Good afternoon, everyone.
So just to make sure you're in the session
that you think you should be in, this afternoon's session is
on Adolescent Access to Sexual Health Education and Services.
So I'll go ahead and introduce both speakers in the order
that they will be speaking.
Our first speaker is Dr. Kathleen Ethier.
Dr. Ethier is the Director of the Division of Adolescent
and School Health in the National Center for HIV-Aids,
Viral Hepatitis, STD and TB Prevention.
Prior to her appointment as Director of DASH she served
in a variety of capacities across the Agency,
including as the Director of the Program Performance
and Evaluation Office in the CDC Office of the Director.
Dr. Ethier's research has included psychosocial,
behavioral, organizational and clinical factors related
to women's health, maternal health and adolescent sexual
and reproductive health.
She has authored or coauthored numerous articles
and book chapters for peer reviewed publications.
Dr. Ethier earned her Ph.D. in Social Psychology
from the Graduate Center of the City University of New York.
Welcome. Our second speaker is Dr. Jessica Sales
and Dr. Sales is an Associate Professor in the Department
of Behavioral Sciences and Health Education
with the Rollins School
of Public Health at Emory University.
She is also a Researcher in the Emory Center for Aids Research
and a Scholar Scientist in the Center for Translational
and Prevention Science at the University of Georgia.
Dr. Sales' research has focused on the development
and evaluation of sexual health interventions tailored
for adolescents, as well as clinical practice improvements
as a way to improve patients' sexual health outcomes.
Welcome, also, Dr. Sales.
Our first speaker, Dr. Ethier.
Thank you.

Good afternoon.
How is everybody doing?
It's post lunch.
As you heard, I'm from the Division of Adolescent
and School Health here at CDC.
We do three things in the Division
of Adolescent and School Health.
We do surveillance on youth behaviors
and experiences among high school students
and school based policies and practices.
We run school district based programs for HIV,
STD and teen pregnancy prevention.
And then we do research and evaluation around those issues.
Today I'm going to talk to you about both sexual risk
and protective behaviors, trends that we've been seeing
in the last 10 years in those factors, and disparities
that we're currently seeing, as well as some of the data
that we've been seeing across the country
on school based practices to prevent sexual risk behaviors
and to promote health.

We focus on HIV, STD and pregnancy prevention among youth because half of all new STDs are among 15 to 24 year olds. Chlamydia cases among 13 to 19 year olds they account for 26% of all chlamydia cases. There have been increases among adolescents in gonorrhea and syphilis. One in five new HIV diagnoses occur in young people. And although we have seen significant declines in teen births we are still one of the highest, our rates are still one of the highest among developing nations. We also know that schools can really play a critical role in promoting the health and safety of adolescents. So there are roughly 26 million students in middle schools and high schools around the country, 95% of school aged youth attend school, they spend at least six hours a day in school. And there are numerous protective factors, like school connectedness and parent engagement that can prevent a whole wide variety of risk behaviors. But stepping back from that in order to address those health outcomes we first, and associated disparities first we have to understand them. And so we run the Youth Risk Behavior Surveillance System for the country. YRBS, as it's commonly known, focuses on behaviors and experiences that cause the most health problems among youth, and we also assess how those behaviors and experiences change over time. This is a high school based survey, it's conducted every other year, and it is anonymous and self-administered, so that we really are able to maintain a high level of confidentiality and that's important when you start to look at kind of some of the results that we have versus some other surveys which are not confidential or are done over the telephone or in people's homes. We collect nationally representative data, which is the data that I'm going to talk to you about today, but we also collect data at the state and local levels, which states and jurisdictions are then able to use to really kind of plan for themselves and draw attention to what's happening in their own communities. Last year, so we collect the data every other year and it's released kind of the following summer after we're done collecting it, so the 2017 data was released last June. And when we did that we produced a special report, we call our data summary and trend report. For us in terms of HIV, STD and pregnancy prevention and those behaviors and experiences with common school based protective factors we focused on four sets of behaviors and experience -- sexual behavior, high risk substance use, violence victimization, and mental health and suicide.
We presented 10-year trends and we also included data on sexual minorities. I'm going today to really only focus on kind of two sets of those data. One on sexual risk behavior, so those sexual behaviors and experience of sexual violence that put youth at risk for HIV, STD and teen pregnancy. And then sexual protective behaviors, so those behaviors like condom use and birth control use that protect against those outcomes.

Overall, as you can see, we've seen improvements over the last 10 years in the proportion of students who experience sexual risk behaviors. We've seen improvements in some of those protective behaviors and lack of improvement or decline in other protective behaviors, like condom use. And so I'm going to spend a little bit of time kind of teasing those apart and looking at some of the breakdowns by gender and by race ethnicity. So, first, let's focus on sexual risk behaviors and experiences. In 2017 almost 40% of youth overall had ever had sex and those rates are higher among males compared to females and among black youth compared to other racial and ethnic groups. But, as you can see, we saw declines over 10 years among both genders and significant declines among all racial and ethnic groups. And one thing to note here that in 2007 there were kind of pretty dramatic differences among groups and the gap between those groups really seems to have closed over time. We're doing some additional analyses to understand whether those gaps have closed significantly. When you look at it it looks like it has, but we're really going to do some more in-depth analyses to understand kind of whether we're seeing kind of more increasingly changes that are happening faster among some groups versus others. It looks like we've seen the greatest declines among black youth. Similarly, for whether or not you've had four or more lifetime sexual partners, this is a risk for youth who have had more sexual partners are just more likely to have had exposure to STDs or to HIV and so it poses a risk factor for those outcomes. And, as you'll see, again in 2017 males and black youth were most likely to have had four or more partners. But again, as you'll see, there have been significant declines over the last 10 years for both genders and really significant declines for all racial and ethnic groups, but particularly for black youth. So I'm going to stop for a minute and talk about sexual violence and why sexual violence poses risk for HIV, STD and teen pregnancy. First, as you'll see here, 11% of female high students have reported
that they have been physically forced to have sex when they did not want to.
Young women who, and there is a significant difference there between females who experience this and males who experience this, so much lower rates of males have experienced forced sex.
There is no significant difference by race ethnicity in terms of the proportion of youth, this is for all youth, but then if you also look among females specifically there are no racial and ethnic differences.
Youth who are forced to have sex don't have choices about condom use, may or may not already be on effective birth control methods, and so forced sex while also being incredibly traumatic and potentially physically harmful it also poses direct risk for HIV, STD and teen pregnancy, and so that's one of the reasons why we look at it in relation to those outcomes.
We find it incredibly disheartening that 11% of high school females have experienced rape, this has not changed in the last 10 years, so for the last 10 years roughly between 10% and 11% of high school females have reported that they have been physically forced to have sex.
Sexual dating violence, which we look at among youth who have said that they had a dating partner in the last year, so this is a smaller portion of the sample, but you see similarly that a higher proportion of female students say that they have experienced sexual dating violence in the last year and a higher proportion of white and Hispanic students also say that they have experienced sexual data violence compared to black students.
So I'm going to talk now about protective behaviors.
These sexual behaviors actually decrease risk for HIV, STD and unintended pregnancy.
So in terms of condom uses you may remember from an earlier slide we have seen declines in condom use over time, over the last 10 years.
Males are more likely to report than females that they used a condom the last time they had sex and there are no differences among racial and ethnic groups in the proportion of youth who used a condom the last time they had sex.
And you'll see that those declines have been primarily, have been particularly since 2013, so if you look at kind of the quadratic you'll see things were pretty stable between 2007 and 2013 and then we started to see declines.
Again, we see declines in the proportion of black youth and white youth who have used a condom.
We do not see those same significant declines among Hispanic youth.
And so we've started to explore why we're seeing these declines, and so the next set of slides I'm going to show you is what we think the answer is.
Which is that we've seen increases over the last 10 years in the use of effective hormonal birth control.
So here you'll see this is for 2017 you'll see
that more females than males say they used effective hormonal birth control the last time they had sex, more white students compared to Hispanic students and black students compared to Hispanic students also said in 2017 that they used effective hormonal birth control the last time they had sex. And so here you'll also see that we've seen steady increases among white students and black students, but not those same increases among Hispanic students. So what we really think is going on here with condom use is that people are method switching, and so the decline in condom use is in direct proportion to the increase in effective hormonal birth control and it's among the same groups. So I think as youth have had more access to highly effective forms of birth control they are using them, as more youth have had access to health insurance they then have more access to clinical services and they have more access to highly effective methods of birth control. While that's great news for unintended pregnancy prevention it's not great news for STD and HIV prevention, and I think the increases that we're seeing in STDs, while we're seeing decreases in teen pregnancy, probably are intertwined with these findings. I want to focus for a moment on condom use among male sexual minority youth because we spend a great deal of time in our school based work with messages for young men who have sex with men for HIV prevention and STD prevention in terms of condom use. And here what we're seeing, this is a slide that shows the proportion who said they did not use a condom the last time they had sex, and so what is of concern to us is that young men, and this is all among young men, young men who identify as gay and young men who only have same sex partners are most likely to say that they did not use a condom the last time they had sex. So we clearly need to do more work in this area. At the same time our messages around HIV testing seem to be getting through, so those same groups, young men who identify as gay and young men who have only same sex partners are least likely to say that they have never been tested for HIV. And I apologize for the double negative there. So I'm going to switch now, so I could go on and on and on about data we've got, a ton of it, and so if you have any more questions about any particular aspect of the data you're welcome to go to our website, our youth online allows you to not only see our data summary and trend report and all of the different breakdowns that I didn't show you today, but also can allow you to do some of your own analyses. You can look at state based data, there's a whole variety
of ways in which you can look at this data, both in terms
of the data that I showed you today
and the other 120 variables that we didn't talk about.
But I want to spend some time kind of as the counterpoint
to where we are in terms of the sexual health of adolescents
in this country, to talk
about what we provide for them in schools.
So the data that I'm going to share with you is
from our school health profile system and this is a system
of surveys that we conduct in schools
in the alternate years to the YRBS.
So in the odd numbered years we collect the YRBS data,
in the even numbered years we collect our school health
profiles data.
It assesses school health policies and practices
in public middle schools and high schools
and covers a wide variety of topics for educational services
and school health based services that we know are important
to prevent the exact behaviors and experiences
that I just presented to you on.
It's self-reported data from principals
and health education teachers.
And so here you'll see starting with quality sex education,
you will see here that most schools
across the country are not providing quality
health education.
So this is the percentage of secondary schools,
that taught 11 key HIV, STD and pregnancy prevention topics
in middle schools and high schools.
And what you want to see is you want to see all states
in the darkest blue colors, in that 75% to 100% of schools
in that state provide that kind of education.
And here what you'll see is that the majority
of states are nowhere near that 75% to 100%.

One of the key ways in which we know
that health education becomes quality health education is
to make sure that the teachers providing it are receiving
professional development.
And so this slide shows the percentage of secondary schools
where the lead health education teacher got professional
development in the prior two years to the survey
on teaching students with different sexual orientations
or gender identities, which we know is key to making sure
that those youth feel included and are really able to take
in the education that's provided to them.
And if you think back to the slide on condom use among males
who identify as gay or who have same sex partners you can see
where this, if that's the source
of their health education the fact
that the professionals teaching those courses are not getting
professional development and how to provide
that for them is really problematic.
So again here what you would want to see is you would want
to see all states in the darkest color blue
and clearly that's not happening.
We also know that in order, again around the same issues in order to really fully prevent HIV and STD and pregnancies among youth, LGBTQ youth really need to receive information that is relevant to them. So that includes information around condom use and that includes information about HIV testing.

The percent of secondary schools, what we're showing here is the percentage of secondary schools that provide curricular supplementary materials that include HIV, STD or pregnancy information that is relevant to LGBTQ youth.

And here again you would want to see all of the states in that 75% to 100% range, and we're not there clearly. So the next set of slides I'm going to show you is the data that we have on whether schools have systems that are set-up to refer you to sexual health services, either in school based health centers connected to their schools or in their communities.

And here what you see is that most schools do not link students to needed health services, so again this is the percent of secondary schools that provide onsite services or refer to community sources of healthcare for seven sexual health services.

And again most of the states are in that zero to 24% range and not even above the 50% range. And again we're not finding a high enough proportion of schools that facilitate access to providers who have experience in providing services to LGBTQ providers.

So to sum up, we have seen improvements in some sexual risk behaviors, but there is clearly more work to be done. So we need to grapple with as we try to encourage youth to take on protective behaviors for pregnancy prevention, which is incredibly important, but they are also protecting themselves from STDs and HIV.

We clearly need to message better to young men who identify as gay or who have same sex partners around the importance of not just HIV testing, but also condom use. We need to do more, particularly from our schools, in both protecting young women against forced sex and sexual violence, but also then helping them with the trauma associated with that experience.

We know that schools play a critical role in reducing adolescent risk for HIV, other STDs and pregnancy, but clearly what we're finding is that that's not happening consistently across the country. So if you look at those maps you will often see that there are places in the country that are doing just fine, but the bulk of states are not.

We know that there are three things that can improve sexual behavior and experiences in schools, that is quality health education, connecting youth to health services, and school environments that support them and help them feel safe and connected.

In our own work with school districts we find
that when schools do this set of things we see improvements over time in those behavioral outcomes and those experiential outcomes. So we know that those are the most important things that schools can do to improve these areas, but we're clearly not seeing those improvements at this point across the country. And so for us I think that is a really difficult issue. We fund school districts and so the places where we fund we do see those improvements in all of these issues. The main problem is that we reach about 8% of the youth in the country with our programs and so that means there's 92% of youth who are not recipients of that. So I'm going to leave that there, if you have any questions I'd be happy to answer them, and look forward to hearing the discussion.

[ Applause ]
>> Thanks, Dr. Ethier.
Dr. Sales?
And if it's okay I'd like to hold questions until the end for both speakers.
Great.
>> Okay, good afternoon, and thank you for inviting me to come and share some information about the type of work that I do in relationship to sexual health promotion with young people. And over the course of my work, my time working in this field, which has been about 15 years now, I've experienced a journey with how I personally also approach engaging youth and sexual health promotion. And so I'm going to share some findings and a new approach that I've been engaging youth in a different way to sort of be more empowered regarding their sexual health promotion.

So adolescent experience, as we just learned, multiple sexual health disparities that impact numerous health outcomes, so we know that young people are still acquiring HIV at some of the highest rates when we look at HIV, new diagnoses by age groups, although teen pregnancy is going down we know that we still have higher rates of teen pregnancy in this country than in other comparatively high income nations, and then also we are seeing an upward trend in terms of STI diagnoses in the United States. So we know that these young people are bearing the burden of a lot of these health disparities, but they are often only superficially, if at all, engaged by adolescent health researchers in the research process itself. So community based participatory research approaches are grounded in a belief that community engagement and social action can bridge the gap between science and practice to increase health equity. CBPR approaches emphasize that key stakeholders in the community, so in the session these stakeholders would
be adolescents, suggest that they should be fully involved in each stage of the research process from conception all the way through dissemination of their results. And by partnering with individuals who are typically seen as the subjects of research the CBPR study is more likely to uncover important factors that are contributing to the real world problems that are of importance to their community that's being engaged in the research. So also by partnering with individuals who are often marginalized without power and resources, like adolescents, the CBPR process can also build community capacity which can be empowering to the individuals that participate in this CBPR approach, but can also contribute to a sense of agency and self-control over their own lives for those participants, but also in communities that embrace and are involved in this approach. As such, CBPR can meaningfully engage adolescents in youth driven research if we choose to adopt these types of strategies as adolescent health researchers. And as a Developmental Psychologist I'm particularly excited and interested in how engaging and using community based participatory research, or CBPR, with adolescents may also function as a positive youth development program. So positive youth development programs aim to meet the developmental needs of youth, as well doing so build the core set of youth assets that are oftentimes referred to as the five C's, and these are things such as building confidence, competence, their contribution to their community, as well as character and caring. And, finally, meaningfully engaging and through meaningful participation in the process of health focused research there are some suggestion that in being involved in this process may also enhance trust in medical research among communities that for historical reasons have high levels of medical mistrust. So I'm going to share with you for the rest of the time today how with some funding from the Patient Centered Outcomes Research Institute we set out to conduct a CBPR program with Metro Atlanta African-American Youth to support their identifying and conducting a research project focused on an adolescent health issue of their choosing that they determined was impacting their community, as well as we wanted to evaluate this program to see if participation in a CBPR process increased the youth assets, the five C's that I just mentioned prior, as well as increase their trust in medical research and health outcomes from that medical research. So through an application process that was disseminated to high schools across the Metro area we recruited 12 African-American high school students.
We also engaged and recruited six adult professionals in Atlanta and we were specifically looking to engage adults who had experience working with adolescents in some capacity to serve as a support and an advisory board to the youth. So these individuals would support and provide feedback and advice to youth as solicited. Now most of the individuals, the students that were involved were in the 10th grade or the 11th grade with a mean age of 15.5. Seven youth attended schools in Cobb County, three in Fulton County, one in Fayette, and one in Henry County, respectively, and more than half of our sample qualified for the national school lunch program in which they received brand reduced lunches. So I'm not going to go into this slide and I apologize for even throwing it up here, but it's just to show you that we had a very intentional process by which we wanted to make sure that as the Emory team that we wanted to be able to impart skills through a series of training to these young people so that they could be empowered to select the research that they wanted to focus on and then conduct that research, interpret its finding, and disseminate it to the communities that they felt most needed to hear the information. So this is just to show you some of the topics and the process by which we went through this. After the youth did decide on their health topic, which they did focus on sexual health as the priority area that they wanted to explore further, they then were supported by our Emory team, as well as the adult advisory board in terms of giving them feedback on the methods and the tools that they were going to be using to collect their data, as well as on the analysis of results and the presentation and sharing of their findings in the community. So I'm going to share some slides now that came from a presentation that was actually created and developed by the youth that served, that were part of that, and they named themselves the Atlanta Research Coalition. And so this is the young people that were involved in this and this presentation that they were invited to give at the Adolescent Medicine Symposium at CHOA this spring. So they labeled their presentation, Sex Mis-Education. Now through their review of the literature, that was one of the things that we were trying to get them familiar with how they can find out information about a topic that they're interested in under their community. So we gave them exposure and training on how to conduct literature searches, how to identify available publicly available datasets, like the YRBS data findings and places where they can find statistics, as well as use publicly available state health databases to start health outcomes, like STI rates, teen birth and HIV. They did a comparison of all the Metro Atlanta counties and they through this process identified Fulton County as the place
where they wanted to focus their needs assessment because they found that Fulton County experienced especially high teen birth rates, as well as STI and HIV rates compared to the other counties for youth in those age ranges experiencing these events compared to the other counties in the Metro area. They were particularly surprised by the number of youth who are recently being diagnosed with HIV, particularly in the southern US and specifically in Georgia. They also then found through Aids View that shows data on HIV rates by age and by the county level in Georgia that Fulton County also disproportionately diagnoses more youth than other areas in the Metro Atlanta area. So they also began to think about what sexual health education resources are available in communities and they examined the sexual health education requirements for the State of Georgia. To the extent possible they wanted to look in and see what the sexual education requirements were by county in the Metro area. They found that sexual education is legally required in Georgia, however, it is not required to be medically accurate, culturally appropriate, age appropriate, unbiased nor unfavoring of religion. And when they uncovered this I can't tell you how upset they were and how it raised a lot of concern about the education that they were receiving in other areas in their school system. So through this process based on their review of the public health literature and conversations that these findings stimulated them to have with members of their community, as well as feedback from the adult board, they felt that comprehensive sex education can, indeed, combat high teen pregnancy, STD and HIV rates in Fulton County, Georgia. So they set out to conduct a community assessment to identify the sexual health education needs among adolescents aged 14 to 19 residing in Fulton County. What they did was they did everything, they wanted to do a mixed methods assessment because they determined that a combination of surveys and qualitative data collection would probably yield the best and the most high quality information. They conducted seven canned informant interviews with adolescent health specialists, principals, school board members and a state representative that represents Fulton County. They conducted two focus groups with students in Fulton County and they predominantly focused on south Fulton County because some of the more granular data that they could ascertain on HIV rates were showing that more diagnoses were being made in south Fulton than in north Fulton County. They then also conducted 111 surveys among high school students in Fulton County. They did everything, they created their tools,
they did the data collection, they did it all within the span of four months. So impressively what they found then the analysis part takes a little longer to put all this together, but what they found and what they concluded when they triangulated and used all their data pieces together that some prominent themes emerged. They found that there were content gaps in what education was being offered to students in Fulton County. They found that a lot of young people had no clue where they could go in their community to access sexual health services or even to get more information about more sex education. They valued this information, they wanted to learn more about this information and they wanted to have it, but they wanted the information to be of high quality and they felt like the education they were exposed to because a lot of them noted being exposed to sex education in school was not delivered with quality. So they reported a lot of concern about the capability of their sex education instructor to actually be qualified to teach the topic. They desired improvements, a lot of improvements in the delivery of sex education in their school, and they also noted that there were a lot of perceived risks so that young people actually were concerned and felt like that they were at risk for some of these health outcomes. So there was some noting of perception of risk in the community among them and we asked the extent to which they felt like they were at risk for unintended pregnancy, STIs, HIV, as well as dating violence? And the numbers were high across all groups. They also noted a prominent theme of stigma. They felt that from multiple sources that they were hearing that the sex education that is delivered in Fulton County is stigmatizing, it's particularly stigmatizing to the LGBTQ community and the students felt like this sort of made it so a lot of people tuned out because they felt like the message was not given appropriately. So some key takeaways that they really focused in on were that adolescents are interested in sexual health and they want to learn more about this information, so we should honor that wish and we should be able to create spaces where they can have access and be able to learn about their sexual health. However, they desired improvements for this education and they wanted overall improvement in their sexual education that were being offered in school. They also noted that less than 50% reported learning about gender identity, community sexual health resources, learning about partner communication about that sexual orientation, less than 50% learned about consent or dating violence. And then, like I noted, the majority of students received sexual health education
that contained stigmatizing messages
to minority sexual identity youth in their settings.
So they walked away and they provided some
key recommendations.
The first one is
that a comprehensive medically accurate sex education
curriculum that is inclusive of all identities and free
of judgment should be implemented
in Fulton County schools, and that teachers should be trained
to follow this curriculum with fidelity
and they also wanted this to provide students
and parents access to handout and resources regarding
where they could get sexual healthcare
in their communities as well.
So I think it just beautifully shows that they fall very much
in line from young people's perspective, research done
by young people who are not experts in this area,
who really don't follow closely the CDC's recommendations,
but they came upon this information
and these conclusions based upon their own data
with young people in the community.
And when I tell you when you get a group of young people
who feel empowered and passionate
about a topic they were able to write a final report
which we shared back with Picori and shared
at several conferences, they prepared an article
for VOX ATL.
I think some VOCs folks were here this morning.
They prepared an article and they put it on their website.
They were invited to speak and share their findings
at a PTA meeting, not in Fulton County
but in Gwinnett County,
where there was a group of parents, they used the same type
of sex education curriculum in Gwinnett as in Fulton
and when they heard that they had these findings suggesting
for a change in the curriculum they were invited by this group
to come share their findings to advocate
for why young people want to have better
and different sexual education.
They also gave the presentation
that I just showed you the slides
from at an Adolescent Medicine Symposium at CHOA
and they created an infographic to be shared
with youth online and on social media.
So these are some
of the individuals while they were doing the presentation
at the Symposium, at the Adolescent Medicine Symposium.
So on our side, what the Emory team did,
we talked about how we wanted to make sure
that we were hypothesizing that going
through this process would serve as sort
of a positive youth enhancement for participants,
as well as increase their trust in medical research.
So we asked young people to participate
in a quantitative survey
that was conducted before they started working with us
on the Atlanta research, Youth Research Coalition,
and then we also conducted, we did that pre and post. And then we also did qualitative interviews with each of the young members after they were done participating in our 18-month program. And through the surveys we were able to assess and use the trust in medical research scale where higher scores indicate greater trust in medical research, and then through the interviews we were able to ascertain the extent to which the experience increased positive youth outcomes. So here are the qualitative findings first, and we'll see and some that I want to highlight more specifically are in relationship to confidence. So here we see that the youth board members reported that they gained confidence talking to adults, in conducting research and expressing their opinions and beliefs. Here's a quote that shows this example, I feel like my confidence went up, I learned how to communicate better and share my ideas, I'm not afraid to share them now. Another area where we were excited to see growth was in the area of character. Youth board members expressed that their participation in this process informed how they will practice ethical research and treat others in their daily lives outside of the program. So one individual stated, I knew about ethics before but I never experienced like asking myself if what we are doing is ethical, I guess it made me try to be more aware of other people's feelings and wellbeing. Another area of growth was in caring and youth board members empathized a lot with the adolescents who were not receiving adequate sexual health education and realized that this not only affected individuals, but also their communities. And one person wrote or noted, I feel bad that adolescents' education is being determined by someone else and that they are missing out on what I feel like everyone should be learning about because it's not just about sex, but you're learning about your body and then why it does certain things and how to keep yourself healthy. And, finally, the area of contribution we also saw was developed in these young members and they noted things like that participating was rewarding because it allowed them to feel like they were affecting change in their community. So they said the project opened my eyes to a lot of things that I didn't know was going on in the world today and I feel like that I can help other people in the future by us doing this project it can change the environment, I feel like I can change the environment. And, importantly, overall we saw this general sense of positive youth development from participants,
where youth board members were excited to be involved in the research process and felt empowered by their roles as key stakeholders driving the agenda. They noted that the adult advisory board helped us instead of only letting us help them. A lot of times kids only get to help adults do things, this program gives me a voice and my opinion matters, I think that's important especially at this stage in life. And related to our findings from pre to post in terms of increases in trust in medical research we saw a significant increase in these young individuals' trust in the medical research and the outcomes of that research after participating in the program. So some conclusions and takeaways that we've had are that these findings suggest that a CBPR approach, the one that we took with these young people, had a strong positive impact on the youth that were involved and that the youth board experienced overall greater trust in medical research and positive changes in pretty much all aspects of positive youth development after participating in the AYRC program. Our findings highlight how meaningfully engaging youth in research can strengthen their own developmental assets of those participating, but that they are also contributing then to meaningful changes and improving adolescent health in their communities, and that when youth do this and they want to share their findings people want to listen. So that's my presentation. Here our wonderful team, some more photos of them in action. So I'm happy to take questions. [ Applause ]

>> Thanks, Dr. Sales. We're going to go ahead and open up the forum for questions. Sure. >> Mike Underwood, Division of Adolescent and School Health. Thanks to both of you for your presentations, they were really, really interesting. Dr. Sales, I was really interested in the youth board, and I can't recall now but I don't think, were any of the students from Gwinnett? >> So, no, we did not have -- we had students from Cobb, Fulton -- no, not from Gwinnett. >> So I found it interesting that Gwinnett was the one willing to listen to them, what was the reaction from Fulton, Cobb, where the students came from? >> So it was very interesting because, so the Gwinnett folks were interested because one of the participants actually that they interviewed when they learned what the students were focusing on and that they were going to have these findings they were being asked to identify young people who could speak to wanting improvements in sex education, so that's why they ended up getting connected to Gwinnett.
In Fulton County they were able to identify a couple of opportunities to participate and share their findings, but by the end of their program there were no more PTA meetings scheduled and so what they're hoping now and they're still interested in being able to share back and come and present, but they committed their report to folks in certain Fulton County schools. They're still trying to get the message out and still actively involved even though they haven't really been required to be involved and sharing the findings.

>> Okay, have a question here?

>> Joe Valentine from the Division of STD Prevention.

And thank you, the presentations were really wonderful. I'm sort of interested especially in this sort of notion about the declining, you know, evidence of declining sexual behavior among very high risk populations, we think of characteristically as high risk populations.

And recently I had read an article that I think was in The Washington Post that talked about basically the US sexual behavior is declining, and one of the striking categories where it was declining the most was among young men 18 to 29. And so I'm like, okay, but the STD rates keep rising so something is going on here, we're having less sex and apparently we're having more unhealthy sex.

So I was thinking in terms of the issue of trying to design or think about what the prevention messages and intervention efforts should be, and both of you can speak to this question -- given that you have less sexual behavior actually happening what then do we need to talk about in terms of the content of our messages because it won't make much sense to keep talking about condom use if people aren't even having sex? And I think we're all getting to the realization that there's probably a lot of unhealthy sexual activity going on with the realization of everything from the Boy Scouts to the Catholic Church and all this evidence of forced sex that's been happening for decades in our society, we haven't really addressed.

So what does that mean, what are our ethical obligations then in terms of designing programs, that we end up still sort of focusing on that individual risk behavior, but I'm wondering how much resonance is that going to have with populations that apparently are having less sex?

>> So we've seen declines in sexual behavior and we've seen declines in numbers of partners. I don't think that translates into kids aren't having sex. So 40% of all high school students have ever had sex and there's still a proportion who have had four or more partners. And so I think that we still have some ethical obligations to provide education for those youth who are having sex.

I think we've hit up against an ethical question around the do you focus on HIV, STD prevention, do you focus on pregnancy prevention?
They're not mutually exclusive necessarily, and we do promote kind of dual protection, so both highly effective hormonal birth control as well as condom use, but it's very difficult to get adolescents to use one method let alone two. And so we're at about 8% of dual use in YRBS data and that has stayed the same for the last number of cycles, so I'm not sure how we promote, what we do to promote that dual protection.

I think, you know, a little bit I do want to get back to something that came up in Dr. Sales' talk in that this idea that sex education is about promoting a method of HIV or STD or pregnancy prevention, but a lot of what it's doing is teaching youth about their bodies. So I will say just for disclosure sake that at one point I was doing some, I was helping out in a Fulton County school who asked me to come really pretty much every semester and do the sex education portion of their health class because there was a lot of things that the teacher was restricted from saying that a guest speaker could come and say. And so I did that for a number of years in one particular school in Fulton County, and what I found was I couldn't even get to prevention methods, I couldn't get to some of those protective behaviors because I spent so much time just describing how bodies work. And so I think from an ethical standpoint when we don't do that we can't even get to, and whether or not you're having sex you need that information, and schools are really the last time we have everybody in one place where we can provide that before they move on to wherever they're going to go from there. So I think, I don't know that this is necessarily answering your question, but I do think that youth deserve to be taught basic information about how their bodies work and then from there to go on to what's going to happen if you don't take care of your body and here are the implications for that. And then the other thing I think is that I think, you know, from what we heard youth are starting to figure out for themselves that adults are not always telling them what they need to know, adults are not, can't always be trusted to tell youth, give youth all of the information, and that's really detrimental to our relationships between youth and adults, if they don't feel like they can rely on us to give them what they need then we're in trouble. So I don't know if you want to add to that?

>> Yes, I would completely agree with everything you just said and then also note that the way in which sex education typically happens is sort of a onetime event in one year of school for most individuals and that year is so rushed to get so much in, especially when you realize that the knowledge, the basic knowledge which a lot of the curriculum is even built
on hasn't even been built, so you have to sort of start from even before to get them to a place to understand the curriculum. That sort of speaks to me that we should consider ways in which we can integrate this material in a regular basis and maybe in different ways across, as you know, other sex education experts have been recommending for a long time to infuse this into a life course sort of approach to addressing sexual health that starts in kindergarten and ends in 12th grade, right, or never ends in our life. But also then making sure that where there are deficiencies or where we're placing a lot of importance on schools to deliver this when there might not be support to have the education be quality, that we are also giving people access and it's our ethical obligation to share where in the community they can engage this information and where they can find and turn to for resources when and if they determine that they need them, when they become relevant, regardless of if that's now or in 10 years from now. So I think that's something we heard a lot also that came out was this really strong interest of young people that participated in this study was having their parents, they really wanted also their parents to get some of this information because they actually felt really comfortable and they wanted to talk to their parents and they wanted their parents to be able to talk with them about it. And so I think that's another element, too, where oftentimes thinking about how to engage and ethically engage families in the conversations as well because sometimes families are great spaces for some people, but might not be safe spaces, especially we know for sexual minority youth in terms of their conversations or questions about sex. >> Thank you.

Okay, we're right at time, so I want to thank Dr. Sales and Dr. Ethier again for their excellent presentations.

[ Applause ]

[ Applause ]