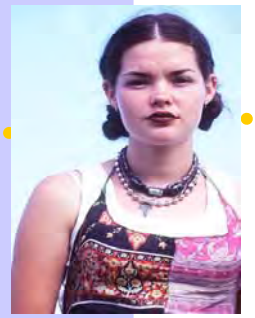
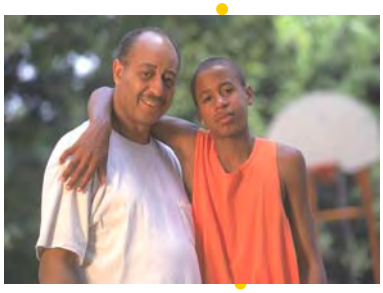
Connecting the Dots: How Practitioners Engage Parents, Families, and Youth Around Reproductive and Sexual Health





A Report of Focus Group Discussions with Reproductive Health Providers

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CARTA

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We would also like to recognize the support of Planned Parenthood Federation of America, Inc. for connecting us with Planned Parenthood clinics and the Office of Population Affairs (OPA), US Department of Health and Human Services for sharing contact information for Title X grantees. Planned Parenthood and Title X clinics were used as a master list from which our sample was recruited. Thanks also to Rachel Jones and the Alan Guttmacher Institute for supporting our efforts and agreeing to collaborate with us around the development of a sampling frame.

All of CARTA's staff worked as a team to realize the completion of this effort. Barbara Sugland provided direction and guidance in all phases of the project and encouraged the development of a report that was accurate in its description and useful to providers and other audiences. Marjorie Innocent served as overall manager to the project, made initial and follow-up calls to participants and hosts, served as moderator and note-taker for several groups, and developed initial and final drafts of this report. Kimberly Ross developed our final sample and moderator's guide, supported recruitment efforts and served as moderator and note-taker. Marcus Artis secured the host sites, worked on participant recruitment, and served as note-taker for group discussions. Sandra Fishman supported logistical arrangements and, with Vanessa Harris and Chandra Gavin, provided invaluable assistance, following up calls to participants.

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We thank all of these individuals for their dedication, support and commitment to CARTA and to the goal of engaging parents and families as partners in adolescent reproductive and sexual health. The authors take full responsibility and apologize for any errors or omissions in this report.

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Connecting the Dots: How Practitioners Engage Parents, Families, and Youth Around Reproductive and Sexual Health

Introduction

As part of its work on Parent and Family Engagement (PFE) in Adolescent Reproductive Health, CARTA continued to document existing PFE program efforts through a series of focus groups. Nine focus groups in four regions of the country were conducted with adolescent reproductive health practitioners. Practitioners were recruited from urban-based clinic settings where some form of PFE was being implemented. Focus groups were designed to provide a forum to share program experiences and to network. Group discussions also provided CARTA with concrete and practical examples of PFE activities that are respectful and responsive to teens and with insights on how to describe this work clearly and succinctly to the provider community.

In order to ensure discussions reflected a diverse group of practitioners from across different areas of the U.S., a sample of clinic providers from different geographic regions serving diverse populations was selected. A master list of clinics was obtained from Planned Parenthood Federation of America and from the Office of Population Affairs, Department of Health and Human Services (HHS). These lists were combined and organized by state and grouped according to the ten regions of the U.S. established by HHS. CARTA secured feedback and collaborated with the Alan Guttmacher Institute (AGI), who was also conducting a large-scale clinic survey on parent-child communication activities at the time these focus groups were being developed. Our main goal in collaborating with AGI was to eliminate the chances of recruiting the same clinics and to ensure clinics were not overburdened or confused by the two projects taking place at the same time. CARTA shared its list with AGI, who then indicated cities from which their clinics would be randomly sampled.[1] CARTA agreed not to contact those clinics directly. In turn, AGI agreed to add a few questions to its screening survey to assess among selected clinics their interest in participating in a focus group on PFE. Interested clinics located in the areas where focus groups were being conducted were contacted by CARTA and invited to participate.

Clinics grouped by region were examined to identify areas with a concentration of clinics that could provide a sufficient number of participants – between eight to ten per group – in a given area. Because of the need to identify clusters of clinics and to minimize travel time by focus group participants, our sample consists primarily of practitioners delivering care in urban settings. Nine cities were selected: Philadelphia and New York City (Mid-Atlantic – Regions II and III); Chicago and Cleveland (Midwest – Region V); Knoxville and Atlanta (South – Region IV); and San Francisco, Los Angeles, and Albuquerque (West – Region IX).

Clinics in each of these cities were contacted and an appropriate person knowledgeable of the clinic's education, clinical and/or community outreach activities was identified. CARTA offered a brief description of the project and the purpose of the focus group discussion. A short screening survey was used to determine whether PFE activities were being implemented and to gauge interest in participating in a focus group. A total of 54 providers took part in focus group discussions.

This report is designed to outline what clinic-based practitioners are doing to connect with parents and families around adolescent reproductive and sexual health, to document training and technical assistance needs, and to outline suggestions by practitioners for how to describe PFE in order to engage more practitioners in this work.

We learned a range of activities is being implemented to connect with parents and adult caregivers. Most PFE efforts are being developed and implemented in response to limited parent knowledge and comfort and to respond to teens' requests to be able to talk more openly with an adult about issues of sexuality. Practitioners lack human and fiscal resources to develop and implement PFE projects thoughtfully and intentionally. In addition, they could benefit from

[1] In order to protect the confidentiality of clinics participating in the AGI study, the specific names of clinics were not shared with CARTA, only the cities from which clinics would be randomly sampled.

a systematic set of materials and supports to guide their program efforts. Finally, we note that along with a clear interest in building parent and family capacity around reproductive and sexual matters, practitioners continue to maintain a profound commitment to youth, working tirelessly to ensure and protect confidentiality of care to teens. In the end, we are encouraged to find practitioners are reaching out to parents while maintaining confidential access to reproductive health services for young people. We believe this work will help guide other providers who are looking to connect with parents/families, especially those who may be concerned about how to do so without jeopardizing their commitment to young people.

This report follows several other documents completed as part of CARTA's PFE project.[2] These reports and materials provide an overview of the project, a definition of PFE, and offer guidance on planning and implementing a PFE effort. Those new to this work are encouraged to review these earlier materials to gain a general and more practical understanding of PFE in action.

[2] A list of documents and materials generated from this project can be found on the last page of this report.

Description of Focus Group Participants

DEMOGRAPHIC CHARACTERISTICS

Table 1 shows selected demographic characteristics of focus group participants (N=54). Practitioners in our focus groups are overwhelmingly female (91 percent) and primarily older in age (59 percent are 40 and older). Roughly half of focus group participants are Caucasian and about one-third is African-American. A significantly smaller percent represent other racial/ethnic subgroups. Participants in these groups are well educated; some 70 percent indicate they have completed college; over 40 percent have graduate degrees.

Table 1: Demographic Characteristics of Focus Group Participants

Gender		Age		Race/Ethnicity		Education	
Male:	9%	<25:	11.3%	Caucasian:	52%	High school:	2%
Female:	91%	25-29:	15.1%	African-American:	30%	Some college:	13%
		29-34:	15.1%	Hispanic/Latino:	7%	Finished college:	30%
		35-39:	0%	Asian/Pacific Islander:	7%	Some graduate school:	13%
		40+:	58.5%	Other:	4%	Finished grad school:	42%

PROFESSIONAL BACKGROUND & POSITIONS

Participants' professional background is summarized in Table 2. While participants' professional background varies quite a bit, a sizeable proportion report having experience in health education (roughly 34 percent), followed by nursing (27 percent). A smaller proportion is in the field of social work (17 percent). The remaining are counselors or case managers, in administrative positions, or other professional areas. A few participants (n=8) listed more than one profession.

Length of time in the reproductive health field also varies across participants. Roughly 25 percent bring less than five years experience in the field; 22 percent have between five and nine years experience; 27 percent have extensive experience of 20 years or more.

The majority of participants have been affiliated with their current provider agency somewhere between one and four years; another 20 percent have been at their current location for as many as nine years. Slightly less than 10 percent have been affiliated with their current clinic less than a year, and 10 percent have extensive experience with their current provider agency (20+ years).

Table 2: Professional Background of Focus Group Participants

Professional Background		Length of Time in RH Field		Length of Time in Current Agency/Clinic	
Health Educator	34%	<1 year:	6%	<1 year:	9%
Nurse/Nurse Practitioner/		1-4 years:	19%	1-4 years:	43%
Nurse Midwife	27%	5-9 years:	22%	5-9 years:	20%
Social Worker	17%	10-14 years:	15%	10-14 years:	9%
Counselor/Case Manager	9%	15-19 years:	9%	15-19 years:	7%
Manager/Administrator	9%	20+ years:	27%	20+ years:	10%
Physician/Physician Assistant	6%				
Community Health/Outreach Worker	6%				
Other[a]	6%				

[a] Responses include child development, lawyer, trainer/consultant

ROLE IN CLINIC AND IN PFE ACTIVITIES

To help CARTA gauge the breadth of PFE activities focus group participants helped to design and implement, participants were asked to describe their role in the clinic or agency where they work and their role in their agency's PFE activities. Participants reported holding a variety of positions, from program coordinator or director of education or of other programs, to director of medical services and program managers to outreach coordinator.

The majority of participants appear to be directly involved in PFE efforts, working in ways that are generally related to education, direct health care services, counseling, facilitation of group and/or individual activities, or social work/services. A small number is responsible exclusively for the oversight or management of activities. A detailed list of provider roles in PFE activities can be found in Appendix A.

Focus Group Discussion Topics

The moderator's guide used to facilitate the focus group discussions focused on six topics:

- *Description of PFE Activities* – Type of activities used as part of the PFE effort; description of the PFE program target audience (teens, parents and adult family members, or both); diversity of the target audience(s) in terms of race/ethnicity, gender and class; primary goal(s) and objective(s) of the programs or activities; and the names and descriptions of any specific models or curricula used in the PFE effort.

- *Program Initiation & Evaluation* – Strategies used to start PFE by clinic staff, including whether the effort got underway as a result of a formal process, such as a needs assessment, or out of more informal mechanisms, like providers' insight or clients' suggestions or preferences.

- *Confidentiality* – Agency challenges to confidentiality and minors' access to reproductive health care in general, and about problems encountered, if any, related to confidentiality within their PFE work.

- *Program Successes & Challenges* – Perceptions of participants about the biggest accomplishments in their PFE work, including recruitment, program impact, serving parents and teens from diverse communities, and getting community input and buy-in. Information on the most salient challenges was also documented, including ways staffs have sought to address these challenges and barriers to addressing challenges.

- *Technical Support Needs to Start & Sustain PFE Efforts* – Based on their own experience with and knowledge of PFE, participants were asked to identify and rank the most important supports providers need to build and to sustain a PFE effort.

- *Feedback on CARTA's Working Definition of PFE & Suggested Language to Encourage Providers to Conduct PFE* – Participants were asked to review and respond to CARTA's working definition of PFE, noting any changes that should be made to the definition, as well as key words and phrases that would be useful for succinctly defining PFE to providers and illustrating its value to the provider community.

In the following pages, we provide highlights of the key themes that emerged across groups for these topic areas.

Key Findings

Description of Parent & Family Engagement Activities

Table 3 provides highlights of various PFE efforts being conducted by focus group participants. Activities are organized according to three types of PFE efforts: youth-centered, joint youth and parent/family centered, or parent/family centered activities (defined in the box to the right). As shown by these examples, PFE activities conducted by focus group participants are mostly youth- or parent and family-centered, with relatively fewer projects taking a joint youth/parent/family-centered approach. Most youth-centered activities seem to take place in the health care agency or clinic and are focused around the delivery of education and/or clinical care to young people, and around attempting to learn from and support youth around two primary issues: 1) identifying the young person's primary source(s) of support, whether parent, family member or another source; and 2) where feasible and with permission from the teen, encouraging and helping young people to connect with this primary source of support about sexuality related matters. Providers implementing youth-centered efforts use their time with youth to provide a safe place to ask questions about how to talk with parents, caregivers, and key adults about issues of sexuality.

Types of Parent/Family Engagement Programs

Youth-Centered. Recognizes the importance of parents, but maintains focus and emphasis on the specific needs of teens. Staffs encourage teens to inform parents in their sexual and reproductive health decisions, and to invite parents to special programs, sponsored by the clinic. Programs tend to be implemented within the clinic setting.

Joint Youth & Parent Centered. Connects parents with specific youth-centered activities, or offers a separate, short-term activity to augment the broader youth-centered effort, such as a health fair specifically for parents to raise awareness about sexual and reproductive health issues.

Parent (Family)-Centered. Offers explicit outreach to and activities for parents/families and only parents/families. Activities are usually community and/or school-based and include adult training communication workshops and multi-media efforts.

In contrast, parent/family-centered efforts appear to occur in non-clinical settings, such as schools and community centers or other neighborhood settings. In fact, more than one provider in our groups noted there is a clear separation in the location of PFE related activities for youth-centered versus parent and family centered programs sponsored by participating clinics. Parent/family-centered efforts include a mix of education and training activities for adults, such as workshops on communication and becoming an "askable" parent; publications for parents and other adults; and wrap-around services that address issues like substance abuse and employment, often primary issues for adult family members.

Although relatively fewer, joint parent/family and youth centered efforts encompass health fairs, theatre group presentations, school presentations, and conferences for pre-adolescents and their parents.

In addition, the majority of PFE efforts (whether youth or parent/family centered) focus on increasing or improving parent-child communication as the primary goal of PFE activities. For example, we did not identify any PFE efforts that focus explicitly on training adults as advocates for PFE or as advocates for reproductive health programs and services.

Providers discussed a number of important factors that helped to shape the kind of PFE activities they offer or the type of strategies used. Some of these factors varied slightly by location. For instance, in Philadelphia, participants mentioned the importance of identifying a responsible adult, not just a parent, such as an older sibling, grandparent, or other family member who can mentor the teen and be a consistent source of support as a prime reason for the type of PFE strategies they developed. In New York City, providers noted their PFE programs focus on teaching parents to initiate and promote communication with teens about all aspects of their lives, not just reproductive health and sexuality, as this seemed to be a critical factor observed among youth and adults in the communities they serve.

Providers in Chicago discussed parents' uncertainty about when to initiate conversations about sex with teens and their frequent denial about their own teens' sexual activity. Providers in Chicago also discussed teens' lack of awareness about their right to confidentiality and access to reproductive health care, and teens' acknowledgement of the value they place on information about sex received from parents.

Providers in Knoxville and Chicago underscored parents' lack of accurate information about sexuality and pregnancy prevention and the importance of PFE program efforts to educate parents while strengthening their communication skills.

In Cleveland and Knoxville, participants talked about extensive collaboration efforts among local providers to serve teens, to educate families about healthy adolescent sexuality and to build parent and community support for services to teens.

Table 3: Selected PFE Activities Described by Focus Group Participants

Youth-Centered	Parent/Family-Centered	Joint-Centered
Teen clinic hours or days: provision of RH services specifically for teens & opportunity for youth to ask questions	Multi-level workshops on communicating & communication skills around sexuality – beginning with "How to Talk about Sex 101" & followed by skills-building in subsequent sessions	School-based group discussions & communication workshops, including some designed for specific cultural groups (Chicago)
Drop-in centers where youth can ask questions about reproductive health & get referrals	*SAFE* – parent peer-educator program (NY)	Teen conference for adolescent girls 10-11 years old & their parents; focus is on parent-child communication
Community-based Adolescent Pregnancy Prevention (CBAPP): effort by local clinics to serve teens daily during designated hours (NY)	In-school presentations to parents at the start of the school year, with support from school administration & PTAs	Teen Theater Group that deals with issue of sexual coercion; parents involved in bringing teens to presentations & generating new ideas for presentations (Cleve)
Engagement activities connected with *Harlem Adolescent Pregnancy Prevention Initiative (HAPPI)*, a comprehensive sexuality education & contraceptive health program; and *Harlem Teen Abstinence Program (Harlem TAP)*, an abstinence education & promotion initiative (NY)	Parent-child communication workshops using Advocates for Youth's *Communication with my Children* curriculum. Focus is on improving parents' communication skills around different topics with teens of different ages; educating parents about "teachable moments"; and showing parents how to stay connected with teens (NY)	Health department health fairs, with family engagement specialist in attendance
Informing parenting teen girls who come to clinic for services about *Single Parents Reaching Out for Unassisted Tomorrows* (*SPROUTS*), a college assistance program (Cleveland)	Providing wrap-around support services on salient issues facing families, such as substance abuse & employment – using a continuum of care approach (Chicago, NY)	
Baby Think it Over: program in which teen participants are responsible for full range of care of a simulated infant, while parents are encouraged to talk to teens about their own birthing & child-raising experiences (ATL)	*How to Talk to Your Kids about Sexuality:* community-based workshop developed by a local teen pregnancy prevention coalition	
TEENS PACT: multifaceted teen pregnancy prevention program that includes clinical services & health education with teen peer educators (NY)	*Askable Adult* Workshops: 8-week program focused on parent-child communication & teaching parents about the reproductive system (ATL)	
Teen Action Group: peer education program in public schools for 6th-8th graders (ATL)	*Sexuality Education Counseling Trainers' Program (SECTS)*: parent-child communication training (KNOX)	
	Communication workshops & seminars during "Let's Talk Month" in October; topics include sexual health and others	
	Publications for parents – newsletters, brochures	

STRATEGIES FOR GETTING PFE ACTIVITIES STARTED

In all groups, participants noted that Title X requires providers to encourage teens to engage their parents and/or family members in discussions about their visit to the clinic and the fact they may be sexually active. Participants also noted that beyond encouraging youth to engage their parents, there are no specific guidelines through Title X for how this parent engagement should be done. In many respects this affords providers flexibility in connecting with parents in ways that are most conducive and comfortable for the teen. It also means, however, that providers tend to develop PFE activities through more informal means. For the most part, PFE efforts were developed after parents and families expressed the desire to learn more about and become engaged in the reproductive and sexual health needs of their teens, or as clinicians and other providers observed the need for greater parental engagement in adolescents' sexual and reproductive health, or when teens specifically indicated they wanted their parents/family members or adult supporters to have more knowledge and comfort around issues of sexuality and reproductive health. In a few instances, PFE activities resulted from a formal needs assessment, as indicated by providers in Philadelphia, New York City, Knoxville and Albuquerque. In these cities, generally youth were surveyed to learn about their support needs and challenges, and parents/adults were surveyed to learn more about their knowledge and comfort with sexuality issues and the supports they needed to address these issues with their children. Results from these assessments indicated numerous requests by teens for help in talking with parents, and parents' expressing a strong desire to be more knowledge and better equipped to discuss sexuality related issues.

In addition, most PFE activities are not organized within a specific program, but are organized and delivered more informally. That is, PFE activities take the form of a series of activities and workshops that are provided as additional services to youth and their adult supporters. While the activities themselves are structured and designed with the hope of eliciting improvements in knowledge and communication, most programs do not generally represent a larger initiative around PFE being conducted by the provider agency. In addition, most do not use specific curricula that have been previously tested by others in different settings.

Nearly all of the groups highlighted the need for culturally appropriate PFE activities for ethnic and racial minorities, such as Latinos/Hispanics, African Americans, Asians and Native Americans. A more detailed discussion of the need for culturally-based PFE activities is described in a separate section of this report.

Finally, most PFE activities have not been formally evaluated. In only a few instances did focus group participants note some type of evaluation effort had been conducted or is underway. In those few instances, evaluation strategies generally included pre- and post-test surveys or satisfaction surveys distributed at the end of a workshop or training session.

IMPORTANCE OF CONFIDENTIALITY

Across all groups, providers spoke about the importance of increasing teens' awareness and understanding of their right to confidentiality and access to reproductive health services, and of emphasizing to teens providers' commitment to protecting this right. Many participants noted that reviewing and explaining confidentiality is one of the first items they discuss with teens during clinic visits. In some clinics, like in Chicago for example, providers are required to attest in writing that they have explained confidentiality rights to teen patients.

In order to maintain contact and ensure confidentiality across visits, providers indicate they work with teens to develop clear, simple strategies to maintain contact by mail or telephone, as well as encourage teens to keep the clinic or agency staff informed of changes in their contact information so that communication can be maintained.

Several focus group participants indicated that teens' confidentiality can sometimes be supported or inadvertently challenged by existing state laws. Some of these challenges and/or supports appear to differ across regions. In Cleveland, for instance, providers discussed inconsistencies between federal Title X laws on the one hand and local

regulations on the other around access to reproductive health care and mandatory reporting of statutory rape and, in some cases, mental health problems.

Providers in New York and Knoxville also spoke about the challenge they face as providers when dealing with reportable information shared by teens, particularly statutory rape. While laws addressing statutory rape are indeed necessary for protecting young people, providers recognize that they can be a barrier to providing services and building a trusting relationship with teens. Specifically, providers make it clear to teens that some things they may share during their clinic visit may need to be reported if this information suggests and/or present a danger to the teen or to others. Providers admit this can lead to teens not sharing important information during the clinic visit or being less than forthcoming with the information they do share. It is a delicate balance they walk on a daily basis to protect teens and to build a strong rapport and trust in order to gain information that is valuable for developing an appropriate and comprehensive approach to addressing young people's reproductive and sexual health needs.

Some communities are able to use specific legislation as a way to work with parents when concerns about parents' rights versus minors' rights emerge. In San Francisco and Albuquerque, providers believe state laws protecting confidentiality serve as an important resource to the youth-serving community. Generally, providers report they work to inform parents about teens' legal rights to confidential access to reproductive health care services, and to help parents understand the reasons for this legislation and the importance of respecting these rights. If needed, staffs from these clinics have been able to cite specific legislation that protects adolescent confidentiality. They also emphasize to parents their commitment to providing teen-friendly services, using a holistic approach to provide a range of services that address teens' physical, psycho-social, sexual health and developmental needs, and the services that are provided to the larger community. This type of strategy has helped to lessen parental opposition to teens' visiting and getting care at these respective clinics, and in many instances has worked to build a stronger relationship between the clinic and parents and family members. Through this dialogue, adults recognize providers are genuinely working to protect the health and safety of young people.

Providers also wanted to remind us that ensuring access to confidentiality is an important factor in seeking care for all teens, irrespective of social and economic status. In fact, for youth from middle and upper middle-income families, community-based clinics can be an important resource for confidential care. According to focus group participants, clinics that provide low-cost or free reproductive health services to teens are not used exclusively by low-income populations, but also by youth from more affluent backgrounds, primarily for confidentiality reasons. Providers in San Francisco mentioned that more affluent teens seeking care in their clinics do so to avoid being seen by their family physician or pediatrician. Providers in New York noted that, in some cultural groups, teens and parents seek care outside of their community because they do not want to be seen accessing services in their community – reasons cited for this fear included possible repercussions from people they know or fear of being stigmatized.

Participants noted one other pattern in teen behavior according to socio-economic status. In Cleveland, it was mentioned that in clinics located in lower-income communities, a significant proportion of teens (estimated at around 70 percent) indicate that their parents know they are seeking reproductive health services at the clinics. In contrast, teens from more affluent communities indicate their parents are not aware that they are seeking reproductive health services. This distinction of parent-child communication and knowledge of service utilization across social class lines was shared with an important caution to providers that some youth come to the clinic with the lines of communication already open, while other youth may need assistance and support to identify sources of support from adults.

FOCUS ON PARENT-CHILD COMMUNICATION

Across focus groups, participants indicate the primary goal of most PFE activities is to improve parent-child communication. Whether in one-on-one counseling sessions with teens, workshops and seminars for parents, or group discussions for teens and parents, strengthening lines of communication between parents/families and teens appeared to be a central goal of PFE activities. While several parent/family focused programs address the issue of educating parents and families about healthy sexuality, this is primarily to help empower parents/caregivers and

family members to communicate with their teens. Furthermore, participants noted that the topic of many communication programs is not limited to sex and sexuality: several of the workshops designed to improve parents' communication skills encourage caregivers to initiate and promote conversation around other important issues in teens' lives, such as school, relationships and personal interests. Better communication between adults and youth around issues other than sexuality is an important foundation for improving the quality of relationships and facilitating discussions around more difficult and sensitive topics like sexuality.

Facilitating parent-child communication within culturally diverse communities was also a critical part of focus group discussions. In fact, the vast majority of focus group participants indicate growing diversity among their client population, with providers serving African Americans, and a growing number of Latinos, Asians and other immigrant groups. Efforts to address the cultural needs of these communities have centered primarily on facilitating and ensuring communication with the client population – such as having a bilingual clinic or program staff and making translators or interpreters available in clinics. Providers acknowledge, however, that to be effective across diverse cultural groups, they have to move beyond simply addressing language barriers to incorporating strategies that reflect cultural preferences and values. Providers' perspectives on the importance of more comprehensive culturally-based efforts are discussed below.

THE RELEVANCE OF CULTURE

The issue of cultural diversity and its impact on PFE in adolescent reproductive health was raised during all of the focus groups. Participants described their efforts to address the needs of teens and families of different ethnic and racial backgrounds, as well as those of recent immigrant groups. Specific issues that emerged are as follows:

Linguistic and Cultural Differences

It is not surprising, given the geographic diversity of the clinics represented in the focus groups, participants' mentioned providing care to a wide range of populations. Indeed, the providers we spoke with have found the populations they serve becoming more and more varied in terms of language, nationality and culture. All participants reported providing reproductive health care to white and African American teens; the majority discussed efforts to serve Latino youth (Mexican, Central American, Cuban, Puerto Rican, Dominican). In addition to these groups, others (New York City, in particular) described the importance of addressing the needs of Caribbean/West Indian and West African and Asian teens and their communities. In Chicago and Cleveland, participants mentioned serving the needs of Hispanic and Latino groups, including Mexicans and Cubans. In the Knoxville and Atlanta, participants commented on working to support a growing Latino and Chinese population, along with refugees from Kosovo, the Sudan and other countries. In San Francisco, Los Angeles and Albuquerque, services were delivered to Mexican, Central American, Mongolian, Chinese, Philippino, Southeast Asian, and Native American communities, among others. Clearly, the cultural landscape served by the adolescent reproductive health providers in these focus groups is rich and complex.

Along with ethnic and cultural diversity comes a basic concern: verbal and written communication. Several providers spoke of their successful efforts in addressing language barriers by having interpreters available in clinical settings and workshop sessions and making key documents available in different languages. Others saw the need for interpreters and translated materials as a challenge that was still not addressed sufficiently, particularly in communities with a growing refugee community. While the ability to communicate is an important component of providing reproductive health services to teens and PFE, it does not address the need for greater cultural understanding and sensitivity among providers working in cultural settings different from their own. In Chicago and Cleveland, participants discussed the significance of recognizing linguistic and cultural distinctions between members of the Hispanic and Latino communities when providing services and developing programs. Providers in New York and Philadelphia commented on the importance of getting to know and working with cultural groups with different norms, and understanding cultural differences in family structures and support systems in multicultural environments. In San Francisco, participants noted that greater cultural competence could help providers understand the cultural

norms of teens' home culture, including reticence to talk about sex in some cultures and acceptance of early childbearing in others.

Another issue raised by a number of participants relates to distinctions in how different cultures address sexuality in general and with young people in particular. Several participants attending focus groups conducted in the West region of the U.S. have found that parents from other cultures often do not speak with their teens about sex, and that teens do not think their parents will understand American culture and ideas about sex. Providers in Albuquerque talked about Native Americans as having a more closed and insulated culture, making it difficult to discuss certain subjects openly and to gain access to the Native American community to support young people and their communities more broadly. They also noted that Native Americans have their own system of care and their own health centers available to them, which further limits non-Native American providers' ability to broach difficult or sensitive topics. In all, while the importance of this cultural context was recognized and respected, providers expressed concerns about how information and supports they may have available could be offered or coordinated through existing services to Native American youth and their families.

Religious beliefs can also impact efforts to serve teens' sexual health needs or engage parents and families around teens' reproductive health and sexuality, as certain religious cultures consider it inappropriate to discuss sexuality with adolescents.

Diversity and Cultural Awareness Among Providers and Program Staff

Providers also spoke of becoming more aware of how cultural differences between providers and communities can create barriers to building trust. The theme of overcoming community mistrust was raised not only in the context of recent immigrant groups, but also with African Americans who have a history of facing racism in various aspects of society including while accessing health care services. Providers' unequal treatment of African Americans and other cultural and ethnic minorities can manifest itself in subtle yet persistent ways: in Cleveland, for example, one participant talked about efforts in her clinic to encourage white medical residents who serve teens to address risk-taking with all teens and not just those of color, after it was learned there was a presumption of non- or lower-risk taking among white teens, which led to fewer discussions, screening and activities with white teens about preventive behavior relative to youth of color.

Addressing divergences in care and the wariness of communities can improve not only health care delivery for young people, but also the relationship between providers and teens' parents, families and community residents. As highlighted in Cleveland, one successful way that providers have used to engage parents and families of different cultural backgrounds is by emphasizing the common goal of improving the health and well-being of teens, regardless of cultural heritage.

Another challenge noted by participants is the lack of diversity in PFE program staffs and the continued lack of diversity among health care providers, especially physicians and nurses. Providers taking part in the discussion in Chicago talked about the benefits of offering programs for parents and families with presenters who know and are familiar to the communities being served. In Los Angeles, providers spoke about Chinese parents' reluctance to talk about sex with teens, but noted that members of the Chinese community have made inroads by making presentations to Chinese parents and producing publications in Chinese, helping to increase support and involvement by Chinese parents.

Going Beyond Clinic Borders

Another important element in successful community outreach with diverse communities is bringing PFE services to the community rather than looking to have community residents seek out programs. As highlighted by one provider in San Francisco, the increase in Asians and Asian Americans being served by the health care institution she works for is likely tied to new clinics opened by that institution in Asian communities. This has helped to create a feeling of

comfort for patients when clinic services are located in their neighborhood and the clinic can be seen as part of the community and word of mouth about community services can quickly spread to community residents.

The significance of providing services where the people are located was also discussed in Chicago: as one participant stated, it is important for providers to know the geographic boundaries of the populations they are trying to serve so that they can offer services in areas familiar and accessible to targeted groups.

Generation Gaps

Many providers talked about the generational conflict between parents and youth of non-American descent, with many parents from culturally diverse backgrounds thinking of U.S. cultural values as directly opposed to their own. As noted earlier, this conflict can also lead to teens' belief that their parents and families will not embrace American ideas about sex.

Generational concerns can also be manifested within American culture and within clinical settings, as several providers emphasized the need for clinic and program staff that can speak teens' language and the need for a more teen-friendly culture in clinics. With respect to connecting with parents/family members, providers also noted that many teen clinics employ staffs that are somewhat younger than parents/caregivers of teen clients. As such, there can be an age, generation and culture gap between provider staff and adult residents. Providers may have to reflect on how to diversify the age of their staffs and work to recruit local residents with the cultural backgrounds of their target audience, in order to build opportunities to establish trust and an entrée into some communities.

Hard-to-Reach Populations

A number of providers also discussed challenges of providing PFE for hard-to-reach youth populations, and in some instances, where PFE in the most traditional sense (e.g., biological parents or family members), may not be appropriate. In Philadelphia, participants talked about the general distrust of gay, lesbian, bisexual, transgender and questioning (GLBTQ) youth and their reticence to involve parents or family members in their sexual health and well-being, as many have limited support from family members, or may experience explicit ridicule or rejection from family members because of their sexual orientation. A participant in New York noted that their clinic now has a mission aimed at including GLBTQ youth and their families, because of the need to ensure GLBTQ are being fully and adequately supported.

In San Francisco, providers mentioned their efforts to serve homeless youth who are difficult to follow and may not have any family members with whom youth or providers can connect. In addition, transient youth, for whom providing consistent care is difficult, as the youth are shuttled from relative to relative and often cannot or do not want to identify a source of adult support that could be connected with PFE activities. Other youth, because of a lack of stability in their lives, have a hard time establishing trust and relationships with adults in general, and feel uncomfortable accessing formal systems of care. One clinician in the group noted providing services on the street in front of the clinic as a way to reach individuals who are uncomfortable entering the clinic for services. Other kinds of "non-traditional" strategies may have to be considered to reach these types of young people.

THE VALUE OF COLLABORATION

In several groups, participants commented on the value of collaboration for strengthening ties with adult community residents and for helping to recruit adult participants into PFE efforts. For instance, participants in Knoxville and Cleveland highlighted the collaborations that exist in their respective cities among different adolescent health providers – the Knox Adolescent Pregnancy Prevention Initiative (KAPPI) and the Adolescent Consortium in Cleveland. KAPPI is a coalition of youth-serving agencies from the greater Knox County area that work collaboratively on local program and policy issues to strengthen teen pregnancy prevention efforts. Coalition members represent a range of public and private groups that serve youth and families, including local health

departments, boards of education, parent-teacher associations, police departments, health care centers, and youth development organizations. Cleveland's Adolescent Consortium is a network of health, education and human service agencies that work to prevent adolescent pregnancy and improve outcomes for parenting teens, as well as address issues around violence, substance abuse, chronic and mental illness, and academic achievement. Like KAPPI, the Consortium takes a youth-development approach to reducing teenage pregnancy by involving a broad spectrum of local organizations concerned with supporting the health and well-being of young people. As a result of these collaborations, providers are able to be part of a network of youth-serving groups that works collectively to serve the needs of adolescents. As an example, participants described referral systems created through these networks that help to increase providers' awareness of resources available to young people and enable teens to access the care and services they are seeking more efficiently.

Another benefit of these collaborations appears to be their impact on increasing parent and community support for PFE. In Cleveland and Knoxville, the collaborative groups described are actively involved in efforts to educate parents about healthy adolescent sexuality and engage them around teens' sexual health and overall well-being. The coalitions work not only to develop parent-focused programs but also to educate communities about the importance of these programs – which, in turn, has led to greater community support for PFE efforts. Based on feedback in several of our focus group discussions, collaboration and community supports were identified as critical to providers' ability to initiate and sustain successful parent and family engagement activities.

SUCCESSES AND CHALLENGES WITH IMPLEMENTING PFE

Participants were asked to comment on what they perceived to be the successes and challenges they have experienced with implementing PFE in their communities. Many of the successes have been described or alluded to in previous sections of this report. In the following pages, we bring to light other key successes and challenges that warrant attention. Participants also commented on the success around providing reproductive health services to teens more generally.

Successes with Implementing Reproductive Health Services

With respect to the provision of reproductive and sexual health more broadly, practitioners felt very strongly that an important success was the continuing and strong declines in teen pregnancy and teen childbearing in the U.S. The continued focus on protecting access to services for teens has helped to promote healthy decision-making among teens that includes abstinence and an increase in contraceptive use among teens, as well as the provision of preventive and screening services for pregnancy and HIV/STDs. Clinical services and the community-based efforts sponsored by clinics and other agencies have educated teens and helped to empower young people to make healthy and responsible decisions. Teens recognize clinics across the U.S. as an important source of information, support, and referral services. For some teens, clinics are the only source for low-cost or free and confidential services. Providers commented on how encouraging it is see a young person with whom they have established a relationship come back to the clinic to share success stories, like going off to school, or getting their first job, or demonstrating they are managing the challenges and responsibilities of being a young parent. These stories simply reinforce the importance and value of community-based clinical care for young people.

Successes with Implementing PFE

Participants also commented that these success stories have helped to increase awareness at the community level about what clinics are really about – about supporting and promoting healthy behavior and well-being among young people. As a result, participants note they have realized greater success in reaching out to and connecting with parents and securing parent participation in education related activities. In many communities there is greater trust between parents and providers, with parents and adult caregivers becoming more open to receiving information from clinics about the services they offer and showing a more positive response to the strategies and activities offered, like fact sheets and/or starter kits on how to begin a discussion with your teen around sexuality and other issues. In

some communities, parents and adults have formed advisory groups that work closely with programs to help inform and give feedback on program activities.

In addition to gaining support and trust from parents and other adults, clinics are increasingly making headway with their efforts to work with diverse communities. While much work still needs to be done, many participants commented they have been able to secure resources to prepare bilingual materials, to hire translators and to engage key members of different community subgroups to help make the initial entrée into immigrant and ethnic minority communities.

Practitioners are also beginning to make head way in connecting with fathers and other adult male family members, although specific strategies to do so are still very much ad hoc. Programs are better able to make connections with the family more broadly, rather than just one parent. The extent to which most clinics are able to take this broad-based family approach is still somewhat limited.

Challenges with Implementing PFE

While participants described numerous successes and accomplishments in their PFE work, discussions illustrate significant barriers still remain to developing and implementing strong PFE efforts. Some of these challenges reflect the need to address restrictive or conflicting federal and state policy, while others reflect the need to continue to work with teens and adults around issues of sexuality, to improve each group's knowledge and understanding of the value of working with the other (i.e., helping adults understand the value of supporting teens and teens the value of trying to work with adults), or to address the growing cultural diversity at the community-level.

For instance, participants commented that providing access to confidential services for teens continues to be a challenge, in light of the growing focus and federal resources earmarked for abstinence-only education. In some states, the push to accept abstinence-only funding makes it difficult to conduct other types of education programs for teens or adults that would reflect the more balanced message clinics would like to get across to adult and youth participants. Similarly, the ongoing debate about abstinence versus teen sexual activity and teens' access to services continues to make it difficult for providers in some communities to gain trust and support from adults or to broaden collaborations with community organizations (e.g., religious groups), or to help adults overcome their naiveté and denial around teen sexual activity. In Philadelphia, providers commented they continue to struggle with how to address and overcome differences between parents' and provider values around teen sex and reproductive and sexuality education, with some parents wanting to ensure an abstinence only message rather than comprehensive sexuality education and contraceptive access. Ongoing opposition is also evident among teachers, who often demonstrate opposition to school workshops and/or presentations conducted by clinic staff.

In the context of addressing opposition to a comprehensive approach to sexuality education and clinical services, providers continue to work on building knowledge and skills of teens around sexuality. Many teens are still uninformed or misinformed about sexuality and their bodies, and as a result are taking tremendous risks with their physical and emotional health. Addressing the dynamics of dating and relationships among adolescents, along with mental health and developmental delays, and how to help teens and adults deal with these issues remains a challenge.

In addition, practitioners are working to respond quickly and effectively to the growing racial/ethnic diversity of local communities across the country. Participants in our focus groups frequently commented they have a hard time keeping pace with the broadening cultural lens at the local level. From addressing growing language barriers, religious differences and cultural nuances, and the disparities between the ethnic/cultural make-up of staff and clients, providers are looking for guidance on how to respond to and support the changing cultural mix of their client base. Also in this regard, there is a tremendous need for assistance with addressing blatant and hidden biases about who is at risk, about styles and strategies for engaging diverse communities, and for addressing the intersection between gender and culture, particularly how to help women and men in various communities respond to and interact

around these issues. The issue of gender and culture in some communities has resulted in educational activities targeting only females and not males, or has limited the opportunities for working with males and females separately so that the needs and concerns of females versus males can be addressed within a cultural context.

Finally, getting adults to participate in PFE activities and sustaining adult participation remains a challenge. In Chicago, participants commented on the challenges of getting males to participate, especially in white communities, while in other areas, such as New York, participants talked about the challenges of getting male participation within communities of color. In Cleveland, Atlanta and Chicago, participants noted parent/adult overload (e.g., work, family and household responsibilities) makes it hard to find a time that is convenient for parents, to make the issue of teen sexuality and PFE a high enough priority relative to other issues to entice parents to participate and to sustain their participation. Finding ways to reach out to low-income parents, especially those returning to work through welfare-to-work programs, is of particular interest to providers, although there is little information about promising strategies for doing so. In Albuquerque, providers commented on the fact there is no formally established PFE curricula and few best practice strategies documented, making it difficult for providers to quickly identify educational resources that can be used or adapted for their local setting.

SUPPORTS NEEDED TO START AND TO SUSTAIN PFE ACTIVITIES

In light of the discussion about success and challenges, focus group participants were asked to identify technical supports needed to start PFE and those needed to sustain PFE work. Participants were also asked to rank the top four supports *most* important for successfully starting and the top four supports *most* important for sustaining a PFE effort. Participants outlined a range of supports, including public education and communication, program staff training, cultural appropriateness, community support and buy-in, and collaboration.[3] Other aspects about program development and design, assessment and evaluation, and financial sustainability were also mentioned.

Table 4 presents the issues that emerged as among the top four supports across the groups. In all, eight support areas emerged for starting a PFE program and nine support areas emerged for sustaining a PFE effort. Interestingly, supports identified by certain participants as most important for starting PFE efforts were also considered most important for sustaining activities. While the exact reason for the similarities across supports to start and sustain PFE are not completely clear (there was not enough time in the groups to discuss this at length), it appears participants believe that the elements needed to get a program underway – a clear direction and set of strategies with the program model and appropriate design; marketing and outreach to engage participants; community buy-in to support and ensure participation; collaboration to facilitate and strengthen implementation; staff training to ensure adherence to the program model and ensure staff buy-in; and teen involvement to make sure the program effort is youth focused and teen friendly – are all at the very core of good programming in general, and not necessarily specific for PFE. That is, these elements reflect the items most essential for creating quality, appropriate and effective programming, and in the end allow for good programs to continue. Additional items in the "sustain PFE" column worth noting include attention to assessment and program evaluation, particularly using evaluation results to refine and modify program efforts, cultural appropriateness to ensure strategies continue to respond to and reflect the cultural context of participants; and financial sustainability, adequate funding to continue the effort, which many participants acknowledged was tied into assessment and evaluation.[4]

[3] In light of the nine groups conducted, at most 36 different "top four" items could have emerged. The list of eight supports to start and nine supports to sustain are aggregated across all the groups.

[4] Participants were asked to think of supports to start and sustain that address issues other than funding. Thus, the lack of funding and/or financial resources on the "start" and "sustain" lists does not necessarily reflect the perceptions of participants about funding, but rather is the result of how the question was posed to the group.

Table 4: Supports Most Important for Starting and Sustaining PFE	
Supports for Starting PFE	*Supports for Sustaining PFE*
Public education & communication • Marketing PFE programs • Publicizing research findings on the importance and benefits of PFE • Developing brochures and other educational materials to share with teens and parents • Conducting local research on what teens know and sharing information about their experiences, including barriers to access • Having community perception of need for PFE	Public education & communication • Developing a marketing campaign to inform community about the importance of PFE and issues teens face • Benefiting from positive word of mouth about PFE activities and services available to teens • Empowering parents to communicate with other parents about available programs • Developing a media campaign to inform communities about programs • Having the perception of program success within the community
Program staff training • Training staff on how to talk with teens • Having staff members who are adequately trained in specific program curricula and have a desire to work with teens and parents • Obtaining and sharing information about program efforts in other cities	Program staff training • Having committed, compassionate and well-trained staff • Offering updated information on PFE classes for providers and online information on PFE
Community support & buy-in • Increasing community buy-in • Getting support from major community-based organizations • Gaining the support of local communities, schools and coalitions • Having administrative and legislative support for services and funding	Community support & buy-in • Receiving full community participation and support, including politicians • Having program presenters exhibit real, genuine respect for participants
Collaboration • Collaborating with local agencies • Partnering with agencies that share a similar vision and can provide resources	Collaboration • Using multiple sources of collaboration
Teen involvement • Involving teens in program planning and design • Having faith of teens that parents/adults can help them • Providing information for teens on starting dialogue with parents	Teen involvement • Having buy-in from teens
Program development & design • Having flexible program hours • Making transportation available, or locating programs near accessible public transportation • Clearly defining program goals, purpose, and target audience • Developing a program design, including hiring and training of staff • Offering incentives to program participants that make participants' lives easier • Identifying and using effective means to contact parents • Offering services that are centrally located to communities being served	Program development & design • Creating opportunities for groups doing similar work to exchange ideas on ways to improve services • Coordinating programs being offered with other providers to avoid duplication of effort • Utilizing assessment and evaluation findings to improve programs • Providing ongoing training for program participants • Recognizing program participants (certificates, awards, etc.) • Knowing the geographic limits of the community being served • Developing innovative programs • Having ability to change program course mid-stream in response to community's needs • Offering a comprehensive range of programs and services • Identifying standardized PFE curricula • Reviewing and updating program content periodically for program staff, parents and teens • Using updated or current technology in programs (computers, surveys) • Having good working equipment
Assessment & evaluation • Holding a discussion with teens and parents/families to identify their needs and determine what program elements would be most effective • Conducting a needs assessment • Researching differences between teens who can talk with parents and those who can't	Assessment & evaluation • Monitoring and evaluating programs to assess program effectiveness • Assessing the community's needs periodically • Utilizing assessment and evaluation findings to improve programs
Other supports • Operating under workable guidelines, including around reproductive health laws and HIPAA	Cultural appropriateness • Determining the cultural appropriateness of efforts and developing culturally-appropriate materials
	Financial sustainability • Sustaining financial support for programs

FEEDBACK -- DEFINITION OF PFE AND SUGGESTED LANGUAGE FOR DESCRIBING PFE

During the focus groups, CARTA staff presented a working definition of PFE developed for the purposes of this project. Participants were asked for feedback on whether and how to modify the definition and on language that could be used to help providers easily understand PFE and feel comfortable with conducting PFE. CARTA's working definition of PFE is as follows:

> *Parent and family engagement in adolescent reproductive health is:*
>
> *Any activity (formal or informal) that directly or indirectly engages parents and/or immediate family, extended family, or family/parent surrogates, in ways that empower adults to promote healthy sexuality among teens without compromising adolescent confidentiality and/or adolescents' right to reproductive health care.*

CARTA was interested in hearing providers' thoughts about this definition as "on-the-ground" participants in PFE efforts. In particular, we were interested in knowing if the definition reflected accurately the goals of their PFE efforts and how well it incorporated the main target audience(s) of their activities – parents and families, teens, or both.

For the most part, participants were satisfied with the definition of parent and family engagement and found it inclusive of different family structures and family/adult supports they have encountered in their work. Most also appreciated the definition's emphasis on the protection of teens' confidentiality and right to reproductive and sexual health care.

At the same time, a number of participants suggest specific changes to the definition, which they believe would make it more reflective of the goals of PFE, less intimidating to providers, and more inclusive still of parents and families. Some of these changes include:

- Adding "caregiver" to the categories of parents and families listed;
- Adding language that reflects the benefits of engagement for teens and parents/families;
- Fitting "teens" in the definition to indicate that PFE is designed to empower both parents and teens;
- Adding "healthy and responsible" sexuality;
- Adding "promote healthy sexuality as teens move through adolescence" to incorporate the developmental transitions that teens experience;
- Adding in "healthy lifestyle," which is broader than sexuality;
- Providing a definition of sexuality, even as a footnote;
- Using less formal language.

The suggestion of including teens in the definition was expressed by many participants across the nine groups. As noted by the group in San Francisco, the definition suggests empowering adults to connect with teens, whereas most providers' experience has been more around talking with teens and encouraging them to communicate with parents; therefore, they believe the definition should reflect efforts directed at teens more explicitly.

Providers were also asked to think of messages or phrases that could be used to illustrate PFE to providers unfamiliar with this work and to encourage them to take part in PFE efforts. Table 5 represents a list of the proposed messages suggested by focus group participants.

Table 5: Suggested Messages for Describing & Promoting PFE to Provider Community	
Window of Opportunity	*An Hour at Clinic vs. 23 Hours at Home*
Parents in Partnership for Healthier Youth	*I Took an Oath*
What a Teen Wants/What a Teen Needs	*Helping Parents Help their Kids*
Opening Doors	*Parents Are Valuable*
Effective Communication	*Parents Are Supports*
Increase Parental & Family Involvement in ARH	*Parents Need to Be Involved*
Educate & Involve Parents More in ARH	*Let's Talk, Parents & Teens*
Tired? Need help? Do you want to teach your clients tools about involving parents more?	*Parents & Children: Open & Honest*
Enter their World: Understanding our Teens	*Just Between Us*
Trading Places – Understanding your Teenager	*Parent Impact/Providers Feel the Impact*
The Real Reality Show	*Providers Should Be Non-Judgmental*
The Family Survival Techniques: Understanding Teens, Building Communication Skills	*Dare to Prepare!*
CEU: Communicate, Educate, Understand	*Improving Communication*
Women's Wellness: Teen Keen	*Promoting Youth Development*
Teens Need Family Support	*Sexuality Scares People Away*
Parents Need to Know	*Communication Avoids Confusion*
Teach the Teachers	*Don't Procreate Before You Educate*
Nursing Goes Beyond Medicine	*It's Not Just About Intercourse – It's About Peers, Sexuality, Overall Health*
Parenting Goes Beyond Birthing	

In the coming months, CARTA will work to incorporate feedback from participants to craft a modified definition and to develop several short-phrased messages that can be used to connect with reproductive health providers and introduce them to PFE.

Conclusions

Discussions with reproductive health providers present a clear and consistent picture of the status of PFE work being implemented by clinic-based agencies in selected communities across the country. In general, many different types of provider agencies are attempting to connect with parents/caregivers and adult family members around the issue of teen sexuality and reproductive health. Efforts are primarily youth-centered – targeting youth and working to build young people's ability to connect with an askable and supportive adult; or parent/family-centered – targeting adult family members with information/resources and education and communication workshops to build knowledge and communication skills around sexuality. Youth-centered efforts are primarily clinic-based (or school-based) in order to tap into youth as they access reproductive health and/or sexuality education programs and services. In contrast, parent/family-centered efforts tend to be community-based, a primary way to reach parents/family members where they are, but also as means for ensuring or protecting minors' access to confidential services. Joint youth and parent/family-centered efforts are a less popular approach for PFE, at least among the providers in our discussion groups. These types of programs, when they do exist, appear to focus on bringing parents/adults and youth together for some type of short-term education and/or training activity, such as a workshop or health fair.

Discussions with providers illustrate PFE efforts appear get started in response to providers' observations about limited knowledge and comfort among adults with discussing sexuality related issues, and/or in response to teens' request for help in connecting with adults around this issue. More often than not, PFE efforts get underway because of a core group of committed providers that has observed the need for this work and has found a way to create additional services and supports and make them available to adults and youth. While Title X specifically requires providers to encourage family participation in the reproductive health decisions of teens, it does not require parental involvement. As a result, providers are able to respond to the specific needs of youth and their clinic by identifying programmatic strategies for PFE that align with the preferences of young people and community residents and that tap into the opportunities and resources available within their agency. While this appears to result in PFE efforts that are more informal than formal, some provider agencies have conducted a needs assessment to document specific areas and supports and to design PFE activities to strengthen youth and adult knowledge and skills around the issue of sexuality.

As part of the ongoing need to ensure minors' access to confidential reproductive health services, providers we talked to were clear in their commitment to support teens' need for access and confidential care. PFE efforts, whether youth- or parent/family-centered, were designed in a way (e.g., content, strategy, and location) that served to protect minors' access to services. Providers talked at length about the number of teens and adult/family members who remain unfamiliar with laws that protect minor's access to confidential services. In some instances, these laws help providers educate parents and supportive adults around the importance of protecting minors' rights and around the important role reproductive health providers play in providing comprehensive and holistic care to adolescents. Access to confidential services remains critical for teens from all socioeconomic and cultural groups, as illustrated by the comments among providers in our discussion groups that confidential access to services allows low-income and more affluent teens, as well as teens from cultural subgroups, to use services comfortably when then need them.

As for the primary goal of PFE related programs, whether targeting adults and/or youth, most efforts focus on improving parent-child communication. It is unclear whether this is in response to observations and/or requests by youth to be able to talk with a supportive adult about sexuality issues, or whether it is the strategy most in-line with the Title X requirement of encouraging family participation. Perhaps the emphasis on communication simply reflects the need to start at the most basic level – building knowledge, comfort and capacity for discussing the issue of sexuality – the very place where many adults and youth in the U.S. are in terms of their ability to discuss and respond to issues of sexuality. Identifying ways to address communication issues within various cultural groups is also a primary focus of PFE efforts, as it addresses the growing racial and ethnic diversity of communities in which reproductive health services are being delivered.

In addition to tailoring PFE work to reflect the communication styles and preferences of different cultural groups, providers are also working hard to ensure the materials and resources they produce around PFE (and other broad-based sexuality issues) can bridge language differences that are emerging across their client populations. However, our participants were quick to acknowledge challenges with diversity go beyond language and extend to the cultural, religious and gender context that reflect the styles, beliefs, values and preferences of different groups that are increasingly becoming part of the American social fabric. In addition, providers recognize the importance of addressing other aspects of culture, including confronting their own biases, both subtle and overt, and addressing the disconnect between the culture of providers and those they are working to support.

While cultural differences present challenges, it also opens up opportunities – opportunities for expanding "conventional knowledge" about what works and about what people from different population groups need and prefer. It also encourages collaboration across community-based agencies. Connecting with organizations (health and non-health) that are respected and well connected with the cultural groups providers are trying to reach can be a useful way to bridge the cultural gap and to build community support and buy-in of PFE and reproductive health services. Collaboration is also an important way to build respect, support and facilitate implementation of PFE. Several providers commented on the value of their collaborative efforts. In some communities, collaboration has been the key to getting programs started, for keeping programs going, and for securing support from communities and residents with which the clinic has had limited prior connections and/or experience. Collaboration also helps diversify the ways in which providers can access adults and youth in PFE efforts. Providers looking to find ways to recruit and sustain adult participation in PFE efforts may find innovative ways to connect their PFE work with other existing services (e.g., employment and training programs, PTA groups), which can reduce the challenges of doing PFE in isolation of other community services that target parents and the barriers to parents who have too many responsibilities and too little time to participate.

In addition to reaching out to racial/ethnic subgroups and to connecting with other community organizations, participants commented on the need to reflect on the appropriateness of PFE and the need to be flexible in our definition of PFE with youth that are difficult to reach or that have special needs. LGBTQ youth, homeless youth or youth in transitional living situations; youth with mental health problems or youth experiencing developmental delays; and youth in public systems all share psychosocial, health, mental health, living and/or family situations that are far from traditional and that may not respond easily to the PFE framework. Great care should be taken when thinking about PFE with youth in these situations and providers should explore how they can identify adult supports (family or otherwise) that can address the short- and longer-term needs of young people in these circumstances.

Finally, providers have a long list of recommendations around technical assistance supports needed to begin and sustain PFE related work. From assistance with program development, to assessment and evaluation, to gaining community support and buy-in, to marketing and outreach, to ensuring teen input, providers' experience suggests help in each of these areas would create stronger and more effective PFE efforts. At least a few groups commented on the need for more standardized PFE curricula and program resources that would provide guidance to local efforts around promising and effective practice. In addition, many of the supports needed to initiate and to sustain a PFE effort were the same or very similar. This suggests these elements reflect the components of developing and maintaining a high-quality and effective program, whether the focus of the program is PFE or some other health or non-health related topic. In short, providers could benefit from supports that address the basic components for designing and implementing good community-based programs. Resources and materials on strategies that reflect promising approaches around PFE provide the context for shaping efforts that address the importance of connecting youth and adults together on this issue.

When we initiated this work some four years ago, we were unclear as to whether and how clinic-based agencies were connecting with adults around sexuality issues. We fully expected providers to be committed to minors' access to confidential services and to work tenaciously to protect it. We also expected providers to be aware and supportive of educating parents/adults around issues of sexuality, as there is a growing body of evidence around the important role of families in shaping teen sexual and reproductive health behavior, and that connecting with the adults that

matter in the lives of youth simply makes good sense. What was unclear was the extent to which *clinic-based* reproductive health agencies would find a way to meet the needs of parents/adults for information and support while ensuring youths' need for support and access to care. In fact, we are encouraged by the number of provider agencies that have found a way to conduct PFE related work without jeopardizing minors' access to confidential reproductive health services. This demonstrates providers' profound belief in the importance of parents/families in supporting teens' sexual health and reaffirms their ability to respond with innovative approaches to meet the emerging needs of teens and adults. The challenges that lie ahead are to provide adequate and timely information, resources and supports on promising PFE strategies and to offer guidance on how to tailor PFE efforts that address the cultural, developmental and special needs of the youth and adult populations participating in PFE efforts. Also needed is an infrastructure for sharing this information and support so that providers can connect, collaborate and share lessons about successes and challenges. This information and networking strategy should serve to build knowledge and capacity for PFE and ultimately enhance the ability of adults and youth to respond to and protect the sexual health of young people.

Appendix:
Role of Focus Group Participant in Clinic/Agency PFE Activities

Education
- Educating/presenting to families regarding healthy sexuality & health issues, especially in reproductive health care
- Education/Educator
- Conduct health presentations for various community programs, often parent-specific programs for women
- Providing oversight for all abstinence education for youth & parents
- Oversee all staff and client education & training
- Educating teens & caregivers about the value of reproductive health & assist with positive decision-making to enhance their growth
- Manage the design & implementation of health education

Direct health care services
- Provide direct primary care
- Coordinate teen clinic, do group prenatal care, & provide care for teens & Latina women
- Family health care
- Do the clinics & talk with teens directly about involving their families
- Manage family planning, prenatal & gynecology programs
- One-on-one with adolescents for prevention activity & work with parents

Counseling
- Counseling teens, partners & parents
- Counseling young ladies about sex & STDs/HIV, and family members if desired
- Informal counseling; parent groups
- Counseling parents & teens in birth control, STDs & reproductive health
- Talk with teens during counseling appointments
- Provide individualized & group family planning sessions to interested clients in English & Spanish; provide pregnancy test counseling & STD/HIV information & counseling
- One-on-one counseling

Facilitation
- Facilitation
- Facilitated & wrote parts of PFE activities

Communication
- Increase communication with family members
- Facilitate workshops on parent/child communication
- Design, develop & implement programs & activities around parent-child communication
- Facilitate & sometimes mediate parent-child communication

Social work/services
- Provide services and/or referrals to enable pregnant/parenting teens [to access] health care & other community resources
- Case management related to reducing infant mortality & morbidity, with emphasis on community's social resources & linkages
- Oversee all social work services, including engagement & family assessments
- Discussing & reviewing teen health history & parent questionnaires to provoke discussion & provide referral
- Supporting youth with their problems

General oversight/management
- Oversight/management
- Managing, planning & overseeing
- Monitor compliance
- Write and set policies & procedures
- Oversee clinic & outreach program activities, including clinic's limited PFE activities

Appendix: Role of Focus Group Participant in Clinic/Agency PFE Activities
o Supervise, promote & decide policies & procedures Multiple roles o Clinician & educator o Provider of direct patient services to teens, & program development o Administrator, trainer & educator o Counselor, educator, clinician, instructor o Developing original materials; facilitating workshops; recruitment of participants; program planning, implementation & evaluation o Planning & instructing o Education, health fairs, one-on-one counseling o Manage treatment program & train health educators on conducting family involvement counseling with all teens o Group leader & counselor o Individual counseling at clinics; sexuality education in schools; parent groups Other roles o Coordinate a condom availability program in 10 public high schools o Technical consultant

CARTA's Parent & Family Engagement Project

CARTA's Parent/Family Engagement (PFE) in Adolescent Reproductive Health has been in existence since early 2000. The goal of the project is to document ways in which clinic-based reproductive health providers are reaching out to parents/families about issues of teen sexuality and reproductive, while maintaining access and confidentiality of care for teens. Now in its fifth year, the project has several documents and resource materials that describe PFE and offer guidance on planning PFE activities and on conducting PFE among culturally diverse communities. For more information on this project, please call us at (410) 625-6250 or visit us at www.cartainc.org/pfeproject. You can also call to request copies of the following publications, produced during earlier phases of the project.

Sugland, B.W., Innocent, M.A., Artis, M. and Harris, V. 2004. Culturally-Based Parent/Family Engagement: What Providers Should Know. What Providers Can Do. Baltimore, MD. CARTA, Inc.

León, J., Sugland B.W. and Peak, G.L. 2003. Engaging Parents and Families as Partners in Adolescent Reproductive Health and Sexuality: A Guide for Reproductive Health Providers. CARTA, Inc. Baltimore, MD.

León, J. and Sugland B.W. 2003. Lessons Learned: Tailoring Parental Engagement Programs for Diverse Populations. CARTA, Inc. Baltimore, MD.

Pelea, B.J. and Sugland B.W. 2003. Lessons Learned: Measuring the Benefits of Parental Engagement Programs. CARTA, Inc. Baltimore, MD.

Sugland, B.W., León, J. and Hudson, R. 2003. Engagement Parents and Families in Adolescent Reproductive Health: A Case Study Review. CARTA, Inc. Baltimore, MD.

Sugland, B.W. and León, J. 2000. Engaging Parents and Families in Adolescent Reproductive Health: A White Paper. Final Report to the Annie E. Casey Foundation. CARTA, Inc. Baltimore, MD.