



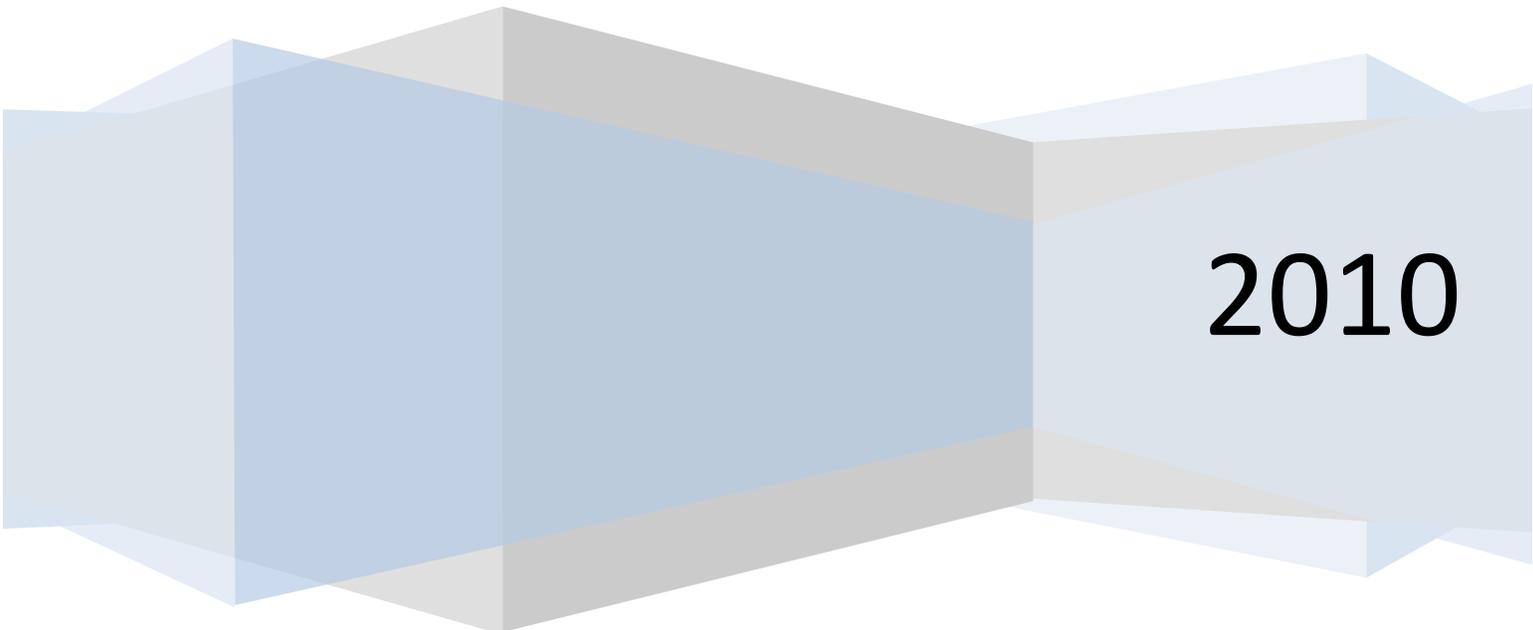
DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Delaware Adolescent Sexual Health State Plan

Addressing Adolescent Pregnancy and STI Prevention

Teenage Pregnancy Prevention Advisory Board

DRAFT VERSION: To be reviewed by state partners in
December 2010

A decorative graphic consisting of several overlapping, semi-transparent rectangular blocks in shades of light blue and grey, arranged in a horizontal, slightly staggered fashion. The year '2010' is printed in a large, bold, black font on the rightmost block.

2010

BACKGROUND NARRATIVE AND STATISTICS 5

THE DEVELOPING ADOLESCENT 5

US TEEN PREGNANCY AND STI BACKGROUND 6

THESE DATA DEMONSTRATE THE SIGNIFICANCE OF THIS ISSUE. 6

DELAWARE DEMOGRAPHICS AND TEEN PREGNANCY AND STI TRENDS 6

Figure 1. Five-year Average Percent Live Births to Teens (15-19) by Census County Division, Delaware 2003-2007 7

STIS AND HIV/AIDS 7

Figure 2. Diagnosed 2009 Gonorrhea cases in Delaware adolescents aged 11-19 years by Census County Division 8

Figure 3. Diagnosed 2009 Chlamydia cases among Delaware adolescents aged 11-19 years by Census County Division 8

HEALTH DISPARITIES 9

IMPACT OF ADOLESCENT SEXUAL RISK BEHAVIOR: TEEN PREGNANCY, CHILDBEARING AND SEXUALLY TRANSMITTED INFECTIONS 9

ECONOMIC IMPACT 10

EDUCATIONAL IMPACT 10

SOCIAL AND PUBLIC HEALTH IMPACT 11

FACTORS THAT AFFECT TEEN PREGNANCY, STIS 11

DRUG AND ALCOHOL USE 11

FAMILY CONNECTEDNESS 11

COMMUNITY INVOLVEMENT 12

ACCESS TO REPRODUCTIVE SERVICES AND CONTRACEPTION 12

School-Based Health Centers (SBHCs) 12

Family Planning and Clinic Resources/Services through Title X 13

COMPREHENSIVE SEXUAL EDUCATION 13

Current state policy on comprehensive sexuality education in Delaware 14

STRATEGIES FOR REDUCING ADOLESCENT PREGNANCY AND STIS 14

DELAWARE STATE PLAN 15

TARGET POPULATION 16

STATE COLLABORATIONS 16

STATE OF DELAWARE’S GOALS AND OBJECTIVES 17

5 GOALS: 17

OBJECTIVES 17

LOGIC MODEL 18

RECOMMENDATIONS 20

GLOSSARY OF TERMS 29

THE DELAWARE TEEN PREGNANCY PREVENTION ADVISORY BOARD 29

CITATIONS 30

Delaware Youth Sexual Health State Plan: Outline of Content

Letter to Governor

Sample Letter:

Dear Governor Markell:

We are pleased to provide the Delaware Adolescent Sexual Health State Plan from the Teen Pregnancy Prevention Advisory Board. We thank you for the opportunity to serve our state on this very important advisory board and acknowledge with deep gratitude the contributions of the many Delawareans who worked tirelessly to develop this state plan.

We are confident that the State plan goals and objectives provide a course of action to reduce the high teenage pregnancy rate in Delaware. If adequately funded, many barriers that result in reduced access to preconception and family planning care among minority populations will be removed. In addition, advocates will be empowered to provide guidance to policy makers, health care providers, health clinics and public school education systems that impact a teen's sexual health. We also anticipate collateral benefits that positively affect adolescents' sexual health.

There was wide agreement among board members that implementation of these objectives would improve teen pregnancy rates and STI/HIV rates. Many of the recommended objectives have been implemented in other states with considerable success in achieving their goals. The goals for the State of Delaware are based on Healthy People 2020 goals for adolescent reproductive health:

1. Adolescents, adults, families must understand and apply essential sexual and reproductive health information and develop communication skills in order to make positive choices concerning relationships and sexual health.

DE teens are more likely to have sex at early ages, have more frequent sexual activity, have more sexual partners, and are less likely to use protection than adolescents in other states. Receiving both current and accurate reproductive health information and increasing knowledge is the first step in preventing unplanned pregnancies and sexually transmitted disease infection. Adolescents and adults also need to learn communication skills to communicate this knowledge as well as share family values and expectations revolving around sexual behavior. Once adolescents and adults in their communities learn the information and communication skills they need, they can communicate more effectively with each other about responsible sexual behavior. By increasing sexual health education and communication skills, we hope to increase the proportion of adolescents who have never had sexual intercourse and increase consistent contraceptive use by sexually-active adolescents.

2. Rates of unintended teen pregnancy are reduced

Delaware has higher teen pregnancy/birth rate than the US average and is currently ranked 23rd highest teen birth rate. Through implementing a multifaceted approach targeting state policy, reproductive education, health care services, access to services and community engagement and support, we seek to lower the rate of unintended teen pregnancies.

3. Rates of subsequent teen pregnancies are reduced

Each year, approximately 1 in 5 teen births in Delaware are repeat births. By encouraging consistent contraceptive use, increasing reproductive health education and services and developing credible life goals, thus reducing subsequent teen pregnancies, we will improve the social and economic outcomes for both the teen mothers and their children.

4. Rates of sexually transmitted infection are reduced

By increasing birth control knowledge, condom negotiation skills and encouraging abstinence and STI testing, the rates of sexually transmitted infection will be reduced.

5. Racial, ethnic and geographic-based sexual health disparities are reduced

Though the black teen birth rate has dropped in recent years, it remains two times higher than the white teen birth rate in Delaware. Black adolescents are disproportionately affected by HIV/AIDS, comprising 60 percent of the cases. By decreasing the racial, ethnic and geographic disparities, Delaware can reduce teen pregnancies and STI and HIV/AIDS infection in minority populations.

Finding the resources to implement these recommendations will not be without difficulty. The Division of Public Health is consistently applying for multiple federal grant opportunities to finance the implementation and expansion of adolescent sexual health programming through the State. In addition, we are exploring other sources of funding from private and public institutions. Through times of economic hardship access to funding sources is challenging. Concurrently we are aware that increased economic stressors are correlated with higher rates of engagement in risk behaviors, teen pregnancy/birth rates, and increased pressure on youth and families. These factors affirm the need for Delaware to establish and follow a rigorous and effective Sexual Health Plan.

We thank you for leadership on this very important issue and for the privilege of serving the people of Delaware in this role. We thank you, most of all, on behalf of the adolescents and families in Delaware whose lives will be bettered when these goals and objectives are achieved.

Sincerely,

Chair, Teen Pregnancy Prevention Advisory Board

Background Narrative and Statistics

The Developing Adolescent

Current research validates what is often thought by adults: teens often think and reason differently than adults. These differences are reflected in decision making, behaviors, and attitudes and are evident in teens' sexual activity. It is important for adults, as parents, program developers, policy makers, and others, to consider that adolescents are still developing and growing. Even though teens may look and, sometimes act, like adults, their brain, thinking, and decision making may not be the same as a rational and informed adult.

Much of the ongoing investigation indicates that the brain is a “work in progress” in which physiological development continues during the teen years. Changes in the structure, or “hardwiring” of the brain, may account for differences in abilities and result in changes in behavior related to maturation of the brain. An increase in the number of brain cells, a decrease in the “clutter” of the brain, and a maturing of these cells results in a brain that is faster, more focused, and more organized. In contrast, as our brains mature we are less able to heal from devastating injury and our learning is slowed from a previously rapid pace.

Our brain matures in a back-to-front pattern in which such functions as primitive emotions and large motor control occur first. As the midbrain matures, creativity, organization, and fine motor function skills are mastered.

The focus of teen brain research has been on the maturing of the front of the brain known as the pre-frontal cortex, or the “area of sober second thought.” This “executive of the brain” provides individuals with the abilities to weigh consequences, assess risks, cognitive controls, establish priorities, organize actions, and problem solve. Decisions made regarding participation in sexual activity, use of safe sexual practices, selection of sexual partners, maintenance of pregnancy, and lifestyle choices are all impacted by the progress of adolescent brain development.

Another component of teen brain development is that nerve cells and chemicals work together to encourage teens to desire to seek new and novel stimulation or sensations. This may lead to reckless behavior and to succumbing to peer pressure. Research tells us that peer pressure is especially intense during the teen years and that social stimuli will continue to impact us throughout our lives. Teens, though, are especially vulnerable to the impact of friends, media, and social influences.

The developing adolescent benefits from concerned advocates, positive role models, a protective environment, a supportive family and community to guide choices, and gradual development of decision making skills to ensure healthy sexual behaviors.¹ This plan addresses these factors to promote sexual health for youth in Delaware.

US Teen Pregnancy and STI Background

The United States continues to have the highest teen pregnancy rate in the industrialized world twice as high as in England or Canada. Though the teen pregnancy rates for females 15-19 years of age have steadily decreased 37 percent from 1990 to 2005, the U.S. saw a five percent increase in the national average teen pregnancy rate from 2005-2007 approximately 69.5 per 1,000 births to 71.5 per 1,000 births. In addition, the teenage birthrate increased by four percent to 41.9 births per 1,000 females and the teenage abortion rate increased one percent to 19.3 per 1,000 females.¹ need new stats.check Hamilton's 2009 art Hamilton, B.E., Martin, J.A., & Ventura, S.J. (2009). *Births: Preliminary data for 2007*. Washington, DC: National Center for Health Statistics/National Vital Statistics System.

While it is too soon to ascertain whether the increase in pregnancy and birth rates is the start of an upward trend, preliminary data on births for 2008 show a leveling off in the birthrate for teenagers.² These data demonstrate the significance of this issue.

Delaware Demographics and Teen Pregnancy and STI Trends

According to the 2008 Kids Count, Delaware's estimated 2008 population was 863,800 residents, of which 13 percent comprise the adolescent and teen population. Over the next decade from 2010 to 2020, there is an anticipated six percent growth in both the 0 – 9 year old and 10 – 19 year old populations in the State of Delaware.

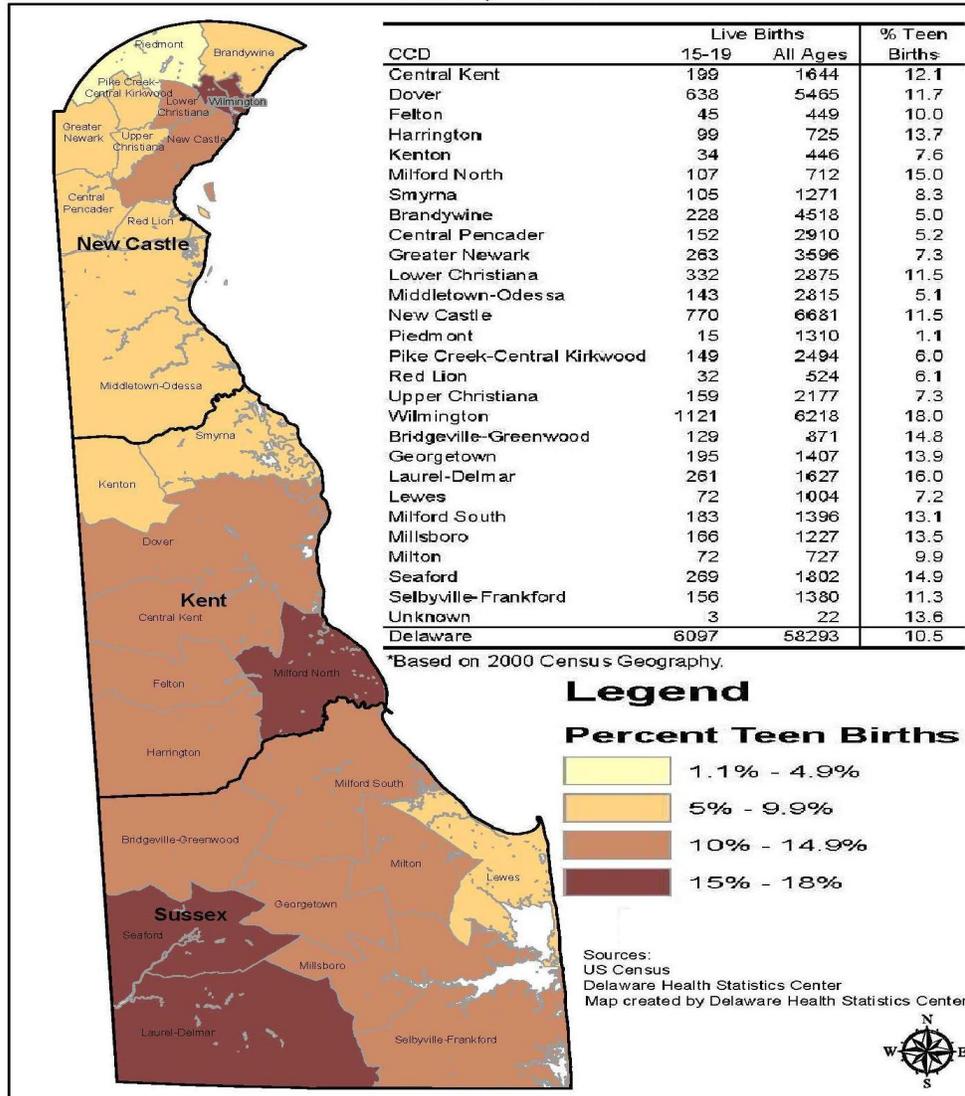
Though Delaware was not one of the 26 states that saw a significant increase in the teen birthrate in 2006, Delaware currently is ranked 6th highest among all states for teenage pregnancy rates (83/1,000 females 15-19) and 23rd highest for teen birth rates. The difference between pregnancy and birth rate rankings might be attributable to Delaware also being ranked 4th highest for teenage abortion rates.²

Geographically, Sussex County and the City of Wilmington continue to have higher teen birth rates than other areas of Delaware. Overall, the highest incidence of teen births (15-19 years old) is in Sussex County. For 15-17 year olds, Sussex County and the City of Wilmington continue to have the highest teen birth rates in Delaware. The five-year average (2003-2007) pregnancy rate for 15-17 year olds was highest in Sussex county, with a rate of 39.6 pregnancies per 1,000 females, followed by New Castle County, with a rate of 37.7, and Kent County, with 31.5. Sussex County's rates remained stable while Kent and New Castle counties' 2003-2007 rates decreased from their 2002-2006 rates. Black teen (15-19) pregnancy rates in Sussex county rose 5.2 percent from 2002-2006 to 2003-2007 while teen pregnancy rates for all other race and county groups declined or remained relatively stable. With the exception of Sussex County, black teen pregnancy rates were nearly twice that of white teens.

The five-year average (2003-2007) pregnancy rate for 18-19 year olds was highest in Sussex County 125.6 pregnancies per 1,000 females and lowest in New Castle County, with 102.3. Each year, approximately 1 in 5 teen births in Delaware are repeat births. The figure below depicts the 2003-2007 average percent live births to Delaware teens aged 15-19 yrs by Census County Division (CCD).

Figure 1. Five-year Average Percent Live Births to Teens (15-19) by Census County Division, Delaware 2003-2007.

Five-year Average Percent Live Births to Teens (15-19) by Census County Division* Delaware, 2003-2007



The map demonstrates an increased need for family planning services for teens that are in and near Wilmington and New Castle CCDs, the Milford North CCD in Kent County and all of Sussex west of Milton CCD.

STIs and HIV/AIDS

In 2009, the Laboratory Information System, from which the Delaware Public Health Clinics, SBHCs, detention centers and community based organizations submit their lab testing, reported 432 teens (190 males; 242 females) aged 11-14 and 7,936 teens (1,720 males; 6216 females)

aged 15-19 were tested for STIs throughout Delaware. Of these teens, 29 teens (3 males; 26 females) aged 11-14 and 942 teens (236 males; 706 females) aged 15-19 tested positive for one or more STIs.

In 2009, five adolescents aged 11-14 and 128 adolescents aged 15-19 were diagnosed with HIV/AIDS. Of these cases, 65 percent live in New Castle County, 20 percent live in Kent County and 15 percent live in Sussex County. The figures below depict the 2009 Gonorrhea and Chlamydia rates among Delaware teens aged 11-19 yrs by CCD.

Figure 2. Diagnosed 2009 Gonorrhea cases in Delaware adolescents aged 11-19 years by Census County Division.

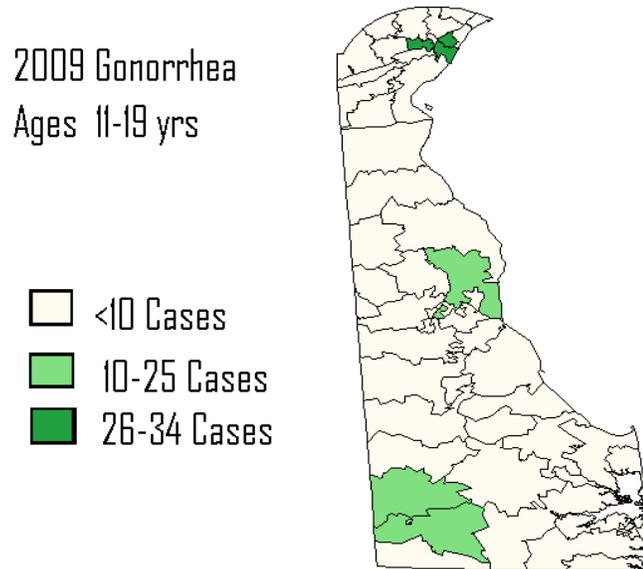
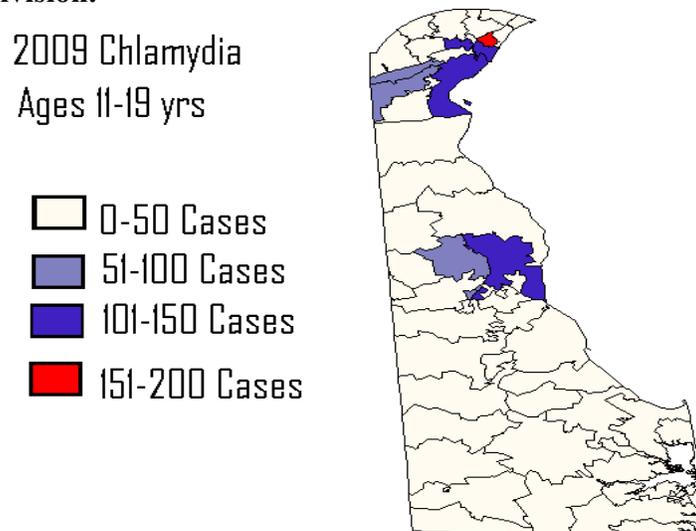


Figure 3. Diagnosed 2009 Chlamydia cases among Delaware adolescents aged 11-19 years by Census County Division.



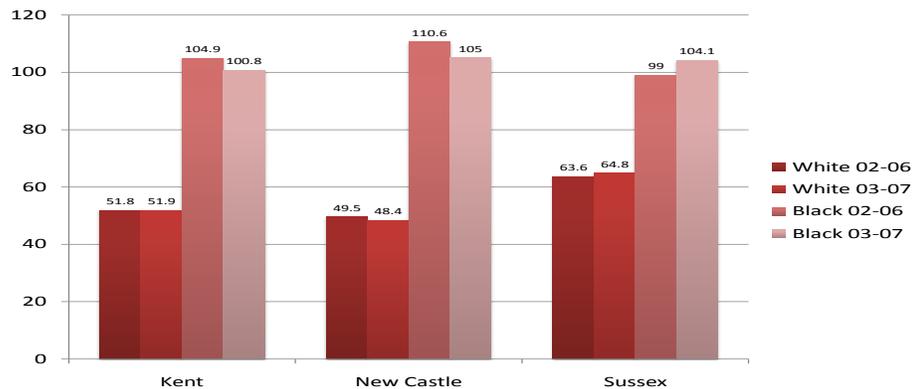
Health disparities

In terms of ethnic and racial disparities, Delaware has the 4th highest pregnancy rate among Hispanic adolescents aged 15-19 years. The Hispanic population in Delaware has increased by approximately 250 percent from 2.4 percent of Delawareans in 2002 to 6.5 percent of Delawareans in 2007. In fact, from 2000-2007 Delaware saw over a 10 percent population growth and much of it has been driven by increases in minority populations.²

Black teen (15-19) pregnancy rates in Sussex county rose 5.2 percent from 2002-2006 to 2003-2007; teen pregnancy rates for all other race and county groups declined or remained relatively stable. With the exception of Sussex county, where white teen pregnancy rates were the highest, black teen pregnancy rates were nearly twice that of white teens.

In regards to HIV/AIDS, Black adolescents are disproportionately affected, comprising 60 percent of the cases, while White and Hispanic adolescents comprised 32 percent and 8 percent respectively.

Five-year Average Teenage (15-19) Pregnancy Rates by County and Race Delaware, 2002-2007



Source: Delaware Health Statistics Center

Impact of adolescent sexual risk behavior: teen pregnancy, childbearing and sexually transmitted infections

Adolescent sexual health risk behaviors have a broader impact than simply on the adolescent. Often, both sexual health education and media messages focus on the impact of sexual risk behaviors on the individual and child. However, teen pregnancy, childbearing, and sexually transmitted infections have been found to have an impact on the education, health, welfare and social service systems.

Economic Impact

There is a strong correlation between poverty and teen pregnancy. The 2010 Alan Guttmacher Institute report's rankings of states by teen pregnancy rates reflect the U.S. Census rankings of states by poverty rates. In Delaware, 13.8 percent of children 18 and under are living at or below 100 percent of the Federal Poverty Level (FPL) and 33.9 percent of children 18 and under are living at or below 200 percent of the FPL. In Delaware, 26 percent of households are headed by females with children and of these families, 26 percent are living in poverty. Research has shown that adolescents residing in communities with high rates of poverty, receiving government assistance, and single-parent households are at higher risk for early pregnancy. Thus, a cycle of poverty continues as teen parents are therefore disproportionately concentrated in poor communities characterized by inferior housing, high crime, poor schools and limited health services^{3,4}. These educational and career limitations are closely linked to poverty as young mothers have limited career options, are relegated to lower paying employment, accrue shorter employment times, access lower paying jobs, are less self-sustainable, more likely to be supported on public assistance, have struggles with childcare, and confront significant difficulties with balancing parenting and work. (These can be edited!)

However, poverty and teen pregnancy impacts more than the adolescent. Nationally, teen childbearing costs taxpayers at least \$9.1 billion each year. In Delaware, teen childbearing in teens 19 years and younger cost taxpayers (Federal, State and local) at least \$28 million in 2004 and the average annual cost associated with a child born to a mother 17 and younger is \$4,194.⁵

Furthermore, poverty will influence health insurance and utilization of available health care services. The longer a person is without health insurance, the higher the likelihood that they will have an unmet need for medical care. Nationally, Medicaid finances 72 percent of teen births. In Delaware, in 2004, annual taxpayer costs associated with children born to teen mothers included:

- \$5 million for public health care (Medicaid and SCHIP)
- \$5 million for child welfare
- \$12 million for incarceration
- \$7 million in lost tax revenue, due to decreased earnings and spending⁵

According to Center for Applied Demography and Survey Research (CADSR) at University of Delaware, Black/African American Delawareans (15.4 percent) and Hispanic Delawareans (32.2 percent) and are more likely to be uninsured than Caucasian, Non-Hispanic Delawareans (11.8 percent). Areas with high concentrations of minority populations are in need of accessible and affordable family planning services.

Educational Impact

As with other high risk behavior, poor academic performance is associated with sexual risk taking. Delaware youth who reported getting Ds and Fs on their report cards were more likely than youth who reported getting As and Bs to have had sexual intercourse, to have initiated sexual intercourse before age 16, to have had four or more sexual partners during their lifetime, and to have first sexual partners who were three or more years older than themselves (2009 Delaware YRBS).

Teen mothers are more likely than their counterparts to drop out of school. The National Association of State Boards of Education (NASBE) reports that 70 percent of teen mothers drop out of high school and only 30 percent of teen mothers complete high school by age 30. Furthermore, according to the National Campaign to Prevent Teen Pregnancy, children who are born to unmarried teen mothers who have not finished high school are nine times more likely to be living in poverty than children of mothers without these risk factors. Educational and economic limitations may result in fewer career opportunities; lower paying jobs, more tenuous employment situations, increased poverty, and less satisfying career options.

Social and Public Health Impact

Teen pregnancy affects both the parents and their offspring. The children of teen mothers also face are more likely to be born prematurely and at a low birthrate, which raises the risk of health issues later in life such as of infant death, blindness, deafness, chronic respiratory problems, intellectual disability, mental illness, cerebral palsy, dyslexia, and hyperactivity.³

The children of teen mothers are more likely to depend on publicly-provided healthcare than the children of older mothers. Moreover, daughters of teen mothers are more likely to become teen parents themselves while sons of teen mothers are more likely to become incarcerated.⁴

Factors that affect teen pregnancy, STIs

The 2009 Youth Risk Behavior Survey (YRBS) data indicate that DE teens are more likely to have sex at early ages, have more frequent sexual activity, have more sexual partners, and are less likely to use protection than adolescents in other states. Fifty-eight percent of 9th-12th graders reported ever having sex compared to 48.3 percent of youth nationally. Moreover, 9.7 percent of Delaware youth reported having sex before 13 years of age, compared to 5.7 percent of adolescents nationally. These statistics are some of the highest in the nation and reinforce Delaware's efforts and need to target adolescents well before high school.⁶

Drug and Alcohol Use

According to the 2009 YRBS, 71 percent of Delaware high school students reported having tried alcohol at least once and 44 percent currently consume alcohol on a regular basis. Adolescents who start drinking at a young age are more likely to take other risks. The same teens who drink early also tend to smoke, use other drugs, and have sex early. Adolescents who are drinking or using drugs are less likely to use contraception than when they are sober. According to the 2009 YRBS, twenty two percent of Delaware adolescents surveyed reporting using drugs or alcohol during last intercourse compared to 21.6 percent nationally.

Family Connectedness

A multitude of literature has found a strong correlation between familial relationships or *family connectedness* and adolescent behavior, including sexual risk behavior. Positive parenting practices, including parental monitoring, guidance and communication have been found to influence adolescent development in all racial and ethnic populations, including decreased risk of adolescent pregnancy.⁸ For example, the National Longitudinal Study of Adolescent Health

(Add Health), which followed more than 12,000 adolescents in grades 7-12, found high levels of parent/family connectedness to be protective against every adolescent health risk behavior that was measured, including early sexual activity.⁹

Community Involvement

Aside from parents and family members, adults in the community can influence young people's ability to make healthful decisions as well as determine access to sexual and reproductive health information and services. To build community involvement, the community must first view these behaviors as beneficial and then reach a consensus to support change. Building community capacity has proven to better enable and sustain positive behavior change longer than only supporting a specific adolescent health program during its duration as adolescent knowledge and behavior are more likely to be reinforced in the communities that underwent normative change. Community social norms and values can include stances on premarital sex and contraception, the appropriate ages for girls to marry and bear children; the importance of providing youth with opportunities to develop skills that empower both youth and adults; mechanisms to develop and attain realistic education and career goals and the need to strengthen community structures and institutions that serve youth.¹⁰

Access to Reproductive Services and Contraception

Community health clinics, physician offices, pharmacies, grocery stores and convenience stores often vary in price and availability of contraception. Literature has shown that adolescents are more likely to consistently use contraception if they have easy access to obtaining the contraception, the contraception is free or affordable and the adolescent perceives they can obtain the contraception in a judgment-free environment.¹¹

School-Based Health Centers (SBHCs)

SBHCs are located in every school district in Delaware. The goals of SBHCs in Delaware are to provide primary prevention and early intervention for health problems among the student population by: Providing preventive care; Detecting signs of emotional stress and psychosocial problems for counseling and/or referral; Facilitating students' use of health care systems by establishing links with primary health care providers; Promoting ongoing comprehensive health care for students of all ages; Encouraging parent involvement in the health care of their adolescents; Working toward the improvement of the students' knowledge of the importance of preventive health care; Improving responsible decision-making about health matters; Reducing risk-taking behaviors; Developing health promoting behaviors; and providing early detection of chronic conditions and early diagnosis and treatment of minor and acute illnesses and health problems.

The first Delaware SBHC was established in 1985. Funded by the State, SBHCs have been successful in Delaware because of the collaborative efforts and ongoing commitment of DHSS, DPH, Department of Education (DOE), hospitals, community family services agencies, school districts, local high schools, community leaders, legislators, school/center staff, students and parents. Placing health services in Delaware high schools assures students easy access to immediate care and guarantees that services fit their needs while complementing the school and community health care systems. Since students are more comfortable with this type of setting, they are more likely to use such medical, mental health and nutritional services that are offered at

each of the centers. Seven medical vendors are responsible for administering SBHC services at twenty-eight sites throughout Delaware.

In Fiscal Year (FY) 2008, SBHCs enrolled 78.7 percent of the school population (34,939) where sited. Reproductive health services (i.e. family planning, gynecological care, contraceptives, etc.) are not provided at any SBHC in Delaware. Students would be referred to a local provider (including Title X providers) for these services. However, students are tested for pregnancy and STDs at 86 percent of the centers and all centers provide mental health counseling. This helps youth address issues that could contribute to risk behaviors such as unprotected sex, multiple partners and alcohol and drug use. DPH works collaboratively with each school district and DOE to provide space and services coordination for SBHCs as an in-kind contribution. The school nurse, guidance counselor, resource officer and principal at each high school also works very closely with SBHC staff in identifying risk, health services coordination, referral and health education. (Do we want to mention one center tests for HIV or better to keep that quiet!)

Family Planning and Clinic Resources/Services through Title X

The DPH Reproductive and Sexual Health Clinics provide full family planning services through 25 locations across the State of Delaware. The services are provided through eight DPH clinics and 17 contracted provider service sites (delegates). Three DPH clinic sites are located in New Castle County and five clinic sites are located in Kent and Sussex Counties. These DPH clinics provide services to 43 percent of the Delaware family planning client population reported on the 2009 Family Planning Annual Report. DPH Clinics serve a greater proportion of poor and minority patients than contracted delegates. DPH Clinics also provide program-wide resources beyond Title X support including staff, laboratory testing and pharmacy services. All DPH clinics are conveniently co-located with other health and social services to facilitate client access and referrals. Each site has the resources to provide basic family planning services. With regards to the current policy on minors' access to contraceptives and STI/HIV testing, Delaware allows a minor to consent to contraceptive services if they are at least 12 years old, however the provider may but is not required to inform the minor's parents.¹²

Comprehensive Sexual Education

Multiple evaluation studies on adolescent comprehensive sexual education programs have found significant positive effects on adolescent knowledge, behaviors and health outcomes. Behavioral outcomes in adolescents who have participated in sexual education programs have included delaying the initiation of sexual intercourse as well as reducing the frequency of sex, the number of sexual partners, and increasing the incidence and consistency of contraception use among sexually active adolescents. Long-term impacts of sexual education programs have included the reduction in adolescent pregnancy and STI rates.^{13, 14, 15, 16}

According to a survey conducted by Sexuality Information and Education Council of the United States (SIECUS) in 1999, 93 percent of parents and adults surveyed support sexuality education in high school and 84 percent supported it in junior high school. In Delaware, the Division of Public Health's Alliance for Adolescent Pregnancy Prevention found that 95 percent of parents reported wanting comprehensive sexuality education in schools. **NEED CITATION FROM AAPP**—

Current state policy on comprehensive sexuality education in Delaware

Currently, Delaware mandates that public schools teach sexuality education and STI/HIV education and require that abstinence be stressed when taught as part of sex education. Delaware does not require parental permission for sexuality education to be taught.

While Delaware law requires that this education stress abstinence, it does not specifically require that students receive information about condoms and contraception.¹⁷

Strategies for Reducing Adolescent Pregnancy and STIs

- 1) **Infrastructure:** Develop state and local infrastructure that sustains the delivery of sexuality education programs in middle and high schools as well as reproductive health services such as applying for funds to fortify clinics and organizational structures. Promote collaborations between the state, clinics, schools and community organizations.
- 2) **Policy:** Support and expand the implementation of evidence-based sexuality education and access programs throughout the state. Provide direction, guide resources, encourage consistency, provide due diligence and help coordinate efforts.
- 3) **Access to Health Care Services:** Increase adolescent access to high-quality, age-appropriate and readily available reproductive health care, including contraception by increasing and improving family planning services and available contraception to all youth and community members. Having equal opportunity to access reproductive health care will encourage contraceptive use and testing for sexually transmitted infection, thus reducing health disparities in terms of the pregnancy and STI rates.
- 4) **Community Engagement:** Create and promote opportunities and connections for youth and adults by engaging them as partners in decision-making. A collaborative approach helps community members gain self-worth and see the value in efforts to increase sexuality education and access to reproductive health care.
- 5) **Education for Youth and Families:** Employ multiple methods of sexuality education to reach both youth AND adults. The topic of sexual health is generally taught for one semester or less in health class, which is only available in one grade throughout school. Employ multiple approaches to increase access to education for both youth and adults through the use of trained peer educators to spread consistent and accurate information throughout both rural and urban areas.
- 6) **Services for Youth and Families:** High quality reproductive health services for youth and adults need to be implemented, improved and accessible, in terms of both transportation and cost in communities. Reproductive health care services must offer a nonjudgmental, culturally competent, age-appropriate and friendly environment to encourage youth and adults to seek services and more importantly RETURN for follow-up care.

7) **Research, Data Collection and Evaluation:** Utilize available state and local data to target vulnerable populations and communities that would benefit from increased efforts to increase and access to sexuality education and reproductive services. Coordinate efforts to collect both process and evaluation data from efforts to ascertain progress.

8) **Commitment and Sustainability of Actions:** Assure residents and target populations of commitment to achieve results through sustained efforts to promote youth well-being.

Delaware State Plan

The Delaware Division of Public Health plans to implement and replicate two evidence-based health education programs targeting both the school-based and community-based adolescent populations in reducing teenage pregnancy statewide. Targeted sites will include census county divisions (CCDs) with correspondingly high rates of social and economic risks, teen birth rates and STD and HIV/AIDS infection rates such as in community centers in the City of Wilmington, Bridgeville/Greenwood, Seaford, Selbyville/Frankford, Milford North/South, lower Christiana, New Castle and Millsboro. Teachers representing all 19 school districts in the state will participate in training provided by the Sexuality Training Institute, which will be established. The first health education program, *Making Proud Choices!* will target adolescents ages 11 – 13 while the program *Be Proud! Be Responsible!* will target adolescents ages 14 – 19.

The goal of *Making Proud Choices!* is to empower young adolescents to change their behavior in ways that will reduce their risk of becoming pregnant and infected with sexually transmitted diseases including HIV. *Making Proud Choices!* is one of the health education programs currently available through the Alliance for Adolescent Pregnancy Prevention (AAPP) and administered by Christiana Care Health Services (CCHS) and Planned Parenthood of Delaware (PPDE), who provides train-the-trainer courses on the curriculum. AAPP has implemented the *Making Proud Choices!* curriculum for three years and in a recent evaluation, found the curricula to significantly increase participants' knowledge and improve attitudes about risky sexual behavior. It has been suggested, in other reports, that in order to sustain the effects of *Making Proud Choices!* over time, supplementation with other programs such as *Be Proud! Be Responsible!* is beneficial.

Originally targeted for HIV at-risk African American adolescents, the *Be Proud! Be Responsible!* curriculum is adapted to target high risk teenage populations, ages 11 to 14. There are three overriding themes that provide the *Be Proud! Be Responsible!* curriculum with a unique approach that has proven to be successful in urban environments: 1) The Sense of Community Approach; 2) The Role of Sexual Responsibility and Accountability and; 3) The Role of Pride in Making Safer Sexual Choices.

There are several reasons why the two evidence-based curricula were chosen for replication. Both programs use skill building strategies and teach negotiation skills that empower adolescents to reduce risky behaviors associated with teenage pregnancies. While both programs support abstinence as being the most effective way to eliminate risks, multiple evaluations of both programs have found the curriculums also give medically accurate, factual information on contraceptive methods and protective factors to reduce the risk of pregnancy and STDs.^{18, 19} The

program materials are culturally sensitive to reach a representative sample of the targeted schools, which are comprised of approximately 30 to 50 percent African American and approximately six to 22 percent Hispanic students. In addition, the activities included in the curricula increase adolescent negotiation skills, improve condom use skills and help teens develop a sense of pride and confidence in their choice to practice safer sex. Both program evaluations demonstrated that students reported engaging in less risky behaviors and having less sexual partners after participating in the programs as compared to teens in control groups. Participants also reported using condoms more consistently and a smaller percentage reported engaging in anal intercourse as compared to teens not participating in the programs. (Does this need to be cited?)

Due to the diversity of settings where the curricula will be implemented, adaptations of the curricula may be considered. While maintaining fidelity to the curricula, both programs allow for flexibility in participants, frequency and length of modules and can be taught in both school and community settings. The curriculums are designed for use by school educators, family life educators, HIV/STD and pregnancy prevention educators and staff working with youth in community-based programs. Each setting and group will be assessed for needed curricula adaptations to serve each group of youth with the highest quality of education possible. Materials such as program adaptation kits will be provided and reassessed to assure that only approved adaptations are implemented to assure fidelity and medical accuracy of the curricula.

Target Population

DPH intends to target adolescents aged 11 to 19 years of age. The 2009 YRBS data indicate that DE teens are more likely to have sex at early ages, have more frequent sexual activity, have more sexual partners, and are less likely to use protection than adolescents in other states. Fifty-eight percent of 9th-12th graders reported ever having sex compared to 48.3 percent of youth nationally. Moreover, 9.7 percent of Delaware youth reported having sex before 13 years of age, compared to 5.7 percent of adolescents nationally. Twenty two percent of Delaware adolescents surveyed reporting using drugs or alcohol during last intercourse compared to 21.6 percent nationally. These statistics are some of the highest in the nation and reinforce Delaware's efforts and need to target adolescents before high school, thus middle school aged adolescents will also be reached through programming. Hispanic and African American adolescents will be targeted as they are disproportionately affected by teen pregnancy and STD infection.

State Collaborations

Using a systems perspective approach, the project seeks to emphasize coordination and collaboration between Delaware State agencies and community organizations serving adolescents during the process of developing a state plan. To avoid duplication of efforts, DPH plans to build upon the existing work and program structure implemented by AAPP. The project team, under the direction of the DPH Bureau of Adolescent and Reproductive Health, will work collaboratively with stakeholders and other community organizations to create an infrastructure to build upon the capacity for the effective implementation of adolescent pregnancy prevention education and services managed by AAPP. The process will begin with the development of a state plan involving stakeholders from public and private agencies, schools, communities and

parents. An infrastructure assessment will be completed to determine the current status of leadership, policy, funding prevention programs, opportunities for continuous improvement, qualified providers of professional development, technical support and data management capacity. A Sexuality Training Institute will be established to provide technical assistance, materials and a train-the-trainers model, in which school teachers and community volunteers will be trained to facilitate one or both programs to adolescents with fidelity to the model.

Inclusive in this process will be the stakeholders—those that the project serves or affects, such as youth, parents and guardians, teachers, service providers, program coordinators, health agency administrators and community members. The partners will influence the implementation strategies identified in the work plan. As the plan evolves it will become necessary to expand membership in the stakeholder’s group. Currently the stakeholders include the Delaware Department of Education, the DPH Teen Pregnancy Prevention Advisory Board, PPDE, Children and Families First: A Resource Center for Youth (ARC), the Federally Qualified Health Centers and the Delaware Department of Services for Children, Youth and Families. Through memorandums of understanding with stakeholders and in conjunction with contractors secured through the request for proposal process, DPH plans to provide the replication of the two-evidence-based health education programs, as well as establish the Sexuality Training Institute. Subcontractors for program services will be determined through the State’s RFP process.

State of Delaware’s Goals and Objectives

5 Goals:

- 1) Adolescents, adults, families must understand and apply essential sexual and reproductive health information and develop communication skills in order to make positive choices concerning relationships and sexual health.**
- 2) Rates of unintended teen pregnancy are reduced**
- 3) Rates of subsequent teen pregnancies are reduced**
- 4) Rates of sexually transmitted infection are reduced**
- 5) Racial, ethnic and geographic-based sexual health disparities are reduced**

Objectives:

The objectives outlined in the State plan were created using the SMART Approach:
Specific,
Measureable,
Attainable/Achievable,
Relevant and
Time bound.

By *****, the Division of Public Health and partners will collaborate to establish a Sexuality Training Institute, that will be responsible for training instructors on evidence-based program curricula, providing program materials and technical assistance, data collection and program monitoring.

By *****, the Sexuality Institute will train ** instructors on facilitating the evidence-based curricula *Making Proud Choices!* with fidelity to the model.

By *****, the Sexuality Institute will train ** instructors on facilitating the evidence-based curricula *Be Proud! Be Responsible!* with fidelity to the model.

By *****, *Making Proud Choices!* will be implemented in *** middle and high schools throughout the State of Delaware.

By *****, *Be Proud! Be Responsible!* will be implemented in *** middle and high schools throughout the State of Delaware.

By *****, *** adolescents will have completed the *Making Proud Choices!* curriculum.

By *****, *** adolescents will have completed the *Be Proud! Be Responsible!* curriculum.

Logic Model

The Delaware Division of Public Health has employed the Behavior-Determinant-Intervention (BDI) Logic Model (developed by Doug Kirby, PhD, 2004) for the State Plan. The BDI Logic Model format was developed specifically for programs which are focused on teen pregnancy and/or STIs and HIV.

In the Logic model....Fourth column...Can we say Foster Attitudes, rather than enforced? Sounds a little autocratic!jwh