

WEBINAR VIDEO TRANSCRIPT

Office of Population Affairs

TPP Tier 2 Showcase Webinar, Day 3

5 March 2020

Important Note

ASYA LOUIS: Good afternoon, everyone. My name is Asya Louis and I'd like to welcome you to today's webinar. This webinar is brought to you by the Office of Population Affairs. As an important note, we will not answer any questions related to open funding opportunity announcements during these webinars. Any questions about open FOAs should be directed to OPA and/or OASH, Office of Grants Management.

I will now turn things over to Richmond Pajela for brief introductions and to talk a little about the purpose and format of the call.

RICHMOND PAJELA: Thank you, Asya. Thank you for everyone for attending this third and final webinar of our Tier 2 program showcase.

Webinar Series Purpose

[Displays text that reads: please note that final-outcome results are not currently available.]

So the purpose of this webinar series is to showcase OPA teen pregnancy prevention Tier 2 programs with promising results.

The series will showcase grantees from our Tier 2A and Tier 2B program. These grantees are finishing a five-year grant program and have focused on vigorously evaluating TPP programs while innovating new TPP interventions.

Webinar Series Schedule

[Displays webinar series schedule: Tuesday, March 3, 2020: EngenderHealth, Inc., University of New Mexico Health Sciences Center, Healthy Teen Network.

Wednesday, March 4, 2020: Planned Parenthood of Greater New York, Boston Children's Hospital, MyHealthED, Inc., Waikiki Health

Thursday, March 5, 2020: Center for Innovative Public Research, Johns Hopkins University, Planned Parenthood of the Great NW & Hawaiian Islands.]

We have showcased Tier 2 grantees who supported and enabled early innovation to advance adolescent health and teen pregnancy prevention. They also provide funding and community-based services to sub ORD.

We also have showcased and will be showcasing today Tier 2B grantees who conduct rigorous evaluations of new or innovative approaches to prevent teen pregnancy, the focus on implementation of programs and evaluation. Please note that this webinar will only highlight promising results. The final outcome results are not currently available.

So this is the third and final webinar of the webinar series that has been running this entire week. You can find recordings of these webinars on our website a little bit later, once we gather them up, but today, we'll be focusing on grantees from our Tier 2B projects.

Introductions

So on the call today, from the office of Population Affairs, is myself, Richmond Pajela. I'm a project officer here and we also have from The MayaTech Corporation, the TA team, Asya Louis, who is a TPP technical assistant and Aina Ramos, who is a TPP TA lead.

Today's webinar will feature, like I said earlier, our Tier 2B grantees were conducting rigorous evaluations of new or innovative approaches to prevent teen pregnancy. First, we have the Center for Innovative Public Research, Girl2Girl text messaging intervention for LGBT+ teen girls. We also have John Hopkins University's, Respecting the Circle of Life—Mind, Body & Spirit, and Sexual Risk Reduction Intervention, Telephonic Native Teens, and the last one, Planned Parenthood of the Great Northwest and Hawaiian Islands and their program, INcluded, which is an intervention that involves adult facilitators and peer educators to address the needs of LGBTQ youth.

Girl2Girl: A Pregnancy Prevention Program for Sexual Minority Adolescent Girls

You will now be hearing from our next presenter, Michele Ybarra, who is a president and the research director at the Center for Innovative Public Health Research.

MICHELE YBARRA: Hi, all. Thank you so much for having me. I'm pleased to be here.

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Before we begin, I'd like to acknowledge our funding from the Office of Population Affairs, as well as the National Institute of Child Health and Human Development. Certainly, the content is solely the responsibility of myself and does not necessarily represent the views of either funder.

Why the need for Girl2Girl

As many of you know, one in four teen women will become pregnant by the time they reach 20 years of age. However, rates for teen pregnancy are even higher for lesbian, gay, bisexual, and other sexual minority teen girls. And those for whom it's unfamiliar, the class sort of denotes other identities that are also sexual minorities. An example would be pangender.

These young women face two to four times the risk of becoming pregnant when they are in their teens, compared to heterosexual girls. Despite this evidence, however, pregnancy prevention programs are completely lacking for this population.

The Design of Girl2Girl

Girl2Girl is a five-month intervention. It is delivered completely over text messaging. We have a seven week—what we call core intervention period where it's a relatively intensive experience. Teens receive about six to 12 messages per day, depending on the topic.

After they finish that seven weeks, they then go into what we call a latent period. It's sort of a three-month time period where they're receiving about one or two messages a week, and those are really intended to just be know sort of a cohort-retention experience.

And then at the end of those 12 weeks, we do what we call a booster. Some might call it just a review week. And it's a week where we reinforce and remind the main messages that we discussed over the core intervention. Again, that week is also a relatively intense experience where they receive six to 12 messages a day.

Every day, we send messages across the day, as opposed to one big message blast. We do have weekly topics that were covered, and the messages sort of build upon each other, so that it feels more like a conversation than just information being directed at young people.

I think it's also important to note that we include inspirational quotes. We've done text messaging-based interventions across different populations and different topics, and sort of universally, we find that people really enjoy the quotes. They don't have to have anything to do with teen pregnancy prevention or even sex, just a nice way to sort of end the day on a positive note.

Our teens in the intervention also have the opportunity to earn what we called badges. We did include two features that are similar to games, to sort of gamify and, therefore, make the intervention experience more fun. So one of them is badges, and so these were behavioral goals that were related to teen pregnancy prevention that we wanted young girls to engage in.

So for example, one of the badges was talking to a health care provider about getting on birth control.

The other sort of gamified experience was "leveling up". And so at the end of each week, teens were given the opportunity to answer a question that referred to the content that we delivered in the previous week, and if they got it correctly, they were able to "level up" to the next level.

If they did not get it correctly, they were given a second chance, a second question, and if they got the second question wrong as well, we would level them up for their effort.

Another important feature of this program is that girls in the intervention were paired together as text buddies, and so it's a didactic experience of two intervention participants, and they talk with each other throughout the program. And the idea is that they're able to sort of process the things that they're learning and also provide social support to each other, which is incredibly important, particularly for sexual minority teens who may feel socially isolated.

We do have a lot of supports around this "Text Buddy" feature. There's almost constant monitoring of it, and we ask our teens to text through what we call the buddy line, so it's a dedicated phone number. It's part of the intervention and so that way we're able to not only monitor the messages, but also protect their privacy so that we're not distributing phone numbers and other information to participants.

Compared to that, the attention match control receives the same number of messages across the same number of days in the five-month intervention, and those messages talk about healthy lifestyle, and so things like self-esteem, how to deal with bullying, and other types of things that may be relevant to teens, but not relevant to teen pregnancy prevention.

Recruitment and enrollment

We really wanted to capitalize on the reach and power of technology, and so we were able to recruit our girls using advertisers on Instagram and Facebook. And so the way this would work is that we would target teens who identified as being female and were girls who are into girls, and they were in our age range, which was 14 to 18 years of age.

Those who saw the ad and were interested in it, they would click into it—click on it, rather, and it would link them into our research page where there was a brief description of the research and then a screener that asked demographic characteristics, as well as sexual behaviors and sexual identity and gender identity.

Those screeners were then sent to us through our system, and the girls who appeared to be eligible, we would reach out to to set up a telephone call to do the enrollment. Girls were contacted sequentially, but with a specific demographic target identified. We wanted to be sure that we had a very diverse sample, and so once a particular demographic bin was full, we then would no longer enroll anybody from that particular demographic characteristic.

So once we had them on the telephone, we would go through a relatively intensive experience, and that's because our IRB did grant us a waiver for parental permission. The waiver was granted so that our girls could take part without having to out themselves to their parents, as this could place them in a dangerous situation, depending on their home life.

The telephone call included what we refer to as a self safety assessment, where we went through very concrete examples of what young people would experience in this program. So for example, what would it be like if your mom or your dad saw a message on your phone that was talking about having sex with girls? What would it be like for you if your partner or your siblings or your friend saw these types of messages? And really worked with the teen to go through these examples so that they could assess for themselves what that might look like for them.

Teens who thought that this might put them in danger, that the outcome might not be a safe one, were not eligible to enroll. Those who passed the self-safety assessment were also asked to pass a capacity to assent, which is a four-question query, basically, just making sure that they understand the information that we went over in the assent. An example would be, what do you do if you no longer want to take part in the study? And the participant needs to answer that question correctly.

The Girl2Girl cohort

[Displays Girl2Girl participant characteristics; see following table.]

Girl2Girl Participant Characteristics	Control (n=474) % or M (SD)	Intervention (n=473) % or M (SD)
Age (M:SD)	16.0 (1.2)	16.1 (1.2)
Female gender	99	99
Race		
American Indian or Alaska Native	2	1
Asian	4	4
Native Hawaiian or Pacific Islander	0.6	0.6
Black or African American	15	14
White	55	59
More than one race	15	15
Some other race	6	6
Do not want to answer	3	1
Hispanic ethnicity	25	22
Abstinence from penile-vaginal sex (past 3 months)	82	83
Number of protected sex acts (past 3 months, among those who have had sex)	4.4 (1.3)	5.7 (1.)

Use any other birth control methods aside from condoms during penile-vaginal sex (past 3 months)	48	39
Pregnancy (ever)	4.0	2.8

So given the relatively intense enrollment effort, we were quite pleased to have enrolled almost 950 teens from across the country. You'll see that we did do well with our demographic targets—about 60% are white race and the remainder are non-white race and 22% to 25% are Hispanic ethnicity. And you'll also see that the arms are balanced, which means that our randomization worked as intended.

Girl2Girl Process Outcomes

[Displays Girl2Girl process outcomes; see following table. Displays text at the bottom of the table that reads: Data are still being cleaned and merged. Responses for the first statement were asked at intervention end; 302 teens included. The second two statements are from core end; 878 teens included.]

	Totally Disagree	Disagree	Neutral	Agree	Totally Agree
G2G gave me skills to prevent pregnancy and STDs	1%	1%	7%	17%	74%
Program messages spoke to issues relevant to me	4%	7%	26%	33%	31%
G2G disrupted my schedule	42%	31%	15%	6%	6%

First, I'd like to talk about our process outcomes. We did ask our teens what they thought about the program and over 90% agreed that Girl2Girl gave them the skills that they needed to prevent pregnancy and STDs. 64% said the messages spoke to issues relevant to them. That's lower than what we would hope, but I'm guessing a lot of it is reflective of the fact that we were talking about how to prevent pregnancy with a lot of girls who really had no intention or desire to have sex with somebody who has a penis. And so although we retained them in the program, the messages didn't always feel relevant.

And I think, importantly, particularly given how intensive the intervention was, three in four disagreed that the program disrupted their schedule, which I think really speaks to how well this integrated into their daily lives.

Preliminary outcomes

Behavioral outcomes. These are preliminary analyses of a subsample of the data. We are in the process of merging and cleaning it. Based upon what we are seeing at the core end—and remember, the core end is that intensive seven-week period—21% of our intervention

participants, versus 13 and a 1/2% of our control participants, reported being tested for HIV or other sexually-transmitted infections.

At the intervention end, which is the five months after they had been enrolled, we have 43% of intervention, versus 24% of control participants saying that they are currently on birth control. And among those who are not yet on birth control, we have 30% of intervention, versus 18% of control participants planning to get on birth control. And planning is defined as those who said they were probably or definitely going to get on birth control.

We see similar to the core end. 29% of intervention versus 8% of control participants said they had been tested for STIs, including HIV in the past three months.

Limitations and conclusions

As I noted, our analyses are preliminary. It is possible that our findings will change when a full sample is examined. Based upon what we're seeing, however, Girl2Girl does appear to be associated with increased rates of HIV and STI testing. Now, that's outside the scope of teen pregnancy prevention, but is an important outcome, I think, health outcome, for sexual minority girls.

Our data also suggests that it is possible that the intervention is associated with an increased likelihood of contraception use. I think it's interesting that we saw those differences at the intervention end, but not at the core end. And what that may suggest is that this type of preventive behavior takes some time to enact, which makes sense because you have to find the time to make an appointment and go in and talk with a health care provider.

And so when we think about how to measure these outcomes, it may be important to make sure that we give our teens enough time to an enact our Be a Girl outcome.

Acknowledgements

I would like to acknowledge our co-investigators on the project, which is Drs. Elizabeth Saewyc, Margaret Rosano, and Carol Goodenow, and also, definitely, the study team as well as the participants for all that they gave to this research.

Thank you very much.

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RICHMOND PAJELA: Right. Thank you, Michele so much for the presentation.

Johns Hopkins Center for American Indian Health Respecting the Circle of Life Program

Now, next, we will be hearing from Rachel Chambers, who is the reproductive health manager at Johns Hopkins University School of Public Health Center for American Indian Health, and she is joined by Hima Patel, the reproductive health program coordinator.

HIMA PATEL: Hi, everyone. Thank you so much for having us. We're just so excited to be here. My name is Hima Patel and I'm actually the program coordinator for the Respecting the Circle of Life Program here at the Johns Hopkins Center for American Indian Health, and Rachel, as I mentioned, is going to be joining me today.

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The disclaimer. So everything that I will meet—that we will be presenting on is the responsibility of me and doesn't actually represent the official views of HHS or OPA.

Brief Project Overview

All right. So before we get started, I just wanted to give you guys a bit of a grounding and as to who we are. So we're the Johns Hopkins Center for American Indian Health and we have a long-standing community partnership with the native communities that we work in. That's a relationship that's been going strong for over 30 years. It's actually a part of our mission that our work and programs are truly informed by the communities that we partner with to fulfill an unmet need in these communities.

RCL was implemented and evaluated as a one-to-one randomized controlled trial and targeted American Indian youth between the ages of 11 and 19 living in a rural reservation community.

When recruiting, youth were highly encouraged to enroll with a parent or other trusted adult. We evaluated the impacts of RCL on condom use, self-efficacy and intention, sexual and reproductive health knowledge, parental monitoring and communication, sexual initiation, number of sexual partners, condom use, contraception uptake, substance use, and STI and pregnancy incidence, so a lot of different things.

RCL: Teen Pregnancy Prevention program designed for Native communities

RCL is a nine-session curriculum which we implemented in a basketball-based summer camp. For those participants that weren't interested in basketball, however, they had the option of taking part in other activities like photography and art.

During the camp, participants took part in eight two-hour long sessions and self-selected peer groups of 8 to 12 youth. Two highly-trained paraprofessional facilitators led these eight sessions.

These lessons were based on a holistic content. The curriculum provided comprehensive sexual and reproductive health education about STI and HIV/AIDS and pregnancy, condom and contraceptive use and skills, communication, and problem solving, decision making, and partner negotiation, values clarification, goal setting, and how to talk with your family about sexual health, among many other topics.

In addition to the eight camp sessions, participants also took part in one two-hour long lesson that was taught at home by one facilitator, the youth and their enrolled parent or trusted adult. This lesson reinforced the topics and skills that the youth had already learned in camp, but also introduced the parent or trusted adult to these sexual health topics and condom use and skills.

However, the ultimate goal of this parent-youth lesson, though, was to open the door for the youth and parent or a trusted adult to have an open dialogue on sensitive topics like sex and STIs and HIV. These conversations can be so difficult, and so this youth-parent lesson actually began with a 20-minute video featuring American Indian youth and their parents or trusted adults who were also embarking on that communication journey together. I'm going to pass the baton on to Rachel. Thank you.

RACHEL CHAMBERS: Great. So Hima mentioned a couple of these, but I'm going to go into a little more detail about key features and innovations.

Key Features & Innovations

And when we started developing this project, this program years and years ago, almost a decade ago, we really went to the community, as we do with all of our projects, and asked them what they thought we should do, and that really drove a lot of the decisions, both around selection of what to include in this curricula but also in how we implement.

Where this was implemented and where we are replicating, which I'll talk about a little later, are primarily rural native communities and reservation communities. We are doing a little bit in urban settings, but these communities are and this one where we did this implementation are very large. They're very rural. And so we really had to work with the community to understand what would work in these communities.

So one of the first things that the community had said was, we know that kids are not going to school or not going to school consistently. We also know that nationally, native youth have one of the highest rates of dropout among all of the races and ethnicities.

So for this reason, we decided we did not want to implement the program through the schools, but instead through a different mechanism that would be able to reach these high-risk kids. So that's why we decided to do it through a summer basketball camp, and then we also did a follow-on with the home-based lessons and that was taught in the home with a parent and the youth.

And the purpose for that, it was sort of twofold. One is transportation is an issue, and so by having the health coach or the facilitator who is teaching that lesson come to the house, you remove the barrier of having to get to an office or a central location.

And the second reason was because we felt it was very important to have the conversation and sort of try and open that door to having youth and their parent or trusted adult start talking about sex in an environment that it would likely happen. So that when we left, they sort of had the feeling of what it would actually feel like to sit in their home and have these conversations.

The other thing about the camp model is that we heard and we know from our decades of experience working in this particular community that boys are hard to engage sometimes in a lot of these programs. And so basketball is a very big thing in this community, and in some other communities where we work, and the tribe basically said, we think it would be a great idea to implement this through a basketball camp. And you'll see later on, we did get about half boys and half girls, so we did have a large number of boys who did attend.

The other thing is the reason that we did the eight peer sessions through the camp model is really, it gave us high rates of retention, and we sort of did this for multiple reasons. One, again, transportation is an issue, and we provided transportation to camp every day. Two, we know that kids forget. They have busy lives. They sign up for something that's weekly and they forget about it, so we really tried to embed this as part of their summer.

So it sort of was two weeks where they would get on the bus every day, come to camp, have snacks, lunch, another snack, and then they'd go home on the bus. And so instead of having something that was an add-on to everything else they were doing, it was sort of what they were doing for those couple of weeks.

And so we'll talk later about retention rates, and we really think that the camp model did ensure high retention rates.

Some other key features about the implementation is really, as Hima mentioned, it's taught to peer groups and then taught at home with a parent. So the first eight sessions, again, are taught in peer groups of 8 to 12 kids through this camp model, and then there's a follow-on session taught to a parent and a child.

And the reason this program is structured in that way is because we know that peers have a huge influence on youth, but we also know that parents do, as well. And so by getting all of the youth together and delivering to peer groups, we're really influencing sort of the peer group think, but then by coming into the home and meeting with the parent, we're really influencing the parent and child dynamic. So we think this sort of twofold strategy really helped change behaviors.

The final thing is that our program was delivered by paraprofessionals. All of our paraprofessionals that deliver the program are native, and almost all of them were from the local community, and we did this for multiple reasons. One is it doesn't require higher levels of education or professional degrees, so there are not a lot of nurses or people with master's degrees, necessarily, that have time or energy to implement this program in rural reservation communities, but there are a lot of people who would love to implement this program. And so by not requiring this higher level of education or professional degrees, we were able to find people who understand the experience and really know what these kids are living to teach this curricula.

That being said, we did have intensive training. We have a five-day training, and it is the basics of reproductive health. It is the basics of classroom management, and so by having a paraprofessional teach this lesson, you do have to recognize that there is potentially some other training that needed to happen.

As you all know, we are a Fiscal Year 15 Grant recipient. The program was implemented through three different cohorts across three summers, so 2016, 2017, and 2018. We then did the night session where the parent use was followed on within three months after that.

Implementation & Evaluation Findings

So we completed our implementation late in 2018. We had a total of 567 youth enrolled in the program and 566 parents or trusted adults. So having a parent or trusted adult was not a requirement for the child to be in the program, however, it was highly suggested and our health coaches and independent evaluators worked really hard with the youth to identify somebody who could enroll with them.

And as you will see, we had a high average dosage rate, and this is just among kids. Kids attended about 80% of the nine lessons across both RCL and Control, and this isn't on the slide, but parents—about 82% of parents attended the night session with the youth.

We also are collecting follow-up data to evaluate impact at 3 months, 9 months and 12 months. We have high retention rates in these assessments and these, again, are youth retention rates. The trusted adults are also completing an evaluation, and the retention rates are very similar.

So at three months, we had an 86.5% retention rate, and at nine months, we have about an 84.1%. I think it's a little higher because this was written before we counted the very final

assessments that have gotten in. And we're almost done, actually, with 12 month follow-up, too, and we're about an 85% with that, so we had pretty high retention rates across evaluation.

This, again, the preliminary results indicate significant between-group differences at nine months on some of our key outcomes, including condom use, self-efficacy, condom use, intention, and we were really happy to see some impacts on alcohol and marijuana use. We know that those are very linked to risky sexual behaviors, and so the fact that this program is impacting that is great to see.

Program Packing & Dissemination

So in addition to the funding from the OPA, we've also received some private funding to package and scale the RCL program. So we have been working with ETR, who I'm sure many of you are familiar with ETR. They are a nonprofit that are focused on providing evidence-based curriculum to communities around the country, and they're really experts in inclusive programming, curriculum development, curriculum distribution, and training.

And so we have worked with them and developed a package that you can go on their website and purchase this package, and it has really everything someone or a site or organization would need to implement the program. It's got the teacher resource guide. It's got the youth workbooks, and then it's also got an implementation guide to sort of talk through how you go about doing a camp like this, and so it's a really useful guide. And of course, all this applies to the curriculum.

We are also currently disseminating the program. It's being disseminated in a couple of places. There's two places in Minnesota, in Minneapolis and then in a rural community in North Minnesota. And how we were involved was we trained the community members to deliver the program and they are now implementing it. We just talked to one of our partners and it seems to be going really well.

We are also replicating the program on the Navajo Nation through the Fiscal Year 19 Tier 1 Grant, and we will have our first camp this summer.

Finally, something that we are working on is currently, we do have an in-person training for RCL for organizations or communities who want to implement the program, but we are also working with ETR, again, to develop a facilitator online training because we know it's difficult to commit five days of staff to training in person, so that should be ready at the end of this year.

And if you click on that [link](#), there is a website or video that was created by our Apache team and features all the actors or quote, unquote, actors from the local community where this program was implemented.

We just want to say thank you to all of you for joining. We have to, of course, say thank you to our tribal partners. The leadership at the tribe is so wonderful, and they have really helped us from the past decade to develop and implement and evaluate this program.

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We thank all of our staff, all of those who put their heart and soul into this program, and also the youth and the parents who participated in this program.

If you have questions about the program, we can answer them later, but also, you can contact any of us. Lauren Tingey is the PI on this study. I manage the study and Hima coordinates the study.

And if you click below on that [link](#), that brings you to our center website that has a little more information about RCL. Thanks so much.

INcluded

RICHMOND PAJELA: All right. Thank you, Rachel, and Hima for the presentation. Next, we will hear from our last presenters, Laura Gardiner, who is based in Seattle, Washington, and is a capacity building specialist in the Education Department at Planned Parenthood of the Great Northwest and the Hawaiian Islands.

LAURA GARDINER: Hi, everyone. My name is Laura Gardiner. My pronouns are she, her, and hers. It seems fitting since I'm based here in Seattle that my picture involves a cup of coffee. I'm really excited to talk to everyone about the program.

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So first off, the contents are my responsibility and do not represent the views of HHS or OPA.

I will be talking about INcluded on this webinar, which the full length name is INcluded Inclusive Health Care Youth and Providers Empowered. This program specifically aims to lower teen pregnancy rates and STD rates among LGBTQ youth ages 14 to 19.

I will interchangeably use the term LGBTQ with queer and trans, as we do when we're talking to youth, just because it can be a little bit of a mouthful.

And so the setting for this program, it spanned across 16 different states, and the places that we implemented ranged predominantly in urban and suburban areas, so some examples would be workshops, ranging from Wasilla, Alaska down to Los Angeles, California. We were in New Haven, Connecticut, Greensboro, North Carolina, so we definitely got to implement in a wide variety of locations.

I do want to take a little step back. I don't want to make assumptions about what folks are familiar with and I do just want to set a foundation for why a program like this is necessary.

Sexual and gender minority youth are more likely to engage in sexually risky behaviors...

We've talked a little bit in an earlier—the first program, which was great, but in the US, you know that sexual and gender minority young people are engaging in riskier sexual behavior just across the board. So that might look like engaging in sex at an earlier age, more likely to be using drugs and alcohol, having sex with more partners, and not using birth control.

There are a variety of reasons for this. It's definitely not one size fits all. Some examples, however, include just general experience, the greater experience of harassment and discrimination, a higher likelihood, of course, of family rejection, which can lead to risky coping behaviors and a greater propensity towards substance use.

There's also, of course, a lack of sexual education that includes the needs of queer and trans youth, specifically, and as a result, it does not adequately educate about the need for birth control and testing among that population. And it's pretty easy to see how parents and youth wouldn't think a typical heteronormative sex education lesson would really be meant for them.

The health care system fails queer youth, contributing to high rates of unintended pregnancy and STIs.

I do want to make it clear, right, this is not only on the shoulders of queer and trans youth to solve this problem, right? So this is a problem that also needs to be solved by working within the system that contributes to this. So not just by supporting young people and changing their behavior, but also by working within the health care system, which currently is failing queer and trans youth by treating those folks worse than their straight and cisgender counterparts, essentially.

And some examples of what this can look like in the context of a clinic visit. For example, it might be outright discrimination or harassment when they go to a clinic. It might be a refusal to provide certain services. It also might look like some microaggressions or just general ignorance about the health care needs of folks of varying identities.

So definitely, a wide variety of negative experiences that can occur, but all of that across the board contributes to LGBTQ folks—young folks having higher rates of unintended pregnancy and STDs than their cisgender and heterosexual peers.

Intervention Overview- A Dual approach

So that was a little context. Apologies for any repetition, but the end result of all of that is our program, the INcluded program, which is actually a dual-approach program. So it is two separate workshops for two very different audiences.

The program, as a whole, is grounded in the health belief model, theory of change, as well as proven sexuality education best practices. So one of the two workshops is specifically for clinic staff, and that is all clinic staff, so from the front desk staff to the clinicians, MAs, nurse practitioners, et cetera, so all are welcome.

And during that three-hour workshop, we focus on creating how they and their clinic can create an LGBTQ youth-friendly environment, specific youth-friendly service best practices for queer and trans youth.

And then because this is a workshop that is facilitated by both our trained adult facilitators, adult sex educators, as well as their trained peer educators, our clinic staff have the opportunity to take part in simulations with our peer educators, who take on queer and trans patient personas and then they get to actually go into an exam room and have an opportunity to practice those recently-learned skills and best practices to interact with and do a little play of what that patient visit can look like.

The other workshop that we do, which is definitely at the heart and the focus of this program and our evaluation, is another three-hour workshop. This time it is for queer and trans youth, specifically. So for those youth ages 14 to 19 and during those three hours, we focus on safer sex for LGBTQ youth, how to access sexual health services, what it looks like to access sexual health care at a clinic, and then having time to learn about and practice advocating for

themselves with a provider, so engaging in that, their own stimulation and role play. So for both of these workshops, both adult facilitators, as well as our teen peer educators, facilitate.

And I do just want to highlight a couple of the reasons this program is fairly innovative, which is that it does take a systems change approach to education by providing referrals to appropriate clinical services. So the youth are told what clinics in their communities have LGBTQ-friendly services in the hope that they will be able to reach out and go.

This is also an LGBTQ-centered sex education curriculum. So for those familiar in the world of sex ed, right, I think the increasing trend is to make sex ed more inclusive, which is fabulous and super important. However, making a program that was not created with queer and trans youth in mind and adding inclusive additions to the curriculum to account for those additional identities, it is both an absolute wonderful step in the right direction, and it is different than an LGBTQ-centered and specific program like INcluded, which from beginning to end is centering the experiences and identities of LGBTQ youth, which is really noticed by our participants.

It's very much appreciated from the moment they enter the room. We decorate it in a way that is extremely LGBTQ friendly. We're listening to LGBTQ artists and the curriculum itself, of course, is made centering all those identities.

That, I think, is one of the reasons it is so unique and exciting for folks to experience and ensures that the queer and trans youth are also seeing themselves in the content and experiences that are shared from beginning to end during the workshop.

I want to talk a little bit about how this program is meeting the needs of the population. And to do that, I just want to take a step back and say that when we created this program, we started by actually going around the country and doing a community assessment in which we listened to queer and trans youth around the country to find out what they wanted from their sexual health education, as well as what they wanted from their clinics and their experience going to the clinic, and what their concerns were so that we really knew what needed to be included in the curriculum.

Queer youth face unique obstacles in accessing care.

Unsurprisingly, of course, queer and trans youth face some unique obstacles when they access health care. A couple of them are on the slide, of course. There are concerns about doctors not understanding what their needs are. There's a fear of judgment and, of course, a big fear around confidentiality, especially when it comes to parents finding out about what they're going to the clinic for, for example.

Queer youth want and need sex education that reflects their identities and experiences.

And all of our assessment findings influenced both the health care workshop, as well as the youth workshop. And most exciting to me, I think, is what they all said they wanted to

experience and affects that program, as well as at the clinic. So they, obviously, want a program and curriculum that reflects their identities and relationships and bodies. So they want relevant, safer sex information, for example. They also want their relationships to be acknowledged and in a non-heteronormative and cis-normative way.

And in terms of the clinic, they want some information and education on how to communicate with their health care providers, as well as receiving respectful and relevant clinical care when they go. So all of this stuff, of course, is fairly straightforward, but it's definitely something that has otherwise been lacking.

Project Highlights

As was mentioned, a lot of our results are still in the preliminary stage. I do want to take a second to thank the involvement of our many partners around the country who've been working with us for the past few years, and that's a combination of other Planned Parenthood affiliates around the country, as well as community-based LGBTQ youth-serving organizations we've had the opportunity to work with. And so we are currently wrapping up our RCT specifically for the youth evaluation component, which does have positive preliminary outcomes, some of which I'll share.

The clinic evaluation component is complete, so that's great and that is final.

And I do also want to mention that the qualitative feedback we were able to get immediately after both workshops, so from both clinic staff, as well as youth. They definitely showed overwhelming positive experiences and feedback. I'll be focusing on the quantitative results for this, but I just like to mention that because it's definitely some inspiring, positive feedback that we get.

So in terms of numbers and quantitative results, we had the opportunity to implement INcluded in 16 different states around the country. And for the youth workshop specifically, which is definitely our main focus, we recruited over 1,400 youth—over by one—and those 1,400 queer and trans-identified youth in all 16 states in our last implementation was in December of 2018.

And so for our youth evaluation results specifically—well, for both, they are doing follow-up surveys three months and 12 months after their workshops, and so that is why we are currently in the midst of gathering all of our—kind of the end of all of our data right now.

We also intend to have our analysis complete, of course, by the end of June, 2020. And I want to highlight that for the clinic evaluation, which is complete, we did have a statistically significant finding in our one year follow-up surveys, which is that for the clinic staff who attended our INcluded workshop, they were more likely than those in our survey-only group to report using inclusive or open-ended questions about sexual relationships. So that is great news.

Positive youth preliminary results in the following areas:

For our youth workshop, we start off—are having really great response rates. The short term follow up, which is the three month survey follow up, is at 88.3%, and the long term follow up, which is still in process, as of November, it was at 87.8%, however, it's likely changed and is higher by now.

And then there are three main areas at the moment that we are seeing some positive preliminary results in terms of our outcomes, and one of those is around long-term knowledge. So youth who receive INcluded are currently demonstrating significantly greater knowledge scores when we ask them a handful of questions, compared to their control-only group of youth.

Also, around self-efficacy, our INcluded program youth are more likely to feel comfortable talking about sexual health with their provider, so that's fabulous that they are able to—when they access health care or are able to more confidently have those conversations.

And then last, but not least, is our preliminary positive health care outcomes, which currently are showing that our INcluded program youth are more likely to both have been to a doctor or clinic for contraception or birth control, as well as that they are significantly more likely to have received contraception or birth control than their youth counterparts in our survey-only control group.

Innovations: What Works for LGBTQ Youth

[Displays image of a cartoon hand holding a pink-colored card.]

We have learned a lot over the last two years about what works and doesn't work for workshops like this and, specifically, for providing sex education for queer and trans youth. Currently, INcluded is one of the only evidence-informed sexual health education programs that is designed specifically to meet the needs of this group of youth, and so these lessons are definitely super useful for us and, hopefully, will continue to be useful as time goes on and, hopefully, even more opportunities and programs are created.

So to start off, it is extremely beneficial to have materials and images and resources that reflect LGBTQ+ identities and experiences. So we have an image included on the slide of one of those such materials. This is our INcluded-zine. It's a workbook that also serves as a resource guide. It is very much LGBTQ-specific. The imagery, the information provided, both includes the information that is gone over in our workshop, as well as build upon that, and our youth get to take that home with them so they can continue to use that workbook and refer to it moving forward. It's definitely a crowd favorite.

Another thing that we learned works well is to have activities that encourage youth to define sex for themselves, to make space for their own realities and desires, as opposed to the more

typical experience of sex ed as saying what sex is. We give youth an opportunity to really talk about it in a much more open-ended way based on their own relationships and behaviors and identities.

And our safer sex demonstrations are definitely expanded. We go beyond just doing an external condom demo. We include dental dams. We include gloves. At the end of the workshop, we provide each youth with a goody bag that they can take home that has a lot of the materials included in that.

During our discussions about barrier methods, we incorporate dimension of sex toys. And when we talk about different birth control options, we're intentional about being clear that there are birth control options for trans and non-binary-identified youth, who—especially those who are taking gender-forming hormones—and that there can still be the possibility of being involved in a pregnancy, and the importance of having birth control options that work for folks who are on hormones.

And then last but not least, the importance of tools and skills related to actually having a conversation with a health care provider, which can be an intimidating thing for anyone, let alone a young person who's already in a marginalized group. So, for example, we get to have a conversation and then, youth get to practice talking about how to share information about their identity, about their identities and behaviors in a way that feels safe, but also as necessary for their sexual health. And then they get to practice what it is like to gently correct the mistakes that might be made by a staff or a provider.

The picture on the slide here is of a cue card. It was created by the cue card project based here in Seattle. It's like a wallet-sized card that all of the youth get in which when you open it up, it's a way for them to fill out some questions about their identity that can be useful for them to show to the clinic staff so that they can kind of share information about themselves in a way that might feel a little bit easier and safer. And that is definitely a popular tool, as well.

Coming Up Next for IN-clued...

And lastly, what's coming up next for us, of course, is we're just finishing our final few months of data collection and analysis. We are also in the process of training a lot of our partners around the country to be able to replicate, include in their own communities. And then we are also in the process of publishing and making it so that INclued will be available online for folks later in the year.

So rolling out nationally and hoping that LGBTQ sex ed will take the world by storm.

Thank you

[Displays presenter's contact information:
Laura Gardiner (She, her, hers)

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And with that, that is it for me. I thank you so much.

ASYA LOUIS: Thank you to much to all of our presenters. It's now time for our question and answer period. Our first question is for Girl2Girl and our audience member has asked, if a girl wanted to enroll but you already met the quota of what particular demographic, would you just turn her away or how would you ensure that she received some support?

MICHELE YBARRA: That's a great question. So for both eligible girls who were not contacted because of bins being full, as well as other sexual minority girls who were not eligible for another reason, we did provide LGBT-inclusive sexual health resources that they could find online.

ASYA LOUIS: OK, great, thank you.

Our next question is for our RCL. How did you address the differences in native culture and language between groups in the curriculum that you taught?

RACHEL CHAMBERS: Do you mean—I don't know if that means between—like within the population that we taught through this grant, and the answer to that is they were all from the same tribal community. However, when we have replicated the program in other tribal communities, we do allow for slight adaptations, and we help guide those adaptations often. I don't know if that answers the question.

ASYA LOUIS: I think so. Thank you. Our next question is for INcluded. How did you address issues of intersecting identities? For example, the needs of a black queer boy might be different than the needs of a white bisexual girl. Can you just talk a little bit about how you navigated that?

LAURA GARDINER: Absolutely. That is a fantastic question. And the truth is is that because this is a one time three-hour workshop, the program does not delve super deeply into any one particular identity. Our workshop participants usually span a wide variety of identities and intersections and, as a result, this was, typically, a more broader—the content was a little bit more big picture.

And that being said, it's something that we hope moving forward when our partners are implementing this in the communities, they are able to make adaptations that are going to be an even better fit for civic identities that are showing up in their workshops and in their communities.

ASYA LOUIS: Great. Thank you, Laura.

ANNIKA SHORE: This is Annika Shore. I'm a colleague of Laura's who was just presenting and I'm the director of this project. Yeah, I just think that's a great question and I wanted to piggyback on what Laura was saying to share that one of the things we did was try to match the facilitators to the identities of youth in our groups. So in areas where we were working with predominantly queer youth of color, we tried to have facilitators who matched that identity.

And while it didn't change the content of the curriculum to be tailored specifically for queer trans youth of color, it did at least sort of help our facilitators be able to answer questions or relate to the experiences that were being shared in stories in the room and that kind of thing.

And then I also just wanted to share that of our 1,400 youth, about 60% were white youth and about 40% were queer and trans youth of color and were intending to do some subgroup analysis to see how the program works for those different populations.

ASYA LOUIS: Great. Thank you so much. That was a wonderful addition.

ANNIKA SHORE: Absolutely.

ASYA LOUIS: We have another question for Girl2Girl. How did you choose which girls got paired up for your program?

MICHELE YBARRA: So it was a relatively light touch, because if it was too specific, then it would be very difficult to pair. So we paired on identities, so those who were lesbian were paired with other young women who identified as lesbian, and those who identified as bisexual and pan were paired with other young women with similar identities.

We also had a distance requirement, so that young girls lived far enough away from each other that it was unlikely that they would be able to either know the other or get in a car or get in a bus and meet up during the program.

And the third—well, there's actually two more. So the third criteria was that they were within two time zones with each other and that's because in the previous intervention, we found that it was really quite disruptive if they were trying to message each other and they're three hours apart.

And the final match was for sexual experience. So those who had never had sex were matched with other sexually-inexperienced girls, versus those who had had sex were matched with those who had had sex.

ASYA LOUIS: Great. Thank you, Michele.

Our next question is for both RCL and INcluded, but we'll have RCL go first. How did you monitor the fidelity of the program?

RACHEL CHAMBERS: Sure. Yeah. So we did a couple of things to monitor fidelity. One, obviously, we tracked all training we did with facilitators. The second thing we did was we observed 10% to 20% of the lesson. So in the peer group sessions, the camp sessions, we actually had somebody sit in the classroom and observe. And they rotated classrooms, so all facilitators were observed, I believe, two to three times.

And then with the parent-youth session, sort of depending on how it felt, we either recorded the session and listened to it or one of our quality assurance staff members actually attended the lesson. That really didn't happen often because it's such an intimate environment.

But so we collected all of that observation data and then we also had all the facilitators fill out facilitator self-assessments at the end of every session they did. And what was included in there were questions about, did you skip anything? Did you feel rushed? Do you feel like the kids understood what you were teaching? And if not, what?

It also had some sort of questions related to, did you enjoy teaching and the content of the curriculum to double check that they did teach the curriculum the way that it should have been taught.

So those were our two big ways to monitor the fidelity program.

ASYA LOUIS: Thank you, Rachel. And for INcluded, we have the same question for you just in terms of your program being in several states. How did you monitor the fidelity?

LAURA GARDINER: Yeah, that's a great question. And some of it is pretty similar to—it sounds like what was just shared. So after each implementation, our facilitators were required to fill out fidelity forms, and on the forms there was opportunity that each training was broken down by each activity, and there was an opportunity for facilitators to make note of any adaptations that were made so that we could keep track of how consistent the implementations were across the board.

We also had similar requirements around observations, and so myself and Annika Shore, who you just heard from, we, as well as other staff around the country who are trained in INcluded, would do site visits and observe about 10% to 20% of our implementations, in order to both fill out these fidelity forms, as well as provide more in-depth qualitative feedback for our facilitators, as well.

And all of our INcluded-trained facilitators received a formal training before doing any implementations, and there were requirements around training their teen peer educators, as well, that they did, as well.

ASYA LOUIS: All right. Thank you, Laura, and thank you to all of our presenters. At this time, I will pass it back to Richmond to end the webinar.

Current OPA Funding Opportunity Announcements (FOAs)

[Displays OPA funding opportunities:

Optimally Changing the Map of Teen Pregnancy through Replication of Programs Proven Effective (Tier 1) (AH-TP1-20-001)

Teen Pregnancy Prevention (Tier 2) -Phase II Rigorous Evaluation of Promising Interventions (AH-TP2-20-001)

Innovation and Impact Network Grants (Tier 2) –Achieving Optimal Health and Preventing Teen Pregnancy in Key Priority Areas (AH-TP2-20-002)]

RICHMOND PAJELA: Thank you. So before we wrap up, I do want to mention that the Office of Population Affairs currently has three funding opportunity announcements currently open, and you can see them here on the site right now.

I do want to note that some of the FOA numbers have changed. The prefix for the FOAs has changed from PA to AH, as you can see on the screen. So if you're having trouble finding these specific FOAs, please contact OPA or OASH, OGM. And you can find these FOAs and the FAQs on the OPA website on the URL that you see here on this slide.

Learn more about OPA

[Displays OPA contact information:

OPA@hhs.gov

[youtube.com/user/TeenHealthGov?sub_confirmation=1](https://www.youtube.com/user/TeenHealthGov?sub_confirmation=1)]

You can see that we have here—please connect with us. Come visit our [website](#), as well as contact us for any questions and follow us on Twitter. And our Twitter handle is [@HHSPopAffairs](#).

Once again, I want to thank all of the presenters on the webinar today, and thank you to all the participants who joined us.

This is now the end of our webinar series.