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DECEMBER 2016

ADOLESCENT SEXUAL HEALTH

RIDE Rhode Island Department of Education

2016–2020 RHODE ISLAND PROFILE

PREPARED BY:

Rhode Island Department of Health

Rhode Island Department of Education

December 2016

Dear Reader:

We are pleased to present Rhode Island's first Adolescent Sexual Health Profile. This topic can be a sensitive subject. Although sometimes difficult to discuss, honest conversations and an open dialogue are important when addressing adolescent's sexual health. Providing insights and solutions that can help young people navigate adolescence and prepare them for adulthood are priorities of this plan.

The term adolescent sexual health encompasses the mental, physical, emotional, social, and spiritual aspects of an adolescent's life. This includes the ability to make positive and beneficial decisions, build safe and healthy relationships, communicate with others appropriately, and develop self-acceptance and a unique identity.

Research has demonstrated that young people have the potential to take responsibility for their sexual health when given the correct information and tools. It is our responsibility to provide socially, culturally, and age-appropriate tools to all adolescents in Rhode Island. Adolescents can utilize this information and apply it to their individual behaviors and lifestyles.

Comprehensive approaches to adolescent sexual health that engage parents, healthcare providers, schools, and communities need to be in place for healthy behaviors to develop and to be sustained.

One of our top priorities is to make Rhode Island communities healthier, which includes stepping up efforts to focus on adolescents. Our young people deserve to live in communities that help them make healthy decisions as they grow and mature into adulthood.

Nicole Alexander-Scott, MD, MPH
Director of Health

Ken Wagner, PhD
Commissioner, Rhode Island Department of Elementary and Secondary Education

ADOLESCENT SEXUAL HEALTH

2016–2020 RHODE ISLAND PROFILE

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EXECUTIVE SUMMARY

This profile describes the current landscape of sexual health among adolescents in Rhode Island. It also provides recommendations for future public health policymaking.

Below are key facts about Rhode Island adolescents related to unintended pregnancy, sexually transmitted diseases (STDs), and health behaviors:

- Annually, about 25 teen girls (ages 15-19) out of 1,000 experience an unintended pregnancy[1].
- In the past five years, there were 15,267 reported cases of chlamydia among adolescents ages 15-24[2].
- About one in four high school students reported that they were currently sexually active[3].
- Two out of five sexually-active high school students do not consistently use condoms[3].
- In the United States, one in five sexually-active high school students report having sex while under the influence of alcohol or drugs[4].
- One in 12 high school students report experiencing forced sexual intercourse[3].

Groups that experience health disparities related to sexual health include adolescents who identify as lesbian/gay/bisexual/transgender/queer (LGBTQ), adolescents with disabilities, adolescents in state care or who are homeless, and racial and ethnic communities of color. Examples of these disparities include:

- Nineteen percent of lesbian, gay, and bisexual* high school students report having sex before age 13 compared to 4% of heterosexual high school students[3].
- Fourteen percent of students with a mental or physical disability have experienced "sexual dating violence"[3].
- The Rhode Island teen pregnancy rate is three times higher for Hispanic/Latinos, and two times higher for Black/African Americans, when compared to Whites[1].

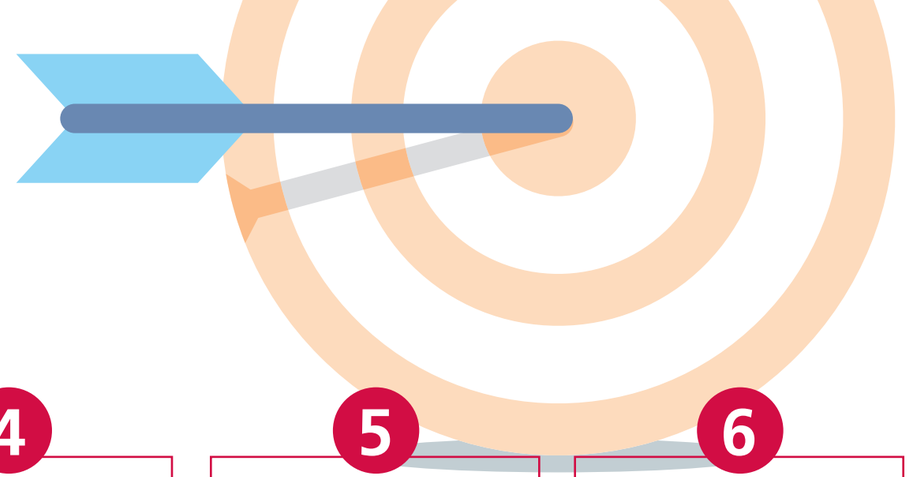
Recommendations to address adolescent sexual health include:

- Improve school environments and support health curricula that meet the needs of adolescents of all ages and backgrounds.
- Engage parents and community partners to help improve the overall sexual health of adolescents.
- Work with healthcare providers to improve "adolescent-friendly" healthcare with the goal of increasing utilization of preventive health services.
- Propose and promote state policies and laws that reduce barriers and improve access to sexual health-related services for adolescents.

*The Youth Risk Behavior Survey does not collect data on students who identify as transgender and queer/questioning.

SIX STRATEGIC GOALS

Staff from the Rhode Island Department of Health and the Rhode Island Department of Education collaborated on this profile and identified six goals. These goals are designed to serve as the foundation for future adolescent sexual health planning activities in Rhode Island. The table below illustrates the overlap between these strategic goals and the Rhode Island Statewide Integrated Population Health Goals.



1 Improve knowledge and skills among adolescents to encourage them to make informed decisions about sexual health and relationships.

2 Reduce rates of unintended pregnancy among adolescents.

3 Reduce the incidence of sexually transmitted diseases (STDs) and HIV among adolescents.

4 Reduce teen dating violence among adolescents.

5 Reduce adolescent use of drugs and alcohol associated with risky sexual behavior.

6 Eliminate health disparities related to sexual health among young people with disabilities and diverse learning needs, different racial and ethnic groups, LGBTQ communities, and other vulnerable groups.

Rhode Island Statewide Integrated Population Health Goals*

	Improve health literacy	Increase patient engagement	Build culturally competent health systems	Promote health of mothers and their children	Promote behavioral health and wellness	Reduce communicable diseases	Reduce chronic illnesses	Improve access to care	Minimize exposure to traumatic experiences	Improve availability of safe living conditions	Reduce Substance use disorders	Support ongoing recovery and rehabilitation	Develop standards for data collection	Expand models of care delivery focused on improved outcomes
1. Improve knowledge and skills	X	X	X		X	X	X				X		X	X
2. Reduce rates of unintended pregnancy			X	X	X			X			X		X	X
3. Reduce STD and HIV incidence			X	X	X	X	X	X			X		X	X
4. Reduce dating violence			X	X	X				X	X	X		X	X
5. Reduce drug and alcohol use		X		X	X	X	X	X			X	X	X	X
6. Eliminate health disparities	X	X	X	X	X	X	X	X	X	X	X	X	X	X

*The complete Rhode Island Statewide Integrated Population Health Goals are found in Appendix B.

ADOLESCENT SEXUAL HEALTH AS A PUBLIC HEALTH PRIORITY

The Centers for Disease Control and Prevention's (CDC) definition of adolescence is ages 10 to 24 and includes the groups often referred to as pre-teens, teenagers, and young adults, including college students. While this profile primarily focuses on adolescents of high-school age, due to the availability of data for this group, it is important to recognize the role that age-appropriate, early-adolescent sexual health education plays in a young person's development before age 15.

Adolescence marks the period between childhood and adulthood when individuals experience a wide variety of physical and psychosocial changes. These changes can be overwhelming and confusing. As adolescents strive to define who they are, experimenting with risky behaviors is frequently part of the normal developmental process.

Adolescents do not always anticipate the consequences of their behaviors, particularly as they relate to their sexual and reproductive health. There can be adverse health outcomes associated with these behaviors. These outcomes can include unintended pregnancies, sexually transmitted diseases (STDs), Human Immunodeficiency Virus (HIV), and sexual, physical, and dating violence. In addition to young people's well-being during adolescence, many of these outcomes can have an impact on their health as adults, as well as the health of their future children.

Improving the sexual health of adolescents is a public health priority because of the potentially serious health consequences that may occur when they do not have access to appropriate education, healthcare resources, or support to help them make healthy decisions and minimize risky behaviors.

Sexual health is a broad term that is best defined by the CDC as: "Sexual health is a state of well-being in relation to sexuality across the life span that involves physical, emotional, mental, social, and spiritual dimensions. Sexual health is an intrinsic element of human health and is based on positive, equitable, and respectful approach to sexuality, relationships, and reproduction that is free of coercion, fear, discrimination, stigma, shame, and violence. It includes the ability to understand the benefits, risks, and responsibilities of sexual behavior; the prevention and care of disease and other adverse outcomes; and the possibility of fulfilling sexual relationships. Sexual health is impacted by socioeconomic and cultural contexts including policies, practices, and services that support health outcomes for individuals, families, and their communities."

RHODE ISLAND SEXUAL HEALTH-RELATED LAWS AND POLICIES

There are a variety of laws and policies in Rhode Island that impact an adolescent's access to sexual health information and services. These laws and policies serve as a foundation for policy development efforts related to the recommendations of this plan.

Schools and Education

- Rhode Island has a strong infrastructure to support exemplary sexual health education. State law requires a 100 minutes per week minimum instructional time for health and physical education. The *Rules and Regulations for School Health Programs* including the *Rhode Island Comprehensive Health Instructional Outcomes and Rhode Island Health Education Framework* provide the foundation for all kindergarten through 12th grade health education in the state's schools [5]. Rhode Island is a locally controlled state where communities select their own curriculum approaches based on evidence-based/informed resources aligned with the *Rhode Island Comprehensive Health Instructional Outcomes and the Rhode Island Health Education Framework* [6,7].
- Family Life and Sexuality and HIV/AIDS education are required in health education by Rhode Island State Law. All parents must have access to the local curriculum upon request. Students may be exempted from sexual health education and/or HIV education through a written parental directive to the school principal [6,7].
- The Rhode Island Board of Regents has a policy that no student shall be excluded from any educational program or activity or discriminated against, bullied, or harassed in any public educational setting based upon actual or perceived sexual orientation or gender identity/expression or through their association with people with the aforementioned characteristics [8].
- The Rhode Island Department of Education (RIDE) has developed and disseminated *Guidance for Rhode Island Schools on Transgender and Gender Non-Conforming Students* [9].

Medical/Healthcare

- Rhode Island students are required to begin the HPV vaccine series before entry into 7th grade, and have at least two doses before entry into 8th grade [10].
- Rhode Island State Law allows minors to consent to STD and HIV testing and care confidentially and without parental approval [11].

Consent and Possession Related to Sexual Health Behaviors

- Adolescents cannot legally consent or agree to sex before age 16 [12].
- It is illegal for minors in Rhode Island to send naked or sexually-explicit pictures of themselves or another minor. Anyone who violates this law can be ordered to go to counseling or treatment programs [13].

A PROFILE OF ADOLESCENTS IN RHODE ISLAND

Many factors influence the health and well-being of adolescents as they grow and mature towards adulthood. The information below provides a profile of adolescent Rhode Islanders that can inform the development of policies and interventions related to adolescent sexual health.

Diversity

72% of adolescents are White, 8% Black/African American, and 21% Hispanic/Latino [14]

67% of all minorities younger than age 18 live in one of the four core cities (Central Falls, Pawtucket, Providence, or Woonsocket) [14]

23% of those younger than age 18 speak a language other than English in their homes [14]

22% of high school students self-identified as having long-term emotional or health problems, learning disabilities, or physical disabilities [3]

Education

83% of Rhode Islanders graduate high school in four years [18]

1 in 8 students in Rhode Island's four core cities drop out, compared to 1 in 20 students in other school districts [18]

69% of public school students receive free or reduced-price lunches [19]

6% of high school students report they did not go to school because they felt unsafe at school or on their way to or from school [3]

Health

6% of Rhode Island children do not have health insurance [15]

17% of adolescents have two or more chronic conditions [16]

12% of high school students are obese [3]

1 in 6 boys and 1 in 3 girls were depressed in the last year [3]

37% of Supplemental Nutrition Assistance Program (SNAP) enrollees were children [17]

Risky Behaviors

46% of high school students texted or emailed while driving a car or other vehicle [3]

17% of high school students rode in a car with a driver who had been drinking alcohol at least once in the last month [3]

26% of high school students drank alcohol in the last month [3]

40% of high school students reported smoking marijuana in their lives [3]

25% reported current use of tobacco (cigarettes, cigars, electronic vapor products) [3]

SPECIAL TOPICS RELATED TO ADOLESCENT HEALTH

The Adolescent Brain

While physical changes are most apparent during adolescence, there are also significant changes in the brain that occur throughout this period of life. During adolescence, the frontal lobe matures within the forebrain, the largest section of the brain. The forebrain is associated with complex cognitive skills such as being able to differentiate among conflicting thoughts, distinguish differences between good and poor choices, identify consequences of actions, and control impulses. An adolescent's tendency to act on impulse without concern of risks or consequences puts them at risk for negative sexual health outcomes such as unintended pregnancy, HIV and STDs, and dating violence. Reproductive and stress hormones are changing within the brain during this period, which influence both social and sexual behaviors. Adolescents have a great capacity to learn information, so it is during this period of intense biological and psychological change when targeted comprehensive education is most influential [20,21].

Healthcare Transitions: Moving From Pediatrics to Adult Care

Healthcare transitions (HCT) can be defined as a purposeful, planned process that addresses the medical, psychosocial, and educational/vocational needs of adolescents and young adults as they move into adulthood. Nationally, the vast majority of youth and young adults and their families are not receiving HCT supports. All youth, particularly those with special needs, should receive HCT services as part of routine primary and specialty care to help them optimize their ability to assume adult roles and activities and to ensure that healthcare services are available in an uninterrupted manner [22]. Empowering youth through transitions fosters the development of self-management skills and tools needed for them to gain more control over their lives.

Technology: How Do Adolescents Communicate?

Adolescents are highly focused on technology, including the use of social media, to develop and maintain relationships with their peers. The unique components of social media allow for immediate and widespread connections and may increase the risk behaviors of adolescents, especially in regards to their sexuality. Risks can include cyberbullying and sharing of sexually-suggestive pictures and can have immediate and long-term impacts on the mental and physical health of adolescents.

- 93% of adolescents, ages 12-17, use the internet, and most use it at least once a day [23]
- 81% of teens use social media sites, and 71% use Facebook [24,25]
- 52% of teens report being cyberbullied [26]
- 3 out of 4 teens have a smartphone [23]
- On average, a teen sends and receives 30 texts per day [23]
- 1 in 10 adolescents have had embarrassing or damaging pictures taken of themselves without their permission, often by cell phone cameras [23]
- 1 in 5 teens have posted or sent sexually-suggestive or naked pictures to others [27]

UNINTENDED PREGNANCY

Background

Nationally, teen pregnancy rates are at the lowest level in 20 years, and teen birth rates are at the lowest level ever recorded. This is likely due to increases in birth control use and a slight decline in sexual activity among adolescents[28,29]. Rhode Island mirrors national trends with a decrease in teen birth rates from 29 per 1,000 adolescents in 2008 to 20 per 1,000 adolescents in 2012[1]. While these trends are promising, there is still work to be done to reduce unintended (mistimed or unwanted) pregnancies among adolescents, especially among groups who experience sexual health-related disparities.

590
teen births in Rhode Island in 2014[37]

Unintended pregnancies among adolescents impact families and communities and are often linked to adverse health, educational, economic, and social outcomes[30]. Having a baby during adolescence may be associated with an increased risk of relying on public assistance, dropping out of high school, and having a second teen birth. For children born to men younger than age 20, the implications for the child may include lower birth weight, lower cognitive and behavioral test scores, and overall poorer health outcomes[31]. Unintended teen pregnancies can perpetuate experiences with systemic inequities of social determinants of health, such as poverty, education and housing[32,33].

According to the CDC, children born to teenage mothers are more likely to have lower school achievement, drop out of high school, have more health problems, be incarcerated at some time during their adolescence, become a teen parent themselves, and face unemployment as a young adult. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, the average cost to taxpayers associated with a child born to a teen mother is $1,682 per year until the child reaches age 15. In Rhode Island, unintended pregnancy among teens costs taxpayers an estimated $41 million a year[34].

Teen pregnancy and birth rates have been decreasing among all populations; however, disparities persist. Importantly, rates of unintended teen pregnancy and births vary by race, ethnicity, and community settings. Young Black/African American and Hispanic/Latino women, especially those who live in urban settings, have significantly higher birth rates than the Rhode Island average[35].

FIGURE 1
Pregnancy and Birth Rates per 1,000 Females, Ages 15-19, Rhode Island, 2009-2013 [1]
Rates based on 2010 US Census Data

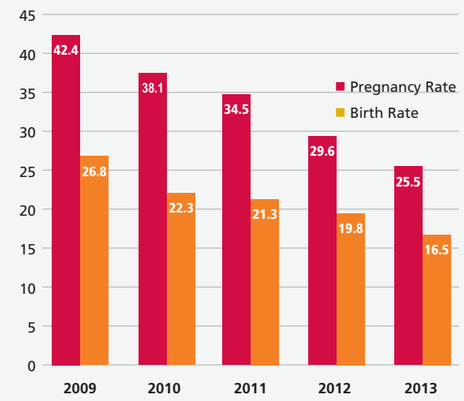


TABLE 1
Teen Birth Rate per 1,000 Females, Ages 15-19, Rhode Island, 2009-2011[1]
Rates based on 2010 US Census Data. The statewide teen birth rate in 2011 was 21.3.
Statewide data is not included with a racial/ethnic breakdown due to the majority of racial and ethnic minorities residing in the four core cities.

Core Community	Community Teen Birth Rate	White	Hispanic/ Latino	Black	Asian	Native American
Central Falls	73.4	48.5	84.2	109.5	*	*
Pawtucket	37.5	29.2	62.8	76.1	*	*
Providence	31.1	13.5	56.9	36.9	25.8	87.9
Woonsocket	63.8	49.7	78.2	178.8	*	*

*Rates for Asians and Native Americans are not shown due to the small numbers.

77%
of pregnancies for women younger than age 20 were unintended (mistimed or unwanted)[36]

25%
of all pregnancies in Rhode Island ended with an abortion in 2011[38]

35%
of high school students have not been taught, or were unsure of being taught, about birth control methods[3]

The Rhode Island teen pregnancy rate is **3x** higher for Hispanic/Latinos, and **2x** higher for Black/African Americans, when compared to Whites[1]

50%
Only of teen mothers have a high school diploma by age 22 versus **90%** of women who do not give birth as a teen[28]

Approximately **25%** of Non-Hispanic Black fathers and **10%** of White fathers in the United States had their first child before age 20 [41]

The pregnancy rate in the United States among youth ages 12-19 is one of the highest in the developed world [39,40]

HIV / AIDS AND SEXUALLY TRANSMITTED DISEASES (STDs)

Background

Sexually-active adolescents are at a higher risk of acquiring STDs due to a combination of behavioral, biological, and cultural influences. Almost half of the 20 million STDs reported in the United States are among young people ages 15-24 [42]. STDs commonly affect sexually-active people across all racial, ethnic, cultural, socioeconomic, and religious groups.

1 in 3 high school students report not using a condom during their last sexual encounter [3]

Although some STDs (chlamydia, gonorrhea, syphilis) can be cured, untreated infections can cause long-term health consequences, including infertility, ectopic pregnancy, pelvic inflammatory disease, cervical cancer, and an increased risk for HIV infection [43,44].

Adolescents often experience barriers when accessing STD prevention resources and services, such as an inability to pay for services, lack of transportation, discomfort toward services designed for adults, and confidentiality concerns with parents and peers. The United States Office of Adolescent Health estimates that 40% of female adolescents who report ever having sex have an STD at any given time [45].

In Rhode Island, 13% of all newly-diagnosed HIV cases from 2010 to 2014 were among adolescents ages 18-24. Nationally in 2014, 18% of newly-diagnosed HIV cases are among young adults ages 20-24. Although the Rhode Island data includes adolescents ages 18 and 19, it continues to be lower than the national average. The majority (75%) of new adolescent HIV diagnoses are among young gay, bisexual, and other men who have sex with men (GBMSM). Prevention measures such as increased testing are crucial to reducing new infections in this population, as the CDC estimates 44% of these youth are unaware of their HIV status [46,47].

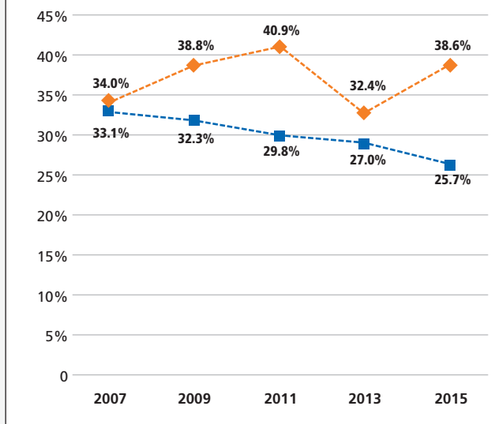
The Human Papillomavirus (HPV) is the most common STD in the United States, with varying levels of symptoms and consequences for both males and females. Since nearly all sexually active people will get HPV at some point in their life, the safe and effective vaccination against this virus is highly recommended, beginning at age 11 or 12, or before the onset of sexual activity [48].

Since 2007, sexual activity among high school students has fallen from 33% to 26%. However, those who are sexually active report more frequent unprotected sex with an increase from 34% to 39% in 2015 [49]. Despite the decrease in sexual activity among adolescents, the number of new chlamydia cases among adolescents (ages 15-19) has remained largely unchanged since 2006 [2,3], and the rates of chlamydia among young adults ages 20-24 has steadily increased during this time period.

Rhode Island had the highest rate in the United States for three doses of HPV vaccine for females and males in 2015 [52]

FIGURE 2

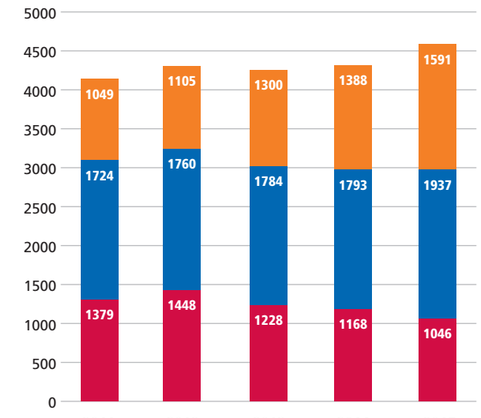
Sexual Activity Among High School Students, Rhode Island, 2007–2015 [3]



*Unprotected sex is among those who self-identify as currently sexually active.

FIGURE 3

Reported Cases of Chlamydia, by Age Group, Rhode Island, 2011–2015 [2]



3% of 6th graders **19%** of 9th graders **57%** of 12th graders have **ever** had sex [3]

About **6%** of sexually-active females ages 15-19 test positive for chlamydia [51]

84% of high school students remember being taught about HIV/AIDS [3]

70% of females infected with chlamydia do **not** have any symptoms [50]

Gonorrhea rates among adolescents age 19 and younger have remained the same, but the rates have increased among 20–29 year olds from 2010 to 2014 [46]

14% of high school students have ever been tested for HIV [3]

TEEN DATING VIOLENCE, ALCOHOL, AND SUBSTANCE USE

Background

Many adolescents experience sexual violence and/or non-consensual sex when they begin to engage in sexual relationships. Adolescents are also more likely to experience sexually-violent crimes than any other age group [53]. Acts of sexual violence can include harassment, assault, rape, unwanted contact, and exploitation. Another form of sexual violence, coercion to partake in unwanted sexual activity, is frequently associated with the use of drugs and alcohol among adolescents [54,55]. Additionally, teen dating violence and sexual violence may increase the risk for unintended pregnancies, as well as the risk of contracting HIV or other STDs [56]. Teen dating violence can be sexual, physical, psychological, verbal, or emotional, and can occur in-person or electronically on cell phones or the internet. Due to increasingly popular and widespread social media use by adolescents, sexual abuse and violence are occurring in new ways.

10% of dating high school students have experienced sexual dating violence [3]

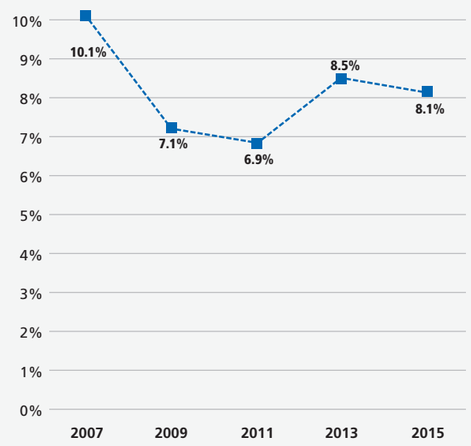
Adolescents may not report sexual assault or violence to their parents, healthcare providers, or law enforcement. Non-reporting could be due to a misinterpretation of the incident, feelings of guilt or denial, confidentiality concerns, fear of punishment, or lack of experience in advocating for their own health and safety [56,57]. These barriers in reporting violence and accessing sexual assault services may lead to under-representation of the true burden, which may exacerbate health complications for adolescents.

A formal definition of **consent** states: "…both people in a sexual encounter must agree to it, and either person may decide at any time that they no longer consent and want to stop the activity. Consenting to one behavior does not obligate you to consent to any other behaviors. Consenting on one occasion also does not obligate you to consent on any other occasion. Consenting means only that at this particular time, you would like to engage in this particular sexual behavior" [58].

6% of high school males and **10%** of females have been physically forced to have sex [3]

FIGURE 4

Forced Sexual Intercourse Among High School Students, Rhode Island, 2007–2015 [3]



It is essential that adolescents receive comprehensive education on what constitutes consent, how to make safe and appropriate choices regarding sexual behaviors, and where they can get age-appropriate victim services. Consent can be a confusing topic for adolescents as they start engaging in sexual relationships.

Because the Rhode Island rates of sexual dating violence are consistent with the national average of 10%, this topic remains a priority for Rhode Island due to the potential for mental and physical ramifications for immediate and long-term health [3].

Alcohol and substance use and their resulting intoxication are also significantly related to the perpetration and victimization of sexual violence among adolescents. The use and abuse of substances has the potential to lead to unhealthy decision-making and health-compromising behaviors. The nationwide epidemic of opioid dependence demonstrates the need for broad statewide drug prevention and recovery initiatives targeted toward adolescents within communities and schools. [59]

Nationally, one in five high school students reported that they used drugs or alcohol prior to having sex, which increases the likelihood of unprotected sex and violence. This indicates that substance use is a priority topic that should be integrated into sexual education and prevention initiatives [60,61,62]. Approximately one-half of sexual assault incidents against women in the United States involve alcohol consumption by either the victim or perpetrator [63]. It is clear that substance-related prevention education is important for adolescents to reduce teen dating violence and sexual assaults.

Rates of current marijuana use for adolescents in Rhode Island are almost 50% higher than the national average [65]

44% of rape victims are younger than age 18 [64]

1 in 20 high school students has ever used cocaine [3]

Approximately **60%** of all sexual assaults are **not** reported to police [64]

1 in 4 girls and **1 in 6** boys will be a victim of sexual abuse before age 18 [64]

12% of high school students ever took prescription drugs without a doctor's prescription [3]

A nationwide survey of public and private universities estimated that **23%** of undergraduate women and **5%** of undergraduate men experienced non-consensual sexual contact in college [66]

62% of undergraduate females reported a form of sexual harassment [66]

Although more than **50%** of undergraduates "witnessed a drunk person heading off for what looked like a sexual encounter," approximately **70%** of females and **80%** of males did not try to prevent it [66]

Among undergraduates, **9%** of males, **13%** of females, and **23%** of transgender women, transgender men, genderqueer, gender non-conforming, questioning, or gender-not-listed (TGQN) students reported intimate partner violence [66]

HEALTH EQUITY AND SEXUAL HEALTH

Background

According to the CDC, health equity is achieved when every person has the opportunity to attain full health potential and no one is disadvantaged from achieving this potential because of socially determined circumstances. Health disparities are closely linked with social, economic, and/or environmental disadvantages that adversely affect groups of people [67]. Significant sexual health disparities often persist among marginalized groups of adolescents. Social determinants of health, such as family income, race, ethnicity, sexual orientation, gender identity, and geography, can all affect sexual health outcomes [68].

For the purpose of this profile, four subpopulations that face sexual health-related disparities are highlighted. It is significant to recognize that adolescents may be a part of more than one of these populations, referred to as intersectionality, thereby increasing and complicating the disparities they experience.

TABLE 2

Sexual Risk Behavior by Sexual Orientation Among High School Students, Rhode Island, 2015 [3]

Question	Hetero-sexual	Gay, Lesbian, Bisexual
Ever had sex	37%	44%
Had sex before age 13	2%	7%
Had sex with > 4 partners	6%	15%
Had sex with at least 1 person in the last 3 months	26%	31%
Did not use a condom	37%	49%

These adolescent groups include:

- LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning) youth; and
- Youth with mental, developmental, or physical disabilities;
- Youth who live in foster care, detention centers, or are homeless;
- Youth who live in racial or ethnic communities of color in urban settings.

Issues of stigmatization, social isolation, and limited access to population-specific sexual health information are just some of the challenges faced by these groups as they strive to lead healthy lives during adolescence and transition into adulthood.

Lesbian, Gay, Bisexual, Transgender, and Queer / Quesitioning Youth

LGBTQ populations face an increased risk for negative health outcomes due to the impact of stigma and discrimination [69]. Among Rhode Island's high school students, 3% identify as gay or lesbian and 7% identify as bisexual. There are no data available for those who identify as transgender or queer/questioning. Therefore, it is estimated that the LGBTQ population comprises at least 10% of the high school population [3]. There are notable differences in behavior between individuals that identify as heterosexual compared to gay, lesbian, or bisexual individuals. For example, the number of sexual partners reported is much higher among the lesbian, gay, and bisexual population, and the age of first sexual encounter and condom use is lower in comparison to their heterosexual peers. Experiences of sexual violence, substance abuse, and STDs also disproportionately affect this population compared to heterosexuals. Working with these individuals requires targeted interventions, a safe and supportive environment, parental engagement, acceptance, and healthcare interventions to improve their sexual health outcomes [69].

Youth with Developmental, Physical, and Mental Challenges

Adolescents with developmental, physical, or mental issues face a range of challenges when it comes to their sexual health and relationships. These disabilities may include visual and hearing impairments, physical and orthopedic disabilities, intellectual and specific learning disabilities, emotional disturbances, speech or language impairments, and/or traumatic brain injuries. Having a disability can lead to challenges in practicing healthy sexual behaviors, an inability to interpret medical terminology or health information, and a vulnerability to abuse and mistreatment by others. This group may not receive the same benefits from education and resources pertaining to sexual health offered to other adolescents [68].

1 in 5 high school students self-identify as having a physical disability, long-term health problem, long-term emotional problems, or a learning disability [3]

14%
of adolescents with a disability have experienced dating violence [3]

17%
of sexually-active high school students with disabilities did not use any method to prevent pregnancy [3]

Students with a disability were
5X
more likely to seriously consider attempting suicide compared to students without a disability [3]

50%
of students with a disability reported feeling sad or hopeless every day for two weeks or more during the past year [3]

Youth Who Live in Foster Care, Detention Centers, or Are Homeless

50% of girls in foster care have been pregnant at least once by age 19 [72]

Many adolescents who are involved in corrections, live in foster care, or are homeless are exposed to or engage in situations that negatively impact their sexual health. National data trends show that these vulnerable populations report higher rates of pregnancy, sexual abuse, STD prevalence, substance use during sex, and survival sex (defined as the act of prostitution out of extreme need for shelter, food, or other necessities) [70]. These sexual health-related consequences may be due to a wide variety of risk factors including environmental stressors, psychological distress, and lack of support [68,70]. Other factors such as mental health issues, absence of stable family or social networks, previous exposure to sexual violence, and educational deficits are possible factors that negatively impact this population's ability to comprehend relevant prevention methods [71]. It has been further suggested that youth in foster care may not have the resources to access information about sex before these negative sexual health issues arise [71]. This population requires targeted interventions to provide them with the early sexual health information, support, and positive role-modeling necessary to achieve optimal health [71].

Young women living in foster care are:

- **More than twice as likely to become pregnant than those not in foster care** [72]
- **More likely to have experienced forced sex** [72]
- **Less likely to use contraception** [72]

Youth Who Live in Racial or Ethnic Communities of Color in Urban Settings

According to the CDC, acknowledging the inequities in STD, HIV, and unintended pregnancy rates by race and ethnicity is one of the first steps in empowering affected communities to organize and focus on each problem. The factors contributing to these health disparities are complex and can include poverty, income inequality, access to healthcare, and healthcare-seeking experiences. Economic and social instability in urban neighborhoods can further contribute to these situations. Another influencing factor is that in communities where STD and HIV prevalence is higher, individuals face a greater chance of encountering an infected partner than those in lower-prevalence communities. Adolescents in high-prevalence communities suffer from negative sexual health outcomes at disproportionate rates.

TABLE 3
Cities With The Highest Burden of Chlamydia, Rhode Island, 2014 [2] *

City	Number of Cases	Rate (Cases per 100,000)	Population Estimate (2010)
Providence	1,601	899	178,042
Pawtucket	514	722	71,148
Cranston	270	336	80.387
Woonsocket	246	597	41,186
Warwick	174	210	82,672
Rhode Island Overall	**4,349**	**413**	**1,052,567**

* This table includes all age groups; and 68% of chlamydia cases are found in people age 24 or younger in Rhode Island.

PROMISING PRACTICES

The field of sexual health includes research related to promising practices that can inform interventions to positively impact the sexual health of adolescents. This research falls broadly into the following areas: schools/education, medical/clinical, and community/family. The following is a brief description of promising practices associated with each of these research areas.

Schools/Education

Comprehensive Sexuality Education

Building a foundation for sexual health beginning at an early age with comprehensive, consistent, and developmentally appropriate education has proven to have widespread positive impacts on adolescents. Comprehensive sexuality education includes health-related topics as well as problem-solving skills, communication skills, and tools to help plan for the future. Benefits can include sexual abuse prevention, delayed sexual initiation, reduced unintended pregnancy, reduced HIV and STD transmission, and reduced health disparities among LGBTQ populations. Comprehensive sexuality education promotes social and emotional competencies that contribute to academic achievement, advance gender equity, promote healthy relationships, and is an evidence-based strategy encouraged by public health and education professionals [73,74].

Community Schools: Expanded Access to Healthcare Services

Certified school nurse teachers, guidance counselors, and social workers provide a minimum healthcare foundation in schools across the state. Schools can continue to build on this infrastructure by strengthening relationships with community providers who can offer sexual and reproductive health, physical, and behavioral healthcare. Further school-based referral programs can help school support professionals connect students to adolescent-friendly healthcare providers, preventive services, testing and treatment of STDs, and contraceptive services. Access to preventive health services can have a significant impact on reducing risk behaviors and is an essential complement to comprehensive sexual health education [73].

Safe and Supportive Environments

Positive, safe school climates are associated with improved health and education outcomes. Prevention of bullying and sexual harassment, including electronic aggression, school connectedness, and parent engagement are the three research domains associated with building safe and supportive environment for all youth, including youth who identify as LGBTQ and others who experience a disproportionate risk [73].

Medical/Clinical

Youth-friendly Reproductive Healthcare Services

Services that provide confidential, respectful, non-judgmental, and sensitive sexual healthcare to adolescents can lead to positive sexual outcomes. Confidentiality is a key component of youth-friendly services, especially for populations that face discrimination, stigma, and other disparities. Allowing for open dialogue between professionals and adolescents can help develop rapport and trust, and maximize information sharing. Youth-friendly health services are inclusive of all adolescents and truly meet the wide range of needs of this population [75].

Free or Low-cost Services

Healthcare services that address unintended pregnancy, HIV/STDs, and teen dating violence are more available to adolescents if they are free or low-cost. Reducing the barriers of cost to receive prevention, education, or treatment services can increase the likelihood of adolescents visiting healthcare services when needed and receiving medical help without parental consent and insurance coverage [76].

Geographically Accessible Health Services and School-Based Health Centers

Promoting healthcare services that are accessible to adolescents in their communities can increase the likelihood of utilizing those healthcare services. An increased number of school-based health centers that provide preventive care, reproductive healthcare, and family planning services can help reduce unintended pregnancies. School-based health center HIV/STD testing and screening can increase the likelihood of testing and treating of STDs among adolescents whose needs would otherwise be unmet due to accessibility barriers [77].

Community/Family

Parental Engagement

Supportive and open family communication about sexuality and healthy behaviors can delay sexual initiation, reduce the number of partners, and increase the use of contraception. Honest and informative conversations as adolescents develop and grow can inform positive decisions regarding sexual health. Parents who are approachable positive role models and are open to questions can improve the sexual health of their children [75]. Parents can play an important role in youth's decisions about sex and involving parents can positively affect attitudes about sexual behaviors and risks [71].

Safe/ Supportive Communities

Supportive and healthy environments free of discrimination and stigma can benefit adolescents in their sexual health practices and relationships, as well as improve their academic and economic opportunities. Positive and protective factors in communities can increase an individual's ability to avoid risks or hazards and promote social and emotional competence.

Cultural Competence

Prevention education and sexual health initiatives must be culturally appropriate and relevant to the diversity of the adolescent population. Impacts of prejudice and discrimination must be taken into account when planning and presenting sexual health information to adolescents. Attitudes, beliefs, knowledge, and communication about health, sexuality, relationships, contraception, and childbearing vary significantly across cultural and ethnic groups. Many youth face additional barriers in accessing healthcare and achieving positive sexual-health outcomes due to different forms of oppression and discrimination. Providing culturally-competent information can reduce these barriers [78].

Condom Accessibility

Implementing condom distribution programs in communities can be an effective approach to increase condom use, increase condom acquisition and carrying, promote delayed sexual initiation, and reduce STD transmission among adolescents [79]. Condom distribution programs can be cost-effective and successful in reaching diverse populations of adolescents [79]. Accessibility to condoms in a variety of community environments, including high school settings, can help mitigate the spread of STDs and reduce unintended teen pregnancies [80].

RECOMMENDATIONS

Advancing the goals of this profile will require involvement of multiple partners from across Rhode Island who are committed to making our communities healthier for our adolescents. The challenges related to addressing the underlying causes related to STD/HIV transmission and unintended pregnancy among adolescents necessitates a comprehensive approach that broadly focuses on four settings: schools, healthcare, communities/families, and government.

These recommendations represent an initial set of priorities that will serve as a catalyst for the development and implementation of policies and programs that will help all Rhode Island adolescents lead healthy lives and be prepared for adulthood.

Government

- Establish an Adolescent Sexual Health Policy Group comprised of state and local public officials to assess, implement, monitor, evaluate, recommend, and disseminate policies consistent with evidence-based strategies to reduce STDs, HIV, and unintended pregnancy.
- Review the *Rhode Island State Integrated Population Health Priorities, Goals and Strategies* (within the Rhode Island Statewide Innovation Model) to identify areas of alignment with this report and propose opportunities for collaboration and partnership with other government agencies and working groups.
- Conduct routine risk behavior, disease, and pregnancy monitoring and surveillance, and publish an annual data report on the Sexual Health of Rhode Island Adolescents. This report should contain a variety of information collected from the Healthcare Effectiveness Data and Information Set (HEDIS) measures, Rhode Island KIDSCount, and other data sources.
- Support policies and regulations that improve vaccination rates among adolescents and protect against STDs.
- Review and recommend changes to state statutes and regulations that address barriers for access to STD, HIV, and pregnancy prevention services and materials.
- Promote widespread dissemination of services that provide sexual and reproductive health services for adolescents.
- Ensure comprehensive confidentiality laws to support access to care for adolescents.

Schools

- Provide access to evidence-based/informed curricula aligned with the *Rhode Island Health Education Framework, Rhode Island Comprehensive Health Instructional Outcomes, and the National Sexuality Education Standards.*
- Develop a system of professional development to support successful implementation of school-based efforts to support youth sexual health.
- Disseminate tools to help schools implement national, evidence-based guidelines such as the *Health Education Curriculum Analysis Tool*, which integrates research findings and national health education standards, to help school districts select or develop health education curricula to reduce sexual risk behaviors among youth.
- Promote youth asset development programs within school settings that teach adolescents social and emotional learning skills, including problem solving, effective communication, and long-term planning.
- Share and promote promising school-based/school-linked practices and structural interventions that increase access to services and materials that support the prevention of STDs, HIV, and unintended pregnancy.
- Support and promote policies that create a safe and supportive environment and school connectedness for all students regardless of sexual orientation, disability, race, or ethnicity.

Healthcare

- Promote routine low or no-cost confidential, comprehensive HIV/STD screening and reproductive health services in medical settings that are age-appropriate.
- Encourage routine screening and treatment of drug and alcohol use among adolescents in medical settings and provide prevention education.
- Support trainings that improve provider/patient communication for adolescents, especially among adolescents who identify as LGBTQ.
- Train and encourage physicians and other healthcare providers to engage with adolescents and families/caregivers using education and information about their role in the HCT process and aid with the development of an HCT plan for all adolescents[81].
- Strengthen relationships between schools and community providers related to physical and behavioral health services.
- Empower youth to advocate in their own HCT and encourage adolescents to assume increasing responsibility for their own healthcare to the fullest extent possible.

Communities/Families

- Support programs that educate and empower young people as peer educators and advocates.
- Provide technical assistance and support to community agencies that integrate STD, HIV, and unintended pregnancy prevention into their programming and services.
- Integrate sexual and reproductive health information and education into youth development programs.
- Publicize and promote local services that provide sexual and reproductive health prevention and care services.
- Promote parent/adolescent communication on sexual and reproductive health topics through the adoption of evidence-based programs in community and faith-based settings.

APPENDIX A:
ADDITIONAL SUPPORTING DATA AND FIGURES

FIGURE A1

Percentage of Students Who Have Ever Had Sex, By Grade, Rhode Island, 2015 [3]

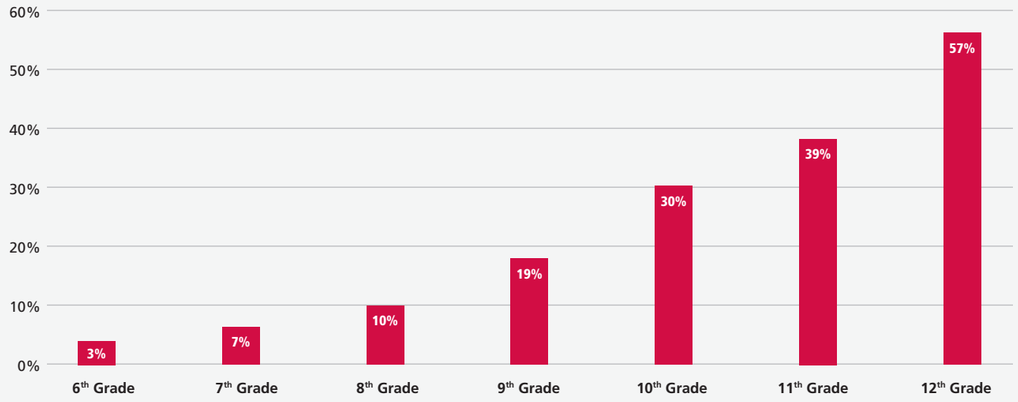


FIGURE A2

Sexual Behaviors Among High School Students, Rhode Island and the United States, 2015 [3]

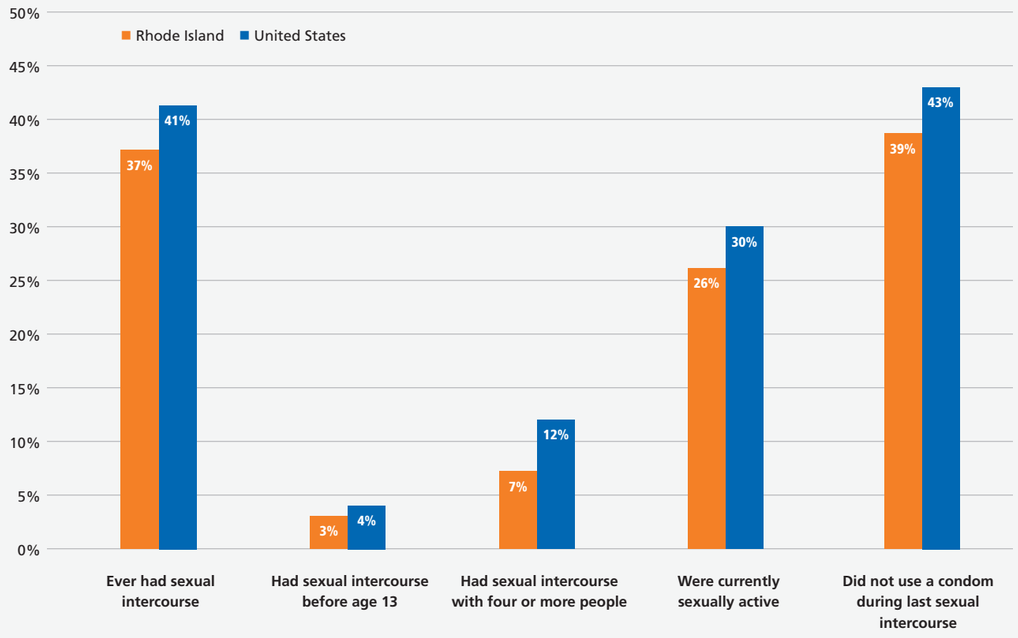


FIGURE A3

Gonorrhea Rates, Rhode Island, 2011-2015 [82]

Rates are expressed as cases per 100,000 population.

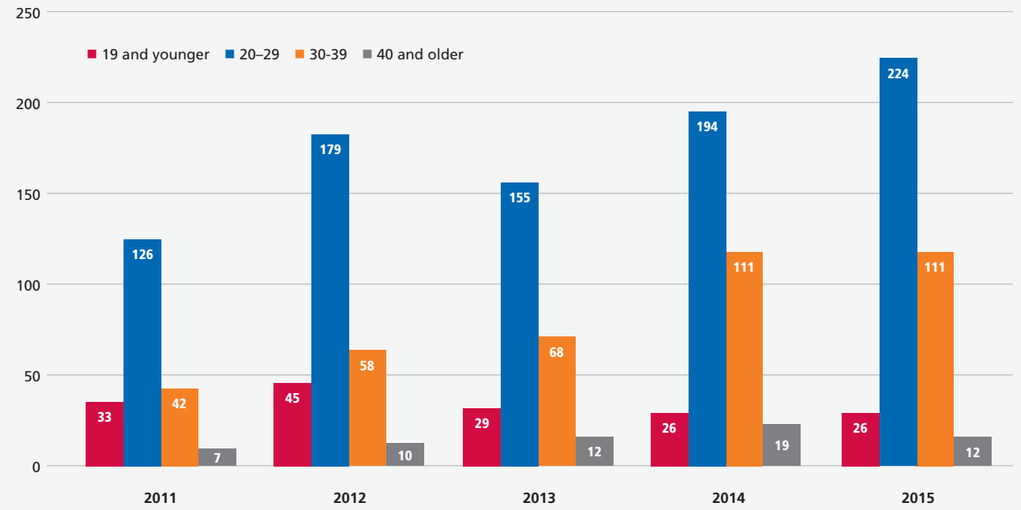


FIGURE A4

Gonorrhea Rates, By Race and Ethnicity, Rhode Island, 2011-2015 [82]

Rates are expressed as cases per 100,000 population. The rates for 2011-2015 are based on the 2010 US Census.

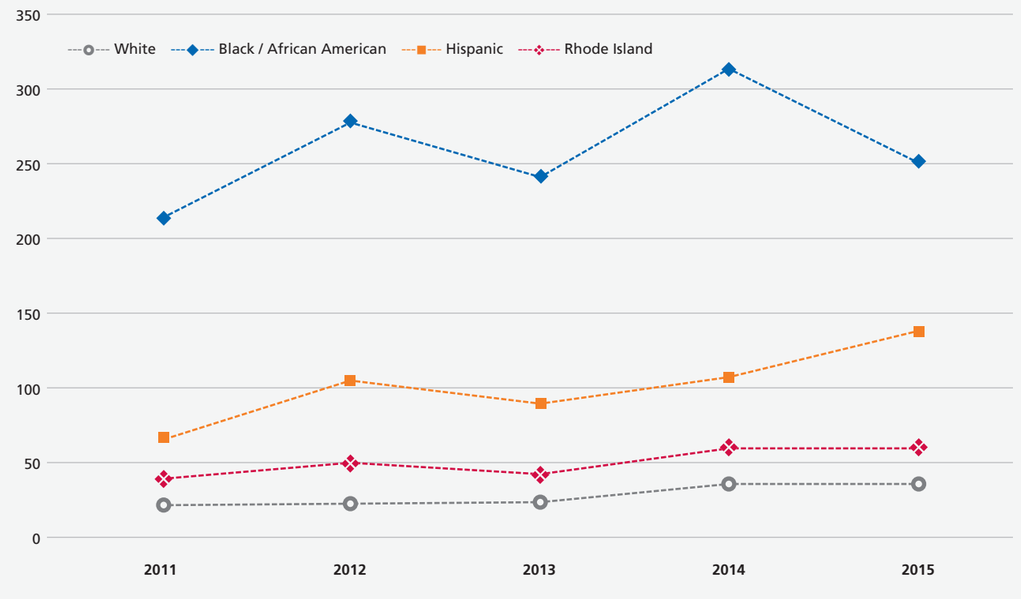


FIGURE A5

Chlamydia Rates, By Race and Ethnicity, Rhode Island, 2011-2015 [2]

Rates are expressed as cases per 100,000 population. The rates for 2011-2015 are based on the 2010 US Census.

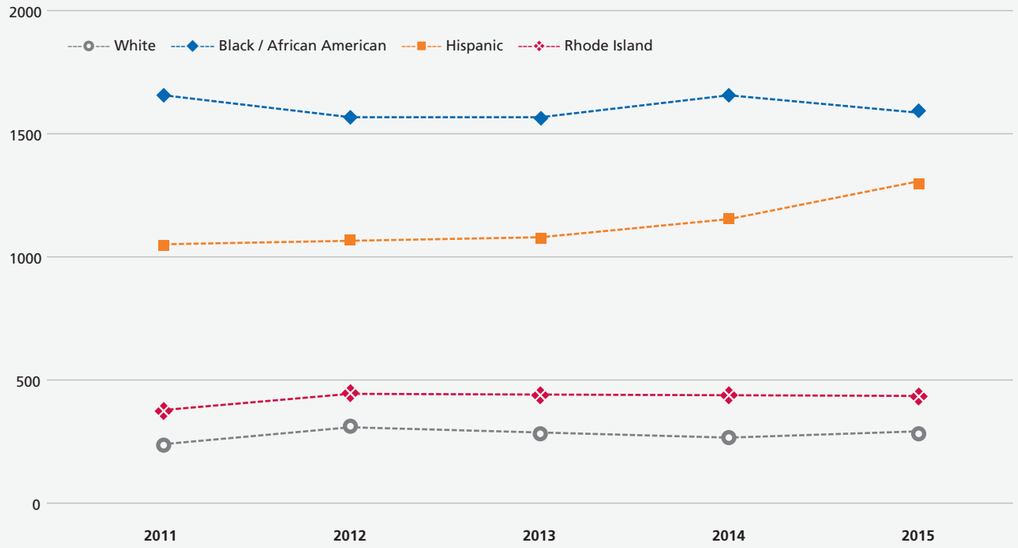


FIGURE A6

Number of Newly-identified HIV Cases, Among Youth (18-24 years), Rhode Island, 2010-2014 [83]

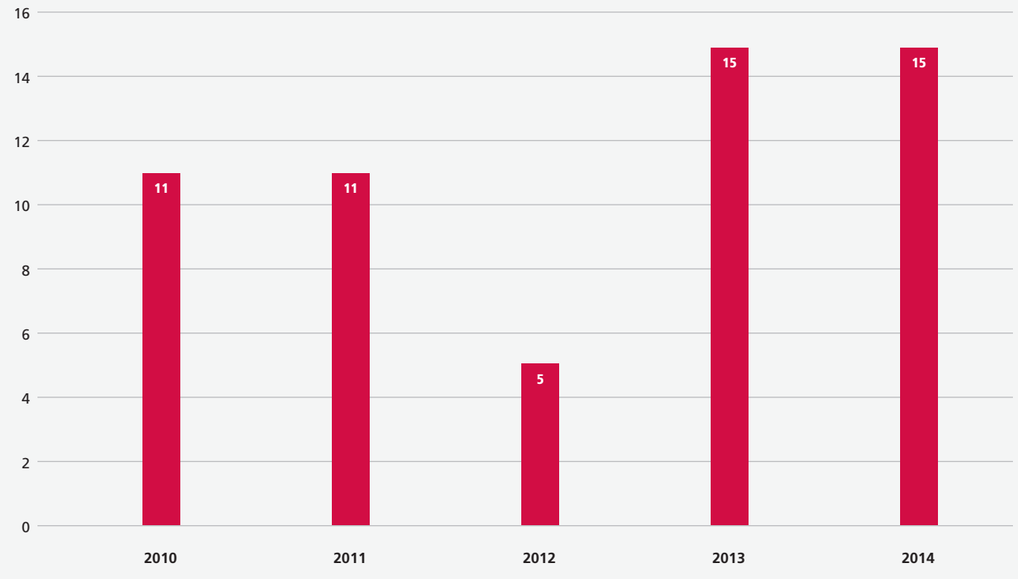


FIGURE A7

Percentage of Adolescents Using Marijuana in the Past Month, 2013-2014 [65]

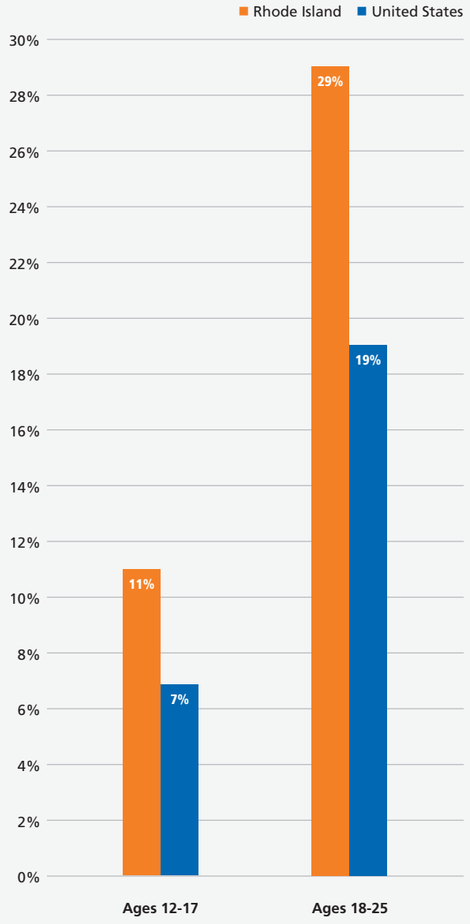


FIGURE A8

Percentage of Adolescents Using Illicit Drugs Other Than Marijuana in the Past Month, 2013-2014 [65]

TABLE A1

Have you ever been taught in school about birth control methods? [3]

	Total	9th Grade	10th Grade	11th Grade	12th Grade
Yes	64.6%	49.3%	60.7%	72.0%	75.9%
No	27.6%	39.5%	29.7%	22.1%	19.3%
Not sure	7.8%	11.2%	9.6%	5.9%	4.7%

APPENDIX B

Statewide Integrated Population Health Goals To Improve the Health of Rhode Islanders

Rhode Island's Statewide Integrated Population Health Goals

Taking into account input from community stakeholders and data assessments, the Rhode Island Department of Health (RIDOH) sought to inform the State's approach to improving the population's health by developing a roadmap of population health goals to which state agency partners can contribute. Anchored by three leading priorities to guide our work, RIDOH outlined five broad strategies to move the work forward within 23 population health goals. A focus on integration reflects the intent of addressing behavioral and physical health system needs together with our partners.

RHODE ISLAND STATEWIDE INTEGRATED POPULATION HEALTH LEADING PRIORITIES, STRATEGIES, AND GOALS

Three Leading Priorities Guide Our Work

- Address the Social and Environmental Determinants of Health in Rhode Island
- Eliminate the Disparities of Health in Rhode Island and Promote Health Equity
- Ensure Access to Quality Health Services for Rhode Islanders, Including Our Vulnerable Populations

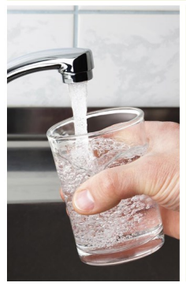
Five Strategies Will Move Us Forward

23 Integrated Population Health Goals and Metrics Align with Statewide Healthcare Planning

Strategy 1:
Promote healthy living for all through all stages of life

- Reduce obesity in children, teens, and adults
- Reduce chronic illnesses, such as diabetes, heart disease, asthma, and cancer
- Promote the health of mothers and their children
- Promote senior health to support independent living
- Promote behavioral health and wellness among all Rhode Islanders
- Support Rhode Islanders in ongoing recovery and rehabilitation for all aspects of health

Strategy 2:
Ensure access to safe food, water, and healthy environments in all communities

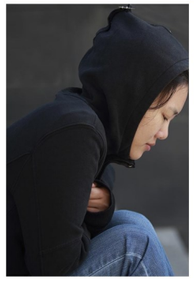


- Increase access to safe, affordable, healthy food
- Increase compliance with health standards in recreational and drinking water supplies
- Reduce environmental toxic substances, such as tobacco and lead
- Improve the availability of affordable, healthy housing and safe living conditions

Strategy 3:
Promote a comprehensive health system that a person can navigate, access, and afford

- Improve access to care including physical health, oral health, and behavioral health systems
- Improve healthcare licensing and complaints investigations
- Expand models of care delivery and healthcare payment focused on improved outcomes
- Build a well-trained, culturally-competent, and diverse health system workforce to meet Rhode Island's needs
- Increase patients' and caregivers' engagement within care systems

Strategy 4:
Prevent, investigate, control, and eliminate health hazards and emergent threats



- Reduce communicable diseases, such as HIV and Hepatitis C
- Reduce substance use disorders
- Improve emergency response and prevention in communities
- Minimize exposure to traumatic experiences, such as bullying, violence, and neglect

Strategy 5:
Analyze and communicate data to improve the public's health

- Encourage Health Information Technology adoption among RI healthcare providers as a means for data collection and quality improvement
- Enhance and develop public health data systems to support public health surveillance and action
- Develop and implement standards for data collection to improve data reliability and usability
- Improve health literacy among Rhode Island residents

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