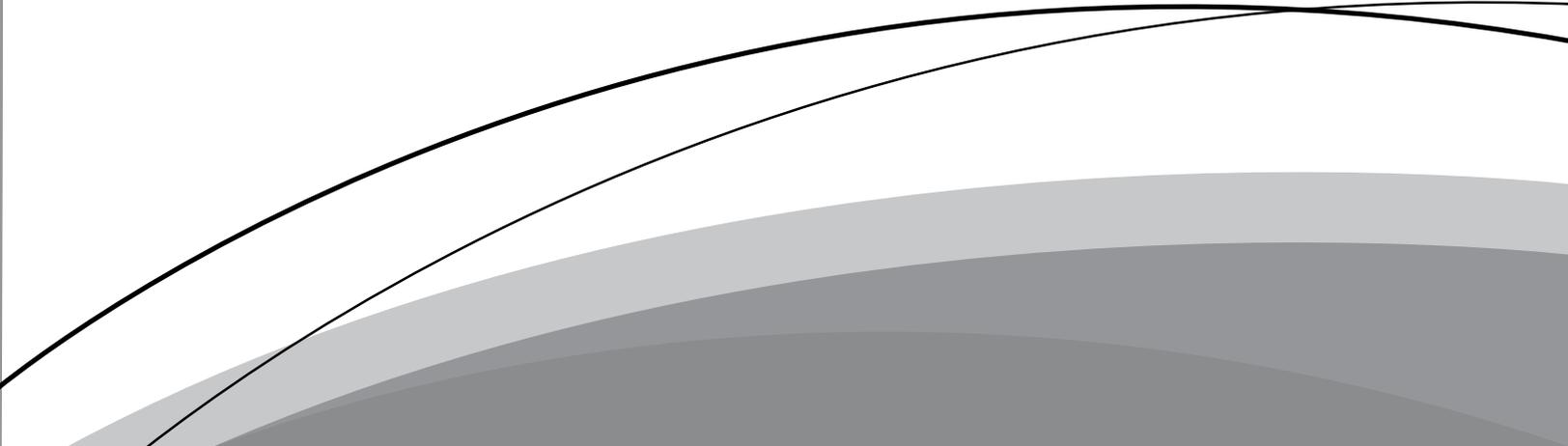
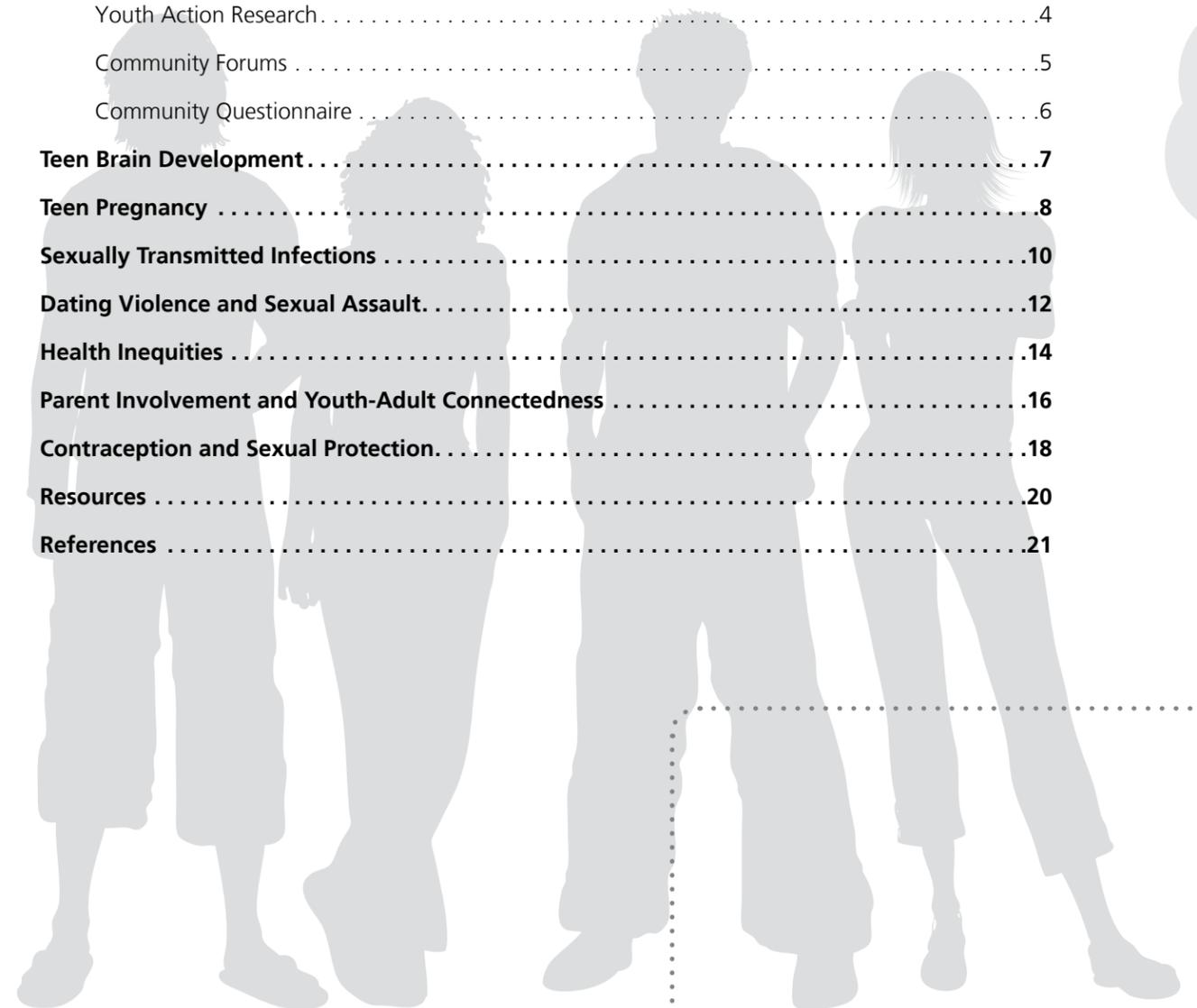


OREGON Youth  
Sexual  
**HEALTH**  
**PLAN**   
APPENDICES



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## Sources Contributing to the Oregon Youth Sexual Health Plan

The Teen Pregnancy Prevention/Sexual Health Partnership (TPP/SHP) conducted a community questionnaire, supported youth to engage in action research in three areas of the state and held nine community forums. Involving multiple perspectives means the plan better represents Oregon's diverse communities. An inclusive process facilitates community ownership of the plan.

The plan incorporates findings from current research on how to best promote the well-being of youth and communities. Following are descriptions of the various data sources used, as well as brief reviews of the scientific literature on teen pregnancy, sexually transmitted infections (STIs), dating and sexual violence, adolescent brain development, contraception and sexual protection, health inequities and parent involvement.

## Youth Action Research

**Background:** As work commenced on this plan in 2005, TPP/SHP sought explicit ways to embed youth development and youth engagement principles in the planning process. Youth action research worked as a mechanism for involving youth in strategic planning, while strengthening an evidence-driven public health approach.

Action research is designed to bridge the gap between experts and service users. It puts research capabilities into the hands of service users (in this case youth) so they gain knowledge about health behaviors while transforming their neighborhoods, communities and institutions. Action research values local, practical knowledge as much as professional, theoretical knowledge and views research as a tool for social change.

Three sites implemented action research projects: Multnomah County and Jackson County health departments and Planned Parenthood of the Columbia Willamette in Deschutes County. Twenty-two 11th and 12th graders were trained as researchers and their findings contributed to the plan's development. They received a small stipend for their participation, as well as the ability to use the research results as part of their senior projects for graduation. Research

mentors – professionals from local universities and health departments – offered training and guidance. Each site chose its own research design. All projects shared a set of core features. Young people:

- Received training in research methods and adolescent sexuality;
- Developed their own research question and corresponding research design;
- Navigated local ethics procedures and collected data;
- Analyzed their findings and developed recommendations;
- Presented their results and recommendations at a community forum.

Projects varied in recruitment practices, training emphasis, number of research questions and focus on data collection versus analysis and action.

**Methodology:** Sexuality education emerged as a key concept of interest for young people in all three projects. Teens wanted to know what their schools were teaching, how this compared to state and national standards and the effectiveness of sexuality education that occurred outside the classroom through peers, parents and religious leaders. Although the teen action researchers selected topics explored in existing scientific literature, they framed the issues to yield locally owned results.

**Participants:** A total of 2,333 youth responded to questionnaires or participated in focus groups across the three sites.

**Results:** Research results were similar across the three pilot sites, despite variations in question wording, survey instrumentation and sample populations. Youth action researchers discovered:

- What was being taught in school did not align with Oregon state law.
- Youth wanted more information about relationships, rather than just the mechanics of sex and sexuality.
- Youth were interested in exploring such issues as gender roles and stereotypes, body image, sexual orientation and intimate partner violence.

- Youth wanted more conversations with their parents and religious communities about sexual development.
- Peer-to-peer support and education often was not sufficiently visible or accessible.

**Recommendations:** Based on their findings, the action researchers compiled a series of recommendations for school, community and state leaders.

At a school level, recommendations included:

- Institute greater peer-to-peer outreach;
- Incorporate action research into health classes and curricula;
- Increase oversight of sexuality education by the local school board to ensure that school-based sexuality education aligns with Oregon statutes and administrative rules.

At a community level, recommendations included:

- Increasing engagement and dialogue with religious groups;
- Offering health classes for parents;
- Having more forums for community members to listen to and talk with young people.

At a state level, recommendations included:

- Offering enhanced, youth-led professional development for teachers;
- Creating greater visibility of the state's existing sexuality education standards;
- Enhancing access to youth-friendly family planning services.

## Community Forums

**Background:** With the help of local health departments and community groups, TPP/SHP organized nine forums throughout Oregon between October 2006 and May 2007. The forums encouraged community dialogue on youth sexual health and gathered input for the development of this plan.

**Methodology:** Facilitators asked a series of questions to stimulate discussion about priority issues and possibilities for improving youth sexual health.

**Participants:** Forums were held in Clatsop, Deschutes, Jackson, Lane, Lincoln, Marion and Multnomah counties. Seven forums included adults and youth. In four forums, participants were exclusively youth. In all, 881 people participated. One forum, held in Northeast Portland, focused on gathering input from African American communities. Another forum, conducted in Spanish in Woodburn, focused on Latino communities.

**Results:** One theme emerged clearly and consistently from youth and adults in all forums: "We need more sexual health education." Participants requested education not only for youth but also for parents, teachers and community members. Youth expressed a desire to have their parents talk to them, but they also wanted parents to have education and resources available so they would be more comfortable communicating.



**Teachers:** All groups felt teachers need more education so they, too, would have greater comfort and confidence discussing sexuality and be able to teach material in a manner that is not judgmental. Youth wanted adults to be realistic about the fact that some youth have sex and some get pregnant – youth in all circumstances need information and support to make their own choices.

**Minorities:** Latino and African American communities identified mainstream media as an obstacle to youth sexual health. Negative role models, unrealistic depictions of sexuality and stereotypes in the presentation of their communities are all pressing problems. Participants in the African American community forum noted churches are important to their community and could play a larger role in helping youth make healthy choices.

Participants in the Latino community forum stressed the importance of promoting gender equality and working against a sexual double standard that encourages girls to be passive and emphasizes virginity, while encouraging boys to be assertive and take pride in their sexuality. Latino youth said girls often receive little information about sexual health and what messages they do receive focus predominantly on clinical services. Males receive almost no formal information about sexual health. However, they hear many messages that have the potential to negatively affect their sexual health including equating being a man with being sexually experienced and that men should be dominant in relationships.

**Adults:** Youth at several forums reported adults appeared reluctant to share information. Withholding information makes youth feel disrespected. Youth expressed that withholding information would not hold people back from making decisions that affect their sexual health and providing information would give them knowledge to make healthier decisions.

**New emphasis:** Historically, sexual health education has focused on the biology of reproduction, abstinence, sexually transmitted infections and risk reduction methods. Youth want more information on relationships – communication skills and how to navigate relationship dynamics. Teens specifically identified lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth issues as important to discuss as part

of sexual health. They also thought people should accept all youth, regardless of gender identity or sexual orientation.

Support for youths' decisions and the importance of not being judged arose consistently from youth at all forums. Youth expressed a desire to have greater involvement and support from all adults. They want open and accurate information and sexual health, as well as guidance and understanding.

The issues and corresponding solutions identified by forum participants reflect the need to move away from an approach that sees youth as part of the problem and sex education that focuses mainly on the mechanics of preventing pregnancy. The emerging philosophy embraces the whole person and uses interventions that respect youths' ability to make informed decisions and empowers them by including them in sexual health intervention development. An approach that connects youth and adults in partnership to make healthy informed decisions is likely to improve the entire community's health.

### Community Questionnaire

**Background:** The Teen Pregnancy Prevention/Sexual Health Partnership (TPP/SHP) surveyed adults and teens on their opinions regarding contraceptive access and school sexual health curricula for teens. In May 2006, the Oregon Department of Human Services contracted with Behavior Works to extend data collection within specific populations, analyze the data and write a final report.

**Methodology:** The survey was self-administered and contained 24 questions for respondents older than age 18 and an additional four questions for those 18 years and younger. Surveys were available in English and Spanish. To increase accessibility, surveys were available on the Internet, handed out in person at health fairs and distributed with a postage-paid mailing label in the May issue of the Rational Enquirer (a youth sexual health magazine distributed statewide). The data collection period extended from March through September 2006. It is important to note this was a convenience sample, not a random sample. Conclusions are therefore representative of those who completed the survey and do not represent the state as a whole.

**Participants:** A total of 1,733 surveys were collected from March 20, 2006, to September 14, 2006. The respondents were predominantly female (81 percent), between the ages of 19-49 (66 percent), Caucasian (61 percent), residents of the Portland tri-county area (55 percent), English speakers (97 percent), married or with a partner (72 percent) and had one or two children (45 percent).

**Results:** Respondents support sexuality education and contraceptive access. Respondents were very clear that they want sexuality education, access to contraception and condoms and teen parent programs. They were less clear about what currently is happening with these topics. Respondents agreed that:

- Age-appropriate comprehensive sexuality education should be taught in their communities' public schools (68 percent strongly agree; 24 percent agree).
- Contraception and condoms should be available to teens in their communities (57 percent strongly agree; 27 percent agree).
- Specific teen parent programs and services should be available throughout their communities (66 percent strongly agree; 30 percent agree).

Respondents generally opposed abstinence-only programs. The majority (80 percent) do not want public schools to limit sexuality education to abstinence and 79 percent would oppose a state requirement to teach abstinence-only sexuality education; however, 16 percent support abstinence-only education.

Attitudes were mixed about current public school sexuality education. Most respondents reported they are neither satisfied nor dissatisfied with sexuality education in their communities' public schools (45 percent). Less than half have children in a public school, so they might not be informed of current programs. Regarding whether the sexuality education in the community's public schools was sensitive to their cultural values and beliefs, one-third (33 percent) thought it was "somewhat culturally sensitive," almost one-third thought it was "a little culturally sensitive" (28 percent) and almost one-third thought it was "not at all culturally sensitive" (29 percent). Researchers need to explore why so many respondents reported sexuality

education is not sensitive to their cultural values and why they are dissatisfied with sexuality education in their communities.

### Teen Brain Development

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The teenage years are full of change and growth. Adolescence is often a time of encountering new freedoms and new situations. Professionals in the political and health care fields still debate how much responsibility teens should be given and at what age (for example see references <sup>8,9,10</sup>). Over the past few years, sound research has emerged that documents the enormous changes to the brain in the developing years between childhood and adulthood.<sup>9</sup> This research can provide beneficial insight when creating and implementing public health policies that affect young people.

Previously, it was thought that most brain development was complete by the end of childhood – that teenagers' brains were as mature as adult brains. As a result of increasingly sophisticated research and imaging abilities, we now know this is not the case.<sup>10</sup> Just as teens' bodies are maturing and their social skills are expanding, their cognitive centers are also in flux.

During adolescence, the brain adopts a "use-it-or-lose-it" pruning system, resulting in a decreasing number of connections among brain cells and a simultaneous increase in the speed and efficiency of surviving connections.<sup>8</sup> Major changes also are in the prefrontal cortex (PFC), known as the "executive planner" of the brain. The PFC is responsible for weighing risks and benefits, strategic thinking and impulse control. Throughout adolescence, the PFC is refining its wiring to become more sophisticated. This is an important window of opportunity for learning and specialization. Studies demonstrate that the PFC is among the last parts of the brain to fully develop, in many cases not maturing until well into the third decade of life.<sup>9</sup> As this construction phase progresses, synapses that normally go through the PFC in an adult brain are re-directed to the amygdala, the emotional center of the brain. When this happens, responses may be more influenced by emotion – fight, flight,

freeze, freak out – than rationality. Feeling strong emotions is a normal part of teen brain development. The amygdala can also misinterpret facial expressions, perceiving fear or nervousness as anger or hostility.

These processes can affect young people’s decision making them more vulnerable to risk taking and impulsive behaviors. If you sometimes feel a teenager is overreacting or misinterpreting, you have likely met his or her developing brain in action.

The adolescent brain is especially sensitive to the effects of dopamine, a chemical neurotransmitter activated by, among other things, substance use, gambling, food, sex, computer games and other stimulating media.<sup>8</sup> When drugs and alcohol are introduced in adolescence, the brain’s natural supply of dopamine can decrease, making teens more vulnerable to addiction. It is still not known how much brain development is influenced by environment and how much by genetics, but evidence suggests constructive learning experiences can positively shape teen cognitive development.<sup>10</sup>

### Supporting brain development

As research results emerge, some public health professionals voice concern that the results will be used to squelch teen independence or rights in areas such as health care decision making. Public health policy and science provide us compelling responses to that concern.<sup>10</sup> First, scientists working in this area note further research is still needed to fully understand the human brain and the practical applications of these new findings. Second, brain development should be just one of several factors considered when designing effective programs and policies. Third, it is important to recognize that successful brain development relies on exercising this organ. From the use-it-or-lose-it perspective of refining maturing brain connections, caring adults need to provide meaningful opportunities for youth to exercise brain functions that require analytical, decision making and valuing skills. For optimal brain development, teens need to have new experiences, succeed and make mistakes in low-risk environments. Encouraging youth to demonstrate their real and valuable role in making good decisions and advocating for their health is one way to help them build their developing brains.

## Teen Pregnancy

The National Center for Health Statistics reported a 3 percent increase in teen births from 2005 to 2006.<sup>11</sup> In spite of the recent increase, overall teen birth rates in the U.S. have declined dramatically during the past 15 years. The birth rate dropped 36 percent for teens aged 15 to 19 from 1990 to 2002.<sup>12</sup> Experts attribute 86 percent of the teen pregnancy decline to more effective use of condoms and other contraception by sexually active teens.<sup>13</sup> Sexually active young people are using condoms more than ever before; reported condom use at last sexual intercourse increased from 46 percent in 1991 to 63 percent in 2005.<sup>14</sup> More young people also are choosing to remain abstinent during early and middle adolescence, accounting for about 14 percent of the teen pregnancy decrease.<sup>13</sup>

Despite success in efforts to decrease teen pregnancy rates, early childbearing continues to be an issue of concern to communities and public health officials around the country. The United States has the highest teen birth rate of any industrialized country and a higher rate than more than 50 developing countries.<sup>15</sup> According to the National Campaign to Prevent Teen and Unintended Pregnancy, each year approximately 900,000 teenagers become pregnant. More than four in 10 young women have been pregnant at least once before they reach age 20.<sup>16</sup> Most teen mothers come from socially or economically marginalized families; having a child often compounds their difficulties.<sup>17</sup> The majority of teen mothers live in poverty during the first 10 years of their children’s lives.<sup>18</sup> Barriers make it difficult for many to complete the education necessary to obtain a higher-paying job.

### Including young men in the picture

The National Center for Health Statistics reported that 17 per 1,000 males in their teens became fathers in 2002.<sup>19</sup> Compared with young men, young women face a disproportionate burden of the consequences of unplanned pregnancy and a sexual double standard that emphasizes female submissiveness and sexual purity. However, young men also are harmed by conflicting messages about sexuality from the media, peers and family members. Many young men feel pressure to engage in sexual behavior in order to demonstrate masculinity. At the same time, society criticizes young men, especially young men of color,

for being hypersexual. Critically examining messages and pressures young men face with regard to sexuality and masculinity will enhance work with young men to promote sexual health and prevent unplanned pregnancy.

Men’s role in sexual health promotion is complex. In 10 percent of teen births, the mother is 15 to 17 and the father is five or more years older.<sup>20</sup> It is important to examine the power dynamics in such relationships and the social factors that lead to relationships with significant age differences. Laws exist to discourage adult men from exploitative or abusive relationships with younger girls. However, improving access to economic opportunities and advancement may discourage adult sexual involvement and childbearing with minors.<sup>20</sup>

### Challenges for teen parents and their children

Some children born to teen parents thrive, but many face significant challenges. Children born to teen mothers are more likely to be poor and twice as likely to drop out of school; teen mothers’ sons are three times more likely to be incarcerated as adults.<sup>21</sup> Children of teen mothers are more likely to engage in sexual intercourse at a young age and become teen parents themselves.<sup>15</sup> Children born to teen parents often do not have a chance to develop close connections with their fathers if the relationship between the mother and father dissolves over time.<sup>22</sup> Teen mothers and fathers need support to develop positive parenting practices and to gain employment and life skills.

Not only are many teen moms faced with poverty, there are medical risks involved with teen pregnancy. Babies born to teen mothers are 50 percent more likely to have low birth weight than babies born to adult women.<sup>21</sup> Having a low birth weight doubles a child’s chance of later being diagnosed with dyslexia, hyperactivity or another disability. There is also a higher rate of infant mortality for teen moms – nearly three times higher than for adult women.<sup>23</sup> Other complications that children of teen moms suffer disproportionately are premature births, pregnancy-induced hypertension and anemia.<sup>24</sup>

Research suggests most teen mothers remain sexually active. Once a teen has had one infant, she is more likely than non-parent teens to have another. Approximately 25 percent of adolescent births are not first births.<sup>16</sup> More effective support and education for teen parents may help them be more consistent users of birth control following a birth.

Many people in the United States believe educational, social, medical and economic difficulties experienced by teen mothers and their children are consequences of teenage childbearing. However, research shows that social and economic disadvantage is among the causes, as well as consequences, of teenage childbearing.<sup>15</sup>

### Models for healthy youth sexuality

Teens in the United States first have sexual intercourse at a comparable age to teens in Canada, Great Britain, France and Sweden.<sup>25</sup> However, in the United States, teenagers have higher rates of pregnancy, births and abortion than teens in other developed countries.<sup>25</sup> Experts note that countries with low levels of adolescent pregnancy, childbearing and STIs share certain characteristics: comprehensive and balanced information about sexuality, societal acceptance of adolescent sexuality and clear expectations about commitment and prevention of pregnancy and STIs within sexual relationships.<sup>25</sup>

In the United States, public policy changes have led to important improvements in youth sexual health. Implementation of comprehensive family life education, improved access to contraceptive care and youth development programs have resulted in delayed sexual debut, improved contraceptive use and reduced pregnancies, abortions and births.<sup>26</sup> This synergistic approach to youth sexual health represents a change from the past, when narrow, single-issue strategies were favored. Research shows narrow approaches such as abstinence-only-until-marriage education and restrictions to contraceptive access are ineffective at reducing teen pregnancies.<sup>13</sup> Many



health advocates have moved toward a positive approach that emphasizes health promotion and changes to structural factors that affect teen pregnancy, in addition to helping individuals make thoughtful choices with regard to sexual health. Emphasizing self-efficacy and supporting autonomy have been shown to be effective in promoting healthy behavior.<sup>27</sup>

By using proven public health strategies — family communication, comprehensive sexuality education and universal access to confidential health services — adults can support young people’s capacity to make decisions that promote their own well-being.

With the desire to give all youth the best opportunities to grow and develop, research can guide Oregon’s efforts to help young people avoid unplanned pregnancies. By using proven public health strategies — family communication, comprehensive

sexuality education and universal access to confidential health services — adults can support young people’s capacity to make decisions that promote their own well-being.

## Sexually Transmitted Infections (STI)

Up to 75 percent of sexually active people will get a sexually transmitted infection (STI) at some point in their lives, making STIs some of the most common infectious diseases in the United States.<sup>28</sup> Approximately 19 million new cases of STIs occur each year, of which about half are among people aged 15-24.<sup>29</sup> Some populations of youth face disproportionate risk of acquiring an STI, including African Americans, young women, youth who have experienced abuse, homeless youth, young men who have sex with men and lesbian, gay, bisexual and transgender (LGBT) youth.<sup>30</sup>

Many STIs show no symptoms; therefore, many people do not know they are infected.<sup>31</sup> Because of the stigma associated with sexually transmitted infection, people may be reluctant to seek STI information or care.<sup>32</sup> These factors make it difficult to accurately track prevalence, provide treatment and prevent the

spread of STIs. Some common viral infections such as human papillomavirus and genital herpes are not centrally reported, making it difficult to estimate their true prevalence.<sup>29</sup>

The Centers for Disease Control and Prevention (CDC) report substantial progress in the prevention, diagnosis and treatment of STIs nationwide; however, STIs are still a public health concern. The CDC tracks new cases of three common STIs: chlamydia, gonorrhea and syphilis. Reported cases of chlamydia have increased in the past few years, from 329 cases per 100,000 people in 2005 to 348 per 100,000 in 2006.<sup>29</sup> Although the increased report may reflect an actual increase in chlamydia prevalence, the CDC states the increase is likely due to improved surveillance, more sensitive tests and increased health care access, especially for youth. Chlamydia prevalence declined in areas with access to screening and treatment programs, although rates may have increased elsewhere. Gonorrhea rates have plateaued at an all-time low, although African Americans especially continue to be disproportionately infected (658 cases per 100,000 population compared to 37 per 100,000 for whites).<sup>29</sup> Syphilis rates reached an all-time low in 2000, but have been climbing in the past five years due largely to increased infection rates among men who have sex with men (64 percent of cases in 2004 compared with 15 percent in 1999).<sup>29</sup>

According to the CDC HIV/AIDS surveillance report, an estimated 4,883 young people received an HIV infection or AIDS diagnosis in 2004, representing about 13 percent of the persons given a diagnosis during that year.<sup>33</sup> In the United States, half of all new identified HIV infections occur in people under age 25; one-fourth occur in people under the age of 21.<sup>34</sup> There have been increasing rates of HIV among youth of color, especially young women of color and young men who have sex with men (YMSM).<sup>35</sup>

### What puts young people at risk?

Youth receive mixed messages about sexual health. Adults tell teens to be sexually responsible, but often do not provide the information and services shown to be effective in helping young people protect themselves from STIs.<sup>36</sup> Lack of health insurance among the working poor can prevent young people from receiving

needed care. Changes in federal Medicaid requirements now demand citizenship documentation and Social Security numbers and limit access for patients with creditable insurance programs such as Oregon’s Family Planning Expansion Project (FPEP). Transportation barriers and lack of services designed to meet the needs of youth also may pose challenges.

Young people living in poverty may not practice behaviors to reduce STI risk if other risks, such as hunger or homelessness, feel more threatening.<sup>30</sup> Estimates of the number of homeless youth living in the United States range from hundreds of thousands to millions.<sup>30</sup> Living on the street forces many to engage in survival sex (trading sex for food, shelter or money), increasing their risk for STIs. They also frequently suffer sexual and physical assault, which increases the risk of an STI. Many homeless youth are also lesbian, gay, bisexual and transgender (LGBT),<sup>30</sup> which may further limit their access to relevant and respectful sexual health information and services.

Prejudice and discrimination affect the sexual health of young people of color, those from low-income families, immigrants and LGBT youth.<sup>36</sup> For example, verbal and physical violence lead to feelings of isolation, high rates of suicide, substance use and risk of STI/HIV infection among LGBT youth.<sup>36</sup> LGBT youth of color face even higher rates of violence based on race, sexuality and gender identity. Youth who experience prejudice may have lower self-esteem or fewer resources and skills to promote their own well-being.<sup>36</sup>

Social norms of gender socialization that value female passivity and male sexual conquest put both young men and young women at risk. Such social norms diminish women’s ability to protect themselves, negotiate condom use or refuse sex<sup>30</sup> and pressure young men to pursue sex to prove their masculinity.<sup>37</sup>

On an individual level, sexually active teen girls and young women are biologically more susceptible to STIs than older women because their cervixes are not yet fully developed.<sup>38</sup> Any person’s risk of becoming infected with HIV is increased by having another STI. Sores associated with some STIs may serve as portals of entry for HIV, and the activation of the body’s immune system as it fights off an STI facilitates the attachment and replication of HIV.<sup>39</sup>

The greater the number of sexual partners a person has, the greater that person’s chance of acquiring an STI.<sup>40</sup> The number of sexually experienced teens and the number who report multiple partners have decreased in the past decade.<sup>41</sup> Approximately 46 percent of U.S. teens aged 15-19 have had sexual intercourse and one in 10 reported four or more sexual partners in the past year.<sup>42</sup> Young men are more likely to report having had multiple sexual partners and multiple concurrent partners than young women.<sup>43</sup> Research suggests a strong association between alcohol and drug use and having multiple partners.<sup>44</sup>

### Helping youth protect themselves

Research shows combining comprehensive sexuality education with accessible health care is the most effective way to curb the spread of sexually transmitted infection among youth.<sup>26</sup> Close relationships with caring adults also are important in shaping young people’s attitudes toward sexuality. Adults can provide crucial role modeling, affirmation, structure and guidance.<sup>45</sup> Higher educational aspirations also are associated with positive reproductive health choices.<sup>46</sup> Creating conditions in which all youth feel a sense of hope and possibility for their futures can motivate them to make healthy decisions.

Access to free or affordable health care is crucial to helping young people protect themselves from STIs. Regular checkups provide opportunities for health education and encourage teens to develop trusting relationships with sources of accurate health information. Research suggests many teens delay seeking services due to lack of health insurance and concerns about confidentiality.<sup>47</sup> All 50 states and the District of Columbia allow minors to consent on their own to STI testing and treatment.<sup>48</sup> In Oregon, a person of any age may seek services for STIs and be provided birth control information and services by a physician or nurse practitioner without parental consent (Oregon Revised Statute) 109.610, 109.640). Many teens and providers are unaware of these protections. Increased education for youth and providers will help ensure access to health care for all youth.

Using latex barriers correctly and consistently significantly decreases the likelihood of STI transmission. Among sexually active youth, condom use has

increased significantly in the past decade.<sup>13</sup> Making condoms and other safer-sex supplies readily available to young people who are sexually active is an effective way to stop the spread of STIs, without increasing the likelihood of sexual initiation, frequency of sex, or number of sexual partners.<sup>49</sup>

## Dating Violence and Sexual Assault

Violence or abuse that involves sex or occurs in a relationship context represents a significant threat to sexual health. Such violence can take many forms: childhood sexual abuse, dating violence or adult sexual assault of youth. Silence and shame often limit discussion of these issues. However, a startlingly high number of youth report such experiences and their considerable negative consequences. More than 20 percent of youth report having experienced psychological or physical violence from an intimate partner.<sup>50</sup> In a national survey of high school students, about 8 percent of respondents reported having been forced to have sex. Females (11 percent) were more likely to report having been forced to have sex than males (4 percent).<sup>51</sup> Available data likely underestimate the true magnitude of

these problems because dating and sexual violence often go unreported.<sup>52, 51</sup>

Sexual violence can have harmful and lasting consequences for the mental, physical and sexual well-being of victims and communities.<sup>53</sup> Some of the chronic physical conditions resulting from physical or sexual abuse are gynecological disorders, back pain, gastrointestinal disorders and headaches.<sup>51</sup> Adolescents who experience sexual assault have greater risk of genital injury than adults.<sup>51</sup> Experiences of physical, sexual or emotional abuse may cause women to experience sexual aversion, mistrust, or inhibition of sexual pleasure.<sup>54</sup> Physical or sexual violence also may play a role in the development of eating disorders.<sup>55</sup>

Victims of intimate partner and/or sexual violence are more likely to participate in unsafe sexual behaviors, such as engaging in unprotected sex; choosing unhealthy sexual partners; having multiple sex partners; and trading sex for food, money or other goods.<sup>51</sup> Sexual violence, whether in the context of a dating relationship or not, increases the risk of unintended pregnancy and sexually transmitted infections, including HIV.<sup>51</sup>

Dating violence among youth is especially troubling because it occurs during a life stage when romantic relationships are beginning and interaction patterns that may last throughout life are being learned.<sup>52</sup> Dating violence may include psychological abuse such as controlling behavior or jealousy; physical abuse, such as slapping or punching; and sexual abuse, such as nonconsensual sexual activity or rape.<sup>56</sup> Teens often have difficulty labeling sexual and physical violence as such and may feel controlling or jealous behavior is a sign of love.<sup>57</sup> Dating violence occurs within all social, economic, religious and cultural groups.<sup>52</sup> To date, most data describe experiences of violence in heterosexual relationships. Although comparable data are limited, violence also occurs in same-sex relationships and appears to follow patterns similar to heterosexual relationships.<sup>56</sup>

According to the National Crime Victimization Survey, intimate partner violence rates are higher among 16- to 24-year-olds than any other age group.<sup>58</sup> One in 10 Oregon women aged 20-55 experienced intimate partner violence, defined as physical and/or sexual assault by an intimate partner, in the five years preceding a 2001-2002 survey.<sup>59</sup>

## Information from the 2006 Oregon Healthy Teens Survey shows that :

- 3.6 percent of eighth grade females and 3.8 percent of eighth grade males have been hit, slapped or physically hurt by their boyfriend or girlfriend.
- 3.7 percent of 11th grade females and 4.9 percent of 11th grade males have been hit, slapped or physically hurt by their boyfriend or girlfriend.
- 5.1 percent of eighth grade females and 1.4 percent of eighth grade males have been physically forced to have sex.
- 8 percent of 11th grade females and 2.1 percent of 11th grade males have been physically forced to have sex.
- 7.3 percent of eighth grade females and 1.8 percent of eighth grade males report giving in to sexual activity when they did not want to because of pressure.
- 19.4 percent of 11th grade females and 5.4 percent of 11th grade males report giving in to sexual activity when they did not want to because of pressure.
- 14.4 percent of eighth grade females and 3.8 percent of eighth grade males received unwanted sexual comments or attention in the past 30 days.
- 15.3 percent of 11th grade females and 3.1 percent of 11th grade males received unwanted sexual comments or attention in the past 30 days.

In contrast to typical dynamics of abusive relationships among adults, studies indicate non-sexual violence in heterosexual teen relationships involves use of violence by both partners.<sup>52</sup> Although young men and young women both experience dating violence in heterosexual relationships, females are more likely to be injured, more likely to be sexually assaulted and more likely to suffer emotionally than their male peers.<sup>60, 61</sup> Another important consideration, given reports of mutual violence, is that most studies do not address the meaning, context or consequences of the violence, or whether female use of violence was in response to male physical or sexual violence.<sup>52</sup> One study that did examine the sequelae of violence found women indicate “emotionally hurt” and “fear” as the two primary effects, while men indicate “thought it

was funny” and “anger” as the major effects.<sup>57</sup> The study also reported anger as the most frequently cited motive for violence by both males and females, but self-defense was the second most frequent motive cited by girls, while boys cited a desire to get control over their partner.

The principal risk factors associated with inflicting dating violence include holding views accepting or justifying the use of violence in dating relationships; having friends in violent relationships; exposure to violence in one’s family or community; alcohol and drug use; and having a history of aggression.<sup>52</sup> The one factor consistently associated with being a victim of dating violence, especially for young men, is inflicting dating violence.<sup>52</sup>

## What works to reduce violence?

Research with adults connects social factors such as poverty, lack of employment opportunities and societal norms that support male superiority and sexual entitlement with perpetration of sexual violence.<sup>51</sup> On an individual level, childhood history of sexual abuse, hostility toward women and hypermasculinity are risk factors for perpetration. Less is known about protective factors, although promoting physical and emotional well-being and helping youth feel connected with school, friends and adults in the community may reduce sexual violence.<sup>51</sup> In addition, teens with high self-efficacy are better able to resist unwanted sexual advances and negotiate safe sex practices than teens with low self-efficacy.<sup>62</sup>

Several school and community programs have shown success in reducing dating violence.<sup>56</sup> Effective programs discuss different forms of dating violence, dynamics of power and control, warning signs and aspects of healthy and unhealthy relationships. They work to change attitudes that condone violence and build conflict resolution and communication skills.<sup>52</sup> There is a need for development of programs that reach out to frequently overlooked lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth and also for programs that teach youth how to help friends who may be struggling with abuse.<sup>56</sup> Health care professionals, teachers, parents and others who interact with young people should talk to youth about dating violence, but not assume youth will disclose abuse, even if asked directly.



Oregon youth action researchers surveyed their peers and found what they want most from sexuality education is help developing healthy relationship skills. Comprehensive sexuality education that includes healthy relationship skill building may also help reduce dating violence and sexual assault.

## Health Inequities

In spite of a slight increase in teen births in 2006, overall indicators of youth sexual health have shown significant improvements during the past decade: more teens are choosing to delay sex; more sexually active teens are using protection; fewer teens are involved with pregnancies; fewer teens are having abortions; and rates of sexually transmitted infections have declined in many groups.<sup>17</sup> Young people deserve credit for making healthy choices for themselves. However, not all youth have access to information and support needed to protect their sexual health; improvements have not been uniform across populations.

### To give a few examples:

- In 2000, the overall pregnancy rate among American women aged 15 through 19 was 84 pregnancies per 1,000 women. The rates were 138 for Latina, 71 for white and 153 for black teens (per 1,000).<sup>63</sup>
- Among American women ages 15 through 19 in 2003, the overall birthrate was 42 births per 1,000 women. The rates were 82 for Latina, 27 for white and 65 for black teens (per 1,000).<sup>63</sup>
- Young women who have sex with women may also have sex with men, causing them to be at risk for unintended pregnancy.<sup>64</sup> According to one study, teenage females who identify themselves as bisexual or lesbian are about as likely as heterosexual peers to have had intercourse; however, they reported twice the rate of pregnancy (12 percent) as heterosexual and questioning young women (5 to 6 percent).<sup>64</sup>

Why do some youth fare better than others in terms of sexual health? How are health inequities related to broader social inequities? How can communities provide support, education and services to ensure all young

people have the skills and resources to make healthy decisions about sexuality?

### Factors that influence health inequities

Experiencing sexism, homophobia and discrimination based on physical or cognitive ability, or other forms of prejudice in everyday life makes it difficult for some young people to achieve their fullest potential, including gaining knowledge and skills to make healthy decisions about sexual well-being. To compound these barriers, health services and sexuality education often are designed with a one-size-fits-all approach and do not acknowledge the unique needs and experiences of multiple groups.

Historical factors contribute to current sexual health inequities. Forced sterilization of African American, Latina, American Indian/Alaska Native and developmentally disabled women in the United States has left a painful legacy in many communities.<sup>65</sup> Until 1973 the American Psychiatric Association diagnosed homosexuality as a mental disorder. Transgender youth may still encounter the label of “gender identity disorder,” a diagnosis used by the American Psychiatric Association.<sup>66</sup> Some populations, such as persons with physical or mental disabilities, are often assumed to be asexual, child-like and dependent, or, conversely, oversexed.<sup>67</sup> Although many people now condemn these actions or beliefs, past stereotypes and mistreatment continue to influence perceptions of health care systems in many communities.

Economics have a major influence on health status. Low-income youth are more likely to have multiple health problems, higher rates of disability, worse outcomes and even higher rates of mortality compared to youth from higher-income families.<sup>68</sup>

Progress has been made in terms of acknowledging the distinct needs of specific groups. However, when research does focus on young people from outside the dominant group, there is often an assumption that everyone in that group is the same and that findings pertinent to some are pertinent to all.<sup>63</sup> For example, due to high average income, academic achievement and cultural stereotypes, Asian Americans are often portrayed as a “model minority.”<sup>69</sup> This overlooks a bimodal distribution in Asian Pacific Islander (API)

communities that comprise affluent Asians as well as recent immigrants and refugees who live below the poverty line, often without access to health care. Consequently, high-risk behavior of the “well behaved” upper class is ignored, while the health needs of those living in poverty go unmet. Similarly, categories such as “Latino” or “Native American” lump people with vastly different languages, cultures and immigration experiences into a single group. When looking for commonalities in assets and factors that aid in promoting well-being for specific groups, it is important to avoid inaccurate and harmful generalizations.

Another way discrimination surfaces in sexual health arenas is in assumptions made about what represents healthy behavior or normal development. Often standards are set based on a Caucasian model. For example, Anglo-centric youth development theory emphasizes independence as an important developmental task of adolescence. But for many youth from communities of color, interconnection – increasing involvement in family relationships and family and community responsibility – is an essential aspect of development, often overlooked and undervalued by Anglo-centric providers.<sup>63</sup>

Invisibility is a major problem faced by lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. LGBTQ youth of color may struggle with discrimination based on ethnicity, sexual orientation and gender identity. Programs, policies and services, such as the federal government guidelines for abstinence-only education, often ignore or overlook the presence of LGBTQ youth<sup>70</sup>, sending a message that being LGBTQ is wrong or that those youth do not matter. Societal homophobia and transphobia, institutionalized in schools and youth programs and expressed in some families, lead many LGBTQ youth to feel isolated and alone.<sup>70</sup>

A report from the U.S. Census Bureau showed 5.2 million American youth ages 5 through 20 had some long-term physical, mental, or emotional disabling condition.<sup>67</sup> These youth face multiple barriers: invisibility, stigma, stereotypes and lack of appropriate sexual health education and services. All people – including young people – need affection, love, intimacy, acceptance and companionship. Youth who live with disabilities may have unique needs with regard to

sexuality education. Paraplegic youth may need to be reassured that they can experience satisfying sexual relationships and receive practical guidance on how to do so. People with developmental disabilities may learn differently than peers, but mature physically at the same rate. Concrete teaching strategies that use pictures, discuss setting boundaries and respecting others’ boundaries and build skills for appropriate sexuality-related language and behavior may be more effective than traditional methods of sexuality education.<sup>67</sup>

Geographic location also affects health outcomes. Approximately 21 percent of rural residents live in poverty in Oregon and 23 percent of Oregonians live in rural counties.<sup>71</sup> Youth in rural areas have significantly less access to medical providers. Issues of transportation, confidentiality in a small community and lack of visibility of youth sexual health needs may present barriers to care for these youth.

Of reproductive health-related visits to school-based health centers in Oregon in 2005-2006, males made up only 18 percent of visits. Historically, boys and men have been left out of reproductive health efforts.<sup>72</sup> More and more providers are recognizing the importance of including young men in sexual health services,<sup>73</sup> and the need to examine the effect of gender roles on sexual behavior and health care-seeking practices of young men.<sup>74</sup>

Immigrant adults and their children face significant barriers to care as well. National changes to welfare laws have severely limited access to Medicaid, food

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stamps and Supplemental Security Income. This has led to drops in insurance coverage for immigrant children.<sup>71</sup> By the time immigrant children reach adolescence, 13 percent report being in poor health, nearly three times the percentage of young people born in the United States. Language and cultural barriers often prevent immigrant youth and families from receiving comprehensive sexual health information, and fear of deportation likely prevents youth from accessing needed health care.<sup>75</sup>

### Models of success

One of the most significant shifts in teens' sexual health behavior during the previous several decades is an improvement in teenage males' contraceptive behavior.<sup>76</sup> Between 1979 and 1988 condom use doubled and improvements continued through the 1990s. These changes show young men are important partners in sexual health promotion efforts and that programs that include them can be highly effective.

Among sexually experienced high school students in 2001, black youth were significantly more likely than their white or Hispanic peers to report condom use at most recent sex (67, 57 and 54 percent respectively).<sup>77</sup> What can we learn from black youth about successful condom use that we might share with white or Latino peers?

For American Indian/Alaska Native young women, positive native identity and a sense of belonging to a native community are strongly associated with positive sexual health outcomes. Studies show that female teens from families who lived on a reservation and spoke a tribal language have sex for the first time at an older age and are more likely to use condoms than those from families who do not and urban-dwelling youth benefit from programs that emphasize a connection to native culture.<sup>78, 79</sup>

In schools with gay-straight alliances (GSAs) or similar student clubs, respect for all members of the school community is promoted and critical support to LGBT students and their allies is provided. Students in schools with a gay-straight alliances reported hearing fewer homophobic remarks, experienced less harassment and assault, and were less likely to miss school because of safety concerns.<sup>80</sup>

Research connects parents' education of their children about ethnic discrimination with children's awareness of their own ethnicity, pride in their ethnicity and healthy outcomes. Children of these parents often respond to incidents of discrimination and prejudice with a proactive approach; for example talking, expressing disapproval, or affirming their culture and ethnicity.<sup>63</sup> Other studies show many Latino parents place a high value on education and their parenting strategies contribute to the college achievement of young Latinas. Strategies include showing strong parental commitment to the importance of education, parental facilitation of the student's autonomy and an array of nonverbal expressions of support for educational goals and tasks.

### Promoting sexual health for all youth

Youth development and resiliency research identifies positive assets and protective factors associated with positive sexual health outcomes. Youth with a positive orientation toward the future, plans for higher education, attachment to school and involvement in extracurricular activities are more likely to delay the onset of sexual intercourse and to use contraception when they do initiate intercourse.<sup>81, 82</sup>

Close and affectionate family relationships, parent-child discussion of health topics, parental value for education, parental involvement in regular activities and parental education about ethnicity and discrimination have all been shown to be protective factors among youth from marginalized groups.<sup>63</sup> Recognizing and developing these strengths in all communities will help eliminate health inequities. In addition to building individual and community assets, addressing systemic social inequities will improve the sexual health of young people who experience discrimination.

### Parent Involvement and Youth-Adult Connectedness

Peers, media, schools and communities all have important influences on youth sexual health. However, the importance of positive relationships with parents and other supportive adults for young people's well-being has been demonstrated in study after study. Parents influence youths' thinking about sexuality. Approximately 45 percent of teens report parents are

the biggest influence on their sexual decision making compared with 31 percent who say their friends are most influential.<sup>83</sup>

Parents who regularly affirm the value of their children help them develop positive, healthy attitudes about themselves. According to Stanton and Burns (2003), kids who avoid early pregnancy and parenthood are more likely to have parents who clearly communicate their values, express their concerns and love for them early and often, and exercise supervision.<sup>84</sup> Overall strength and closeness of the relationship between youth and their parents appears to best prepare young people to make healthy choices about sexuality.<sup>83</sup>

Youth whose parents are warm and firm and grant them psychological autonomy show higher school achievement, report less depression and anxiety and rate higher on measures of self-reliance and self-esteem than teens whose parents do not show these characteristics.<sup>85</sup> Positive communication between parents and youth helps young people develop and express their individual values.

One study showed Native American youth who reported that their families understood and cared about them had better emotional and physical health and resiliency than peers who reported less family closeness.<sup>86</sup> Another study showed sexually experienced African American female teens who lived with their mothers in a family they perceived to be supportive were 50 percent less likely than teens in a non-supportive family to report unprotected sex in the last 30 days and to report sex with a non-steady partner in the past six months. In other studies, youth who reported feeling a lack of warmth, love or caring from parents also more frequently reported emotional distress, lower self-esteem, school problems, drug use and sexual risk behaviors.<sup>85, 87</sup>

### Communication about sexual health

Youth, including those surveyed by Oregon youth action researchers, report that they want more open information about sexuality and relationships, including information about abstinence and contraception, rather than one or the other (see "Youth Action Research" in this document).<sup>88</sup> One poll showed

89 percent of people in the United States feel it is important for sexuality education in schools to include information about preventing unintended pregnancy and sexually transmitted infections, including HIV.<sup>85</sup> It is important that accurate and comprehensive information is provided in schools, but teens also express a desire to discuss sexuality with their parents, even if they may not act like it.<sup>83</sup>

Experience suggests most parents want to talk with their kids about sexuality as well, but many feel unprepared.<sup>89</sup> Many discussions of sexuality between parents and young people use a "top down" communication style that does not give youth the opportunity to discuss their own thoughts, feelings and desires, or draw the links between their own and their parents' perspectives.<sup>85</sup> The National Campaign to Prevent Teen and Unplanned Pregnancy suggests using media to start conversations.<sup>82</sup> Asking young people what they think about sexual images or relationships on TV, in movies, music, or magazines is one way to start.

A series of focus groups with African American and Latino parents explored how they talked with their kids about sexuality. One mother's approach involved presenting factual information when talking with a teenage son about difficult topics. She feels this strategy helps prevent him from feeling it is a "moral thing."<sup>89</sup>



Another mother discussed how she thinks initiating discussion of difficult subjects is important. For her, practice talking about tough topics makes it easier; also, talking about any one difficult subject opens the door to talking about others in the future.

### Connections with school and supportive adults

Not all young people have close contact with their parents. Some young people immigrate from other countries to Oregon without parents, some live in foster families or with relatives and some live on the streets, often because of family conflict. Young people can receive valuable support from adults other than their parents. Youth who reported a natural or informal mentoring relationship with an adult showed favorable outcomes across a variety of measures including school completion, self-esteem, life satisfaction, physical activity and birth control use.<sup>90</sup>

Relationships with teachers and peers developed at school can have a positive impact on youth well-being and development.<sup>82</sup> School characteristics affect norms and attitudes about dating practices and sexual behavior.<sup>91,92</sup> Having a positive connection to school decreases a young person's likelihood of engaging in risky behavior.<sup>82</sup>

A study of 36,000 middle and high school students by Resnick and colleagues showed the importance of a sense of connectedness to family and school for young peoples' well-being. Experiencing caring and connectedness surpassed demographic variables, such as family structure, as protective factors against high-risk behavior. The authors suggest efforts to support young people to make healthy choices must "critically examine the ways in which opportunities for a sense of belonging may be fostered, particularly among youth who do not report any significant caring relationships in their lives with adults."<sup>87</sup>

### Contraception and Sexual Protection

Significantly more sexually active teens are using contraception and other sexual protection correctly and consistently than did so a decade ago.<sup>93, 94</sup> This demonstrates young people's ability to make

thoughtful choices when provided accurate information and accessible health services. The following section reviews recent data on birth control use and STI prevention measures among teens and the large body of research on what influences teens to use or not use protection.

In the 1995 National Survey of Family Growth (NSFG), a population-based household survey that includes adolescents aged 15 years and older, 71 percent of sexually active young women and 82 percent of sexually active young men aged 15-19 reported using a method of contraception and/or protection at last intercourse. In 2002, these figures were much higher: 83 percent for young women and 91 percent for young men.<sup>95</sup> Oregon teens are no exception to this trend. The proportion of Oregon ninth through 12th graders who reported using a method of protection at last sex increased from 82 percent in 1997 to 90 percent in 2005.<sup>96</sup> More frequent use of condoms accounts for much of the increase in overall use of sexual protection.<sup>93, 94</sup> Similar national or state-level data on protective behavior among youth who sometimes or always have same-sex partners are difficult to come by. However, some smaller studies suggest that use of sexual protection may be lower among this group.<sup>97, 98, 98</sup>

### Factors that influence contraceptive use

Condom use has been studied more extensively than teens' use of methods that protect exclusively against pregnancy, such as oral contraceptives or Depo-Provera. In this review, condoms and other methods are referred to jointly as "sexual protection," except in cases where the evidence in question is method-specific.

Both research and common sense suggest that a multitude of factors can affect the use of sexual protection among adolescents. In 2005, Kirby and colleagues published a review of more than 400 scientific studies of factors affecting teen sexual behavior.<sup>100</sup> Some of those factors are individual, whereas others, such as parental attitudes toward contraceptive use or neighborhood stability, pertain to teens' families and communities.

**Proximal factors:** The factors most strongly related to teens' sexual protection behavior are their own

attitudes and skills. Teens who have a positive impression of condoms and other contraceptives, who perceive more benefits than barriers to the use of such methods, who are confident in their ability to use protection or to ask that it be used and who are motivated to avoid pregnancy and STIs are more likely to use contraception.<sup>100</sup> Another study showed girls and women who are satisfied with their bodies and resist objectification report more consistent use of condoms than other girls and women.<sup>101</sup>

**Mid-range factors:** Among factors with a less direct influence, research indicates that older age, advanced cognitive development and a sense of control over events are most closely associated with increased use of sexual protection. Kirby and colleagues suggest that the impact of these factors is primarily through their ability to influence attitudes, motivation and skills. Teens are also more likely to use sexual protection when they have their partners' support for its use, when their peers support it and use protection themselves and when their families and other groups with which they are connected support sexual protection and responsibility.<sup>100</sup>

High self-esteem and/or positive self-concept have been hypothesized to affect protective behavior but the evidence for this assertion is mixed. Parental encouragement of condoms and contraceptives before a teen becomes sexually active can increase their use. Involvement in school and other organizations and – for women only – sports can increase use of sexual protection if the involvement is substantial. In this case, it is likely that such involvement is related to motivation to avoid pregnancy and STIs, which in turn increases the likelihood of a teen taking steps to protect him- or herself.<sup>100</sup>

On the other hand, there are factors that clearly inhibit use of sexual protection. A history of sexual abuse is strongly connected to no or poor contraceptive use. Victimization of gay youth in schools is also associated with lack of protection.<sup>102</sup> Teens who begin having sex at a young age are less likely to use protection. For younger females only, having a partner who is at least three years older reduces the likelihood of using sexual protection. Drug and alcohol use are often cited as risk factors for risky sexual behavior among teens, but Kirby and colleagues caution that

the association between substance use and sexual risk-taking sometimes disappears when other factors are taken into account. Similarly, it has been observed that Latino youth are less likely to use protection at first sex compared with non-Hispanic whites and non-Hispanic blacks. However, controlling for socio-economic factors often weakens these associations.<sup>100</sup>

**Distal factors:** Given their conceptual distance from the outcome of interest, it can be difficult to demonstrate conclusively that family- and community-level characteristics are related to teens' pregnancy and STI prevention measures. In one recent study, researchers found that a variety of neighborhood-level factors did affect age of sexual initiation (with important differences by gender) but had very little effect on contraceptive use.<sup>103</sup>

Research on teens' access to protection is variable. A few specific methods – condoms and emergency contraception (EC) – have been investigated extensively, with studies generally concluding that access to these methods increases their use without increasing sexual activity.<sup>92, 104, 105, 106,107,108,109</sup> Kirby (2007) reports that when EC is provided to youth to have on hand in case of emergency, they are more likely to use it than those who don't have it on hand, but no more likely to have unprotected sex.<sup>110</sup> A study using 1995 NSFG data demonstrated that county-level availability of family planning services was associated with an increased probability of contraceptive use at last intercourse for 15- to 19-year-old girls.<sup>111</sup> Confidentiality is a key component of access for adolescents. Several recent studies suggest that a perceived lack of confidentiality would decrease teens' use of reproductive health services and, by extension, their use of sexual protection.<sup>112, 113,114</sup>

**Method choice and quality of use:** As with overall use and non-use, a variety of factors can influence how teens choose which method(s) of protection to use and how consistently they use them. Sporadic protection is common across all age groups, but particularly among teens.<sup>95, 115</sup> However, studies suggest that use of sexual protection is habit-forming; that is, teens who used contraception and/or STI protection in past relationships are more likely to use them in current ones.<sup>116</sup> Many of the factors that facilitate use of sexual protection in general (e.g., desire to avoid pregnancy and STIs, communication with and support from partner) also

support its consistent use.<sup>117</sup> With respect to method choice, it appears that teens use barrier methods that offer protection against STIs (e.g., condoms) more often in new relationships or with less well-known partners, but tend to switch to hormonal methods that prevent pregnancy more effectively (e.g., pills) when relationships or partnerships are more established.<sup>118</sup> Finally, method choice and consistency are interrelated; teens who use intercourse-specific methods such as condoms tend to use them less consistently than those who use non-intercourse-specific methods such as the pill.<sup>117</sup>

**Boys and young men:** Historically, efforts to include heterosexual young men in promoting sexual health have been limited. However, one of the biggest shifts in teenage reproductive behavior has been males' increased use of condoms – doubling from 1979 to 1988, according to the National Survey of Adolescent Males.<sup>76</sup> With growing recognition of the important role men can play in the use of all methods of sexual protection, more efforts are being directed to men and the work appears promising.<sup>76</sup> Researchers have found some differences between teen men and women in terms of use of protection. For men but not women, endorsement of traditional gender roles was strongly negatively correlated with contraceptive use.<sup>120</sup> Other studies indicate that relationship and partner characteristics are less predictive of protection

The association between HIV and men who have sex with men (MSM) led sexual health advocates to

focus interventions on this population. Although use of sexual protection increased significantly for a time, recent increases in unprotected sex suggest MSM may be experiencing “prevention fatigue” – the challenge of maintaining safer sex behaviors over time.<sup>119</sup> Also, younger MSM may not have personal experience with HIV as a deadly disease.

#### **Sexuality education**

A strong body of evidence exists for the effectiveness of comprehensive

sexuality education and the ineffectiveness of abstinence-only-until-marriage programs in encouraging sexual protection among sexually active teens.<sup>16,122, 123</sup> Education that includes information relevant to teens who engage in same-sex sexual activity has a stronger influence on their behavior than standard instruction.<sup>97</sup> The Oregon Administrative Rules, rewritten in 2007, now state that school districts shall have a medically accurate, age-appropriate comprehensive plan of instruction on human sexuality education, HIV/AIDS and sexually transmitted disease prevention for both elementary and secondary school students. The instruction shall include information on abstinence, condoms and contraceptives and shall include materials, language and strategies that recognize different gender identities and sexual orientations (see OAR 581-022-1440).

### **Resources**

Ideas for parents to talk with kids about sexuality  
[www.noplacelikehome.org/](http://www.noplacelikehome.org/)

Birth control, safer sex, pregnancy, parenting, adoption, infections, diseases, lesbian, gay, bisexual, transgender, body image, relationships with family and friends, abortion, school, careers and activism...for teens  
[www.teenwire.com/](http://www.teenwire.com/)

Similar to the above, developed by and for teens  
[www.sexetc.org/](http://www.sexetc.org/)

Videos by teens about pregnancy/STI prevention  
[www.stayteen.org/](http://www.stayteen.org/)

Options counseling for pregnant teens  
[www.yourbackline.org/](http://www.yourbackline.org/)

Sexual health care and education services for youth and adults  
[www.plannedparenthood.org/](http://www.plannedparenthood.org/)

Sexual health activism for youth and adults  
[www.advocatesforyouth.org/](http://www.advocatesforyouth.org/)

Policy and advocacy resources  
[www.siecus.org/](http://www.siecus.org/)

Teen pregnancy information for teens, parents, policy makers and professionals  
[www.teenpregnancy.org/](http://www.teenpregnancy.org/)

Research-based curricula and programs  
[www.etr.org/](http://www.etr.org/)

Science-based resources for researchers and practitioners  
[www.socio.com/](http://www.socio.com/)

Oregon Revised Statute on Human Sexuality Education (ORS) 336.455  
[www.leg.state.or.us/ors/336.html](http://www.leg.state.or.us/ors/336.html)

Oregon Administrative Rule on Human Sexuality Education (OAR) 581-022-1440  
[http://arcweb.sos.state.or.us/rules/OARS\\_500/OAR\\_581/581\\_022.html](http://arcweb.sos.state.or.us/rules/OARS_500/OAR_581/581_022.html)

### **References**

- Centers for Disease Control and Prevention. Trends in reportable sexually transmitted disease in the United States. Atlanta, Georgia. 2006.
- Elman A. Confronting the sexual abuse of women with disabilities. VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. 2005. [http://new.vawnet.org/category/Main\\_Doc.php?docid=416](http://new.vawnet.org/category/Main_Doc.php?docid=416) (accessed 11/11/2007).
- Horner-Johnson W and Drum CE. Prevalence of maltreatment of people with intellectual disabilities: a review of recently published research. *Research Review*, 2006; 12:57-69.
- Sobsey D. Faces of violence against women with developmental disabilities. In: Abramson WH, Gaylord V, Hayden M, editors. *Impact: feature issue on violence against women with developmental or other disabilities*. Minneapolis, MN: University of Minnesota, Institute on Community Integration. 2000. 1-6.
- Oregon Department of Human Services, Public Health Division. *School-based Health Centers 2007 Status Report*. 2007.
- Ray N. *Lesbian, gay, bisexual and transgender youth: an epidemic of homelessness*. New York: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless. 2006. <http://graphics8.nytimes.com/packages/pdf/national/20070307HomelessYouth.pdf> (accessed 11/11/2007).

- Oregon Center for Health Statistics. 2007 Oregon Healthy Teens Survey Frequently Asked Questions. [www.dhs.state.or.us/dhs/ph/chs/youthsurvey/abouttoht.shtml](http://www.dhs.state.or.us/dhs/ph/chs/youthsurvey/abouttoht.shtml) (accessed 1/10/2008.)
- Kastner L. Current trends in adolescent research: The brain, developmental theory and emerging treatment approaches. Proceedings of the National Network of State Adolescent Health Coordinators Conference. 2006.
- Bloom MD et al, editors. *The Dana Guide to Brain Health*: The Charles A. Dana Foundation. 2003.
- Weinberger DR et al. The adolescent brain: a work in progress. National Campaign to Prevent Teen and Unplanned Pregnancy. 2005.
- National Campaign to Prevent Teen and Unplanned Pregnancy. NCHS releases preliminary birth data. 2007. [www.thenationalcampaign.org/resources/birthdata.aspx](http://www.thenationalcampaign.org/resources/birthdata.aspx) (accessed 1/6/2008).
- National Campaign to Prevent Teen and Unplanned Pregnancy. Teen pregnancy rates in the United States 1972-2002. 2006. [www.teenpregnancy.org/resources/data/pdf/pregrate\\_Oct2006.pdf](http://www.teenpregnancy.org/resources/data/pdf/pregrate_Oct2006.pdf) (accessed 9/11/2007).
- Santelli JS et al. Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use. *Am J Public Health* 2006;97:150-6.
- Child Trends. Condom use. 2006. [www.childtrendsdatabank.org/indicators/28CondomUse.cfm](http://www.childtrendsdatabank.org/indicators/28CondomUse.cfm) (accessed 10/26/2007).
- Feijoo A. Teen pregnancy, the case for prevention. 1999. [www.advocatesforyouth.org/PUBLICATIONS/coststudy.pdf](http://www.advocatesforyouth.org/PUBLICATIONS/coststudy.pdf) (accessed 10/26/2007).
- Kirby D. Emerging answers: research findings on programs to reduce teen pregnancy. National Campaign to Prevent Teen and Unplanned Pregnancy. 2001.
- Moss T. Adolescent pregnancy and childbearing in the United States. 2004. [www.advocatesforyouth.org/publications/factsheet/fsprechd.pdf](http://www.advocatesforyouth.org/publications/factsheet/fsprechd.pdf) (accessed 10/26/2007).
- Upchurch DM et al. The impact of nonmarital childbearing on subsequent marital formation



- and dissolution. In: Wu LL, Wolfe B, editors. *Out of wedlock: causes and consequences of nonmarital fertility*. New York: Russell Sage Foundation; 2001. 344-80.
19. Kimball C. Teen fathers: an introduction. *Prevention Researcher* 2004;11(4):3-5.
  20. Duberstein L et al. Age differences between minors who give birth and their adult partners. *Family Planning Perspectives* 1997;29:61-6.
  21. The children of teen parents. Florida State University Center for Prevention and Early Intervention Policy. 2005. [www.cpeip.fsu.edu/resourceFiles/resourceFile\\_78.pdf](http://www.cpeip.fsu.edu/resourceFiles/resourceFile_78.pdf) (accessed 1/11/2008).
  22. Horn WF. Father facts. National Fatherhood Initiative. 1998.
  23. Forrest JD. Epidemiology of unintended pregnancy and contraceptive use. *Am J Obstet Gynecol* 1994;170:1485-9.
  24. Davidson NW et al. Adolescent pregnancy. *Qual Med Pub Inc* 1992:1026-40.
  25. Teenagers sexual and reproductive health: developed countries. Guttmacher Institute. 2001. [www.guttmacher.org/pubs/fb\\_teens.html](http://www.guttmacher.org/pubs/fb_teens.html) (accessed 1/11/2008).
  26. Brindis C. A public health success: understanding policy changes related to teen sexual activity. *Am Rev Public Health* 2006;27:277-95.
  27. Butterworth S. Effect of motivational interviewing-based health coaching on employees' physical and mental health status. *J Occup Health Psych* 2006;11(4):358-65.
  28. STDs, HIV and safer sex. Planned Parenthood Federation of America. 2007. <http://plannedparenthood.org/sexual-health/stis-stds-101.htm> (accessed 10/25/2007).
  29. Centers for Disease Control and Prevention. Trends in reportable sexually transmitted diseases in the United States, national surveillance data for chlamydia, gonorrhea, and syphilis. 2006. [www.cdc.gov/std/stats/trends2006.htm](http://www.cdc.gov/std/stats/trends2006.htm) (accessed 10/25/2007).
  30. Alford S. Adolescents – at risk for sexually transmitted infections. 2003. [advocatesforyouth.org/publications/factsheet/fssti.pdf](http://advocatesforyouth.org/publications/factsheet/fssti.pdf) (accessed 10/25/2007).
  31. Facts on sexually transmitted infections in the United States. Guttmacher Institute. 2006. [www.guttmacher.org/pubs/fb\\_sti.html](http://www.guttmacher.org/pubs/fb_sti.html) (accessed 10/25/2007).
  32. Barth KR et al. Social stigma and negative consequences: factors that influence college students' decisions to seek testing for sexually transmitted infections. *J Am College Health* 2002;50(4):153-58.
  33. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2004. Vol. 16; 2005. [www.cdc.gov/hiv/stats/hasrlink.htm](http://www.cdc.gov/hiv/stats/hasrlink.htm) (accessed 10/25/2007).
  34. Office of National AIDS Policy. Youth and HIV/AIDS 2000: a new American agenda. 2000.
  35. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2002;14. [www.cdc.gov/hiv/stats/hasrlink.htm](http://www.cdc.gov/hiv/stats/hasrlink.htm) (accessed 10/25/2007).
  36. Davis L. Adolescent sexual health and the dynamics of oppression: a call for cultural competency. 2003. [www.advocatesforyouth.org/publications/iag/oppression.pdf](http://www.advocatesforyouth.org/publications/iag/oppression.pdf) (accessed 1/11/08).
  37. Schooler D et al. Boys' body image: a mixed-method exploration of body image and sexual health among adolescent boys. Submitted for publication.
  38. Centers for Disease Control and Prevention. STD surveillance 2004 special focus profiles: adolescents and young adults. 2005. [www.cdc.gov/std/stats04/adol.htm](http://www.cdc.gov/std/stats04/adol.htm) (accessed 10/25/2007).
  39. Way PO et al. The global epidemiology of HIV and AIDS. In: HolmesHolmes KK SP et al, editors. *Sexually transmitted diseases*, 3rd edn. New York, NY: McGraw-Hill; 1999. 77-94.
  40. Sainly JS et al. Multiple sexual partners among U.S. adolescents and young adults. *Family Planning Perspectives* 1998;30(6):271-5.
  41. U.S. teen sexual activity. Kaiser Family Foundation. 2005. [www.kff.org/youthhivstds/upload/U-S-Teen-Sexual-Activity-Fact-Sheet.pdf](http://www.kff.org/youthhivstds/upload/U-S-Teen-Sexual-Activity-Fact-Sheet.pdf) (accessed 11/5/2007).
  42. Terry-Humen E et al. Trends and recent estimates: sexual activity among U.S. teens. *Child Trends*. 2006. [www.childtrends.org/Files//Child\\_Trends-2006\\_06\\_01\\_RB\\_SexualActivity.pdf](http://www.childtrends.org/Files//Child_Trends-2006_06_01_RB_SexualActivity.pdf) (accessed 10/25/2007).
  43. Sonenstein FL et al. Changes in sexual behavior and condom use among teenaged males: 1988 to 1995. *Am J Public Health* 1998;88(6):956-9.
  44. Miller HG et al. Correlates of sexually transmitted bacterial infections among U.S. women in 1995. *Family Planning Perspectives* 1999;31(1):4-9 and 23.
  45. National Campaign to Prevent Teen and Unplanned Pregnancy. Science says: parental influence and teen pregnancy. 2004.
  46. Rodgers K. Parenting processes related to sexual risk-taking behaviors of adolescent males and families. *J Marriage Fam* 1999;61(1):99-109.
  47. Newacheck PW et al. Adolescent health insurance coverage: recent changes and access to care. *Pediatrics* 1999;104(2):195-202.
  48. Minors' access to STD services. Guttmacher Institute. 2006.
  49. Alford S. Condom effectiveness. 2005. [advocatesforyouth.org/publications/factsheet/fscondom.pdf](http://advocatesforyouth.org/publications/factsheet/fscondom.pdf) (accessed 11/12/2007).
  50. Roberts TA & Klein J. Intimate partner abuse and high-risk behavior in adolescents. *Arch Pediatrics Adol Med* 2003;157:375-80.
  51. Centers for Disease Control and Prevention. Sexual violence fact sheet. 2007. [www.cdc.gov/ncipc/pub-res/images/SV%20Factsheet.pdf](http://www.cdc.gov/ncipc/pub-res/images/SV%20Factsheet.pdf) (accessed 10/22/07).
  52. O'Keefe M. Teen dating violence: a review of risk factors and prevention efforts. 2005. [new.vawnet.org/Assoc\\_Files\\_VAWnet/AR\\_TeenDatingViolence.pdf](http://new.vawnet.org/Assoc_Files_VAWnet/AR_TeenDatingViolence.pdf) (accessed 10/22/07).
  53. Centers for Disease Control and Prevention. Understanding intimate partner violence fact sheet. 2006. [www.cdc.gov/ncipc/dvp/ipv\\_factsheet.pdf](http://www.cdc.gov/ncipc/dvp/ipv_factsheet.pdf) (accessed 11/22/2007).
  54. Tiefer L et al. Beyond dysfunction: a new view of women's sexual problems. *J Sex Marital Therapy* 2002;28(S):225-32.
  55. Centers for Disease Control and Prevention. Understanding teen dating violence. 2006. [www.cdc.gov/ncipc/pub-res/DatingAbuseFactSheet-a.pdf](http://www.cdc.gov/ncipc/pub-res/DatingAbuseFactSheet-a.pdf) (accessed 11/22/2007).
  56. Varia S. Dating violence among adolescents. 2006. [www.advocatesforyouth.org/publications/factsheet/fsdating.pdf](http://www.advocatesforyouth.org/publications/factsheet/fsdating.pdf) (accessed 11/22/2007).
  57. O'Keefe M. Predictors of dating violence among high school students. *Journal of Interpersonal Violence* 1997;12:546-68.
  58. Rennison C et al. Bureau of Justice special reports: intimate partner violence. 2000. [www.ojp.usdoj.gov/bjs/pub/pdf/ipv.pdf](http://www.ojp.usdoj.gov/bjs/pub/pdf/ipv.pdf) (accessed 10/22/2007).
  59. Oregon Department of Human Services. Intimate Partner Violence (IPV) Data Collection Project. Intimate partner violence in Oregon: findings from the Oregon women's health and safety survey. 2004. [egov.oregon.gov/DHS/ph/ipv/survey.shtml](http://egov.oregon.gov/DHS/ph/ipv/survey.shtml) (accessed 11/22/2007).
  60. Halpern CT et al. Partner violence among adolescents in opposite-sex romantic relationships: findings from the national longitudinal study of adolescent health. *Am J Public Health* 2001;91(10):1679-85.
  61. Physical dating violence among high school students - United States, 2003. *MMWR* 2006; 55(19): 532-535.
  62. Olson CE et al. Identifying and supporting young women experiencing dating violence: what health practitioners should be doing now. *J of Pediatric and Adol Gynecology* 2004;17:131-6.
  63. Alford S. The sexual health of Latina adolescents – focus on assets. 2006. [www.advocatesforyouth.org/publications/frtp/latina.pdf](http://www.advocatesforyouth.org/publications/frtp/latina.pdf) (accessed 11/11/2007).
  64. Gilliam J. Young women who have sex with women: falling through the cracks for sexual health care. 2001. [www.advocatesforyouth.org/publications/iag/ywsw.pdf](http://www.advocatesforyouth.org/publications/iag/ywsw.pdf) (accessed 11/11/2007).

65. Howell M. Walk in my shoes: a black activist's guide to surviving the women's movement. Advocates for Youth. 2007. [www.advocatesforyouth.org/publications/walkin-myshoes.htm](http://www.advocatesforyouth.org/publications/walkin-myshoes.htm) (accessed 11/01/2007).
66. Schneider et al. Answers to your questions about transgender individuals and gender identity. 2006. [www.apa.org/topics/transgender.html#isbeing](http://www.apa.org/topics/transgender.html#isbeing) (accessed 11/11/2007).
67. Keshav D & Huberman B. Sex education for physically, emotionally, and mentally challenged youth. 2006. [www.advocatesforyouth.org/PUBLICATIONS/frtp/challengedyouth.pdf](http://www.advocatesforyouth.org/PUBLICATIONS/frtp/challengedyouth.pdf) (accessed 11/11/2007).
68. Hughes DC, Ng S. Reducing health disparities among children. *The Future of Children* 2003;13(1):153-64.
69. Bridges E. The sexual health of Asian American/Pacific Islander young women – focus on assets. 2007. [www.advocatesforyouth.org/publications/frtp/api.pdf](http://www.advocatesforyouth.org/publications/frtp/api.pdf) (accessed 11/11/2007).
70. Gilliam J. Respecting the rights of GLBTQ youth, a responsibility of youth-serving professionals. 2002. <http://advocatesforyouth.org/publications/transitions/transitions1404.pdf> (accessed 11/11/2007).
71. An issue of fairness: reducing health disparities. Status of Oregon's Children: County Data Book. Children First for Oregon. 2006.
72. Yamey G. Sexual health: what about boys and men? *Brit Med J* 1999;319(7221):1315-6.
73. Armstrong B et al. Involving young men in reproductive health. *Am J Public Health* 1999;89(6):905-6.
74. Kalmuss D, Austrian K. Real men do...real men don't: masculinity narratives and men's use of sexual health care services. Submitted for publication.
75. Mohanty S. Health care expenditures of immigrants in the United States: a nationally representative analysis. *Am J Public Health* 2005;95(8):1431-8.
76. Sonenstein FL et al. Involving males in preventing teen pregnancy: a guide for program planners. The Urban Institute. 1997.
77. Augustine J et al. Youth of color – at disproportionate risk of negative sexual health outcomes. 2004. [www.advocatesforyouth.org/publications/factsheet/fsyouthcolor.pdf](http://www.advocatesforyouth.org/publications/factsheet/fsyouthcolor.pdf) (accessed 11/11/2007).
78. Mitchell C. Structure of HIV knowledge, attitudes and behaviors among American Indian young adults. *AIDS Educ Prev* 2002;14(5):419-31.
79. Simoni JM. Triangle of risk: urban American Indian women's sexual trauma, injection drug use, and HIV sexual risk behaviors. *AIDS Behav* 2004;8(1):33-45.
80. Gay and Lesbian School Education Network (GLSEN). The national school climate survey. Executive summary. 2007. New York, New York.
81. Blum RW et al. Protecting teens: beyond race, income and family structure. Minneapolis: U of Minn Center for Adol Health; 2000.
82. Resnick MD et al. Protecting adolescents from harm: findings from the national longitudinal study on adolescent health. *J Am Med Assn* 1997;278(10):823-33.
83. Albert B. Science says: parental influence and teen pregnancy. 2004. [www.thenationalcampaign.org/resources/pdf/SS/SS8\\_ParentInfluence.pdf](http://www.thenationalcampaign.org/resources/pdf/SS/SS8_ParentInfluence.pdf) (accessed 10/22/2007).
84. Stanton B, Burns J. Sustaining and broadening intervention effects: social norms, core values, and parents. In: Romer D, editor. Reducing adolescent risk: toward an integrated approach. Thousand Oaks: Sage Publications; 2003.
85. Lagina N. Parent-child communication: promoting sexually healthy youth. The facts. Advocates for Youth. Washington, DC. 2002.
86. Cummins JR et al. Correlates of physical and emotional health among Native American adolescents. *J Adol Health*;5:31-5.
87. Resnick MD et al. The impact of caring and connectedness on adolescent health and well-being. 1993. [www.parent-teens.com/articles/adolescent\\_health.html](http://www.parent-teens.com/articles/adolescent_health.html) (accessed 10/22/2007).
88. National Campaign to Prevent Teen and Unplanned Pregnancy. With one voice 2003: America's adults and teens sound off about teen pregnancy; 2003.
89. Bean S, Roller L. Parent-child connectedness: voices of African-American and Latino parents and teens. ETR Associates. 2005. [www.etr.org/recapp/research/PCCFocusGroupReport.pdf](http://www.etr.org/recapp/research/PCCFocusGroupReport.pdf) (accessed 10/22/2007).
90. DuBois DL et al. Natural mentoring relationships and adolescent health: evidence from a national study. *Am J Public Health*;95(3):518-24.
91. Teitler JO et al. Effects of neighborhood and school environments on transitions to first sexual intercourse. *Sociology Ed* 2000;73(2):112-32.
92. Kirby D. The impact of schools and school programs upon adolescent sexual behavior. *J Sex Res* 2002;39(1):27-33.
93. Santelli JS et al. Adolescent sexual behavior: estimates and trends from four nationally representative surveys. *Family Planning Perspectives* 2000;32(4):156-65 & 94.
94. Anderson JE et al. Trends in adolescent contraceptive use, unprotected and poorly protected sex, 1991-2003. *J Adol Health* 2006;38:734-9.
95. Abma JC et al. Teenagers in the United States: sexual activity, contraceptive use, and childbearing. National Center for Health Statistics. 2004.
96. Oregon Center for Health Statistics. Oregon Healthy Teens 2007. [www.dhs.state.or.us/dhs/ph/chs/youthsurvey/ohtdata.shtml](http://www.dhs.state.or.us/dhs/ph/chs/youthsurvey/ohtdata.shtml) (accessed 10/22/2007).
97. Blake SM et al. Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: the benefits of gay-sensitive HIV instruction in schools. *Am J Public Health* 2001;91(6):940-6.
98. Saewyc EM et al. Sexual intercourse, abuse and pregnancy among adolescent women: does sexual orientation make a difference? *Family Planning Perspectives* 1999;31(3):127-31.
99. Valleroy LA et al. HIV prevalence and associated risks in young men who have sex with men. *J Am Med Assn* 2000;284:198-204.
100. Kirby D et al. Factors affecting teen sexual behavior, pregnancy, childbearing and sexually transmitted disease: Which are important? Which can you change? The National Campaign to Prevent Teen and Unplanned Pregnancy. 2005.
101. Gillen MM et al. Associations between body image and risky sexual behavior. *J Youth Adolescence* 2006;35:230-42.
102. Bontempo DE & D'Augelli AR. Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior. *J Adol Health* 2002;30(5):364-74.
103. Cubbin C et al. Neighborhood context and sexual behaviors among adolescents: findings from the national longitudinal study of adolescent health. *Persp Sex Repro Health* 2005;37(2):125-34.
104. Sidebottom A et al. Decreasing barriers for teens: evaluation of a new teenage pregnancy prevention strategy in school-based clinics. *Am J Public Health* 2003;93(11):189-1892.
105. Blake SM et al. Condom availability programs in Massachusetts high schools: relationships with condom use and sexual behavior. *Am J Public Health* 2003;93(6):955-62.
106. Gold MA et al. The effect of advance provision of emergency contraception on adolescent women's sexual and contraceptive behaviors. *J Ped Adol Gynecology* 2004;17(2):87-96.
107. Schuster MA et al. Impact of a high school condom availability program on sexual attitudes and behaviors. *Family Planning Perspectives* 1998;30(2):67-72 & 88.
108. Raine T et al. Direct access to emergency contraception through pharmacies and effect on unintended pregnancy and STIs. *J Am Med Assn* 2005;293(1):54-62.
109. Rocca CH et al. Beyond access: acceptability, use and non-use of emergency contraception among young women. *Am J Obst Gynecology* 2007;196(29):e1-e6.
110. Kirby D. Emerging answers: research findings on programs to reduce teen pregnancy and sexually transmitted diseases. The National Campaign to Prevent Teen and Unplanned Pregnancy.

2007. [www.teenpregnancy.org/product/pdf/6\\_11\\_2007\\_13\\_14\\_8Fullreport\\_EmergingAnswers2007.pdf](http://www.teenpregnancy.org/product/pdf/6_11_2007_13_14_8Fullreport_EmergingAnswers2007.pdf) (accessed 1/11/2008).
111. Averett SL et al. The impact of government policies and neighborhood characteristics on teenage sexual activity and contraceptive use. *Am J Public Health* 2002;92(11):1773-8.
112. Reddy DM et al. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *J Am Med Assn* 2002;288:710-4.
113. Thrall JS et al. Confidentiality and adolescents' use of providers for health information and for pelvic examinations. *Arch Pediatric Adol Med* 2000;154(9):885-92.
114. Franzini L et al. Projected economic costs due to health consequences of teenagers' loss of confidentiality in obtaining reproductive health care services in Texas. *Arch Ped Adol Med* 2004;158:1140-6.
115. Goodman DC et al. Geographic access to family planning facilities and the risk of unintended and teenage pregnancy. *Matern Child Health J* 2007;11(2):145-52.
116. Manlove J et al. Contraceptive use and consistency in U.S. teenagers' most recent sexual relationships. *Persp Sex Repro Health* 2004;36(6):265-75.
117. Davies SL et al. Predictors of inconsistent contraceptive use among adolescent girls: findings from a prospective study. *J Adol Health* 2006;39(1):43-9.
118. Ott MA et al. The trade-off between hormonal contraceptives and condoms among adolescents. *Persp Sex Repro Health* 2002;34(1):6-14.
119. Beyrer C. HIV epidemiology update and transmission factors: risks and risk contexts. *Proceedings of the XVI International AIDS Conference; 2006; Toronto; 2006.*
120. Kowaleski-Jones, Mott. Sex, contraception and childbearing among high-risk youth: do different factors influence males and females? *Persp Sex Repro Health* 1998;30(4):163-9.
121. Manlove J et al. Patterns of contraceptive use within teenagers' first sexual relationships. *Persp Sex Repro Health* 2003;35(6):246-55.
122. Bennett SE & Assefi NP. School-based teenage pregnancy prevention programs: a systematic review of randomized control trials. *J Adol Health* 2005;36:72-81.
123. Trenholm C et al. Impacts of four Title V, Section 510 abstinence education programs: final report: Mathematica Policy Research, Inc. 2007.

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