

CDC *Vital Signs* Town Hall Teleconference

Preventing Repeat Teen Births  
Q&A

April 9, 2013  
2:00–3:00 pm EDT

Dr. Dan Baden: Thank you very much for that presentation. I'd like to remind everyone that you can get in queue by pressing star 1 to ask a question. You'll need to record your name when prompted and then you'll be announced into the conference.

I encourage you all to take advantage of this opportunity to share your stories, your strategies, lessons learned, challenges—all those types of things, or to ask the presenters questions.

To start us off, I'm remembering a patient I had several years ago. She was a very intelligent, but fairly rebellious 12-year-old who was pregnant. She had a fairly detached mother, so there wasn't a good home situation.

And can you give us, or me, some advice on how you could help her not to -- to avoid a second pregnancy?

Kristen Plastino: Sure, Dr. Baden. This is Kristen Plastino in San Antonio.

One of the things we ensure is for these young moms is talking to them about contraception during their pregnancy. This isn't something that should wait until after they deliver, so talking to her during the pregnancy.

Around six, seven months start talking to her about is she going to be sexually active, what's her home situation going to be, presenting the idea of long-

acting, reversible contraceptives, or LARCs, like the implants or the IUD, and figure out which one would work best for her and what she would be most inclined to use, and get her physician to begin to talk to her about that and prepare for doing that, the implant three weeks after she delivers—between three and four weeks after she delivers. And the IUD can be placed six weeks after she delivers, or some are even doing it immediately postpartum with the copper IUD.

Dr. Dan Baden: Okay great, thank you very much. Jeff, do we have any questions in queue?

Coordinator: Yes, we do. Dr. Sal Giorgianni, your line is open.

Sal Giorgianni: Okay, good. Yes, I'm chair of the American Public Health Association Caucus on Men's Health, and I have a comment and a question.

I was very, very happy to hear of the work that's done— to work with young men in the Connecticut program.

Oftentimes the young men are neglected in outreach efforts. And I think this is a very, very important approach that has to be taken, and needs to be taken more often.

Question is, in the San Antonio program, did you also do outreach to young men and boys? And what was your model to do that? Thank you.

Kristen Plastino: Yes, this is Dr. Plastino in San Antonio again. Yes, we do absolutely include men. The Nurse Family Partnership, while they go out and work with the pregnant girl, herself, it includes the entire family unit, which includes the

father of the child as well as grandparents, aunts, uncles, and siblings of that pregnant teen.

We also have a men's health program with the clinic that we work with directly. And so they are very much in tune with male health needs.

And then in the probation department, we actually have a 60/40 ratio where 60% of the probationers are actually male.

So as we were talking to their probation department regarding adolescent sexual health, it was regarding both the female and the male.

Sal Giorgianni: That's wonderful. Thank you very much for that summary, and thanks for doing the very important work that you're doing.

Kristen Plastino: Thank you, sir.

Dr. Dan Baden: Okay, thank you. And again, press star 1 if you have any questions to get into queue.

I have a second one—I think Texas-related as well. You mentioned your peer educators in the community college. Are you working with the Promotoras? Are the Promotoras still active in that area or community health workers?

Kristen Plastino: Yes, the Promotora model, or community health worker model, is something we've been looking into.

That is not exactly how we do the peer educators at the community colleges. The Promotora model is more of a going into the neighborhood, into the homes of the people in the neighborhood.

The peer educators are on the college campuses working with those kids on the campus, not going into their homes. But it's a similar idea in that, you know, it's some member of their community that's talking to them and not an outsider coming in telling them what to do.

Dr. Dan Baden: Okay, very good. I think we have a question on the queue.

Coordinator: Louisa Benson, your line is open.

Louisa Benson: Question is for Dr. Plastino. Did you have a particular evidence-based curriculum that you are using for the school board, for the schools and having the school boards to approve?

Kristen Plastino: Yes, we actually utilized the Getting Your Outcomes process. It's a 10-step process that the CDC has helped us with to really do a needs assessment on our community.

And so there wasn't an evidence-based program that we walked into each school district and said, "this is the program you need to do."

We really did a needs assessment, did focus groups, met with administrators of the school, community members, parents.

We had something called School Health Advisory Councils, met with all these people to get the input of what type of teen pregnancy prevention program they wanted, looked at the list from the Office of Adolescent Health and saw which components each program had, and then brought opportunities to them, two or three for them to look at to see if that was something they would like to implement in their school.

At that point we presented it to the various committees that we needed to prior to school board approval and then took it to school board approval.

So one of the biggest take-home messages I'm getting in evidence-based program somewhere is not just to tell them what they need to do, but to really do a needs assessment of what they want and what they think they can implement in their school and then look at the options on the evidence-based list to be able to decide which is the best fit.

And then after we implemented those evidence-based programs we actually went back and did continuous quality improvement to see if it really fit the needs of what they wanted to accomplish and did we need to add something else or take away something remaining with the fidelity of the evidence-based program.

Louisa Benson: Thank you.

Kristen Plastino: Yes, ma'am.

Coordinator: The next question is from Sharon Wong. Your line is open.

Sharon Wong: Hello. Thank you so much for your presentation. These are really helpful and it's clear that you've done a lot.

A lot of the research that we look at and—I'm at the Division of Adolescent and School Health at CDC—shows that lesbian, gay, and bisexual youths are more likely than their heterosexual peers to be pregnant or to get someone pregnant.

Do you address, I guess, lesbian, gay, or bisexual issues as far as the clients that you serve?

Kristen Plastino: This is Kristen Plastino again. Yes, I am very aware of the literature that show specifically that lesbian teens have a much higher unintended pregnancy rate.

The things we have utilized here in San Antonio are, first, with regard to our clinics. We have done in-services to all our clinics that are becoming teen friendly to make sure they understand how to ask these questions in a sensitive manner.

So, it's not, "so when was the last time you had sex with your boyfriend," a lot more general questions to be able to ask the teen which type of sexuality she is or might not know.

And so, the in-services we do for the clinics were very important. It's also when we are doing evidence-based program training that is something that comes up.

But what we always talking about is that really any type of sex—same sex or opposite sex—can spread STDs. And we also talk about the unintended pregnancy rate being higher.

So we include it in our evidence-based programs. We include it in our clinical trainings. Stakeholder education is always part of that. And that's really part of our final component of being culturally sensitive in working with diverse populations.

Sharon Wong: Thank you. And as far as what's going on in Connecticut as well?

Shelby Pons: In Connecticut, the social workers work on their individualized plans with the girls. As for providing services that are focused directly toward that

population of lesbian, gay, bi, and transgender, we are not currently targeting them in the schools and holding a specific targeted groups for that population.

However, we are doing school-wide education on sex education. Does that answer your question?

Sharon Wong: Yes, thank you.

Dr. Dan Baden: This is Dan Baden. I've got another one. Are you using social media much as an outreach mechanism?

Kristen Plastino: This is San Antonio again. In the CDC project, we are using our Facebook page, which we do advertise; it was on the back of my slide set. And so we do have about 500 likes on that right now. And we do utilize that with our teens, as well as with our youth leadership team.

As far as another grant that I have, where we're doing innovative sex education and testing it in a rigorous evaluation model, social media is a main component of those curricula.

Dr. Dan Baden: Okay, thank you. And then I had one other question, back to the earlier comments about IUDs and teens. I thought that this used to be an issue. Is it still an issue? Is this population base more risky for using an IUD?

Kristen Plastino: This is San Antonio again. As an OB/GYN, the American College of OB/GYN strongly advocates for IUD use in teens. It is not any higher risk of infection than in an older population.

That said, we used to, back when I was training, you always check for gonorrhea and chlamydia one visit and bring the teen back to get the insertion at another visit.

Now what is recommended is that you actually check for GC/chlamydia and place the IUD at the same visit. If they do come back positive for chlamydia, you just treat the chlamydia and leave the IUD in. There's no reason to remove it, or wait for the result.

And this is really called the quick-start method. And there's a lot of literature on the quick-start method on how to do it with regard to long-acting reversible contraceptives.

Lorrie Gavin: Dan, this is Lorrie from CDC. I just want to add one additional point to Kristen's, which is that in 2010, CDC adapted WHO (World Health Organization) guidelines on contraceptive safety called Medical Eligibility Criteria for Contraceptive Use, that address this question plus a whole range of other contraceptive safety issues.

And if people are interested in more information about that, they can Google "medical eligibility criteria" on the CDC website.

And those recommendations say that LARC with IUDs and implants are safe for nulliparous teens, as well as postpartum teens, as well as adult women, and both the implant and both IUDs are generally safe to place immediately after delivery.

Dr. Dan Baden: Very good, that's good to know. I'm getting ready to close up. There are no questions in queue right now. So, as I'm closing up, if you've got a burning question, please just press star 1 and we'll get to you before we finish.

So, what I'd like to say is please take a moment and look at the next to last slide in your presentation. It's slide number 43.

You'll be able to find Dr. Plastino's and Ms. Pons' presentations from the states there. They'll be featured in the Public Health Practice Stories from the Field.

This series highlights how a broad range of public health practices are being implemented in the field. You can find links directly to these stories on the *Vital Signs* Town Hall Teleconference website, or you can visit the link at the bottom of the slide so you can see all the Public Health Practice Stories from the Field.

And it looks like we have another question. So, Jeff, can you open that up?

Coordinator: Jennifer Drake, your line is open.

Jennifer Drake: Good afternoon, sorry for dialing in a little bit late with my question. But this is specifically for Shelby.

Thank you so much for sharing such great information about the work that you are doing with teen parents. I think it's really important.

My question is about whether or not the identified core services, that you mentioned a few times, included family planning in some way, or if there was—what I'm assuming—is a drastic reduction in the teen pregnancy or birth rate doesn't happen by accident.

So, I'm wondering if there was some concerted effort to refer or to counsel about various contraceptive methods and sort of how that percentage of less than 5% of the youth you served experience a repeat teen birth, sort of how that compares to the general population of students and what you know about pregnancy occurring among the students that you serve, just more broadly?

Shelby Pons: Well, each of the school-based programs has a nurse on site. And they use a prenatal curriculum, and all sites follow the same prenatal curriculum.

And many of our schools have school-based health clinics, and so they're able to get contraceptives right in school.

Jennifer Drake: Wonderful. Thank you very much.

Shelby Pons: You're welcome.

Dr. Dan Baden: All right, well, I want to thank all the presenters and all the participants for a wonderful discussion. I learned a lot here and hopefully you found it informative as well.

But there is one more way you can help us. We would like to know how we can improve these teleconferences even more to make them more beneficial to you.

So, if you have comments or feedback, please let us know and give us your suggestions at [ostltsfeedback@cdc.gov](mailto:ostltsfeedback@cdc.gov). That's O-S-T-L-T-S feedback—all one word—at CDC dot gov.

At this point I think I will close the conference. And again, thank you to everyone who presented and have a good afternoon.

Coordinator: This concludes today's conference call. You may now disconnect.