

**“EMERGING ANSWERS 2007”
CONFERENCE CALL
Edited TRANSCRIPT
TUESDAY OCTOBER 30, 2007
3:00 P.M. EASTERN TIME**

OPERATOR: This is a recording of the “Emerging Answers 2007” conference call for the National Campaign to Prevent Teen and Unplanned Pregnancy for Tuesday, October 30, 2007 at 2:00 PM, central time.

Excuse me everyone, thank you for your patience in holding, we now have your speakers in conference. Please be aware that each other line is in a “listen only” mode. In conclusion of the speaker’s presentation, we will open the floor for questions. At that time, instructions will be given as procedures to follow if you’d like to ask a question. I’ll now turn the conference over to Kristen Tertzakian, ma’am, you may begin.

KELLEEN KAYE: Welcome to today’s conference call, Emerging Answers 2007, my name is Kelleen Kaye. I’m here with Kristen Tertzakian, Katy Suellentrop and Corinna Sieber, some of my colleagues here at the National Campaign to Prevent Teen and Unplanned Pregnancy. We’re very pleased that we have over 150 participants from across the country; hailing from state and local health departments, state and local coalitions to prevent teen pregnancy and a number of other community-based organizations. So here at the Campaign: one of the number one questions we receive is: What works to prevent teen pregnancy? And to help answer this question, back in 2001, you may recall that the National Campaign released a ground-breaking report, *Emerging Answers*, research findings on programs to prevent teen pregnancy, which was authored by Dr. Doug Kirby, a Senior Research Scientist at ETR Associates. The report reviews the research behind the variety of prevention based programs, including curriculum-based abstinence and sex education

programs, as well as youth development, clinical, early childhood and service learning programs. And of course, a lot changed since 2001, and that's no surprise to you all. We have a lot of new data and several more evaluated programs, so we've been fortunate enough to have Doug with us today to talk about the updated Emerging Answers. So, then, a few moments after Doug gives us an update, Kristen is going to provide a brief overview of the new interventions that are included in this publication. And last, I just wanted to mention a couple of housekeeping factors. Because there are so many people on the line with us, for now all the lines are going to be muted, but then after these two quick presentations, it's going to be an operator moderated question and answer period and we're really looking forward to hearing from all of you. In addition to the agenda, and we're hoping that you have received a web link to the *Emerging Answers 2007* summary report, we would like to mention that this is embargoed until November 5th, so if you could please not circulate it too widely. Next Monday we'll be posting the full report, summary report, tables and charts and hopefully today's call transcript as well (Please Note: Emerging Answers will now be released on November 7th). So, lastly we just wanted to take a moment to thank the CDC for supporting the development of this publication and today's call and to thank you all for your participation and joining us in the question and answer period. Now I'll turn it over to Doug.

DOUG KIRBY: Great, thank you. I want to thank everyone for joining me today, or joining us today. I've been working on *Emerging Answers 2007* for most of the last year. When I started off, I thought it was going to be a small task, representing a relatively small update and wouldn't be terribly time consuming and that's probably been the greatest underestimate in my entire life and that's quite an achievement to underestimate it even more than my other underestimates.

I wish I could see all of you, but I know you're out there. I wish I could see if you're agreeing with what I'm saying and so forth, but I can't. I'm going to try in about 20 minutes to summarize all of the many findings, kind of the highlights of the findings in *Emerging Answers 2007*. And to make some order out of it, I'm going to go through it, chapter by chapter. And I'm certain, I'm sure that I'm going to miss some points, just because there's a lot in it. In 20 minutes, I just can't do justice to all of them.

So, starting with Chapter One: Chapter One, like its predecessor, *Emerging Answers*, focuses on sexual risk taking, its consequences, pregnancy and STDs. When we look at that, what we find is that, as many of you know, we have had a large decrease in teen pregnancy and teen birth rates in this country. The rates have gone down by roughly one-third. And that is a huge achievement, and many of you who are listening are partially directly responsible for making and helping those rates go down especially all of you work with teens. So that's been a huge achievement. Despite that, however, our teen pregnancy and birth rates are still incredibly high, both in terms of the cost to teens and the children that are born to them, but also in comparison with European countries and other developed countries where rates are just dramatically lower. In this country, it is still true that 7.5% of teenagers become pregnant each year and that's a lot of teens. By the time they become 20, 30% of them have become pregnant and the vast majority of those have been unintentional.

When we turn to STD rates, we again see that we have high rates of some STD's and it's true that about one third of all young people, who have sex, will become infected with an STD by the age of 24. That's a high percentage, particularly when you think about the consequences of some of the STD's for young people.

The second chapter focuses, not on pregnancy and STDs, but really on the behaviors that have an impact on pregnancy and sexually transmitted disease. This is an

entirely new chapter and frankly, it comes, in part, from the work that I've done in Africa and trying to understand why HIV declined so dramatically in Uganda. I learned a great amount by working with international experts on sexually transmitted disease. In the United States, we have typically focused upon abstinence and condoms and contraception when we think about how to prevent teen pregnancy and teen sexually transmitted disease. That's three behaviors and in a presentation I gave, I asked people what behaviors we ought to be focusing upon in order to reduce pregnancy and STD. They came up with those three and they actually added a fourth one; reducing the number of sexual partners. The reality is, there are not three or four behaviors that have a large impact upon sexually transmitted disease, there are actually ten. The other six, we either have totally ignored, or we've given very little information about. So, Chapter Two talks about those ten and it really is a new chapter, with, I think, new information. The reason it's so important is because we've learned that giving a clear message about behavior is one of the most important characteristics of effective programs. We've learned that by emphasizing that young people should delay sex, we can, in fact, reduce the percent of young people across the entire country and that's really amazing, across the entire country who have had sex. By emphasizing condom use, we have increased the percent of young people who use a condom each time they have sex. We've done that all across the country. We've also increased other forms of contraceptive use and as a result, our pregnancy rates have come down and that's a real achievement. So, that's three or four of the behaviors. What are these other six, that I haven't yet mentioned, that have an impact, not on pregnancy, so much, but on sexually transmitted disease? They include, and I'm just going to list them quickly and maybe say a thing or two about a couple of them. Decreasing frequency of sex, the more frequently young people have sex, the more likely they are to contract a sexually transmitted disease or to become pregnant; and that's assuming they don't use condoms or

contraception. I mentioned number of sexual partners. It turns out that it is extremely important in terms of sexually transmitted disease. Modeling work has been done in this area. If a large number of young people have either one or two or three sexual partners, such that they have an average of 1.7, now that's an important number, 1.7 sexual partners, then 2% of all of those people will end up being in the largest sexual network, through which some STD's might pass. That's just 2%. If we increase the mean number of partners, simply from 1.7 to 1.9, that's only two tenths of a partner, not even a whole partner, just two tenths of a partner, the percent of all the young people who'll be in the largest sexual network increases from 2% to 64%. That's just a huge increase. If you increase the mean number of partners beyond 1.9, the percent of the population that'll be in the largest sexual network increases even further. It is true at the individual level, that if you double your number of partners, then you roughly double your risk of contracting a sexually transmitted disease. But at the population level, we find that young people become far more likely to be inter-connected in sexual networks and hence, far more likely to contract a sexually transmitted disease, if they increase the number of sexual partners by only a small amount. So, that becomes very important.

It also becomes very important whether or not young people have sexual partners sequentially, that is, whether they have sex with one person, and stop having sex with that person and then begin having sex with another, or alternatively have concurrent partners, such that they may have sex with person A, then B, then back with person A. It turns out that having concurrent partners greatly increases the transmission of sexually transmitted diseases.

It is also true that the amount of time -- the number of months -- between sexual partners is very important. If you just think about it, many of you, who are listening, may have gotten the flu sometime during the last year, but now you may very well be shaking

hands with people with the confidence that you're not giving them the flu. That's because your viral load has diminished and your flu may be gone. The same thing is true with most, but not all, sexually transmitted diseases. With the passage of months, people become less infectious, even in many cases, but not all cases, if they're not tested and treated.

Another important behavior is being tested and treated for STD's. Another one, a new one, is being vaccinated for Hepatitis B and for Human Papillomavirus.

And the last behavior, which I'm not particularly recommending in this country, that turns out to be very important internationally, is having males being circumcised. We have very strong evidence that when males are circumcised, they are much less likely to contract HIV from their partners and there's weaker evidence, but some evidence that they're less likely to contract other sexually transmitted diseases from their female partners.

So we see, there are not four behaviors, there are ten and this is important, because we need to think about how to expand our messages to include some of those. Ten is too many. We need to eliminate a couple of those; we need to cluster them; we need to group them in some way so that we can frame messages for young people. But clearly, we need to go beyond simply abstinence and condoms and contraception. I can say much more on this topic, but I've spent too many of my 20 minutes already.

The third chapter focuses on the factors that affect teen sexual behavior. This is an update from *Emerging Answers*; it previously included a chapter on this topic. The review now includes more than 400 studies of different kinds of factors that either increase or decrease the chance that teens will engage in risky sexual behavior. Those factors involve: communities, families, friends and peers, romantic partners, and the teen themselves. Many of those factors are sexual psychosocial factors, things such as: their beliefs, their values, their attitudes about having sex, about condoms, about contraception, the perceptions of peer behavior, their intentions, their confidence in their ability to not have sex or to use

condoms or contraception. Those factors end up being the most strongly related to actual sexual behavior, not perfectly, of course, but still strongly related to them. And there are non-sexual factors as well: belief in the future is very important, connection to family is important, connection to school, doing well in school, etc, those are important, even though, they don't have anything to do with sexuality. What this means, then, is that organizations who are involved with sexuality, can have an impact and it also means that organizations that work with youth that do nothing with sexuality can also have an impact in terms of affecting non-sexual risk and protective factors.

I'm kind of going through chapters like a logic model. First, I talked about teen pregnancy and STD and how that has changed and then behaviors that needed to be changed in order to reduce pregnancy and STD and then the risk and protective factors. I'm now going to turn to the rest of the chapters, most of which really focus on programs which are designed to change those risk and protective factors and thereby affect the behaviors and then also on pregnancy and STD. Chapters four through eight summarize both the methods and also the research findings for 115 different studies that are now summarized in *Emerging Answers 2007*.

To be included in these summaries of the effects of programs, the programs had to focus on middle school or high school age adolescents. They had to have reasonably strong experimental or quasi-experimental design. They had to have a sample size of at least 100, employ good statistical analysis, and measure impact upon actual behavior. Of that the programs and studies that met these criteria, all fell into three groups: those that really focused on sexual behavior, those that focused on non-sexual behavior, and those that focused on both.

In *Emerging Answers 2007*, we took a much more rigorous examination of the quality of the studies and the various biases that might have occurred. As the number of studies

being reviewed increased to 115, this meant that we examined lots and lots, many hundreds of tests of significance and this certainly then raised the possibility that the positive findings that I talk about in *Emerging Answers* might have caused, in part, or largely, just by chance. If you have more than 100 studies, and if each of them have, say ten results, that's a thousand results. Five percent of those, or 50, are going to be caused simply by chance, if you use .05, or 5% as your level of confidence.

But to be sure that the conclusions that are reached were not caused by chance, we undertook a very thorough analysis of all the methods that were used, including the number of tests of significance that we looked at, etc. And we also created a set of decision making rules about which outcomes and which statistical analyses to include, and which ones to not include. This was actually done jointly with the World Health Organization, which became involved in an earlier stage in some of these reviews.

The things that I'm going to talk about now are all findings that would not have occurred by chance and for which there is some amount of evidence -- some amount of good evidence.

The largest number of studies -- 56 of them -- are studies of curriculum-based sex and STD, HIV education programs. These are in chapter six and this is an update of the previous chapter of these studies. The difference now is that there are more studies, the criteria for including studies is more rigorous than it was in *Emerging Answers*, and the findings are more clear.

Basically, we can divide them into abstinence programs which focus upon abstinence, and which encourage young people to delay having sex, but do not encourage them to use condoms or contraception and secondly, comprehensive programs, which emphasize that abstaining is the best approach, but encourage those young people who do have sex to use condoms and contraception. What we find is there are far fewer studies of

abstinence programs -- eight different studies that met the criteria. Those eight studies tell us that a small number of abstinence programs clearly do not have any impact upon behavior and that's not good news. They clearly do not have an impact upon behavior. We cannot generalize from that small number of studies, to all studies, because, abstinence programs are very diverse. There are a great many different kinds and only a small number of them have been evaluated. So we cannot generalize and say that all abstinence programs are not effective, but we do know, quite clearly, that some carefully chosen abstinence programs that people believed would be effective at delaying initiation of sex, in fact, did not do that. There are a couple of studies with slightly encouraging results about behavior but the evidence is not strong for them; it's weak. It is still true that we do not have any programs -- any abstinence programs -- with strong evidence that they delayed initiation of sex. What we do have are a couple of programs with some encouraging evidence that for particular groups of youth, programs might be delaying initiation of sex or reducing number of sexual partners.

When we turn to comprehensive programs, that are emphasizing abstinence, but also encouraging young people to use condoms and contraception, we find that there are 48 studies. About half of the programs delayed initiation of sex. About a fourth reduced frequency of sex. About half of them reduced the number of sexual partners, about half of them increased condoms, about half increased contraceptive use and about two-thirds to three- fourths of them actually reduced sexual risk taking behavior.

We can ask a slightly different question, which is: "What percentage of them had a positive impact on any behavior?" And we find that 69% did. So slightly more than two thirds of all the programs had a positive impact on one or more behaviors. In my mind, that's really an incredible achievement, because to be completely honest, some of the programs

that were studied were pretty modest and not all of them were terrifically good, and yet, more than two thirds had a positive impact.

We know that many had a positive impact, but to be balanced, we have to ask the question: "How many had a negative impact?" And we see that 4% of them did, and that 4%, just like 4% of the 69%, were caused by chance.

We can ask the question: "How many had an impact on two or more behaviors?" and 38% did, or just more than a third.

Thus, the bottom line is, we know that comprehensive programs do not increase sexual behaviors, the evidence is very strong for that, although I didn't give you all the numbers. We also know that some of them, but not all of them, can delay sex, reduce the number of partners, or increase condom and contraceptive use. Consequently, emphasizing abstinence, and fewer partners and condoms and contraception, doing that's not conflicting. They're compatible messages. We know that programs are robust; they're effective with many different kinds of groups in the United States. Not every program, but one or more programs were effective with males or females, all major racial ethnic groups, those who've had sex, those who've not. And the programs are particularly effective in those communities where the need is greatest, where pregnancy rates and STD rates are particularly high.

We also know these programs are not the complete solution, by any means. They reduce sexual risk by roughly one third. That's a very rough estimate because the confidence intervals are really quite large. In my mind, if we reduce pregnancy and STD with relatively short, relatively modest programs and we can do that by about a third, that would just be a huge achievement. On the other hand, we clearly need lots of other kinds of initiatives as well; we need reproductive health services in the community. We need parents to make clear their values about sexuality and contraceptive use and pregnancy, etc. With

young people, we need youth development programs, etc. So, these programs are not a magic solution, but in my mind, they're part of the solution.

When these programs are effective, you can ask the question: "What happens if you take a program that has been found to be effective in one community by researchers with, perhaps a lot of money and a lot of skill and resources, etc. and you implement it somewhere else?" And there again, the evidence is really quite positive. Just using two examples, "Reducing the Risk" was evaluated in four studies and in all four of them it delayed the initiation of sex; in two of them it increased condom or contraceptive use.

"Be Proud, Be Responsible" and its sequel "Making Proud Choices", have been evaluated in five studies, in four of them it had a positive impact on condom use and in several of them it had a positive impact on reducing numbers of partners. One of those studies was a study of 86 community-based organizations. So across all those organizations, it actually had an impact on condom use and that's quite an achievement.

One study, a fifth study, provided inconsistent results -- it did not find an impact on condom use. Why? Well, it deleted some of the condom activities. If you take out the condom activities, you don't have an impact on condom use.

We have done much more work in terms of identifying characteristics of effective programs in Chapter Seven. Some of you may remember that *Emerging Answers* had ten characteristics. We did a very thorough and exhaustive analysis of curricula that were effective and had strong evidence for impact, and those that were not, and identified 17 different characteristics. Because of time, I won't go over each of them, but they describe both the process of developing the curriculum, the contents of the curriculum itself, and the process of implementing the curriculum.

Turning now to other types of programs, and I'm just going to give bullets, or a sentence about each kind. There are too few studies that have been done to involve

parents in programs to reach strong conclusions. But we do now have at least one parent-child program which does have strong evidence that it actually reduced sexual behavior among the teens themselves, in addition to increasing communication with the teens. We have more evidence than we did before that programs for parents and their teens, or in some cases, just parents alone can have an impact on the teen's behavior. That's good news. We have evidence that, short slides, or computer programs, for young people are not effective. However, longer, interactive videos or computer-based programs that actually involve youth for a half hour, on multiple occasions, where they have choice, where they can choose what parts to look at, etc., those can have an impact on behavior for as long as six months.

We know that large numbers of young people obtain contraceptives from family planning clinics and that doing so reduces teen pregnancies each year. We still don't have good estimates, though, as to exactly how many. We know that by improving clinic protocols within the clinic setting, clinics can increase the use of contraception and do not increase sexual activity. Giving a clear message during those protocols, doing some role playing, doing some other things, which are consistent with the 17 characteristics, produce success, even when the interaction between the clinician and the patient is quite short.

We know that giving emergency contraception in advance to young people, so that they have it when they need it, increases use of that emergency contraception. The evidence is quite consistent, but not perfectly consistent, that it does not increase sexual risk taking in any other way. The evidence on school-based and school-linked clinics and condom availability programs has not changed since *Emerging Answers*. It is still mixed with some positive findings and some indicating that those kinds of programs do not have an impact.

There's more evidence that community-wide programs can have a positive impact on behavior, including pregnancy rates for entire communities over long periods of time.

There's evidence that such programs can delay sex and improve contraceptive use and reduce pregnancy and birth rates. There are multiple studies of welfare reform requirements for adults. These are not focusing upon the teens, but upon the parents of the teens. Those studies consistently show that the welfare reform requirements for adults did not have an impact on teen childbearing. There are youth development programs that did not have an impact upon teen pregnancy or sexual behavior; there are other youth development programs that did have an impact.

It is still true, that service learning programs have strong evidence that they can either delay sex and possibly also reduce teen pregnancy rates during the academic year in which the young people are involved. These programs that are effective are very intensive, they aren't short; a day picking up trash at a park is not going to reduce teen pregnancy. Involving teens for 100 hours in after school programs may reduce teen pregnancy during the academic year in which they're involved.

Some programs focus on both sexual and non-sexual behaviors. The Children's Aid Society Carrera Program still is the only study to demonstrate that a program reduced teen pregnancy for three years among all the females who were involved in that program. The program had no impact upon the males. It's also true that attempts have been made to implement the program elsewhere, either with support from the CAS Carrera Program staff or without the benefit of that support. In these replications, the positive effects have not always been replicated. So, it's an intensive and challenging program to implement and has clearly been effective in New York City. The evidence is less strong that it is effective elsewhere.

Tying to the last chapter, Bringing It All Home, and applying the results to the community, we see that there are three different strategies that are particularly promising for organizations to implement, in regards to reducing teen pregnancy and sexually transmitted disease. The first strategy is to implement, with fidelity, programs that have been found to be effective with similar populations in other places. It's often true that it is not always possible to do that. When that's the case, then, the second most promising strategy is to identify and implement with fidelity, programs that incorporate the 17 characteristics of effective programs, that's the second most promising strategy. And the third most promising strategy is to design entirely new programs that actually complete the five activities, five out of the 17 characteristics of effective programs, that are typically completed by people who design effective programs. And then to design activities consistent with characteristics of effective programs, and finally to implement programs consistent with the 17 characteristics.

And I sit back and look at all of this; I'm pleased that the number of programs with strong evidence for impact has increased to 15. Kristen's going to talk about those in just a moment. When I look back across all of these results, what I'm struck by, in part because they have the greatest number of studies, are the results of the programs which involve sex and STD/HIV education that are curriculum based and that include the 17 characteristics. We have the strongest evidence that those have a positive impact upon behavior. They have the greatest number of studies, from many different settings, etc. We also have evidence that some youth development programs, such as service learning and the Carrera program, can be effective. When I look across all of them, it's also clear that for many of them -- service learning being the one partial exception -- in many of them, giving a very clear message about avoiding unprotected sex and involving youth interactively, so that they personalize that message, that is one of the most important things to do with young people in order to reduce their sexual risk taking.

That's the highlights of the highlights. I may have gone over my 20 minutes, I apologize for that. I'll turn it back to the Campaign.

KRISTEN TERTZAKIAN: Well, thank you so much, Doug. This is Kristen Tertzakian from the National Campaign and I'm just going to go over, as Doug mentioned, some of these programs and then we will break for questions. So bear with me, I'm going to go through it pretty quickly. But as Doug mentioned, back in 2001, we had eight programs that had the strongest evidence of behavioral impact and now we're up to 15 in 2007. For purposes of this phone call, I'm going to take just a few minutes to highlight the new programs.

The first is ¡Cuidate! This is an HIV prevention program, it's an adaptation of "Be Proud, Be Responsible", which is another effective HIV curriculum. They adapted it by bringing in Latino cultural values that effect sexual decision making such as the importance of family and gender role expectations. There are five 60-minute lessons and they emphasize both abstinence and condom use. It was evaluated in Philadelphia, and at the one year follow up survey, adolescents were less likely to report engaging in sexual intercourse, having multiple partners, or engaging in unprotected sex. Moreover, the Spanish speakers were more than five times more likely to have used a condom at last intercourse and had a greater proportion of protected sex, compared to the control group. This program was also evaluated in Mexico and found similar results and it's going to be implemented in a number of locations including: Denver, Colorado in the next year.

Another program is SIHLE, and this stands for "Sistahs Informing, Healing, Living and Empowering," an HIV/STD prevention program that was developed and evaluated for African American girls. It was implemented in a community health center setting, with sexually active girls, but it can be implemented in a number of community settings. The

curriculum explores issues related to ethnic and gender pride, risk reduction strategies such as correct and consistent condom use, negotiating safer sex and healthy relationships. At the six month follow up evaluation, the program participants had a 30% higher level of consistent condom use and it also lowered pregnancy and STD rates and lowered the number of sexual partners.

The third program is “Draw the Line, Respect the Line.” This is a school-based HIV/pregnancy prevention program, 19 lessons taught across sixth, seventh, and eighth grade. The underlying principles in this curriculum includes that not having sex is the healthiest choice and that students can set sexual limits. The program was evaluated in 19 schools in Northern California, where 60% of the youth participants were Latino. The program was effective with boys, not with girls. At the three year follow up evaluation, the male program participants delayed the initiation of sex and increased abstinence. At the two year follow up, it reduced the frequency of sex and the number of sexual partners, again this is just for boys. And these programs materials are available in both Spanish and English.

As Doug mentioned just a few minutes ago, we now have one mother/adolescent program that has been shown to be effective, and this is called “Keeping It R.E.A.L”. It’s an HIV/STD prevention program. It was designed to delay first sex and to enhance mother/child communication about sex. It was conducted in the Boys and Girls Club of Metro Atlanta and the mothers and their teenage children attended seven, 2-hour workshops. And at the two year follow up evaluation, the teen program participants had increased condom use.

A community-wide strategy that has been found to be very effective is the HIV prevention for adolescents and low income housing developments. This is an HIV prevention, community-wide program and it included two 3-hour skill training workshops, with follow up sessions and then there were also a number of community activities and

events and also education for parents. The program was tested in 15 housing developments, in five US cities and at the 18th month follow up evaluation, those who participated in the program delayed the initiation of sex and also had increased condom use.

Another program is Aban Aya and this addresses many different risk factors. The curriculum based program is held in school and encourages abstinence. It teaches students how to avoid drugs and alcohol and also had to resolve conflicts non-violently. It included 70 sessions, over a four year period, over grades five, six, seven and eighth. It's an Afro-centric programs and it incorporates themes of unity, self determination, sense of self and cultural pride and it also incorporated story telling and proverbs, as well as African and African-American history and literature. It was tested with boys and girls in twelve Chicago area schools, and they did three different interventions; two of the interventions were found to be effective with just the boys, and this intervention included a parent/school wide and community component. The boys who participated had reduced the incidents of sex and increased their condom use and they also experienced less of an increase in violent behavior, school delinquency and drug use, compared to boys in the control group. And this can be implemented during school time and also in community settings.

And I have two more programs to cover and then we'll turn to question and answers.

The second to last is a clinical, clinic based program, and it's called "Reproductive Health Counseling for Young Men". This one hour, single session is held in a clinic and it addresses pregnancy and STD/HIV prevention for boys 15 to 18 years old. The young person watches the video by himself and then he participates in one-on-one counseling with a clinical practitioner. At one year follow up, the programs participants were more likely to use an effective contraceptive and also the sexually active female partners of the program participants were more likely to use effective contraception. And this can be implemented in a hospital or a clinic setting.

And then the last isn't an actual program or curriculum, but it's advancing the provision of emergency contraception. And we have some studies that show that by having a clinic protocol to provide emergency contraception in advance to teen girls, before they have unprotected sex, instead of providing it upon request afterwards when they really need it, those girls are more likely to use emergency contraception when necessary. And please note that this clinical protocol did not increase sexual activity.

So, I know I went through that really quickly, if you're interested in learning more about any of these programs, or the programs that were featured in both the original *Emerging Answers* that are now in the new one, please feel free to give me a call. Again, this is Kristen Tertzakian from the National Campaign and my number is: 202-478-8556, or you can feel free to email me.

So, now I'd like to turn it over to the operator to start the question and answers.

OPERATOR: At this time, we'll open the floor for questions. If you'd like to ask a question, please press the "*" key, followed by the "1" key on your touchtone phone now. Questions will be taken in the order in which they are received. If at any time you'd like to remove yourself from questioning queue, press "*2". Once again, to ask a question, please press "*1" now. Our first question comes from Tanya Gonzalez.

TANYA GONZALEZ: Hi, this is Tanya from Advocates for Youth, so just to be clear, how come some of the programs on the previous list didn't make it onto the existing new programs?

DOUG KIRBY: I don't think any program that was previously listed is not on here. Kristen just went over the new ones that were added, but the old ones are still there.

(Technical Note: "Making a Difference" was on the list of programs with the strongest impact on behavior in the original *Emerging Answers*. While it remains to be an effective program, it is not featured on the list of most effective programs in *Emerging Answers 2007* due to more stringent inclusion criteria).

TANYA GONZALEZ: Okay, all the, there was eight originally? Is that what I heard?

DOUG KIRBY: I think so, but I don't have the number right here in front of me.

TANYA GONZALEZ: Okay, thank you.

DOUG KIRBY: Sure.

OPERATOR: Thank you, our next question is from Chris Kraus.

CHRIS KRAUS: Hi, regarding the interpretation of the one-third drop in teen births and teen pregnancies, I've seen, I'd like your opinion about a study that 75% of that drop is attributed to Depo-Provera and 25% of that drop is attributed to teens less frequently having sex?

DOUG KIRBY: I don't know of any study that attributes it to Depo-Provera in particular. There is a study by John Santelli that indicates that among older teens, those who are 18 and 19, the decrease in teen pregnancies is due primarily, if not entirely to increases in use on contraception, which would include Depo, but would also include an increase in use of condoms and other methods as well. And that among younger teens,

those who are 17 and younger, the decrease in pregnancy rate was due, both, to a delay in initiation of sex -- that is abstaining from sex -- and also to greater contraceptive use.

CHRIS KRAUS: Okay, thank you.

DOUG KIRBY: Sure.

OPERATOR: Once again, if you'd like to ask a question, press "**1" now. Our next question comes from Nancy Birkhimer.

NANCY BIRKHIMER: I'm from Maine and my question is not about birth control in middle schools, but it is about the sort of unique characteristics of our state and that we're a very rural state and I'm curious, in terms of the effective programs, do any of the studies focus specifically on rural adolescents?

DOUG KIRBY: There are certainly some studies that have been done on rural areas. There is a table in *Emerging Answers 2007*, I think, that breaks it out by urban versus rural, although, I'm not certain of it. There are lots of tables. There are programs that have been found to be effective in rural areas. It is also true though, that more studies have been conducted in urban areas and particularly in urban areas where you have higher risk populations. By higher risk I simply mean populations where young people engage in sex at an early age and are less likely to use condoms and contraception when they do have sex.

NANCY BIRKHIMER: Thank you.

DOUG KIRBY: Sure.

OPERATOR: Our next question comes from Chris Mesler.

CHRIS MESLER: Hi, I'm looking at my desk for the question and if you saw my desk, you'd know I can't find it, but I remember reading, recently, an article, I think it was in the *New York Times* and it referenced Susan Philliber saying that the progress that we've made with delaying the onset of sexual activity for adolescents is starting to plateau and we may not be able to claim much more of this, do you have any comments on that, or any information on that?

DOUG KIRBY: I have seen the study, at least one, perhaps two. There's one by John Santelli and another one, possibly that I'm not sure who the authors are. Both of which indicate, if you look at the YRBS data, they indicate that the percent that have had sex in high school has plateaued. John Santelli looked at data from the National Survey for Family Growth, I believe, and also found that the percent has plateaued. So, it may be the case that it did go down for a number of years and may be stopping now, and of course, that leaves the question "If it is plateauing, why?" And goodness, one could come up with a lot of different reasons why and I don't know the answer.

CHRIS MESLER: Thank you.

OPERATOR: Our next question comes from Susan Lovett.

SUSAN LOVETT: Hi, I was wondering about the reproductive health counseling for young men, with the video and the one hour session and wondering what kind of information is shown in the video?

DOUG KIRBY: That's in the clinic setting, is that right? That's one of them (talkover). Okay. That was actually a slide presentation and it's an older one. It is now disseminated by Sociometrics. I don't have a copy of it, so I can't tell you what's in the slides or video. I'm quite sure they've updated it and provides more current information, but I can't tell you too much about it, because I haven't seen it.

SUSAN LOVETT: Okay, thank you.

FEMALE SPEAKER: And just to jump in, they do tailor the one on one counseling session, depending on what the youth wants to talk about. And you can find more information about that particular program on the Sociometrics website, which is www.socio.com.

OPERATOR: Thank you, our next question comes from John McDade.

FEMALE SPEAKER: This is actually Molly, thanks, I'm calling from Portland, Oregon and I'm wondering, actually, to tie in with that last question, increasing the number of programs that are focusing on young men, and I'm wondering about any that talk about gender, masculinity, or gender socialization and its influence on sexual behavior.

DOUG KIRBY: There are a few programs that do that, and they're certainly a number of different groups across the country that have strongly promoted talking about gender, as part of the comprehensive curriculum. It is not the case, however, that that is one of the 17 characteristics of effective programs. Some of the programs, a few of them that were effective, did talk about gender, some did not.

KRISTEN TERTZAKIAN: This is Kristen, just to jump in, you know, Aban Aya talked a lot about the role of young men and also Cuidate in bringing in Latino cultural values. They also did talk about machisimo. You may want to look at those curricula. And both of those were found to be effective with boys.

MOLLY: Thank you.

OPERATOR: Thank you, our next question comes from Alison Spitz.

ALISON SPITZ: Hi Doug, Allison Spitz, CDC, this is a really nice piece of work. I'm wondering if you can talk a little more about some of the youth development programs that you looked at and the outcomes regarding young women.

DOUG KIRBY: Sure, there are not many more youth development programs in 2007, than in *Emerging Answers*, let's call it 2001, its predecessor (talkover). Aban Aya was one, it was effective, but it was effective only with males. The Children's Aids Society Carrera program was effective only with the females, so we do actually find a gender effect, you know, across the programs. "Draw the Line" for example was effective -- that's not a youth development program. It was effective only with males. So, it's not clear to me why

some work with only males and other with only females. We need more good research (talkover), why some programs work better with males, some better with females. We don't know. In the case of the Carrera program, which did work so successfully in New York City with the female young people there. They were giving a very clear message to the girls. Of course, the staff were doing a lot. The Carrera programs are very intensive, comprehensive programs, with multiple components, designed to get them to have long term goals, to do better in school, to get jobs, to participate in sports, to do drama and, in addition, it's has a reproductive health component. So they did encourage young people not to have sex and they succeeded at that. Of those who did have sex, they improved access to reproductive health and contraception. That may partly have been why it worked better with girls than with boys. It was not focused so much on preventing STD and HIV and didn't give as much emphasis to condoms, and hence, possibly for that reason, and certainly for other reasons as well, may not have had as large an impact on males.

ALISON SPITZ: Thank you.

DOUG KIRBY: Sure.

OPERATOR: Our next question from Joan Helmich.

JOAN HELMICH Hi Doug, (talkover), hi there, my question is about advanced provision of EC. I'm really fascinated to see that on the list and I noticed in the footnote that it is only in conjunction with Carrera Program. Is that, it there any other research that shows that it's effective for teenagers and another part of my question is; is there research about adults as well?

DOUG KIRBY: Let me just clarify one thing. If the executive summary says that this advanced provision of emergency contraception was only effective with the Carrera Program, then that's an error that we'll have to correct. It sounds; I don't think it says that (talkover).

JOAN HELMICH It was not implemented with the benefit of the Carrera training, etc, it was not effective.

DOUG KIRBY: That reference belongs to the Carrera Program, not to emergency contraception. If the footnote has been placed in the wrong place, that needs to be fixed (talkover).

FEMALE SPEAKER: We're fixing that right now.

DOUG KIRBY: We're fixing it right now.

DOUG KIRBY: Okay, thank you for catching that error. If you find any others, let me know. Thanks for bringing that to our attention. So, no, emergency contraception has nothing to do with the Carrera Program, just to make that clear to everybody. Oh, and the second part of your question was; "Has it been found to be effective at increasing use of emergency contraception with adult women as well?" and the answer is "yes", there are many studies which show that providing it in advance does increase its use with both young women and women in their twenties, as well. The studies don't show, an impact on

pregnancy rates and there's a statistical, reason for that, which I won't try to go into now, on the phone. It's partly a matter of sample size, etc.

JOAN HELMICH Thank you.

DOUG KIRBY: Sure.

OPERATOR: Thank you, our next question comes from Chris Kraus.

CHRIS KRAUS: It's a series of questions about peer educators. If you team reviewed peer educators and if you drew any conclusions about their impact, noted they're not specifically mentioned in the 17 characteristics, but I also noted that in characteristic number 11, when the information is personalized, that seems to be a key factor. What have you concluded, if anything, about peer educators?

DOUG KIRBY: A couple of different things. If you simply count the number of studies that have been found of curriculum based STD/HIV education programs that have been taught by adults, and found to be effective, there are more of those than have been implemented or taught or led by peers and found to be effective. That doesn't mean that the adult programs are more effective, it just means there are more studies of them.

My kind of tentative conclusion -- I say tentative because there's some evidence for this, but not really strong evidence -- my tentative conclusion is that both can be effective. Again we have stronger evidence for adult programs than for peer programs. We also have a couple of randomized trials which indicated that it didn't make much difference whether or not it was adults or peers that implemented the program, that both can work. And we have

formative research, from a couple different studies, which indicate, again, much more important than the age of the educator, it whether or not that person can relate to youth and is knowledgeable and is trusted by the youth and of course, both peers and adults can have those qualities, or not.

CHRIS KRAUS: Thank you.

DOUG KIRBY: Yes.

OPERATOR: Our next question comes from Helen Robinson.

HELEN ROBINSON: Hi, I'm calling from Georgia. Once this is released, if a community organization wants to replicate one of these programs, will it be linked to you know, who do you contact, where do you actually access the curriculum, purchase it, that sort of thing?

DOUG KIRBY: That would depend. Many of the programs do have references. I believe all of the 15 that have the strongest evidence for impact and meet the most stringent criteria have references, and I think the references for all of those specify where they can be obtained, if there is a source from which they can be obtained. For advanced provision of contraception, there's no source. That's just a policy or a protocol that is changed in a clinic. You can check the references in the full report when they come out, and if the program is not one of the 15 with references, then I encourage you to do what I do, which is just use Google and track it down.

(Technical Note: A summary of each of the 115 studies will be posted on line. These summaries often contain the e-mail addresses of the authors and you can use these to track down the program.)

HELEN ROBINSON: Okay.

OPERATOR: Thank you, our next question comes from Allyna Steinberg.

ALLYNA STEINBERG: Hi, this is Allyna Steinberg from the New York City Department of Health. I have two questions; one about the “Keeping it Real” program, I was wondering what age the young people, the children of the mothers were, and if the findings thought that that age was important and also, coming from a perspective where we want to send a unified message around HIV/STI’s and pregnancy prevention, do you have any words of wisdom for places that are looking to adopt programs that only target pieces of that?

DOUG KIRBY: Okay, regarding “Keeping it Real”; a couple things I want to say, there are actually two or three different programs around the country that are called “Keeping it Real”. So, when you get it, make sure you are getting the one that is mentioned in *Emerging Answers 2007*. It’s a very popular title these days, and you just need to get the right one. I’m forgetting, let’s see, I’m forgetting the exact age (talkover).

KRISTEN TERTZAKIAN: Doug, we have it here. The teens were 11 to 14 years old. They were pretty young and actually, in the original evaluation, most of the teen participants were males.

DOUG KIRBY: So, it's for mothers, but most of the teen participants were males?

FEMALE SPEAKER: Yes.

DOUG KIRBY: Okay. Incidentally, there's also a program with a different name, designed and evaluated by the same authors, Colleen Dilorio, which was designed for fathers and teens, as opposed to mothers and teens and the evidence for that program is also quite strong, but for one particular scientific reason, a research reason, it didn't quite meet the criteria for inclusion, but I want to add that the evidence is almost as strong, but not quite good enough to get onto the list of 15.

ALLYNA STEINBERG: Yeah, my second question was about groups that wanted to combine their HIV and STI prevention messages with teen pregnancy program messages and any guidance for adopting existing evidence based programs that only focus on one of them.

DOUG KIRBY: I see, I think my recommendation would be to integrate the two messages throughout as much as you can. That doesn't mean you can't have a set of activities which talk about the consequences of pregnancy and a separate section that talks about the consequences of contracting an STD, but we know that teens, and there's lots of evidence on this, teens either abstain from sex, or use condoms when they do have sex, really, for both reasons, both because of concern about pregnancy and because of concern about sexually transmitted disease. So, integrating both, the pregnancy and the STD message throughout a curriculum is likely to reinforce its impact.

ALLYNA STEINBERG: Thanks.

OPERATOR: Thank you, our next question from Chris Rollison.

CHRIS ROLLISON: (Inaudible).

OPERATOR: Chris Rollison, your line is open to ask a question. (Inaudible). Okay, our next question comes from Susan Lovett.

SUSAN LOVETT: Oh hi, this is Wanicha Coggins with Susan Lovett. We have a few questions, first, can you repeat the name of the father/teen program, again please.

FEMALE SPEAKER: It's called "Real Men".

WANICHA COGGINS: "Real Men", okay, then we'd like to hear you comment about "Plain Talk" programs and parent/child communication encouragement type of programs. And also, your comment about the potential of long term contraceptives, such as (inaudible) and Implanon and making an impact on teen pregnancy.

DOUG KIRBY: The, let's see, you're speaking of the "Plain Talk" that was and is promoted by the Annie E. Casey Foundation, is that what you mean by "Plain Talk"?

WANICHA COGGINS: Yes.

DOUG KIRBY: Okay, the research on that did not meet the criteria for inclusion in *Emerging Answers 2007*. So, it's not in there. It does have some evidence that it had a positive impact, but it's not a strong research design. I think, in principle, it does some good things, but at this point in time, it does not have strong evidence that it had an impact on teen behavior or pregnancy rate.

WANICHA COGGINS: And then, lastly, about long term contraceptives, that's comparable to Depo Provera, such as (sp?), is there a plan to include this in terms of evaluating accuracy of the clinic's services, using (sp?)?

DOUG KIRBY: Regarding "Emerging Answers 2007", one thing it does not do, is talk about the relative effectiveness of different methods of contraception. It really focuses more on programs, or other kinds of intervention, but not on the effectiveness of different methods of contraception. Many of the programs that were evaluated did include methods of contraception, particularly those who were focused on pregnancy and not solely on sexually transmitted disease and HIV. They did include discussion of different methods of contraception and typically, of all the methods that were available, up to the point in time when they were implementing the curriculum. Is that answering your question?

WANICHA COGGINS: Yes, thank you.

DOUG KIRBY: Okay.

KRISTEN TERTZAKIAN: I have about five minutes after 4:00, and we were supposed to end at four, and since we started late, let's take just a couple more questions.

OPERATOR: Once again, if you'd like to ask a question, please press "**1" now.

Our next question comes from Erin Johnson.

ERIN JOHNSON: (Inaudible).

OPERATOR: Miss Johnson, your line is open. Okay, our next question comes from Sarah Rumann.

SARAH RUMANN: Yes, we were wondering about the TOP program, only being effective for girls, what was the effect on guys?

DOUG KIRBY: I don't know. The evaluations did not report the results separately for males and females, most of the participants were female, and therefore, they reported the results only for the females.

SARAH RUMANN: Thank you.

KATY SUELLENTROP: There was a second evaluation conducted in 2001, of the TOP program that found no difference between males and females, just to throw that out there, and most of the participants in that evaluation were males.

DOUG KIRBY: Thank you, I had forgotten that. So, in that evaluation, when you say no difference, meaning that is was equally effective at reducing reported teen pregnancy, both for males and females?

KATY SUELLENTROP: They didn't look at that, they looked at the interaction term for gender and they found no significance.

DOUG KIRBY: Okay. (Talkover).

SARAH RUMANN: We have one additional question, on, in regard to a curriculum called "Making a Difference"; I recall that there was an effort to study that and to see if it was going to make the list. What was its problem and why didn't it make the list?

DOUG KIRBY: You're speaking of the Jemmott curriculum?

SARAH RUMANN: Correct.

DOUG KIRBY: Okay. To meet the list, actually, let me back up a second, there are a set of criteria that a study has to meet in order for that study to be included in *Emerging Answers 2007* at all. To be included on the short list of 15 programs, there's a much more strict set of criteria that has to be met and on that more strict set of criteria, one of them is that it had to have a positive impact on behavior for at least one year. (Technical Note: Making a Difference program delayed initiation of sex for 3 months. Condom use was measured at three points in time with two different measures. Five of the six coefficients were not significant; only one showed positive effects on condom use. Because this did not represent compelling evidence for impact on condom use, Making a Difference is not included among the 15 programs).

SARAH RUMANN: Okay, thank you.

OPERATOR: Thank you, our next question comes from Susan Washinger.

SUSAN WASHINGER: Hi, I was wondering if any of the programs were evaluated for secondary pregnancy prevention.

DOUG KIRBY: They were not. The National Campaign conducted a review of programs for secondary prevention a number of years ago, and consequently, for “Emerging Answers”, we limited those studies to those that were focused on primary prevention. Kristen, do you want to give the title of the review and when it was done?

KRISTEN TERTZAKIAN: Sure, it’s called *Another Chance*. We released it with “Healthy Teen Network” and it was written by Dr. Lorraine Klermann from Brandeis University. I believe it was released in 2003.

DOUG KIRBY: It’s a good review. I encourage you to look at it.

KRISTEN TERTZAKIAN: Great report, and basically, the bottom line is one of the most effective programs in reducing secondary pregnancies among teens is the Nurse Family Partnership.

SUSAN WASHINGER: Thank you.

OPERATOR: Currently there are no questions in the queue.

KRISTEN TERTZAKIAN: Well, given that it's ten minutes after the hour, and we have kept you too long, I just wanted to give many, many thanks to Dr. Doug Kirby for undertaking this huge endeavor of updating "Emerging Answers" and for speaking on today's conference call. And also a "thank you" to all of you for participating. In the mean time, if you think of additional questions, feel free to call me, this Kristen Tertzakian, 202-478-8556, or you can email me and we'll make sure that either someone from the Campaign, or Dr. Kirby answers your questions. Remember, for you colleagues who weren't able to participate on today's call, the full report summary, call transcript and recording of the call will be posted on our website on Monday. thank you very much to everyone for participating and to Dr. Kirby.

DR. DOUG KIRBY: Thank you everybody.

KRISTEN TERTZAKIAN: Thanks.

OPERATOR: Thank you. This concludes today's conference call, you may now disconnect.

