb, Sternberg, Xu, Datta, McQuillan, Berman & Markowitz, 2008).

Despite the fact that HIV has claimed the lives of nearly 600,000 Americans, there is not a great sense of urgency about this issue (The White House Office of National AIDS Policy [WHONAP], 2010). This may be because HIV transmission rates have decreased significantly and HIV-positive persons are living longer and more productive lives (WHONAP, 2010). Nonetheless, the White House has made HIV/AIDS prevention a national priority, of which its primary goals are: to reduce the number

of people who become infected with HIV; to increase access to care and improve health outcomes for people living with HIV; and to reduce HIV-related health disparities (WHONAP, 2010).

Colorado data about AIDS and HIV show us that the majority of people living with AIDS and HIV are male (about 90%) and White (about 68%) (CDPHE, 2008). The majority of HIV/AIDS cases are among men who have sex with other men (68%) (Luerssen, Ware & Walsh, 2011). The majority of transmission in men occurs from male-to-male sexual contact while the majority of transmission in women occurs from high-risk heterosexual contact (CDPHE, 2008). African American men who have sex with other men account for a disproportionate number of new HIV infections among men who have sex with men due to older sexual partners, unprotected anal intercourse and lack of communication in negotiating condom use (Oster, Dorell, Mean, Thomas, Toledo & Heffelfinger, 2011).

Youth who are HIV positive often engage in sexually risky behaviors that could be harmful to themselves and their partners, often as a result of dating challenges and a lack of self-efficacy around condom use negotiation with partners (Leonard, Markham, Bui, Shegog & Paul, 2010). HIV/AIDS also disproportionately affects Latino adolescents because they are less likely to use condoms than their peers (Villarruel, Jemmott & Jemmott, 2006). Finally, young gay men are most at risk of becoming infected with HIV due to lack of resources for this population, mental health problems such as depression, and lack of education that addresses the stigma, homophobia and discrimination surrounding this particular STI (Luerssen et al., 2011).

Lack of communication may also be an important factor in determining transmission risk of HIV/AIDS. One study found that some sexual partners were unaware of each other's health status and behaviors. These behaviors included concurrent partners, drug injections, STI diagnoses, and a small percentage of women (two percent) and men (four percent) who were unaware their partner was HIV-positive (Witte, El-Bassel, Gilbert, Wu & Chang, 2010). HIV-positive persons with histories of childhood sexual abuse tend to engage in more HIV-risk and sexual-risk behaviors than their HIV-positive peers (Sikkema, Wilson, Hansen, Kochman, Neufeld, Ghebremichael & Kershaw, 2008). Clinics should be more aware of these particular populations

and address their needs and behaviors more directly. A coping intervention group was also found to be successful in reducing transmission risk behavior among HIV-positive men and women with histories of childhood sexual abuse (Sikkema et al., 2008).

## Teen Pregnancy and Parenting

Overall the risk of becoming pregnant has declined over the past 15 to 20 years, mostly due to improved contraceptive use; however recently this decline has somewhat leveled off and prevention efforts should be renewed (Santelli, Orr, Lindberg, Diaz, 2009). Approximately 80% of teen pregnancies are unintended (Kirby, 2007). The majority of teens believe that it is okay for an unmarried female to have a child, evidence of changing trends in family structure in the United States (CDC, 2010). However, most females (58%) reported they would be very upset if they themselves got pregnant (CDC, 2010). Teens are more likely to have health complications while pregnant and engage in risky behaviors such as drinking and smoking while pregnant (Colorado Children's Campaign [CCC], 2011).

Certain groups are disproportionately affected by teen pregnancy. In Colorado, Hispanic youth and youth who live in rural areas have disproportionately high rates of teen pregnancy (CDPHE, 2009). A study of American Indian youth highlighted the limited access their communities have to comprehensive pregnancy prevention, community-based programs and contraception (Garwick, Rhodes, Peterson-Hickey & Hellerstedt, 2008). Other marginalized groups at risk of experiencing an unintended teen pregnancy are any youth of color, youth in foster care, youth who are homeless, youth who are immigrants, youth who are disabled, youth involved in the juvenile justice system, and LGBTQ youth (Healthy Teen Network [HTN], 2008). Latina youth are often influenced by cultural factors such as acculturation, familialism, collectivity and an emphasis on traditional roles for women (Rocca, Doherty, Padian, Hubbard & Minnis, 2010). These factors seem to influence Latina adolescents regarding pregnancy intentions and happiness towards being pregnant; having a mother who had given birth as a teenager was associate with elevated pregnancy risk as well (Rocca et al., 2010).

There are many negative health outcomes and social consequences that result from teen parenthood. Poverty is

highly associated with teen pregnancy and parenting (Ziol-Guest, 2011). Teen pregnancy is considered the number one reason teenage girls drop out of high school (Colorado Children's Campaign, 2011) and only 1.5% of teen mothers ever earn a college degree (Walker, 2011). Teen parenting can also cause males to drop out of high school and not receive a degree because of the need to work and provide for their new families (Mollborn, 2010). Children born to teen mothers are more likely to live in poverty, drop out of high school and face barriers to accessing quality health care (CCC, 2011; Giardino & Sanborn, 2011). Furthermore, girls born to teen mothers are more likely to become teen mothers themselves and boys born to teen mothers have higher rates of incarceration and are more likely to become teen fathers (Kirby, 2007).

Recently there has been an increase in subsequent births to adolescent mothers; as high as one fifth of infants born to teen mothers are a second or third child (AFY, 2009; Schelar, Franzetta & Manlove, 2007). These subsequent births only increases disadvantages the teen mothers already face (Schelar et al., 2007). Programs such as the Nurse Home Visitor Program has shown to successfully support teen mothers improve their social conditions and reduce rates of subsequent teen births (AFY, 2009; Colorado Children's Campaign, 2011).

The prevention of teen births could save taxpayers at least $167 million per year (CDPHE, 2009). The United States has seen recent reductions in adolescent pregnancy rates. These reductions have been attributed to teens delaying sexual activity longer and improving their contraceptive use (Santelli, Lindberg, Finer & Singh, 2007). Future prevention strategies should focus on establishing networks of agencies that reach youth in different capacities, promoting positive and healthy youth development, building partnerships to involve parents and implementing effective programs that fit the needs of the community (CDPHE, 2009). The FOCUS (Families in Our Community United for Success) program has shown to be a very successful teen pregnancy prevention program due to its commitment to community buy-in and involvement to the program (Goldberg, Frank, Bekenstein, Garrity & Ruiz, 2011).

## Youth in Foster Care/ Youth in Transition/ Homeless Youth

Youth who are homeless or in the foster care make up a significant proportion of the population of adolescents in the United States and have disparate health outcomes in comparison to their peers. Youth in foster care are two and a half times more likely to have been pregnant by age 19 compared to youth not in the foster care system (HTN, 2008). They also face other disadvantages such as lower household incomes, lower levels of education and tend to live in poorer neighborhoods (Kott, 2010). Youth in foster care also have difficulties accessing health and mental health services after they "age out" of the foster care systems and have trouble sustaining the care they were receiving while in foster care (Child Welfare League of America [CWLA], 1998).

Youth in foster care are at a higher risk of academic failure, delinquency and substance use than their peers, all of which are co-occurring factors with risky sexual behavior and teenage pregnancy (Kerr, Leve & Chamberlain, 2009). Youth who engage in delinquent acts and use drugs and alcohol are at increased risk of contracting HIV (Thompson & Auslander, 2011).Youth in foster care are also at a greater risk for contracting sexually transmitted infections in comparison with youth not in foster care (Kott, 2010). There are a number of risk behaviors that contribute to high rates of sexually transmitted infections among females who have spent time in foster care, such as initiating sex earlier, having more partners, having casual sex and having sex for money (Kott, 2010). Youth in foster care also face a greater likelihood of experiencing mental health problems that may lead to high-risk behaviors (Kott, 2010). Despite the success of multidimensional treatment foster care in reducing delinquency among girls in foster care, evaluation of the program did not show any effects on decreasing the likelihood of pregnancy (Kerr et al., 2009).

The Family and Youth Services Bureau (2001) estimate there are between one million and 1.3 million homeless and runaway youths. Homelessness can lead youth to engage in risky sex as a means of survival (Walls, Potter & Van Leeuwen, 2009). Risky sexual behaviors may result due to factors such as increased drug and alcohol use and inconsistent condom use (Hollander, 2008). Even when homeless youth are

living with their families in a shelter, they are still at risk of increased drug use and early onset of sexual behavior (Messam, McKay, Kalogerogiannis & Alicea, 2010). Homeless families that are able to overcome barriers that hinder parent-child communication and parental monitoring of their children may be able to decrease their children's risk contracting HIV/AIDS or becoming pregnant (Messam et al., 2010). Sexual minority youth are overrepresented among homeless youth populations and already are at an increased risk of suicide attempts than their heterosexual peers (Walls et al., 2009). However, engaging in survival sex can also increase heterosexual homeless youth's risk of suicide attempts (Walls et al., 2009). Comprehensive models of service for youth in transitional states such as foster care or who are experiencing homelessness have the potential to improve the above health outcomes (Bass, 1992).

## Youth Outreach Leaders

### Hiring Process:

The Youth Outreach Leader position was created to ensure that a youth perspective informed the development of the state plan. Youth Outreach Leaders aided in focus group development and implementation, attended monthly meetings, and interviewed their peers. Community organizations and local health departments were contacted to aide in recruitment of youth for this position. These organizations distributed a job announcement as well as an application. The application was open for 10 days. Interviews were conducted with five youth over three days, and two out of those five were hired. A mandatory three-hour training was conducted with the youth emphasizing communication skills, job expectations and roles, and the state of adolescent sexual health in Colorado.

### What the Youth Outreach Leaders Did:

The Youth Outreach Leaders worked with the Project Team on the state plan for eight months. These youth aided in the development of informal focus group questions, recruitment of youth, as well as co-facilitating the informal focus groups. Additionally, youth aided in the construction of youth statements about sexual health that were used in the community conversations. Furthermore, these youth conducted interviews with their peers about youth sexual health over the course of four months with guided questions as determined by the youth and the Project Team.

### Future Recommendations:

This position was a vital and influential piece of the plan. Depending on the size of the work of the state that is developing a plan, more youth could be hired for this position. A vigorous application and interview process provided the Project Team with the two best youth for the job. For future state plans, these youth outreach leaders could become involved with youth advisory boards across the state to further engage youth to participate in the development of the plan, as well as the advocate for youth sexual health action plans in their communities when the plan is released to the public. Finally, an improvement that could be made to this position could be in having youth videotape interviews with their peers and create a short video about youth sexual health in the state that could be used as part of the plan.

## Sample Youth Outreach Leader Recruitment Letter for Community Partners

Dear partners and associates of [Organization],

As you may be aware, the [State Public Health Department] has contracted with [Organization] to prepare, design and write a Statewide Youth Sexual Health plan. This plan is intended to provide state and local communities in [State] with a guide to improve sexual health for youth, decrease STI and teen pregnancy rates, as well as provide education on sexual assault prevention.

A large component for the data collection part of the plan involves two to four youth outreach leaders who will serve as co-facilitators in the development and implementation of informal youth focus groups and community conversations about sexual health. In addition to these responsibilities, the youth outreach leaders will attend community advisory meetings whenever possible. For their work, they will be provided with training and a stipend. They are expected to work with [Organization] on this project from [Timeframe of YOL position].

Attached you will find a copy of the youth outreach leader job description, as well as the application for the youth to fill out. Applications will be open from [Dates]. They will be reviewed after [Date], and youth will be contacted for an interview during the dates of [Dates]. The training will take place the night of [Date] at [Location]. Please send the attached documents to youth age 15-19 who are involved with your organization that you feel have a passion for the advancement of education surrounding sexual health in [State], as well as individuals who would grow and thrive with this project.

If you have any additional questions, please contact [Contact Name and Information].

Thank you in advance for taking the time to recruit and collaborate on this vital portion of the statewide youth sexual health plan!

Sincerely,

_____

## Sample Job Announcement: Youth Outreach Leader

**[Organization] is looking for two to four exceptional youth between the ages of 15 to 19 to work on the development of the Statewide Youth Sexual Health Plan.**

**Project Description:** [State Public Health Department] has contracted with [Organization] to prepare, design and write a Statewide Youth Sexual Health plan. This plan is intended to provide state and local communities in [State] with a guide to improve sexual health for youth, decrease STI and teen pregnancy rates, as well as provide education on sexual assault prevention. Part of the plan involves community conversations and informal focus group discussions on youth sexual health. Youth leaders are needed as organizers and developers for these and other aspects of the project.

**Key Responsibilities:**

- Aid in the development and carrying out of informal youth focus groups and community conversations about sexual health
- Attend community advisory board meetings for the plan whenever possible
- Provide feedback on draft documents of the informal youth focus groups and community conversations
- Co-present final report findings at state board meeting

**Qualities of the Ideal Candidate:**

- Passion for the improvement of youth sexual health education in [State]
- Strong demonstration of leadership in community
- Able to work independently and with groups
- Good written and oral communication skills

**Compensation:** $10/hour, approximately 3-5 hours/month. Position runs from [Timeframe of YOL position].

**Please send completed applications to:** [Insert Name and Contact Information]

All applications must be received by [Date]. Applications will be open from [Dates]. You will be contacted via email or phone by [Date] if you have been selected for an interview. Interviews will be held on [Dates].

## Sample Youth Outreach Leader Application

Application Due: [Insert Date]

Name: _____

Age: _____

Address: _____

_____

City _____ State _____ Zip: _____

Date of Birth: _____ Race/Ethnicity: _____

Gender: ❍ Male ❍ Female ❍ Other

School:
Current Year in School: ❍ Freshman ❍ Sophomore ❍ Junior ❍ Senior ❍Other: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Emergency Contact Name: _____
Emergency Contact Phone Number: _____

(continued on next page)

## Sample Youth Outreach Leader Application, continued

**Please respond to the following application questions.**

We are aware that not all people feel comfortable with this type of written application. Therefore, we welcome you to answer the following question by expressing yourself through video, audio, artwork, poetry, etc. (Be sure that all videos or audios are limited to 3-5 minutes each.) Please be aware that the deadline is still the same if you choose to utilize this option.

1. Why are you interested in participating as a Youth Outreach Leader at [Organization]? Tell us how you will benefit from serving in this position with these organizations.(Example: interested in improving adolescent sexual health, interested in serving as a leader...)

2. Describe any unique qualities and/or experiences you have had relevant to the Youth Outreach Leader position. (i.e. passion for youth health and wellness, volunteer at school clinic, leader in school organization, etc.)

3. What experience do you have working with sexual and reproductive health issues, including prevention of teen pregnancy, HIV and other sexually transmitted infections?

4. What issues are you currently involved with in your community? Check all that apply.
   - ❍ Condom/Contraceptive Access
   - ❍ LGBTQ Rights
   - ❍ Comprehensive Sex Ed.
   - ❍ Global HIV/AIDS
   - ❍ Peer Education
   - ❍ Gender Based Violence
   - ❍ Marriage Equality
   - ❍ Bullying Prevention
   - ❍ Gay Straight Alliance
   - ❍ HIV Prevention, Treatment, Care for Youth
   - ❍ Other: _____

5. What three strengths are you most excited to share with the Youth Outreach Leader position? Describe an experience in which you used or showcased these strengths. (Example: good leadership, ability to express ideas, ability to get along well with a wide variety of people, etc.)

6. How did you hear about the Youth Outreach Leader position?

7. Please describe your public speaking experience(s). What skills and/or support would you need to feel more confident in public speaking?

8. Please describe your experience(s) with being in a leadership position. (Please note: This is not limited to formal positions). What skills and/or support would you need to feel more confident in being in a leadership position?

9. Please provide us with the names and emails/phone numbers of <u>three references</u> (2 professional, 1 personal preferred):

   1. _____

      _____

   2. _____

      _____

      _____

   3. _____

      _____

10. Individuals selected as Youth Outreach Leaders will be expected to attend a mandatory in-person training at [Insert Location and Date]. They will also be expected to commit to approximately 3-5 hours per month, including some nights and weekends, from [Expected Job Timeframe]. Please describe your ability to meet these time commitments, including your Transportation Plan. Also, please let us know if you need help developing one.

Youth: My signature affirms that if my application is selected, I will make a 25-hour commitment from [Date] to [Date] working on the [State] Statewide Youth Sexual Health Plan. I will represent [Organization] in a positive and professional manner.

Youth comments:_____

Youth Signature_____

Date_____

Parent/Guardian: My signature affirms that I am aware and supportive of my child's application to [Organization] to be a Youth Outreach Leader. I have read the one-page Youth Outreach Leader job description, and I understand what will be expected of my child. I agree with his/her time commitment and transportation plan. I give my permission for photographs and videotape of my child to be used in publications.

Parent/Guardian Comments_____

Parent/Guardian Signature_____

Telephone_____

Date_____

Due: [Insert Date] To: [Insert Name and Contact Information]

## Sample Youth Outreach Leader Interview Questions

**Introduction:** *Thank you for coming in today! We have about 10 questions to ask you and allotted 30 minutes for your interview. This means we have about 3 minutes per question. Please keep this in mind as we continue with your interview.*

1. Based on the job announcement, what experiences do you feel that you have that qualify you for this position?
   - Why do you want this job?
2. What are your future goals?
3. As we discussed on the phone, this is part-time position that will require a flexible schedule with some night and weekend availability.
   - How would this position fit with your current schedule and life?
   - Do you have your own transportation?
4. What strategies would you use to organize in diverse communities? What barriers would you anticipate, and how would you overcome these barriers?
5. How would you respond to a derogatory comment by a peer or a mentor? (or about someone else that you heard, or even about yourself)
6. If you were on a team, what position would you play? How do you or would you motivate others?
7. Think about a conflict that you have had with a peer or adult. Briefly describe what happened, what you did, and what you learned from it.
8. Where do you think teens get their information about sex?
9. How do you define comprehensive sexual education?
   - Share with us the pros and cons of your own sexual health education.
   - How does this relate to sex and dating violence prevention, bully prevention, LGBTQ health, educational equity, and social justice?
10. Other questions from their application:

Notes:

## Sample Youth Outreach Leader Reference Check Form

Applicant name: _____

Date: _____ Position applying for: _____

Reference name: _____

Title: _____ Company: _____

Phone #: _____ Relation to applicant: _____

1. In what capacity do you know [applicant]? How long have you known her/him?

2. What advice would you give to help set up [applicant] for success?

3. How many years have you worked with the applicant?

4. What are his/her strongest qualities?

5. What qualities can he/she improve on?

6. Any other comments about this applicant?

## Sample Youth Outreach Leader Training Schedule

**Resources needed:**

1. Staff
2. Big Ball with statements written on it
3. YOL Binders
4. Candy/Rewards/Snacks
5. Timer
6. Different size objects
7. Conference Room (& Flip Chart Paper)
8. Piece of Paper & Pens and 1 envelope

**4:30-4:50-** *Introductions/Icebreakers*

- Everyone shared one nickname they have and why they have it, as well as a short introduction to who we are and what our role is with working on the plan.
- We used the game "Two Truths and a Lie", where everyone shares one false statement about themselves as well as two true statements and everyone must guess which statement is false. This provides an opportunity for everyone to get to know each other better before we begin working together.

**4:50-5:00- Break-** *Circle Activity*

- Another game to get to know one another's names better.
- 1st time around- One object, passed from person to person in any order, say name and adjective that starts with first letter of first name. Pass to next person, they say name plus adjective. Pass to next person, they repeat everyone's names with adjectives.
- 2nd time- Same *ORDER*, same object, incorporate new object
- **Where is object being dropped? What can be done to combat this problem? (Development of problem solving skills for us working together in future)

**5:00-5:15-** *Organization Introductions*

- All organizations share what their organization does as well as how they are involved in the development of the plan.

**5:15-5:30-** *Youth Outreach Leader- Job introduction responsibilities and expectations*

- Put large piece of paper on the board with statements and fill in the blanks. Youth must read first statement, fill in blank with answer possibilities. The purpose of this activity is to ensure that the youth understand the job and what will be expected from them when working with us.

**5:30- 5:40-** *Break*

**5:40-6:00-** *The Issue- Big Ball Game*

- On a big ball, statements are written about the issue and solutions surrounding youth sexual health. Future youth outreach leaders catch ball and must read the statement facing them, asking the question to everyone. All other youth or staff responds. This was used to provide more answers to sexual health questions and job responsibilities to the youth outreach leaders.

**6:00-6:20-** *Communication Skills*

**a. Iceberg of communication**

Present the "Iceberg of communication" and different types of communication.
*Which one is most influential?*

**b. Verbal and non-verbal communication**

Give example by saying same statement twice, first time enthusiastic, second time, sarcastic. Ex.: "Good job!"
*What is being exemplified here?* (Answer: Tone of Voice)

Then stand next to youth leader and say something, roll eyes and cross arms. Repeat with the same example statement as tone of voice example.
*What is being exemplified here?* (Answer: Nonverbal cues)

**c. Demo of how to react**

Two people act out a sample informal focus group question and response with a "shocking" answer. The person reacting overreacts to the statement.

*Ask youth:* How do YOU react to situations?
How do you control your reactions?
How can we work on improving and being more aware of our reactions?

**d. Wrap-Up**

How important are your reactions? Have youth brainstorm their own patterns and ways they react. Can you recognize these in the future? Brainstorm ways to be aware of reactions and how we can improve and work on being more subtle with our reactions.

When communicating with people, be aware of:

. tone of voice
. verbal communication (in person and online, through text)
. subtle nonverbal cues

Keep these in mind as you develop and implement informal focus groups, work with other youth leaders and staff.

**6:20- 6:30-** Break

**6:30-6:45-** *Informal Focus Groups: An Introduction*

a. What is an informal focus group?
   i. Usually 6-12 *homogeneous* people recruited to specific location. In what ways is it homogenous? (In this case, just adults, just youth).
      - Why is it homogenous? Have youth respond with their ideas.
      - Is **NOT** a community conversation (where people can discuss an issue and there is little restriction on conversation), is very specific and ***SCRIPTED***.
      - Timeframe: 3-4 hours for a few questions that are **SPECIFIC** and **SCRIPTED**.

   **b. Roles**: (Have youth guess what each one does, then come up with key words for each, and who would be this person?)
      - Moderator
      - Facilitator and Co-facilitator
      - Scribe/Note taker

   c. Who are they aimed at?
      - Specific communities. In our case we are looking at youth and adults in the community to gain their perspectives on youth sexual health.

**6:45-6:55-** *How to Get Support*

a. Who can support you?
   i. Youth answer question:
      - What adults in your life have helped you become who you are?
      - What did they do? Discuss why this is important.
      - What ways can we support each other?
      - What ways can you support yourself?

- **What kinds of support do you need? How to get support & how comfortable are you asking for support?**

b. What stresses you out the most? How do you deal with it?
   i. Have youth answer the questions, write answers on flip chart paper.
   ii. Brainstorm together ways to manage stress, write down and choose three that work.

**6:55-7:15-** *Wrap up, Binders, next meeting(s), HW!*

**Wrap-Up:** Have youth discuss the skills they have learned today (problem solving, communication, informal focus group best practices, trust/support)

**HW:**
- Youth create a 5-minute elevator speech about their job using what they have learned. At the next meeting, create a common one they can all use.
- Interview your peers/friends about sex, dating, and relationships.

# Sample Youth Outreach Leader Orientation Manual

## [Your State]

Statewide Youth Sexual Health Plan

**[Logos of Host Agencies/Organizations Here]**

**Sample Youth Outreach Leader Manual Index:**

1. Contact List
2. Organization Information
3. 1 pager about the State Plan
4. Job Description/Expectations
5. Timeline of Plan
6. Communication Tips and Tricks
7. One page information sheet about youth sexual health
8. HW Assignment #1 (see training schedule)

## Sample Youth Outreach Leaders "Interview Your Peers" Questions

1. What questions do you have about sex, dating, and relationships?

2. What do you want to know more about with sex, dating, and relationships?

3. What questions would you ask adults about sex, dating, and relationships? And which adults would you ask?

4. What questions would you ask your friends about sex, dating, and relationships?

5. What would you like to learn or get out of a sex ed class?

6. Where do you get your information about sex?

7. Do you know your parent's values about relationships and sex?
   a. If yes, what are those values?
   b. If no, do you want to know what those values are?

8. If you or your friend needed condoms or contraceptives, would you know where to go?
   a. If yes, where would you go?
   b. Do you feel comfortable going there?

9. Please add a personal reflection on the process. What was challenging? What wasn't challenging? What did you learn that surprised you? What do you want to know more about?

## Sample Youth Outreach Leader Midpoint Evaluation

**Name:**
**Job/Position:**
**Months Worked:**

**Describe the top 3 favorite things about your job (1-2 sentences each):**

1.

2.

3.

**Describe 3 things that were challenging about your job (1-2 sentences each):**

1.

2.

3.

**3 things learned from peers/people I interviewed about youth sexual health:**

1.

2.

3.

**3 things I'm excited about with my work (1-2 sentences each):**

1.

2.

3.

## Community Conversations

### The Process:

Community conversations were used to collect a broad overview of information about youth sexual health in Boulder, Glenwood Springs, and Lamar, Colorado. These cities were chosen to provide perspectives from community members representing different diverse areas in Colorado. While these cities varied in population size, geographic location, and socioeconomic status, many similar themes about youth sexual health emerged.

As with the informal focus groups, community organizations were contacted to aid in recruiting participants for the community conversations. Flyers were distributed by organizations in their respective communities and participants had to RSVP to attend. The community conversations were formatted to accommodate 20 to 40 community members of all ages. In addition to recruitment, community organizations were asked for recommendations and help in organizing locations for the community conversations to take place in their communities on predetermined dates set forth by the Project Team. Seventy community members participated in the community conversations.

The community conversation agenda was constructed using the social ecological model, reframed for public conversation as the "Spheres of Influence," which looks at influences on health behaviors from the most broad level to the most personal level. Because community conversations were not as specific as the informal focus groups, questions were not directly asked to community members, but rather community members were asked to provide insight into what is and isn't available for youth in their communities. Furthermore, community members were also asked to write down recommendations for what they believe youth need to attain sexual health.

### What Was Found:

The community conversations provided a rich view of the state of youth sexual health directly from community members. A key theme that arose across communities was how the cycle of poverty affects equitable access and availability of health resources in communities. Moreover, community members stressed the importance of having accurate and reliable information for themselves and others when discussing youth sexual health. Services and

resources should support youth in their communities. Finally, role models and having a trusted adult or mentor for youth were expressed as important for youth to achieve optimal sexual health.

### Future Recommendations:

For future state plans that will conduct community conversations, we recommend that collaboration and coordination with local community organizations begin early in order to secure a location and desired number of participants. Furthermore, RSVPs helped the Project Team prepare participants for the varied perspectives that we hoped to engage in the conversation and allowed for the effective coordination of logistics. Additionally, incentives such as food further entice participants to attend. Finally, youth outreach leaders provide a youth perspective and insight in the creation of the overall plan, including the youth statements used to inform the agenda. Without these youth working with us, the community conversations would not have been as effective or relatable for participants.

## Sample RSVP Tracking Form for Community Conversation

For community conversation in _____ on _____.
(County) (Date)

Name _____
City Representing _____
Address _____
Age _____ Gender _____ Occupation _____
Phone Number _____ Email Address _____

Preferred Method of Contact ❍ phone ❍ email
Do you need a bus pass to attend the community conversation? ❍ yes ❍ no

Will you need childcare during this event? ❍ yes ❍ no
If yes, number of children and their ages _____

How did you hear about this event? _____

Why are you interested in being involved in this community conversation? _____

_____

What other things are you involved in your community? _____

_____

We will be asking your opinions about sex education, dating violence, sexually transmitted infections, HIV, relationship communication, teen pregnancy and teen parenting among other topics. Are you open to sharing your thoughts and opinions on these topics with people who may have different opinions than you? ❍ yes ❍ no

**Remind participants of:**

- Date and time of community conversation
- Location of conversation
- Childcare and food provided
- We will be following up the day before to remind them of their participation
- Give contact information if they have questions or need to cancel

SAMPLE Community Conversation Flyer

# We want to hear YOUR voice!

## Join us for a community conversation for youth AND adults about youth sexual health!



The Colorado Department of Public Health and Environment has joined with two state organizations to work on a plan to improve youth sexual health in Colorado.

**We want to hear your voice as we develop this plan!**

Come and share your thoughts and opinions about:

Youth sexual health
Infection and disease prevention
Teen pregnancy prevention

Positive, youth-friendly approaches
....and more!

**Where: [Insert location]**

**When: [Insert day, date, and time]**

**Youth and adults welcome! Food and childcare (with RSVP) will be provided!**

**For more information and to RSVP please contact:**

[Insert contact information]

[Insert host agency/organization logos]

## Sample Checklist for Community Conversations

**Date** _____ **Audience** _____

**Facilitators** _____

**Location** _____

❍ **Space confirmed**

Where will the informal focus group be held? _____
Address _____
Key contact for location _____
Phone number of contact _____
Fee for use of location? ❍ Yes ❍ No If yes, how much? _____

❍ **Community Partners identified**

Who are the main partner contacts for this community?

| Name | Organization | Phone Number/Email |
|---|---|---|
| | | |
| | | |
| | | |

❍ **RSVPs**

- Fill out initial screening survey for each RSVP
- Follow up with participants who RSVP and confirm their attendance the day before leaving

❍ **Materials**

- Snacks/Drinks and plates/napkins/cups/utensils as needed
- Map of location, directions
- Follow-up contact information for host organizations, information about how to stay involved
- Meeting Space fee (if applicable)
- Facilitation materials – flip chart, markers, sticky wall, note cards
- Roles and Expectations Sheet
- Copies of the community conversation script for facilitators
- Voice recorder (if applicable)
- Organizational publications to hand out
- Name tags
- Release and demographics forms

## Sample Community Conversation Facilitator's Outline

**Prep:**

- Print a set of 10 youth goal-statements.
- Flip Charts:
  - Agenda
  - Spheres of Influence design
  - "Greatest Challenges"
  - "Who Else?"
  - "Forgot to Add…"
  - "Spheres Activity Instructions"
    - What ACTION(S) need to happen to support a youth to achieve this goal?
    - WHO can help make this happen?
    - Briefly discuss 1st impressions with your small group.
    - Write your action items on the flip chart, under one of the three categories: Family and Relationships, Community Resources and Society and Policy. If you are a youth, you can also write on the Self/Me page.
    - Move to another goal-statement. Repeat.
- Big dots
- 10 sheets, topped with 1 youth goal-statement each, posted around the room

**Supplies:**

- ❍ Sign in sheet – include email if want to receive SURVEY!
- ❍ Host organization Information
- ❍ State Plan fact sheet
- ❍ Markers –for flip charts and tables
- ❍ Flip charts
- ❍ Name tags
- ❍ Toys
- ❍ Dots

**This agenda is designed for a 2-hour time period, with 15 minutes built in/unscheduled for late starts, longer conversations, etc.

**1. Welcome and Introductions – 10 minutes**

- Thank you for participating in today's community conversation. Today you are here to provide your personal perspective on topics related to youth sexual health.
- I am [Name, Position at Organization], and I will be co-facilitating our conversation with [Name, Position at Organization] today. We'll tell you a little bit more about the plan and what we hope to learn from you in a minute.
- We have a photographer here. Use orange highlighter on nametag if you DON'T want to have your picture taken.
- (IF TIME) Please take a moment to introduce yourself to the person sitting next to you and share one reason why you're here today.
- Here's our agenda for today [review flip chart].
  - Welcome
  - Plan Overview
  - Activity One: Defining Sexual Health
  - Activity Two: Spheres of influence
  - Activity Three: Goal Statements – Putting Vision into Practice
  - Activity Four: Quick Closing Brainstorm
  - Thank You!
- Today's meeting is scheduled to end at [Time]. Please help yourself to food [other logistics go here].

**2. Overview of Plan – 15 minutes**

- Our goals
  - So what is this all about? The **[State Public Health Department]** has hired **[Organization]**, to listen to your **feedback about what works and what doesn't work** with teens and sexual health. We've been getting feedback from communities around the state, and we're looking at existing research about what helps youth make healthy decisions. We'll be putting it all together to develop the state plan for youth sexual health!
  - This **plan will be used** in the following ways:

- To help communities and decision-makers make sure that all youth have access to the accurate information, skills, and quality health services they/we need to make good decisions about their/our lives.
- To inform elected officials, parents, teachers, schools, doctors, organizations, and other people in our communities help you/youth to make good decisions about sexual health and build safe, healthy relationships.
- Unfortunately it will not be written FOR youth but we've learned from other states how to make it youth-informed, and useful TO youth, working with their communities.
- The plan will not *require* communities to do anything, but rather will *recommend* ways we all can take action to ensure that youth have opportunities to prevent pregnancy and STIs, have health equality, and have complete skills and knowledge to make well-informed decisions about their relationships and future.

**Any questions so far? Please let us know if you'd like clarification at any time…**

Full disclosure: **Our underlying assumptions and beliefs** about what we want:

- We want to prevent unplanned teen pregnancy and risk of getting a sexually transmitted infection, including HIV
- We want all youth to have healthy, safe relationships and to make decisions that are in line with their values
- We want all youth to have access to condoms and birth control and know how to use them
- We want all youth to feel good about the relationships that they are in and the choices they make
- We want all youth to feel supported by their community, family, friends, school, etc.

…and we want you to help us figure out how to get there.

Because we're asking you for your opinion and this is a natural although **sensitive subject**, this can get personal. This discussion can bring up some emotions. We are not a support group, but we will acknowledge your feelings and provide resources if you want them, after we are finished here with the conversation. In order for everyone here to feel like they can share their honest opinion, we'd like you to help us develop a few group guidelines

**Group Guidelines** – what would help you share your best thoughts, ideas, opinions and experiences on this topic?

1. Confidentiality , anonymity (participants shouldn't share responses or experiences with others outside of this conversation; what we use in the plan will not be attached to anyone in any identifiable way)
2. Respect for all opinions
3. Ask questions
4. Check your assumptions
5. Participate! Step Up if you haven't spoken much, Step Back if you have

What other guidelines would you like to add?

Any questions so far?

**Activity One: Defining 'sexual health' – 10 minutes**

We've already shared with you our assumptions in creating this plan. Now we'd like to read a definition of 'sexual health' to you and get your input. This definition is adopted from the World Health Organization – we've broken it up in parts to get your thoughts:

> **Sexual health:**
> *Sexual health is a normal state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.*

- First reactions?
- What do you like?
- What doesn't work for you?
- What's missing?

*For sexual health to be attained and maintained, all people must have access to accurate and comprehensive education, services and resources to make healthy decisions about their sexuality and their families, and the sexual rights of all persons must be respected, protected and fulfilled.*

- First reactions?
- What do you like?
- What doesn't work for you?
- What's missing?

*Youth sexual health requires a long-term commitment from individuals, families, communities and society, which can be attained when we centralize the experiences and leadership of young people, working in partnership with their communities.*

- First reactions?
- What do you like?
- What doesn't work for you?
- What's missing?

What questions, comments do you have? What do you like about this? What's missing?

**3. Activity Two: Spheres of influence (15 minutes)**
Overview of the Spheres of Influence [*visual on flip chart*] – **(10 minutes)**

- How many of you have heard of the social-ecological model? How many of you have seen this or something like this?
- We also refer to this model as the "spheres of influence" – highlights the nested layers of influence over a person's choices/behaviors, or in our case, a young person.
- EXAMPLE:...What in your own life has impacted your ability to make a healthy decision?
  - Family 'taboo' – can't talk about it, find out elsewhere
  - Social circle – what are your peers doing?
  - School policy
  - Health care access – policy that increases access to Medicaid
- As we develop the state plan, this is this model that we'll be keeping in mind. The reason this model fits the plan so well is because it will present multiple opportunities – uses different levels of influence that addresses factors to help support youth sexual health –For example- from policy, community resources, or local or state evidence-based youth sexual health programs. Really, an inexhaustible list of options.
- This framework will help communities map out what youth need, what's already in place, and what capacities or resources are needed to create successful and sustainable outcomes.

**4. Activity Three: Goal Statements – Putting Vision into Practice (40 minutes)**
**PREP:** *Hang 10 flips charts with four quadrants: Self/Me, Relationships, Community Resources and Society and Policy. Place each youth goal-statement (numbered) at the top of one pairing of flip charts.*

Now we're about to read you goal-statements from young people, about what they want for their own sexual health. These statements reflect the many aspect of their life. Please first listen to these goal-statements as we read them...[*read statements-ALTERNATE VOICES, face group when reading statements*]

Now we'd like to ask you to get in small groups of 3-4 [10 groups max] and, with your group, stand in front of one of the 10 flip charts around the room. Each flip chart has one of the goal-statements you just heard, divided into four categories:

At your flip chart, briefly review the statement and discuss:

- What ACTION(S) need to happen to support a youth to achieve this goal?
- WHO can help make this happen?
- These can be things that already exist in your community, or what you think could work or be used

Write your action items on sticky notes and place them on the flip chart, under one of the four categories: Family and Relationships, Community Resources and Society and Policy. If you know of a specific school or organization doing this work, write this on the flip chart.

- Under "Self/Me" please add to this **ONLY** if you are a youth and only if you would like to add to that goal-statement.

Each small group will only have 3 minutes at each flip chart. Don't edit your ideas – just share the first thoughts that pop into your head!

We'll move you through as many flip charts as possible.

When this phase is done, take 3 DOTS and do a Walkthrough…review all the flip charts and choose the top 3 action steps that are the most important to you. Place a dot on the sticky note directly.

Share your top priorities with the group.

*Facilitators will group themes, discuss clusters and gaps.*

**5. Activity Four: Quick Closing Brainstorm (10 minutes)**
- Greatest Challenges [to implementing plan]
- Who Else? [needs to inform this Plan]

- Anything you'd like to add? [that we forgot to ask]

**6. Thank you! (5 minutes)**
- For more information about the plan, join our mailing list
- For more information about [facilitators' organizations], see resources.
- SURVEY!

| **Community Conversations "Framework for Action" Grid:**<br>**What actions need to happen in each Sphere of Influence to support healthy youth?**<br>This framework was created using the social ecology model, the social determinants of health and positive youth development principles. | | | | |
|---|---|---|---|---|
| **Spheres of Influence** | **Healthy Youth (Self/Me)**<br>Quotes from Youth | **Family and Relationships** | **Community Resources** | **Society and Policy** |
| **1. Self-awareness, self-confidence** | I am in control of my sexual health. I make choices that I'm proud of. | | | |
| **2. Relationships** | I feel safe in my relationship. I feel comfortable talking with my partner about what I want and don't want. I'm respected by my partner. | | | |
| **3. Family** | I am/want to be open with my family about my sexuality and all aspects of sexual health. I'm not afraid to talk with my family and trusted about the questions I have. | | | |
| **4. Family Support** | My family has the resources they need to raise healthy children and be healthy themselves. | | | |
| **5. Community Support** | My community is thriving. I feel safe, I know my neighbors, and we have access to opportunities. | | | |
| **6. Health resources & services** | I feel comfortable accessing health care. I know where to go to get reliable and confidential information, resources and services if I need them. I can afford these services. | | | |
| **7. Education** | I am educated in the different forms of contraceptives. I know how to effectively prevent disease and pregnancy. My educational resource is a good place for me to learn about sexuality and healthy and safe relationships. | | | |
| **8. Skill-building** | I have the confidence, skills and knowledge to make choices that are right for me and my relationships. | | | |
| **9. Future goals, career options** | I feel supported in what I value and what I want to achieve. I receive positive support in developing my future goals and in planning for the future I want for myself. | | | |
| **10. Teachers, mentors, trusted adults** | The teachers, mentors and trusted adults in my life are knowledgeable, trustworthy, supportive and non-judgmental. | | | |

## Informal Focus Groups

### The Process:

Informal focus groups were used to collect information from youth and adults about what is available for youth regarding sexual health, what adults can do to support youth, and what can be improved. Two informal focus groups were conducted with youth ages 14 to 24 years old in the cities of Pueblo and Aurora. These cities were chosen to offer a snapshot of youth perspectives from diverse and underrepresented Colorado communities. In addition, there were two informal adult focus groups, one in Aurora, and one conducted in Spanish in Greeley. In order to participate, adults had to be a parent or guardian of a youth who was 14 to 19 years old.

Community organizations were contacted to aid in recruiting participants for the informal focus groups. Flyers for the informal focus groups were distributed by these organizations in their respective communities. Interested youth and adults had to RSVP to the informal focus groups. In addition to recruitment, community organizations were asked for recommendations and help in organizing locations for the informal focus groups to take place in their communities on predetermined dates set forth by the Project Team. Seventeen youth and thirteen adults participated in the informal focus groups.

Questions for the informal youth and adult focus groups utilized the social ecological model, reframed for public conversation as the "Spheres of Influence," which looks at influences on health behaviors from the most broad level to the most personal level. This model was used to gain insight on the different levels of society that influence youth sexual health, including: policies/systems, community, family/peers, and youth/self. Using this model, the informal focus group began with broad level policies/systems questions to open up the conversation and ended with more personal questions about youth/self.

### What Was Found:

Many overlapping themes were found from both the adult and informal youth focus groups. Youth expressed a strong need for comprehensive sexuality education every year in school, not just one time. Family attitudes and peer pressure were stated as large influences on the decision to delay or initiate sexual activity for youth. Finally, youth stated they would like to feel more confident in themselves and have higher

self-confidence and goals, but must have appropriate opportunities and role models in their lives to develop these personal attributes.

Similar to youth, adults felt that youth today should have more information about comprehensive sexuality education in school, especially with the high amount of sex that is shown in the media. Parents and trusted adults understood that they are primary source of information about sex, although some expressed a lack of understanding about what to say and how/when to say it. All parents believed that you should have at least one trusted adult with whom they could have open communication about sexual health. Finally, parents felt that peer pressure is a large influence on initiation of sex, and without proper information or guidance from trusted adults, youth may engage in unhealthy behaviors.

### Future Recommendations:

For future state plans that will conduct informal focus groups, we recommend that collaboration and coordination with local and community organizations begin early in order to secure location and participants. Furthermore, RSVPs helped the Project Team prepare participants for the varied perspectives that we hoped to engage in the conversation and allowed for the effective coordination of logistics. Additionally, incentives such as a stipend and food further entice participants to attend. Finally, having youth outreach leaders involved in the process provided a youth perspective for question development as well as informal focus group recruitment, which was extremely beneficial to the process and results.

## Sample RSVP Information for Informal Focus Groups

For an informal focus group in _____ on _____.
(County) (Date)

Name _____
City Representing _____
Address _____
Age _____ Gender _____ Occupation _____
Phone Number _____ Email Address _____

Preferred Method of Contact ❍ phone ❍ email
Do you need a bus pass to attend the community conversation? ❍ yes ❍ no

Will you need childcare during this event? ❍ yes ❍ no
If yes, number of children and their ages _____

How did you hear about this event? _____

Why are you interested in being involved in this informal focus group? _____

_____

What other things are you involved in your community? _____

_____

We will be asking your opinions about sex education, dating violence, sexually transmitted infections, HIV, relationship communication, teen pregnancy and teen parenting among other topics. Are you open to sharing your thoughts and opinions on these topics with people who may have different opinions than you? ❍ yes ❍ no

**Remind participants of:**

- Date and time of community conversation
- Location of conversation
- Childcare and food provided
- We will be following up the day before to remind them of their participation
- Give contact information if they have questions or need to cancel

Sample Youth Informal Focus Group Flyer

# Seeking YOUTH for an Informal Focus Group!

The Colorado Department of Public Health and Environment has joined with two state organizations to work on a plan to improve youth sexual health in Colorado.



**If you are a teen between the ages of 14-19, We want to hear your voice as we develop this plan!**

**Come and share your thoughts and opinions about:**

**Youth sexual health**

**Teen pregnancy prevention**

**Infection and disease prevention**

**Positive youth-friendly approaches**

**And more!**

**Where: [Insert location] | When: [Insert day, date, time]**

**SELECTED PARTICIPANTS WILL BE PAID FOR THEIR TIME!**

For more information and to RSVP please contact:
[Insert contact information]
[Insert host agency/organization logos]

## Sample Informal YOUTH Focus Group Scripted Guide

**Supplies:**

- ❍ Flip chart and stand
- ❍ Markers
- ❍ Pre-made flip charts
- ❍ Pre-made big words
- ❍ Masking tape
- ❍ Dots for voting
- ❍ SNACKS – water, bars, fruit
- ❍ Sign in and Sign out sheets
- ❍ Demographics and Consent forms
- ❍ Pens
- ❍ Clip boards
- ❍ Stipends
- ❍ Fact sheet about The Plan
- ❍ CYM info
- ❍ The Alliance info
- ❍ Name tags for first names
- ❍ Toys
- ❍ Other:
- ❍ Voice recorder

**Room Set-Up:**

- If possible, arrange chairs in circle.
- Hang flip chart pages:
  - ❍ Agenda
  - ❍ Group Guidelines + One blank sheet
  - ❍ Community
  - ❍ Are Doing | Wish They Were Doing
  - ❍ Healthy | Unhealthy
  - ❍ Get Info | Whose Opinion Matters?
  - ❍ Split in quarters:
    - Good
    - Bad
    - Change from Past
    - Bring to Future
- Hang big words: dating and relationships, sexually transmitted infections, sex in the media, contraceptives, condoms, sexual orientation, coming out, teen pregnancy and parenting, dating violence prevention, bully prevention, comprehensive sex ed, other…
- Put out snacks, toys
- Write agenda?
- Other:

**Key Facilitator Points:**

- Call on people by name
- Acknowledge all perspectives
- If going off script, only ask clarifying questions
- Let the recorder capture key points – don't single out any one good quote! (as excited as you may get)

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 15 minutes | Informal welcome, Sign in | | Need pre-registration list, check off names, name tags (first name only) | Hi…welcome! So glad you could come! Etc. |
| 10 minutes | Formal welcome | | | Thank you for participating in today's informal youth focus group. Today you are here to provide your personal perspective on topics related to sexual health of youth.<br><br>I am **[Insert name and position at organization]**, and I will be co-facilitating our conversation with **[Insert name]** today. We'll tell you a little bit more about why you're here in a minute. First, I'd like to ask the rest of our team introduce themselves and let you know the role that they will be playing in our conversation tonight:<br><br>• **[Name]**, Youth Outreach Leader for the State Plan. Tonight I will be co-facilitating our talk with **[Name]**.<br><br>• **[Name]**, Youth Outreach Leader for the State Plan. Tonight I will be one of two note takers.<br><br>• **[Name], [Position at organization]**. Tonight I will be the other note taker.<br><br>Here's our agenda for today **[review flip chart]**. Today's meeting is scheduled to end at 9pm. Think of your participation in this conversation like a job: You will be paid **[$]** for participating from beginning to end and for sharing your honest opinions. You will get paid at the end of the meeting as you leave. We'll take one short break mid-way through. |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 5–10 minutes | About the Plan | | | So what is this all about? The **[State Public Health Department]** has hired our two organizations, **[Name of Organization]**, to listen to your feedback about what works and what doesn't work with teens and sexual health. We'll also be getting feedback from other community members and look at existing research about what helps youth make healthy decisions for themselves. From there, we'll develop a state youth sexual health plan.<br><br>This plan will be used in the following ways:<br><br>• To help communities and decision-makers make sure that all youth have access to the accurate information, skills, and quality health services they/we need to make good decisions about their/our lives.<br><br>• To inform elected officials, parents, teachers, schools, doctors, organizations, and other people in our communities help you/youth to make good decisions about sexual health and build safe, healthy relationships.<br><br>• Unfortunately it will not be written FOR youth but we've learned from other states how to make it youth-informed, and useful TO youth, working with their communities.<br><br>• The plan will not require communities to do anything, but rather will recommend ways we all can take action to ensure that youth have opportunities to prevent pregnancy and STIs, have health equality, and have complete skills and knowledge to make well-informed decisions about their relationships and future.<br><br>Today, we will be asking for your personal feedback, which will help elected officials, parents, schools, organizations, doctors and nurses best serve your health, help you to make good decisions about your sexual health and allow you to be safe in your relationships.<br><br>Any questions so far? Please let us know if you'd like clarification at any time. |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 5 minutes | What we want | | | We want to be up front with you about our underlying assumptions and beliefs about what we want:<br>• We want to prevent unplanned teen pregnancy and risk of getting a sexually transmitted infection, including HIV<br>• We want all youth to have healthy, safe relationships and to make decisions that are in line with their values<br>• We want all youth to have access to condoms and birth control and know how to use them<br>• We want all youth to feel good about the relationships that they are in and the choices they make<br>• We want all youth to feel supported by their community, family, friends, school, etc.<br>...and we want you to help us figure out how to get there.<br>Because we're asking you for your opinion and this is a sensitive subject, this can get personal. This discussion can bring up intense emotions. We are not a support group, but will acknowledge your feelings and support you after we are finished here with the informal focus group.<br>In order for everyone here to feel like they can share their honest opinion, we'd like to propose a few Group Guidelines: |
| 10 minutes | Group Guidelines | | **[Name]** reviews pre-written flip chart with "Group Norms." Ask if anyone needs clarification. Add any additional guidelines that the group recommends. Use extra paper if needed. | 1. Responses are anonymous (first name only, no i.d. information about anyone).<br>2. Confidential responses (participants shouldn't share responses or experiences with others outside of the informal focus group space).<br>3. Safe space to share thoughts, ideas, opinions, experiences.<br>4. All questions are good questions!<br>5. Check your assumptions, ask questions.<br>6. All voices will be heard.<br>7. Participate! Step up if you haven't spoken much, step back if you have.<br>What other guidelines would you like to add?<br>Any questions about any of this? |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 35 minutes | Informal focus group questions: Community | | [**Name**] stand by the flip chart labeled "Community," write down words quickly as youth say them. | Now it's your turn! To get started, we'd like you to think about your "community," whatever that means for you. This could be neighborhood, school, home, etc. What is your "community"? Just shout out some words. Keep these words in mind as we ask you the following questions.<br>• What do you like about your community? (As people answer, can follow up with):<br>• Why do you feel that way about your community?<br>• What's fun to do in your community?<br>• What would you like to see more of?<br>• What do you want to happen that isn't happening in your community?<br>• What barriers do you see/feel/hear that keep you from being healthy? (Can ask participants about their experiences in relation to these barriers or supports: what was it like, how did it make them feel, etc.?) |
| BREAK | | | | |
| 45 minutes | Informal focus group questions: Family/Relationships | | **[Name]** write on flip chart with "Are Doing" and "Wish They Were Doing," record responses | **[go in circle, ask whole group]** What is your family and/or other close adults in your life doing that you feel supports your sexual health? (clarify role of 'close adult'—parent, sibling, teacher, aunt, etc.)<br>• What do you wish they were doing?<br>• How do your friends impact your sexual health? How do they help you? How do they hurt you? |
| | | | **[Name]** write on flip chart with "Healthy and Unhealthy," record responses | **[go in circle, ask whole group]** For the next question, think about your romantic relationships in the past or currently, your friend's romantic relationships, etc. and tell us:<br>• What does a healthy and unhealthy relationship look like?<br>• How would you describe a healthy or unhealthy relationship?<br>• How would you feel in a healthy and unhealthy relationship?<br>• How can all youth—including those who identify as LGBTQ [may have to explain this term]—be supported to have healthy dating relationships?<br>Follow-up question: What's the best way to tell a date/partner/boyfriend/girlfriend what you want? |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 45 minutes | Informal focus group questions: Self | | Write on flip chart split in half, one side says with "Get Info." The other says "Whose Opinion Matters?" Record responses | **[go in circle—ask whole group]** Now we want to hear about what influences your own decisions about dating and sex (either to wait or to have sex).<br>• Where do you get your information?<br>• Whose opinion matters most to you? |
| | | | **[Name]** write on flip chart split in quarters:<br>-Good<br>- Bad<br>- Change from Past<br>- Bring to Future | Tell us a little bit about your dating experience.<br>• What has been good?<br>• What has been a challenge?<br>• What would you have done differently?<br>• What would you change for the future? IF you haven't dated yet, what is one thing you're looking forward to about dating?<br>Refer to topics posted on the wall. |
| | | | **[Name]** Help hand out dots. Blank sheets to add topics. | Finally we want to know the topics that you would want more information about, support, and/or resources. Look at the topics on the wall—you get three dots, three votes. Put a dot on the top three topics that you wish adults would talk with you about more often. |
| 10 minutes | Thank you, Closing Logistics | | | Any final closing questions or comments about our conversation? On behalf of all of us, we really appreciate your time today. Thank you! Now I'll turn it over to **[Name]** to tell you how to check out. |
| | | | | Thanks to everyone for sharing tonight. We just want to remind you that your responses will stay anonymous and we'll just use general comments in the Plan.<br>If you have any questions, want more information after you leave here tonight, and want to see a copy of the Plan when it's complete, please contact **[Name]**, whom you spoke with prior to getting here tonight.<br>I'll meet you by the door to give you your stipend. Thanks again for your time and help! |

Sample Informal Adult Focus Group Flyer

# Seeking PARENTS for an informal focus group about youth sexual health!

The Colorado Department of Public Health and Environment has joined with two state organizations to work on a plan to improve youth sexual health in Colorado.



## If you are a parent of youth ages 14-19, we want to hear your opinions as we develop this plan!

**Come and share your thoughts and opinions about:**

**Youth sexual health**

**Teen Pregnancy Prevention**

**STI prevention**

**Positive, effective, youth-friendly approaches**

**...and more**

**Where: [Insert location] | When: [Insert day, date, time]**

**SELECTED PARTICIPANTS WILL BE PAID FOR THEIR TIME.**

For more information and to RSVP please contact:
[Insert contact information]
[Insert host agency/organization logos]

## Sample Informal ADULT Focus Group Scripted Guide

**Supplies:**

- ❍ Flip chart and stand
- ❍ Markers
- ❍ Pre-made flip charts
- ❍ Pre-made big words
- ❍ Masking tape
- ❍ Dots for voting
- ❍ SNACKS – water, bars, fruit
- ❍ Sign in and Sign out sheets
- ❍ Demographics and Consent forms
- ❍ Pens
- ❍ Clip boards
- ❍ Stipends
- ❍ Fact sheet about The Plan
- ❍ [host organization] info
- ❍ Name tags for first names
- ❍ Toys
- ❍ Other:
- ❍ Voice recorder

**Room Set-Up:**

- If possible, arrange chairs in circle.
- Hang flip chart pages:
  - ❍ Agenda
  - ❍ Group Guidelines + One blank sheet
  - ❍ Community
  - ❍ Are Doing | Wish They Were Doing
  - ❍ Healthy | Unhealthy
  - ❍ Get Info | Whose Opinion Matters?
  - ❍ Four quadrants:
    - Good | Bad
    - Change from Past | Bring to Future
- Hang big words
- Put out snacks, toys
- Write agenda?
- Other:

**Key Facilitator Points:**

- Call on people by name
- Acknowledge all perspectives
- If going off script, only ask clarifying questions
- Let the recorder capture key points – don't single out any one good quote! (as excited as you may get

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 15 minutes | Informal Welcome | | Sign in<br><br>Need pre-registration list, check off names, name tags (first name only) | Hi…welcome! So glad you could come! |
| 10 minutes | Formal Welcome | | | Thank you for participating in today's parent informal focus group. Today you are here to provide your personal perspective on topics related to sexual health of youth.<br><br>I am **[Name, Organization, Position at Organization]**. I'll tell you a little bit more about why we invited you here in a moment. First, I'd like to ask the rest of our team introduce themselves and let you know the role that they will be playing in our conversation tonight:<br><br>**[Names, Organization, Position, Role in Informal Focus Group]**<br><br>Here's our agenda for today **[review flip chart]**. Today's meeting is scheduled to end at **[time]**. Think of your participation in this conversation like a job: You will be paid **[$]** for participating from beginning to end and for sharing your honest opinions. You will get paid at the end of the meeting as you leave. We'll take one short break mid-way through. |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 10 minutes | About the Plan | | | So what is this all about? The **[State Public Health Department]** has hired **[Organization]**, to listen to your feedback about what works and what doesn't work with teens and sexual health. We'll also be getting feedback from other community members and look at existing research about what helps youth make healthy decisions for themselves. From there, we'll develop a state youth sexual health plan.<br><br>This plan will be used in the following ways:<br><br>• To help communities and decision-makers make sure that all youth have access to the accurate information, skills, and quality health services they/we need to make good decisions about their/our lives.<br><br>• To inform elected officials, parents, teachers, schools, doctors, organizations, and other people in our communities help you/ youth to make good decisions about sexual health and build safe, healthy relationships.<br><br>• Unfortunately it will not be written FOR youth but we've learned from other states how to make it youth-informed and useful TO youth, working with their communities.<br><br>• The plan will not require communities to do anything, but rather will recommend ways we all can take action to ensure that youth have opportunities to prevent pregnancy and STIs, have health equality, and have complete skills and knowledge to make well-informed decisions about their relationships and future.<br><br>Today, we will be asking for your personal feedback, which will help elected officials, other parents, schools, organizations, doctors and nurses best serve youth and help them make good decisions about their sexual health and relationships.<br><br>Any questions so far? Please let us know if you'd like clarification at any time. |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 10 minutes | What we want | | | We want to be up front with you about our underlying assumptions and beliefs about what we want:<br>• We want to prevent unplanned teen pregnancy and risk of getting a sexually transmitted infection, including HIV<br>• We want all youth to have healthy, safe relationships and to make decisions that are in line with their values<br>• We want all youth to have access to condoms and birth control and know how to use them<br>• We want all youth to feel good about the relationships that they are in and the choices they make<br>• We want all youth to feel supported by their community, family, friends, school, etc.<br>...and we want you to help us figure out how to get there.<br>Because we're asking you for your opinion and this is a sensitive subject, this can get personal. This is not a support group, but we will acknowledge your feelings and support you after we are finished here with the informal focus group. In order for everyone here to feel like they can share their honest opinion, we'd like to propose a few Group Guidelines: |
| 10 minutes | Group Guidelines | | **[Name]** reviews pre-written flip chart with "Group Norms". Ask if anyone needs clarification. Add any additional guidelines that the group recommends. Use extra paper if needed. | 1. Responses are anonymous (first name only, no identifying information about anyone)<br>2. Confidential responses (participants shouldn't share responses or experiences with others outside of the informal focus group space)<br>3. Safe space to share thoughts, ideas, opinions, experiences<br>4. All questions are good questions!<br>5. Check your assumptions, ask questions<br>6. All voices will be heard<br>7. Participate! Step up if you haven't spoken much, step back if you have<br>What other guidelines would you like to add? Any questions about any of this? |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 20 minutes | Informal focus group questions: Challenges and opportunities for youth, experiences of parents | | | • What do you think are the greatest challenges youth face today? What are the biggest opportunities?<br>• What kinds of situations do parents like you face when it comes to dealing with your adolescent, their relationships and decisions about having sex?<br>• What do you wish you knew more about so you could improve your communication with your adolescent about these issues?<br>If all participants are not responding, go around the circle and have each person list one or two things they wish they knew more about. |
| BREAK | | | | |
| 40 minutes | Informal focus group questions: Information about sex | | | There are many ways that parents get information and help on these issues. (Do nothing, read something, school/community organization/church workshop/talking with a friend or a relative, internet, e-mail, television).<br>• When you need support and information, where do you go?<br>• Is the information you receive meaningful to you? Does it make sense? Is it in line with your values? |
| | | | **[Name]** write on flip chart. List places across the top of flip chart | • Where would you like your adolescent to get information about their sexual health? |
| | | | **[Name]** Write on flip chart under each category. | • What kind of information, resources, and/or services would you like young people to receive from each of these places to help them make healthy decisions about their sexuality?<br>If group has not already identified them, may ask if the following places are relevant locations: Family, School, Church, Community, Clinic<br>• What messages would you like your adolescent to hear and see about sexuality and relationships? |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 35 minutes | Informal focus group questions: Statements from youth | | | I'm going to read you statements from young people about what they want from adults:<br>1. "My parents never said a word to me about sexuality or sexual health and I had to figure everything out on my own. I'm concerned because my little brother is getting near the same age I was when I became sexually active and I know that they are raising him the same way they raised me. I got lucky, I mean I took a number of risks when I first started and nothing happened to me but I worry for him. I've even asked them if I can sit down with him and explain things but that's not something they're comfortable with."<br>2. "I think that a lot of parents do this exaggeration. 'Don't even date until you're 35.' Seriously, do you want that for your kid? How terrible to be told that you should be alone until then. And yeah, they're kidding, they're exaggerating but for them to really expect that, to me it's nuts. You really think that you're encouraging your kids to really wait that long? I don't really understand what their thinking process is. I'm sure they are thinking that this is teaching [us]...but I think that if they were open about it we would be open about it."<br>3. "Parents in our community are saying, 'Don't you dare get pregnant! If you get a disease, that's on you.' I don't think parents are doing [this] on purpose, I just don't think they realize how important [talking with us about sex] is."<br>What are your first reactions to these statements?<br>How would you respond if your son or daughter told you that she or he were gay?<br>What resources would you need to be a supportive parent?<br>Overall, how can you support your adolescent to make healthy decisions about their sexual health?<br>What information can you provide? This can include referrals and does not have to come from you directly—if so, who would you want your adolescent to talk with? |

| Time | Agenda Item | Facilitator | Logistics | Script |
|---|---|---|---|---|
| 15 minutes | Thank You!<br>Closing Logistics | | | Any final closing questions or comments about our conversation? On behalf of all of us, we really appreciate your time today. Thank you!<br><br>Thanks to everyone for sharing tonight. We just want to remind you that your responses will stay anonymous and we'll just use general comments in the Plan.<br><br>If you have any questions, want more information after you leave here tonight, and want to see a copy of the Plan when it's complete, please write down your contact information with **[Name]**.<br><br>**[Name]** will meet you to give you your stipend. Thanks again for your time and help! |

## Statewide Survey

### The Process:

The Youth Sexual Health Survey was designed as an extension of the community conversations we initiated for the State Plan. The Project Team wanted to reach a larger audience of youth and adults in Colorado to understand what is and isn't working in their communities, as well as what gaps in knowledge and services exist. The survey was created through *www.surveymonkey.com*. A Quick Response (QR) code was also created, which enabled participants to scan a barcode-like image to link to the survey online via their smart phone.

The survey began with several demographic questions and questions about the existence of resources in their community. Survey respondents who identified as youth were directed to one part of the survey while respondents who identified as parents of youth or adults who work with youth were directed to a different set of questions. Those who didn't fit into any of those categories exited the survey at that time. The youth portion of the survey heavily drew from community conversation themes.

### What Was Found:

The online survey was very successful in reaching a broad audience of Colorado youth and adults. There were 858 survey respondents from 52 of Colorado's 64 counties. Youth and adults overwhelmingly expressed a desire for education around safe and healthy relationships in sexuality education classes, as well as STI, HIV and unplanned pregnancy prevention. A more thorough overview of survey results can be found on later in this document.

### Future Recommendations:

If a state was to put forth a statewide survey as part of the development of the state plan, we recommend that the outreach and recruitment of participants be aided with community organizations. Furthermore, having the questions divided to be youth and adult specific gave the Project Team a large amount of information to build off of when writing the plan. Finally, we believe that using a QR code to scan from a smart phone increased the number of participants immensely (see description of the QR code, above).

## Survey Instructions

Thank you for taking the time to complete our survey. This survey is open to all people, although we are specifically looking for the opinions of youth, parents of youth, and professionals who work with youth regarding adolescent sexual health. Your opinions will inform the Colorado State Plan for Youth Sexual Health sponsored by the Colorado Department of Public Health and Environment (CDPHE). The goal of the Plan is to effectively guide state and local communities in the improvement of the sexual health of Colorado youth. The data from this survey will be collected by staff members of Colorado Youth Matter and The Healthy Colorado Youth Alliance. If you have any questions about the survey or would like more information about the state plan, please contact [**enter email address**].

You will have the option to enter your name at the end of this survey to enter a drawing for a $50 VISA gift card. Your responses will be absolutely anonymous, so please be honest. Please mark the best response to each statement or question. The survey should take between 5-10 minutes to complete. If you have completed this questionnaire before, please do not take it again but rather forward it to someone you think may be willing to complete it.

## Demographic Questions

What is your gender?

- Man
- Woman
- Transgender
- Other

In what year were you born?

What is your 5-digit zip code?

How do you describe yourself (Please mark all that apply)

- Asian
- African American or Black
- Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- Caucasian or White
- American Indian or Alaska Native
- Multiracial
- Other

In my community, sexual health programs and services are available for youth.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

The following programs and services for teen parents are available in my community. (Please mark all that apply)
- Educational/GED Support
- Affordable childcare
- WIC (Women, Infants and Children)
- Teen parent social worker in school
- Flexible school scheduling
- Access to Medicaid
- Access to affordable housing
- Nurse Family Partnership
- There are no programs and services for teen parents in my community
- Don't Know
- Other

Youth in my community know how to access sexual health programs and services.
- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

Which best describes you?
- I am a youth between the ages of 14 and 24.
- I am a parent or guardian of a youth.
- I am an adult who works with youth.
- None of the above.

## Youth-specific questions

I go to a (Please mark all that apply)
- Public School
- Charter School
- Private School
- Home School
- College/University
- I am a youth and I am not in school
- Other

What information and skills do you want to gain from a sexuality education class? (Please mark all that apply)
- Unplanned pregnancy prevention
- STI and HIV prevention
- Sexuality and sexual orientation
- Condoms and contraceptives
- Abstinence
- Decision-making and goal-setting
- Safe and healthy relationships
- Other

What questions do you need answers to? (Pick up to three choices)

- What is dating?
- How can I prevent dating violence and/or sexual assault?
- How can I create safe, healthy relationships?
- What is HIV?
- What are sexually transmitted infections?
- How can I get a sexually transmitted infection?
- How can I prevent an unwanted pregnancy?
- What is abstinence?
- What is comprehensive sexual health education (sex ed)?
- Where can I learn more about the changes in my body?
- How do I use condoms?
- How do I use birth control/ contraceptives?
- How can I talk to a trusted adult about my sexual orientation?
- How can I talk to my parent or a trusted adult about sex?
- How can I talk to my partner about sex?
- I don't have any questions at this time.
- Other

Do you have a trusted adult in your life that you feel comfortable asking questions to about sexual health?

- Yes
- No

This person(s) is: (mark all that apply)

- A mentor
- A coach
- My parent(s) or guardian(s)
- My sibling(s)
- Other family member(s)
- My friend(s)
- My teacher(s)
- My doctor(s) or other health professional
- My counselor(S)
- There is no one that I can talk to
- Other

Instructions: Think of the following statements as they relate to your own sexual health and rank whether they are always, mostly, sometimes or never true for you.

**Relationships**

I feel safe in my relationship.

- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me
- I have never been in a relationship.

I feel comfortable talking with my partner about what I want and don't want.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me
- I have never been in a relationship.

I am respected by my partner.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me
- I have never been in a relationship.

**Self-confidence**

I am in control of my sexual health.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I make choices that I'm proud of.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Family**

I am open with my family about my sexuality and all aspects of my sexual health.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I want to be open with my family about my sexuality and all aspects of my sexual health.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I'm not afraid to talk with my family about the questions I have.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Family Support**

My family has the resources they need to raise healthy children and be healthy themselves.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Community Support**

I feel safe in my community.

- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I know my neighbors.

- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

My community offers me access to opportunities that I want.

- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Health Resources and Services**

I feel comfortable accessing health services.

- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I know where to go to get reliable information, resources and services if I need them.

- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me
- I can afford the health services I need.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Education**

I am educated in the different forms of contraceptives and I know how to use them.

- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I know how to effectively prevent disease and pregnancy.

- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I have an education resource(s) (school, doctor, friends, family, etc.) that is/are a good place for me to learn about sexuality and healthy relationships.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Skill-building**

I have the confidence, skills and knowledge to make choices that are right for me.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I have the confidence, skills and knowledge to make choices that are right for my relationships.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Future Goals and Career Options**

I feel supported in what I value and what I want to achieve.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I receive positive support in developing my future goals.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

I receive positive support in planning for the future I want for myself.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Teachers, Mentors, Trusted Adults**

The teachers, mentors and trusted adults in my life are knowledgeable, trustworthy, supportive and non-judgmental.
- Always true for me
- Mostly true for me
- Sometimes true for me
- Never true for me

**Parent and Adult-specific Questions**

The youth I work with and/or the youth in my care go to a (Please mark all that apply)

- Public School
- Charter School
- Private School
- Home School
- College/University
- I am a parent and my youth are not in school
- I work with youth who are not in school
- Other

What kinds of resources can best help educate youth about sexual health? (Please mark up to three choices)

- Health professionals
- Schools (teachers, sexuality education classes)
- School-based health centers
- Clinics located outside of the school
- Friends and family members
- Internet
- Videos
- Community trainings
- Books or pamphlets
- Religious settings and/or leaders (such as church, mosque, synagogue, temple, etc.)
- Other

What kinds of resources do you currently use to education the youth in your life about sexual health? (Please mark all that apply)

- Health professionals
- Teachers and sexuality education classes at school
- School-based health centers
- Clinics located outside of the school
- Friends and family members
- Internet
- Videos
- Community trainings
- Books or pamphlets
- Religious settings and/or leaders (such as church, mosque, synagogue, temple, etc.)
- Personal experiences
- Other

I know where to find information to help the youth in my life be healthy.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

I feel confident providing sexual health information to the youth in my life.

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree
- Don't Know

What information and skills do you want youth to gain from a sexuality education class? (Please mark all that apply)

- Unplanned pregnancy prevention
- STI and HIV prevention
- Sexuality and sexual orientation
- Condoms and contraceptives
- Abstinence
- Decision-making and goal-setting
- Safe and healthy relationships
- Other

How important is it to you that information in a sexuality education class is:

- Medically accurate
- Important
- Neither important nor unimportant
- Unimportant
- No opinion
- Evidence-based
- Important
- Neither important nor unimportant
- Unimportant
- No opinion
- Culturally relevant
- Important
- Neither important nor unimportant
- Unimportant
- No opinion
- Age appropriate
- Important
- Neither important nor unimportant
- Unimportant
- No opinion

What questions do you need answers to? (Pick up to three choices)

- How can I prevent dating violence and/or sexual assault for the youth in my life?
- How can I promote safe, healthy relationships for the youth in my life?
- What is HIV?
- What are sexually transmitted infections?
- How can I help youth prevent an unwanted pregnancy?
- What is abstinence?
- What is comprehensive sexual health education (sex ed)?
- How do I teach youth to use condoms?
- How do I teach youth to use birth control/contraceptives?
- How can I talk to young children about body parts and age-appropriate topics about sex?
- How can I talk to youth about sex?
- When should I talk to my child about sex?
- I don't have any questions at this time
- Other

## Colorado Youth Sexual Health Survey Results

Total started survey: 858

Total completed survey: 701 (82% completion rate)

### DEMOGRAPHICS

**Gender**

81% women
17% men
1% transgender
1% other: queer, neither, genderqueer (x6), Two-spirited

**Age**

Youngest respondents (5) born in 1997, age 14
Oldest respondent born in 1932, age 79
The most common age was 21 years old (51 respondents)

52 respondents between the ages of 14-17
151 respondents between the ages of 18-21
111 respondents between the ages of 22-25
96 respondents between ages of 26-30
146 respondents between ages of 31-40
140 respondents between ages of 41-50
158 respondents age 51 and above

250 respondents (31.6%) identified as a youth (between ages 14 and 24)
121 respondents (15.3%) identified as a parent or guardian of a youth
356 respondents (45.0%) identified as an adult who works with youth

**Race**

81.6% Caucasian or White
12.9% Hispanic or Latino
3.8% Multiracial
3.6% African American or Black
2.2% Asian
2.0% American Indian or Alaska Native
1.5% Other: Indian, Mexican (x2), European (x2), Ethiopian, Human (x2), Jewish, Arab, Chicano/a (x2)
0.7% Native Hawaiian or Other Pacific Islander

**Counties represented (52 total listed alphabetically)**

Adams, Alamosa, Arapahoe, Archuleta
Baca, Bent, Boulder, Broomfield
Chaffee, Cheyenne, Conejos, Costilla, Crowley
Denver, Douglas
Eagle, El Paso, Elbert
Fremont
Garfield, Grand, Gunnison

Huerfano
Jackson, Jefferson
Kiowa, Kit Carson
La Plata, Larimer, Las Animas, Lincoln, Logan
Mesa, Moffat, Montrose, Morgan
Otero, Ouray
Park, Phillips, Pitkin, Prowers, Pueblo
Rio Grande, Routt
Saguache, San Miguel, Summit
Teller
Washington, Weld
Yuma

**Counties with highest respondents**
Denver 24%
El Paso 12.5%
Boulder 9%
Arapahoe 8.5%
Larimer 7.5%
Jefferson 6%
Adams 4%
Montrose 4%
Weld 3.5%
Garfield 3%

**OTHER RESPONSES**

**51.5%** of respondents "Agree" that sexual health programs and services are available for youth in their community.

18.5% disagree and 15.4% don't know

The most well-known programs and services available for teen parents in the community are:

- Education/GED support (57.6%)
- WIC (57.4%)
- Access to Medicaid (52%)
- Nurse Family Partnership (26.9%)
- Flexible school scheduling (23.8%)

**34.6%** of respondents don't know if these programs are available for teen parents in their community.

**39.2%** of respondents "Disagreed" that youth in their communities know how to access sexual health programs and services. **26.4%** agreed and **20.2%** didn't know

## YOUTH SPECIFIC QUESTIONS

61.3% of youth respondents attend college or university

22.6% of youth respondents attend public school

**88%** of youth want to receive information and skills on **safe and healthy relationships** in a sexuality education class.

Other topics include:

- STI and HIV prevention (84.3%)
- Condoms and contraceptives (78.3%)
- Unplanned pregnancy prevention (74.2%)
- Decision-making and goal setting (69.1%)
- Sexuality and sexual orientation (66.4%)

Other topics to consider including are anti-bullying, mental, emotional and social factors in sex and pregnancy, biology of sexual organs and the act of sex, communication skills, positive sexuality and body image, abstinence.

"The word abstinence makes sex sound like drugs and alcohol. But it's important to learn that it's okay not to have sex if you're not ready."

"We need to address the Madonna-whore paradigm, and how that creates extreme, conflicting, and psychologically unhealthy attitudes towards women's sexuality. It also has disastrous physical consequences – we are less likely to take care of our bodies if we are ashamed of them. (Why is this important? Women are over half the population, in case our sex-ed program creators forgot.)"

The top questions youth need answers to are:

- How can I create safe, healthy relationships? (32.3%)
- How can I talk to my partner about sex? (30%)
- How can I prevent dating violence and/or sexual assault? (17.1%)

Other questions respondents added include:

- What is common in sex? What should I expect? What is abnormal sex? What happens to your body during sex?
- Where, other than school, can I find resources with answers to any of the above questions?
- 30% of respondents did not have any questions

**82%** of youth have a trusted adult they feel comfortable asking questions to about sexual health. This person is most often a friend(s), parent(s) or guardian(s), or doctor(s) or other health professional(s).

60.4% always true: I feel safe in my relationship.

46.5% always true: I feel comfortable talk with my partner.

57.6% always true: I am respected by my partner.

74.2% always true: I am in control of my sexual health.

45.2% always true: I make choices that I'm proud of.

34.6% mostly true: I am open with my family about my sexuality and my sexual health.

40.6% mostly true: I want to be open with my family about my sexuality and sexual health.

30.9% sometimes true: I'm not afraid to talk with my family about the questions I have.

61.8% always true: My family has the resources they need.

47.9% mostly true: I feel safe in my community.

30.9% tie between mostly and sometimes true: I know my neighbors.

33.6% mostly true: my community offers me access to the opportunities I want.

49.3% always true: I feel comfortable accessing health services.

50.7% always true: I know where to go to get reliable information, resources and services.

37.8% always true: I can afford the health services I need.

64.1% always true: I am educated in the different forms of contraceptives and I know how to use them.

69.6% always true: I know how to effectively prevent disease and pregnancy.

63.6% always true: I have an educational resource that is a good place to learn about sexuality and healthy relationships.

63.1% always true: I have the confidence, skills and knowledge to make choices right for me.

59.4% always true: I have the confidence, skills and knowledge to make choices right for my relationships.

69.1% always true: I feel supported in what I value and what I want to achieve.

70.5% always true: I receive positive support in developing my future goals.

69.1% always true: I receive positive support in planning for the future I want for myself.

49.8% always true: The teachers, mentors and trusted adults in my life are knowledgeable, trustworthy, supportive and non-judgmental.

**ADULT SPECIFIC QUESTIONS**

Most of the youth (87.7%) that adults work with or the youth in their care go to a public school.

The top three resources to best help educate youth about sexual health are:

- Schools (teachers, sexuality education classes) (71.5%)
- Health professionals (56.5%)
- School-based health centers (44.4%)

Other resources adults suggested were:

- Parents (x9)
- Internet
- Social media (x2)
- Abstinence education programs (x2)
- School nurses
- Our Whole Lives program (x2)
- Role models (high school or college age)
- After school programs (x6)
- Peer support programs like Friends First and STARS
- Youth centered groups.

The most commonly used resources adult use to educate youth about sexual health is:

- Health professionals (60.4%)
- Teachers and sexuality education classes at school (51.6%)
- Books and pamphlets (44.2%)
- Friends and family members (43.3%)

Other resources adults use are

- After school programs
- A disease intervention specialist
- School nurses
- Peer educators
- One-to-one conversations
- Baby Yourself for Life (formerly Healthy Women, Healthy Families) curriculum
- Boys and Girls Club
- Girls Inc.
- Our Whole Lives
- Teen Companion Program (Montrose county)
- Films, DVDs
- After school pregnancy prevention program funded by Medicaid
- Sisters of Color United for Education
- Friends First program
- Planned Parenthood
- Case managers
- Reality television

Most adults **"Agree" (47.9%)** that they know where to find information to help youth be healthy.

Most adults **"Strongly Agree" (48.6%)** that they feel confident in providing sexual health information to youth.

The most requested information and skills adults want youth to gain from a sexuality education class is:

- Safe and healthy relationships (95.8%)
- STI and HIV prevention (92.4%)
- Unplanned pregnancy prevention (91.2%)
- Decision-making and goal setting (90.5%)
- Condoms and Contraceptives (84.5%)

Other topics adults would like to include are:

- Self-esteem
- Media literacy
- How to have healthy relationships without having sex
- Violence prevention
- "That sex can and should be a positive experience"
- Communication skills
- Basic anatomy and physiology
- Intersection of gender identity and sexual identity
- Negotiation and refusal skills
- Self-empowerment
- Emotional effects of sex

Adults think it is important that sexuality education is medically accurate (98.6%), evidence-based (90.3%), culturally relevant (88.7%), and age appropriate (94%).

The top three questions adults need answers to are:

- How can I promote safe, healthy relationships for the youth in my life? (48.4%)
- How can I prevent dating violence and/or sexual assault for the youth in my life? (32.9%)
- How can I talk to young children about body parts and age-appropriate topics about sex? (20.1%)

Other questions that arose for parents were:

- How to make state agencies understand the cultural relevance of abstinence and marriage education programs?
- How to organize training sessions for parents?
- What culturally relevant information should I be aware of in sex ed?
- How to work in a strong Christian conservative environment?
- How can the community become more comfortable addressing the real issue of sexual health and THEIR youth?
- Is it appropriate or necessary to talk to youth about sex toys or masturbation in a safe sex curriculum? How do you address it delicately and appropriately?
- How to keep children safe from online dangers?

## Online Resources

Advocates for Youth
www.advocatesforyouth.org

AIDS Coalition for Education (ACE)
www.acecolorado.org

Association of Reproductive Health Professionals
www.arhp.org

Bedsider
www.bedsider.org

Centers for Disease Control and Prevention – Adolescent Reproductive Health Center
www.cdc.gov/reproductivehealth/drh/activities/AdolescentRH.htm

Centers for Disease Control and Prevention – 10 Essential Public Health Services
www.cdc.gov/nphpsp/essentialservices.html

Colorado Law – Standards for Sex Education (The Healthy Colorado Youth Alliance Fact Sheet)
www.healthycoloradoyouth.org/images/stories/pdf/co_law1292.pdf

Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
www.colorlatina.org

Colorado School-Based Health Centers
www.casbhc.org

Colorado Youth Matter
www.coloradoyouthmatter.org

Colorado Youth Partnership for Health
www.healthyyouthcolorado.org

Denver STD/HIV Prevention Training Center
www.denverptc.org

Education, Training and Research Associates
www.etr.org

Effective Interventions: HIV Prevention That Works
www.effectiveinterventions.org/en/Home.aspx

Families are Talking
www.familiesaretalking.org

Girls Inc.
www.girlsinc.org

Guttmacher Institute
www.guttmacher.org

The Healthy Colorado Youth Alliance
www.healthycoloradoyouth.org

Healthy People 2020
www.healthypeople.gov/2020

Healthy Teen Network
www.healthyteennetwork.org

Healthy Teen Network Fast Facts: The Unique Sexual and Reproductive Health Needs of Gay, Lesbian, Transgender, and Questioning (LGBTQ Youth)
healthyteennetwork.org

Mid-America Prevention Training Center
www.cdphe.state.co.us/dc/hivandstd/MAPTC/index.html

My Life Colorado
www.mylifecolorado.com

The National Campaign to Prevent Teen and Unplanned Pregnancy
www.thenationalcampaign.org

The National Coalition Against Domestic Violence
www.ncadv.org

National Women's Law Center Title IX Fact Sheet
www.nwlc.org/sites/default/files/pdfs/ProtectionsforPregnantandParentingStudents.pdf

Planned Parenthoodwww.pprm.org

Sex Etc.
www.sexetc.org

STD Prevention Online.org
www.stdpreventiononline.org

Talk Early Talk Often
www.michigan.gov/miparentresources/0,1607,7-107-37383---,00.html

Talking with Kids
www.talkingwithkids.org

Teen Wire
www.TeenWire.com

Wise Guys
www.wiseguysnc.org

This is an incomplete list of the many resources available in support of youth sexual health across Colorado. For more information about other youth resources in Colorado, visit www.cdphe.state.co.us.