



# MIXED MESSAGES:

THE CURRENT STATE OF TEEN PREGNANCY  
PREVENTION IN TRAVIS COUNTY, TX

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## **MIXED MESSAGES: THE CURRENT STATE OF TEEN PREGNANCY PREVENTION IN TRAVIS COUNTY, TX**

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# EXECUTIVE SUMMARY

Teen pregnancy is a priority issue of adolescent health due to the potential immediate and long-term impacts for teen parents, their children, and society (CDC, 2015a). Healthy Youth Partnership (HYP) examined statistics on teen birth rates for Travis County, Texas, and the United States and found that both Travis County and Texas have higher birth rates than the United States reports overall.

HYP is a volunteer-led collaboration working to support youth-serving professionals in the Central Texas community. HYP's collaboration originated from professionals working in adolescent sexual health, however it has expanded to include all youth-serving professionals. HYP's goal is to connect all youth-serving professionals with the skills, resources, and networks to further enhance their work in the Central Texas community.

HYP conducted this needs assessment in order to determine the types of services that are available to teens, how accessible services are, and what barriers teens and their families encounter when trying to access services. HYP also considered the social determinants of health and societal structures that influence teen and unplanned pregnancies, such as poverty, access to health education, and preventative health care. In addition, HYP examined individual, peer, romantic partner, family, and community factors and to what degree they serve as risk or protective factors to teen and unplanned pregnancy.

## Current Study

Starting in January 2012, a volunteer, collaborative, multi-disciplinary research team developed surveys and focus group questions to obtain a holistic and complete perspective of teen pregnancy in the Central Texas community. Utilizing a mixed methods approach for data collection, the present study sought to answer the following questions:

- 1 What are the barriers to teen pregnancy prevention in Travis County?
- 2 What are the strengths in teen pregnancy prevention in Travis County?
- 3 What recommendations does the community have to reduce the teen birth rate in Travis County?

## Methods

HYP collected data from seven separate groups within the Central Texas Community. Service providers, educators/school staff, medical providers, and teens completed surveys, while focus groups with teens, teen mothers, teen fathers, and parents were conducted. Survey findings were reported, and focus groups were examined within the context of the social determinants of health. This framework recognizes the interrelated social and societal factors that place teens at risk of early and unintended pregnancy and may influence the outcomes of those directly impacted. A way to fully integrate these social determinants is to explore the risk and protective

factors that impact the likelihood of teen pregnancy and births. Kirby and Lepore (2007) utilized over 400 studies that examined individual, peer, romantic partner, family, community, and environmental factors that influence not only teen pregnancy and childbearing, but sexual initiation, number of partners, contraceptive and condom use, and incidence of sexually transmitted infections, all of which are interrelated to teen childbearing. This framework was utilized to determine barriers, strengths, and recommendations within our findings that were relevant to teen pregnancy prevention in Travis County.

## **Summary of findings**

Through purposive sampling, HYP recruited a convenience sample of 73 focus group participants from 10 Central Texas community agencies, to include 16 separate focus groups with 36 teens, 16 teen mothers, 4 teen fathers, and 20 parents. The provider surveys were administered to HYP listserv members, annual HYP Provider Conference attendees, and additional providers via snowball sampling, and was completed by 84 service providers, 38 educators, and 13 medical providers for a total of 134 youth-serving professionals.

### **Barriers to teen pregnancy prevention in Travis County**

Within our findings, barriers to teen pregnancy prevention were found on the individual, peer, romantic partner, family, and community and environmental level. Our teen participants provided valuable insight, expressing their attitudes and beliefs around sexual activity and birth control. Teens discussed the pressures they perceive from their peers and romantic partners to engage in sexual activity. Teens perceived their peers as sexually active and normalized sex as a natural part of life, but still cited barriers to safer sex practices, including access and misinformation about birth control, embarrassment when purchasing condoms and the restriction requiring them to get parental consent to access reproductive services, which is the case outside of Title X clinics in Texas. Some teens held negative beliefs and limited knowledge about birth control, citing concerns about side effects of hormonal contraception and reduced pleasure when using condoms. Parent participants emphasized the need for parent-child communication around sex, but the level of comfort and confidence in talking about sex varied, which was also found among our provider participants as well. Teens and teen parents discussed how commonplace teen pregnancy seemed to them, citing how their schools had specific services for teen parents and talking about how they all knew peers who had become pregnant or given birth. Cultural and/or familial validation of teen pregnancy was also found to be a factor among our participants' experiences.

Another potential barrier is the stigmatization of teen sexual activity within the Central Texas community. Our teens discussed conflicting attitudes towards sexual activity, citing a promotion of male sexual activity and a stigmatization of female sexual activity. Teens also discussed how there was a negative stigma around remaining abstinent. Teen parents discussed the negative reactions and shaming they received from the adults, peers, and schools. This stigmatization also extends to our provider participants whose level of comfort discussing teen pregnancy-related topics varied. Our providers cited lack of parental support, lack of agency funding, and state laws as common barriers to providing services to teens, and believed that unsupportive parents, lack of agency funding, and lack of health insurance were most likely to be always a barrier for teens in accessing services.

Our teen parent participants cited additional barriers to receiving services such as their age (being under the age of 18 and having minor status), waitlists for childcare, and little to no guidance from service providers. Concerns over preventing a second pregnancy were cited as a result of teen parents no longer being able to afford birth control because funding had been cut from their clinic or service provider.

### **Strengths to teen pregnancy prevention in Travis County**

A majority of our teen participants were in support of birth control use. Teens also agreed that the decision to have sex should be a mutual agreement between two partners. All of our teen respondents reported receiving some type information on sex education topics; the most common was “how to say no to sex” and “the importance of using birth control if you have sex.” Teens cited condoms as the most common birth control method and were able to name several local resources for birth control including Planned Parenthood, CommUnity Care Clinic, Round Rock Women’s Center, and St. David’s Wellness Center, in addition to drugstores like Wal-Mart and Walgreens. Teens were also able to identify services for teen parents available in some schools, such as daycare and assistance with obtaining diapers or formula. Religion was seen as a teen pregnancy protective factor among some of our participants. Our teens, teen parents, and parents all believed one should be financially and emotionally stable before getting pregnant. Future orientation or having career or educational goals is a known protective factor (Kirby & Lepore, 2007). Teen parents discussed how they were going to attempt to break the cycle of teen pregnancy by having conversations with their own children about sex as they grow up.

### **Community recommendations to reduce the teen birth rate in Travis County**

Teens, teen parents, and parents recommended increased, open, and honest communication about sex in their communities by providing comprehensive sex education that includes contraception methods and raises awareness of available sexual and reproductive health resources for teens in the community. Participants also suggested this sex education be provided earlier, at younger ages. Teens recommended peer-led sex education while teen parents offered to share their experiences of teen parenting with other teens. All three groups suggested promoting parent-child communication about sex that does not focus solely on prohibiting children from having sex, and provides comprehensive information about birth control. Parent participants recommended more community involvement through community meetings about teen pregnancy, and involving local churches and schools to educate parents on communication with their children about sex. Targeted social marketing and media campaigns were suggested ways to raise awareness throughout the community about local resources and information about sex and reproductive health.

## Key recommendations

Based on these findings, the Healthy Youth Partnership has identified three areas in which youth-serving professionals and policymakers can affect changes in attitudes and behaviors that contribute to teen and unplanned pregnancy; working with youth, working with caregivers, and improving policies. To fully address these three areas HYP proposes the following recommendations:

|                         |   |
|-------------------------|---|
| Working with youth      | <p>Adopt a <b>gender-transformative approach</b> to break down rigid, binary concepts of gender and gender stereotypes, and build in inclusive approaches for more advanced conversations around gender identity, gender expression, and sexual orientation.</p> <p>Provide <b>educational and occupational opportunities</b> that address realistic pathways for youth to achieve adult status.</p> <p>Implement <b>youth-driven services</b> that involve peer educators.</p> <p>Prioritize developing <b>teen-friendly policies and practices</b>, requiring or encouraging staff to participate in professional development around building trust and rapport with youth.</p> |
| Working with caregivers | <p>Provide caregivers with <b>direct education</b> on how to talk to their children about sex, utilizing a <b>sex-positive approach</b>.</p> <p>Develop <b>community marketing campaigns</b> that focus on challenging caregivers to talk to their teenage children about sex and learn to become more comfortable with the notion that their teenage children are sexual beings.</p>   |
| Improving policies      | <p>Advocate for statewide and local school district policies that <b>encourage real, open, and honest communication</b> around topics of sexuality and sexual health.</p> <p>Advocate for <b>funding dedicated to holistic approaches</b> to positive youth development and sexual health.</p> <p>Advocate for policies that provide <b>support for teen parents</b>, both prenatally and postnatally.</p>  |

## Conclusion

HYP conducted this needs assessment to determine teen pregnancy prevention barriers and strengths in Travis County, and collect recommendations from our participants on how our community can better support youth in preventing pregnancy. We learned from our participants that Travis County teens are receiving mixed messages about sex and pregnancy, and they feel judged no matter what choices they make around abstinence and sexual activity. As a community, we need to LISTEN to youth, and recognize youth as experts in adolescence, TRANSFORM policies and practices to ensure every voice is heard and valued, and CLARIFY messages through open, honest communication throughout a child's lifespan. Based on our findings, HYP has developed recommendations around improving our work with youth, working with caregivers, and improving policies to address teen pregnancy and childbearing in our community. This report is intended to serve as a source of support and information for local community members, youth-serving professionals, and stakeholders in an effort to improve the well-being of adolescents throughout our community and beyond.



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# SECTION

# 1

## BACKGROUND

Status of teen sexual health in Texas and Travis County

Understanding teen pregnancy: Risk and protective factors

Effective programs and interventions

Policies

Purpose of study



# BACKGROUND

Teen pregnancy is a priority issue area of adolescent health due to the potential immediate and long-term impacts for teen parents, their children, and society (CDC, 2015a). Teen pregnancy does not exist within a silo. It is therefore critical to not only examine its potential impacts, but also to examine teen pregnancy within the context of the social determinants of health. *Healthy People 2020* defines the social determinants of health as the social, physical, and emotional “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (Healthy People 2020, 2014). This approach recognizes the interrelated social and societal factors that place teens at risk of early and unintended pregnancy, and that may influence the outcomes of those directly impacted. With so many factors at play in why young people may become pregnant, research is unable to determine if teen pregnancy is in itself a cause of the potential consequences, or if it “simply reflect(s) the preexisting differences in family background, such as poverty and other factors” that demonstrate the difference between young people who become pregnant and those who delay childbearing (Hoffman & Maynard, 2008).

The associated adverse consequences of early pregnancy and childbearing for the young parents, children and society include, but are not limited to, financial costs, reduced economic opportunity, psychological stress, and physical limitations. Although teen birth rates have decreased over the last decade, the United States has the highest teen birth rate (29.4) of similarly industrialized countries (United Nations Children’s Fund, 2001; Vexler & Suellentrop, 2006; Martin et al., 2013). Addressing factors that contribute to early pregnancy will help identify gaps in teen pregnancy prevention programs in the U.S. and create programs that can effectively relieve the potential negative outcomes (Hoffman & Maynard, 2008).

## **Economic and educational impacts**

Eighty-two percent of teen pregnancies are reported as unplanned, and unplanned pregnancy disproportionately affects economically disadvantaged women, who are reported to have an unintended birth rate six times higher than that of higher-income women, sustaining a persistent cycle of poverty (Guttmacher, 2013b).

Nearly 750,000 women ages 15 to 19 will become pregnant each year in the United States (U.S.) (Kost, Henshaw & Carlin, 2010). According to the National Campaign to Prevent Teen and Unplanned Pregnancy, teen pregnancy and childbearing has a statistically significant association with reduced education and economic attainment of young mothers (Ng & Kaye, 2013). Only 38% of teen mothers who had a child before they turned 18 will earn a high school diploma by age 22 and less than 2% earn a college degree by age 30 (Ng & Kaye, 2012a). This educational disparity is often followed by decreased economic opportunities and earnings in later years; by age 30, teen mothers on average earn 57% of the annual salary of those who delayed childbearing (Hoffman & Maynard, 2008). Forty-one percent of mothers who gave birth before age 20 were living below federal poverty guidelines and nearly two-thirds rely on public assistance within the first year of their child’s birth (Ng & Kaye, 2012b).

Children of teen parents are also more likely to struggle in school; they are 50% more likely to repeat a grade, less likely to complete high school, and are shown on average to score lower on standardized tests than children born to older parents (Ng & Kaye, 2012a).

In addition to the direct consequences that teen parents and their families face, teen and unplanned pregnancy is calculated to have high costs for society. Nationwide, adolescent pregnancy is estimated to cost U.S. taxpayers over \$12 billion per year (Furstenberg, 2003; Hoffman & Maynard, 2008). An analysis from the National Campaign shows that teen childbearing in Texas alone cost taxpayers an estimated \$1.1 billion in 2010. These public sector costs are calculated from public health care costs, child welfare, increased rates of incarceration, and “lost tax revenue due to decreased earnings and spending” (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2014).

## **Social impacts**

During adolescence, it is important for a young person’s psychosocial development to “socialize, develop as an individual, and learn how to develop healthy interpersonal relationships (and, hence, a support network),” and typically teen mothers have less time and energy to dedicate to their own development (Hoffman & Maynard, 2008).

The relationships between young mothers and the biological father of their child are greatly impacted by early and unintended pregnancy: 72% percent of teen mothers report being single at the time of their child’s birth (Ng & Kaye, 2012b). On average, teen mothers spend five times more time as single parents than mothers who gave birth in subsequent years (Hoffman & Maynard, 2008).

Research on teen parents has focused primarily on teen mothers, largely due to limited available information on legal fathers (Scott, Manlove, Steward-Streng, & Moore, 2012). In the state of Texas, biological fathers who are not married to the biological mother at the time of their child’s birth must sign the “Acknowledgment of Paternity” document to establish themselves as the legal father of their child. Without doing so, the child would have no legal father and the father would have no legal tie to the child (Texas Office of the Attorney General, 2014). Given the statistic that most teen mothers are single at the time of the child’s birth, it is difficult to even obtain an accurate count of teen fathers (Ng & Kaye, 2012b; Scott et al., 2012). It is estimated that about 30% to 50% of children born to teen mothers also have teen fathers (Mollborn & Lovegrove, 2011). Although research is less extensive on teen fathers, recent findings show significant influence of teen childbearing on teen fathers’ educational attainment and economic stability, similar to young mothers (Ng & Kaye, 2012b; Scott et al., 2012).

These social impacts can trickle down to affect the children of teen parents: sons are twice as likely to be incarcerated and daughters are three times as likely to become teen mothers themselves as children born to older parents (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2007).

## **Physical and mental health impacts**

Unplanned pregnancy is associated with unhealthy maternal and child outcomes including “delayed prenatal care, premature birth and negative physical and mental health effects for children” (Guttmacher, 2013b).

Children of teen parents are more likely to be born premature and at a low birth weight, increasing the probability of a number of other health concerns including infant death, blindness, deafness, chronic respiratory problems, and mental illness. They are also twice as likely to suffer abuse and neglect as children born to older parents.

The argument that pregnancy is always an adverse event in a teen's life can be disputed. Sociologist Frank F. Furstenberg, Jr. proposes that teen childbearing in itself is not the issue, but rather "how our political culture has responded to the ancillary problems of poverty, sexuality, gender relations, and the like" that proves to be challenging for young parents (Furstenberg, 2003). Pregnancy has been shown to be a protective factor against continued criminal activity and drug and alcohol use among women who come from a lower socioeconomic status (Kreager, Matsueda, & Erosheva, 2010). More recent research has also found that the economic hardship teen parents face in their adolescence and early 20s might dissipate later in life when compared to mothers who delayed pregnancy to a later age, and when appropriate statistical adjustment is performed (Hoffman & Maynard, 2008). Teen parenting programs that provide parental education, focus on improving birth outcomes, reduce rapid subsequent childbearing, and improve the care-giving environment and children's outcomes, can greatly mitigate the adverse effects of teen parenting (Beers & Hollo, 2009; Seitz & Apfel, 1999), but teen parents do not always have access to the most effective programs and services (Sarri & Phillips, 2004).

HYP recognizes that there are many causes for teen and unplanned pregnancy and most importantly, that the multiple interrelated social and societal structures that influence teen pregnancy rates must be critically examined from multiple perspectives. HYP asserts that it is essential to consider social determinants of health that increase an individual's risk of teen childbearing such as poverty, access to health education, and preventative health care. This report utilizes Douglas Kirby's *Sexual Risk and Protective Factors* to present a brief overview of how individual, peer, romantic partner, family, and community factors influence teen pregnancy and to provide a framework for analyzing the findings of this needs assessment (Kirby & Lepore, 2007). However, full exploration of these root causes is beyond the scope of this needs assessment. HYP encourages readers to think critically about the structural and societal factors that contribute to risk and protective factors and how service providers can design interventions that address them.



# Status of teen sexual health in Texas and Travis County

According to the Center for Disease Control and Prevention's (CDC) Youth Risk Behavior Surveillance System (YRBS), nearly 46% of Texas high school students reported having ever had sexual intercourse (CDC, 2014). Of those roughly 46% of Texas students, 47.1% reported not using a condom at last sexual intercourse and 79.8% reported not using hormonal methods of birth control (including birth control pills, implant, IUD, shot, patch, or ring) at last sexual intercourse (CDC, 2014). Over the course of this needs assessment, the percentage of students who have reported ever having sexual intercourse has dropped 11%, down from 51.6% in 2011. The percentage of students who report not using hormonal contraception at last intercourse has also decreased from 84.3% down to 79.8%, however the percentage of students reporting not using of condoms at last intercourse has slightly increased from 46.2% to 47.1% from 2011 (CDC, 2012).

## Pregnancy rates

Pregnancy rates reflect the number of pregnancies per 1,000 persons identified as female using pregnancy and population counts, and may be subject to reporting bias. The most recent county-level data for teen pregnancy shows a rate of 33.6 per 1,000 females ages 10 to 19 getting pregnant in Travis County in 2009 (Texas Department of State Health Services [Texas DSHS], 2014). Travis County reported 1,964 pregnancies to females 10 to 19 in 2009. Thirty-one of those pregnancies were to early adolescent females, ages 10 to 14 years old. The remaining 1,933 pregnancies were to females ages 15 to 19 years old, resulting in a pregnancy rate of 63.1 for this age group (Texas DSHS, 2014).

## Birth rates

Birth rates are calculated to determine the number of births per 1,000 persons identified as female using birth counts and population counts, and do not reflect individuals that did not carry their pregnancy to term. Birth rates are used over sheer number of births to identify population growth, and high birth rates may indicate "health impairments and low life expectancy, low living standards, low status of women, and low levels of education" (Frank, 2002).

Throughout the course of this needs assessment, county-level birth data was released for 2009, 2010, 2011, and 2012. Over these four years, Travis County has seen a significant drop in birth rates to adolescent females 10-19 years of age. Table 1 below outlines the birth rates for the 10-14 year old and 15-19 year old age groups, broken down by year and show the descending trend of births to teens (Texas DSHS, 2014).

**Table 1. Travis County teen birth rates per 1000 females, 2009-2012**

| Year | 10-14 years | 15-19 years |
|------|-------------|-------------|
| 2009 | 0.9         | 51.1        |
| 2010 | 1.0         | 39.8        |
| 2011 | 0.7         | 37.7        |
| 2012 | 0.5         | 33.2        |

Source: Texas Department of State Health Services (2014). Austin, TX: Center for Health Statistics

The teen birth rates in Travis County were 0.9 for females ages 14 and younger and 51.1 for females ages 15-19 in 2009. Using the latest available data (2012), Travis County has seen a 44% decrease in the 10-14 year old teen birth rate and a 35% decrease in the 15-19 year old teen birth rate over the past four years (Texas DSHS, 2014).

Comparing the rates of Travis County to the state of Texas, Travis County has consistently shown lower teen birth rates, as well as a greater percent change in reduction of births to teens. In 2012, Texas' teen birth rate for 10-14 year olds was 0.6, a 40% decrease over the past four years, and the birth rate for 15-19 year olds was 42.3, a 26.3% decrease since 2009 (Texas DSHS, 2014). However, both Travis County and Texas maintain higher birth rates for both age groups when compared to the United States, demonstrating the need for continued efforts targeting the issue area. The United States reported a birth rate of 0.4 for adolescents ages 10 to 14 and a birth rate of 29.4 per 1,000 adolescents ages 15 to 19 (Martin et al., 2013). Table 2 below demonstrates the comparison of birth rates between Travis County, Texas, and the U.S.

**Table 2. Travis County, Texas, and U.S. teen birth rates, 2012**

| Mother's Age | Travis County | Texas | United States |
|--------------|---------------|-------|---------------|
| 10-14 years  | 0.5           | 0.6   | 0.4           |
| 15-19 years  | 33.2          | 42.3  | 29.4          |

Source: Texas Department of State Health Services (2014). Austin, TX: Center for Health Statistics

Despite the overall decrease, teen pregnancy still disproportionately affects certain minority groups in central Texas. Table 3 below demonstrates the demographic breakdown of birth rates to adolescents in Travis County in 2012 by race/ethnicity.

**Table 3. Travis County teen birth rates by race/ethnicity and age of mother, 2012**

| Race/Ethnicity      | 10-14 years | 15-19 years |
|---------------------|-------------|-------------|
| White, Non-Hispanic | 0.09        | 8.8         |
| Black, Non-Hispanic | 0.3         | 34.9        |
| Hispanic            | 0.9         | 61.6        |
| Other               | 0.7         | 6.8         |

Source: Texas Department of State Health Services (2014). Austin, TX: Center for Health Statistics.

Adolescents who identify as Hispanic have the highest teen birth rate of all ethnic groups in Travis County, accounting for over 77% of all teen births in 2012. This equates to teen birth rates of 0.9 for 10-14 year olds and 61.6 for 15-19 year olds, significantly higher teen birth rates than the county as a whole. Hispanic females made up approximately 44% of the teen female-identified population in Travis County in 2012, with White females making up 37%, Black females making up 10%, and females identifying as an "Other" race/ethnicity making up 9% of the total teen female population that year. Similar to the county's overall rates, the birth rates for Hispanic female teens have consistently dropped, however the percentage of births to Hispanic female teens has remained consistent (Texas DSHS, 2014). Table 4 demonstrates the trend of birth rates to Hispanic teens and the percentage of births to Hispanic teens compared to all births within that age group.

**Table 4. Birth rates for Hispanic teens in Travis County, 2009-2012**

| Year | 10-14 years | % of total births to Hispanic teens (10-14yrs) | 15-19 years | % of total births to Hispanic teens (15-19yrs) |
|------|-------------|--|-------------|--|
| 2009 | 2.0         | 100%   | 93.1        | 75.9%  |
| 2010 | 2.0         | 93.1%  | 74.0        | 75.2%  |
| 2011 | 1.2         | 73.9%  | 67.9        | 75.6%  |
| 2012 | 0.9         | 77.8%  | 61.6        | 77.2%  |

Source: Texas Department of State Health Services (2014). Austin, TX: *Center for Health Statistics*.

## Understanding teen pregnancy: Risk and protective factors

Perhaps the most common discussion of adolescent pregnancy is within the context of risk and protective factors that impact the likelihood of teen pregnancy and births (Franklin, Corcoran & Ayers-Lopez, 1997; Franklin, Corcoran & Harris, 2004; Kalil & Kunz, 1999; Kirby & Lepore, 2007; Rounds 2004; Smith, 1994). Risk factors of teen sexual activity are individual, social or environmental characteristics or conditions that may lead a person to become pregnant or contract sexually transmitted infections (STIs)(Kirby & Lepore, 2007).

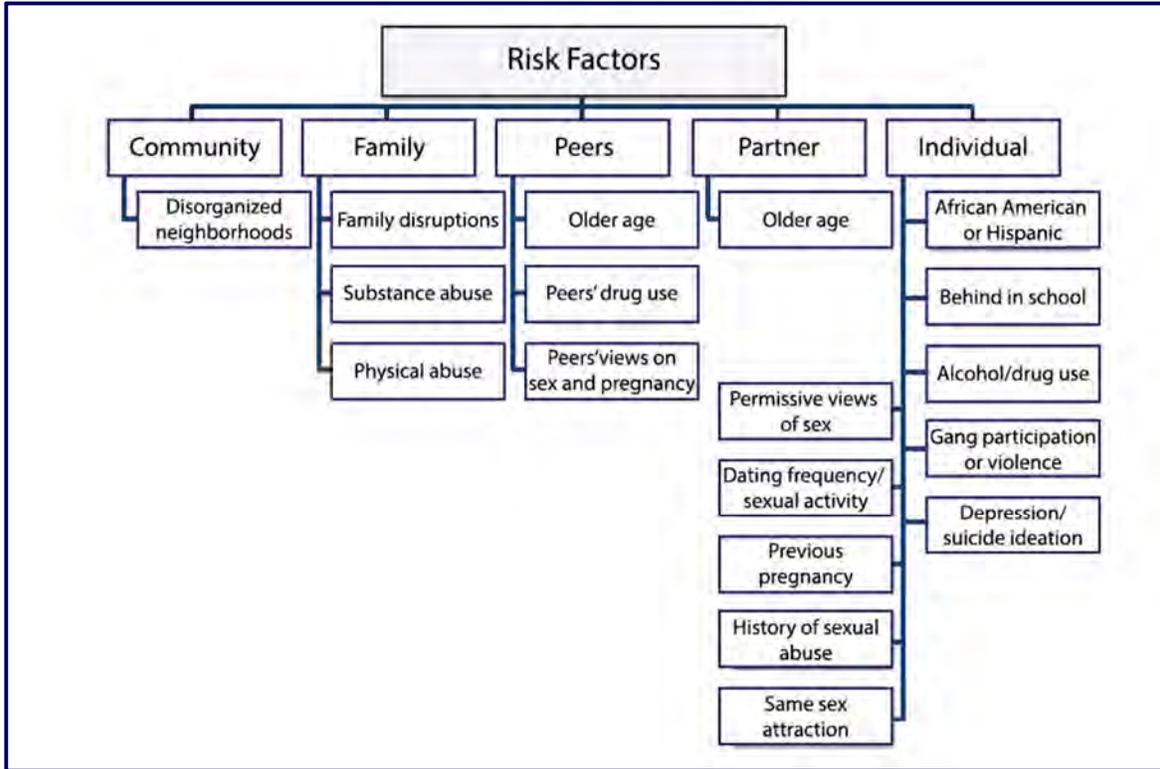
Protective factors for teen sexual health are those factors and conditions that discourage behaviors that can lead to pregnancy or STIs. In designing programs to reduce unhealthy and risky sexual behaviors, protective factors are generally used to target points of intervention. Because it may be difficult to completely eliminate risk factors in any one intervention, increasing protective factors through interventions is often seen as a means of countering the impact of risk factors (Kirby & Lepore, 2007).

Kirby and Lepore (2007) reviewed over 400 studies exploring risk and protective factors for teen sexual activity and identified over 500 different factors that influence teen sexual behavior and its potential consequences. These factors range from conditions that cannot be changed or influenced, such as an individual's cultural values, age, or physical development, to more proximal influences that can be addressed through programming, such as knowledge, attitudes and skills. Kirby and Lepore focused specifically on eight types of behaviors or circumstances; Initiation of sex, frequency of sex or sex during a specified time, number of partners, use of condoms, use of contraception, pregnancy or impregnation, childbearing, and STIs. They divide risk and protective factors that contribute to teen sexual behavior into categories of individual, peer, romantic partner, family and environmental factors (Kirby & Lepore, 2007).

The following discussions of risk and protective factors are drawn from information in Kirby and Lepore's 2007 report and provide a strong framework for the analysis of HYP's needs assessment results. Understanding these two categories as related to sexual behavior is important not only to changing that behavior, but also to identify the teens who are at greater risk of engaging in sexual behaviors that lead to teen pregnancy. All of the eight behaviors identified by Kirby and Lepore (2007) have been shown to be interrelated to each other. It may not be feasible to address all factor associations with a certain sexual behavior; however, it is recommended to focus on the most changeable and important factors when designing interventions. Although the factors identified below demonstrate correlations between teen pregnancy and other risk

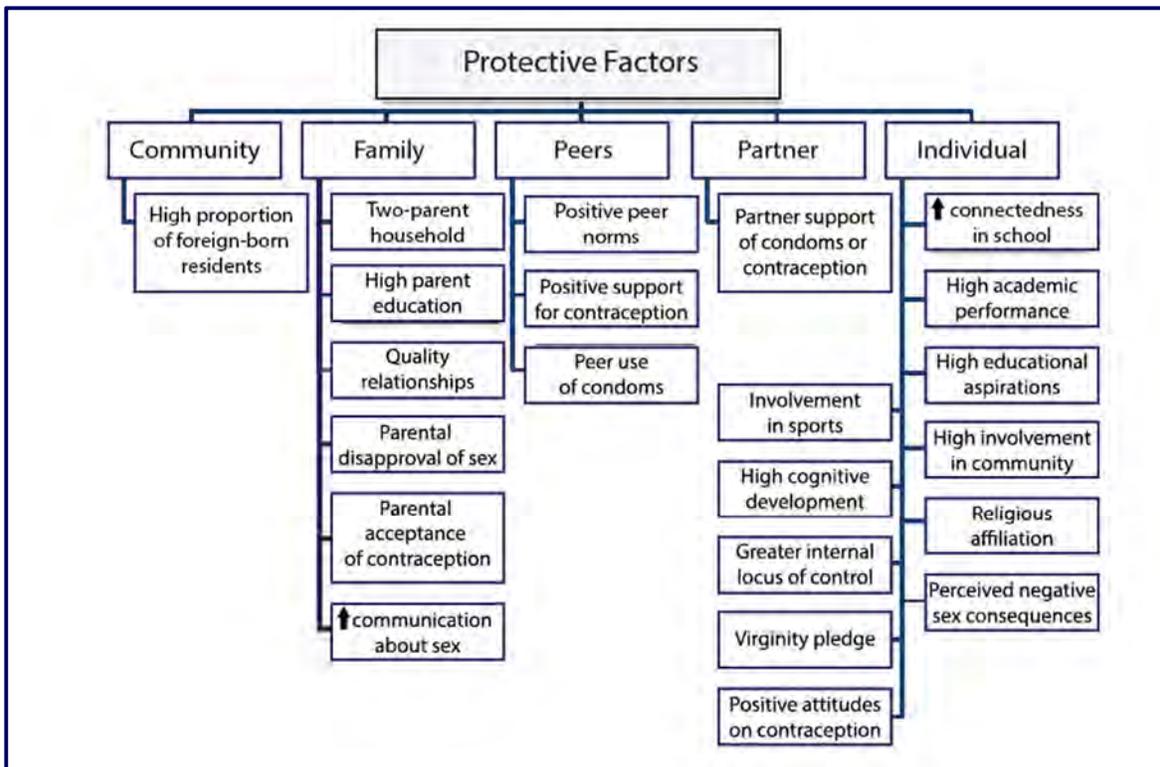
factors, they do not infer causality. In other words, it cannot be determined whether the risk factors or the sexual behavior came first. However, it is vital to know which factors have been shown to affect what behaviors in order to adequately influence them. Figure 1 on the following page is a chart of risk factors that may contribute to teen pregnancy or the contraction of STIs. Figure 2 is a chart of protective factors that may discourage behaviors that can lead to pregnancy or the contraction of STIs. A discussion of the data within the Figures follows.

**Figure 1. Risk factors for unhealthy sexual behavior**



\*Adapted from Kirby & Lepore, 2007

**Figure 2. Protective factors for healthy sexual behavior**



\*Adapted from Kirby & Lepore, 2007

## **Individual factors**

Individual risk factors include individual behaviors, beliefs, attitudes as well as biological and social characteristics. Some Individual biological factors that have been shown to be associated with the risk of teen pregnancy and childbearing are being an older adolescent and having higher cognitive development. Race and ethnicity may contribute to risk factors for teens. Particularly, there is a very high correlation between having minority race or ethnic status, particularly African American or Hispanic, and being more likely to have sex at a younger age, to have more sexual partners, to become pregnant and to contract an STI. This can be contributed to the relationship that exists between poverty, lack of opportunity, structural and individual discrimination, and minority status (Kirby & Lepore, 2007).

A teen's relationship with family has shown to be associated to teen pregnancy. Greater quality of family relationships and connectedness and greater parent/child communication about sex and birth control have all shown to be protective against teen pregnancy and childbearing. Experiencing sexual or physical abuse, a greater number of sexual partners, greater frequency of sex, gang membership, same sex attraction or behavior, substance use and abuse, greater sensation-seeking reckless behaviors, and previous pregnancies have been shown to be risk factors for teen pregnancy and childbearing. Previous, regular, and effective use of contraception and older age of sex initiation are associated protective factors. Religiosity and religious affiliation, higher self-esteem, and greater internal locus of control are associated protective factors against pregnancy and childbearing, but depression and suicidal thoughts may put youth at risk. Positive attitudes towards condoms, and having perceived greater negative consequences of pregnancy may also be protective factors against teen pregnancy (Kirby & Lepore, 2007).

Better educational performance, participation in school related activities, future orientation and plans for higher education have been associated as protective factors, while having problems in school have shown to be risk factors of teen pregnancy and childbearing (Kirby & Lepore, 2007). Other factors that have significant protective associations to other sexual behaviors besides teen pregnancy and childbearing include discussing contraception or STI prevention with partner, perceiving partner approval of contraception, greater self-efficacy for condom use and refraining from sex, greater knowledge that condoms are effective and don't reduce pleasure, and greater knowledge and perceived risk of STI/HIV transmission (Kirby & Lepore, 2007).

## **Peer factors**

Peer and partner-related factors may also have a large influence on the sexual behaviors of adolescents. Associating with peers with poor grades, and who engage in deviant behaviors are risk factors to teen pregnancy and childbearing. Having a good friend who has been pregnant or gotten someone pregnant, and having friends who are teen moms has also been associated as teen pregnancy and childbearing risk factors. Peers with permissive attitudes about sex are a risk factor for initiation of sex. Adolescents who associate with sexually active peers or an older peer group are more likely to have sex, emulating their peers' sexual behaviors and attitudes (i.e. permissive attitude about sex, frequency of sex, and multiple sexual partners). Risk-taking behaviors among peer groups, such as alcohol consumption or other drug use, may also induce an adolescent to do the same, which may lead to early initiation of sex (Kirby & Lepore, 2007).

Peer groups with positive attitudes toward preventive health and who support the use of condoms and/or contraception positively influence the sexual behaviors of adolescents and

support pregnancy prevention. Adolescents are more likely to delay sex if their peer group delays sex (Kirby & Lepore 2007).

### **Romantic partner factors**

Ages of partners and partners' attitudes regarding contraceptive use are significant factors that influence the sexual health of teens. Adolescents whose romantic partners are older are more likely to initiate sexual activity, less likely to use condoms or other forms of contraception, and are at a higher risk for pregnancy. (Kirby & Lepore, 2007).

Adolescents whose romantic partner supports the use of condoms and/or contraceptives positively influence sexual behaviors, correlating with the prevention of pregnancy and STI transmission (Kirby & Lepore, 2007).

### **Family factors**

Family characteristics are very important in determining adolescent sexual behavior. Disorganized family dynamics—divorce, family members' substance use and violence, and involvement in the child welfare system—have been shown to increase the chances that teens will engage in sexual activity. Research has also indicated that parents or siblings of teens who model engaging in early sexual activity place teens at a higher risk of engaging in that behavior themselves (Kirby & Lepore, 2007).

In contrast, family protective factors may support prevention of early initiation of sex, pregnancy, and contraction of STIs. Family protective factors include dual parent households, high level of education for parents, higher socio-economic status, greater parental religiosity, greater parent involvement in adolescent education, greater parental monitoring, and quality relationships and communication between the parent and the child. Mothers who gave birth at an older age was also associated as protective against the risk of teen pregnancy. Parent disapproval of teen sex and parent conversations about sex and contraception correlate with delaying the initiation of sex and increasing contraceptive use if teens do decide to have sex (Kirby & Lepore, 2007).



## **Environmental and community factors**

The primary community-related risk factor impacting teen sexual health is social disorganization in communities. Disorganized communities include those with higher rates of violence, substance use, unemployment, and hunger. Studies have shown that teens living in these types of communities are more likely to initiate sex at an earlier age and become pregnant. Community stress was also identified as a risk factor for sexual behaviors of teens (Kirby & Lepore, 2007).

Protective factors in communities point to youth involvement. Teens living in communities with greater community opportunities were found less likely to have children. Teens who experience greater neighborhood cohesion and neighborhood monitoring by adults are far more likely to delay sexual activity, and if the teens decide to have sex, the chances of using contraceptives increase (Kirby & Lepore, 2007). Other environmental protective factors that have been shown to reduce the risk of teen pregnancy and childbearing are contraception instruction and condom distribution in schools, and higher levels of state funding for family planning (Kirby & Lepore, 2007).

## **Effective programs and interventions**

Growing evidence shows a number of programs and interventions that have proven to help prevent early and unintended pregnancies among youth by delaying onset of sexual activity and improving contraceptive use among sexually active youth. Programs that use an experimental program evaluation design in which participants are randomly assigned to treatment and control groups are considered to have the strongest evidence base due to the focus on behavior changes among participants. For programs that have not had the opportunity or resources to undergo an experimental evaluation, researchers have also identified distinct, common characteristics among curriculum-based programs that have been proven effective. One core characteristic of effective programs is that they provide a clear message. For example, instead of simply listing out the pros and cons of initiating sex at an earlier age, an effective program will encourage its participants to practice abstinence or use contraception if they choose to have sex. Other characteristics of effective programs include implementation over a longer period of time; engagement of participants in an interactive setting; teaching communication skills; addressing peer pressure; reflecting the age, sexual experience, and culture of the youth participants; and selecting leaders who are passionate about the pregnancy prevention program (Suellentrop, 2011). In addition to implementation characteristics, prevention programs that target interpersonal and problem-solving skills are most effective at preventing pregnancy because they build on skills that promote self-efficacy and support adolescents in healthy sexual decision-making (Franklin & Corcoran, 2000).

Examining best practices nationwide can help identify program components that successfully decrease teen pregnancy and those that are less effective. By deriving what works and what does not work from programs that have proven effective, gaps in teen pregnancy prevention can be identified and addressed. The following sections will discuss types of effective programs, how these programs were evaluated, and identify characteristics of effective programs.

## **Evidence-based interventions**

Evidence-based programs are evaluated using an experimental or quasi-experimental design, which assigns an independent variable and measures the resulting dependent or responding variable. The experimental design includes a treatment group and a control or comparison group to evaluate the effectiveness of each program on reducing teen pregnancy rates, reducing STI rates, delaying sexual initiation and other risk factors and sexual behaviors (Advocates for Youth, 2012). The Office of Adolescent Health in the U.S. Department of Health and Human Services (HHS) has partnered with Mathematica Policy Research and Child Trends since 2009 to conduct a systematic review of evidence-based teen pregnancy prevention programs (TPPs). This partnership evaluated the effectiveness of TPPs based on the strength of evidence supporting the programs' impact on reducing teen pregnancy, STIs, and other sexual risk behaviors (Mathematica Policy Research & Child Trends, 2012). The evaluation identified the following **priority outcome measures for teen pregnancy prevention**:

- 1. Sexual activity**
- 2. Contraceptive use**
- 3. Sexually transmitted infections**
- 4. Pregnancies or births**

In order for programs to meet the HHS criteria for evidence-based programs, the program's evaluation "must show evidence of a positive, statistically significant impact on at least one priority outcome measure for either the full analytic sample or a subgroup defined by (1) gender or (2) sexual experience at baseline" (Mathematica Policy Research & Child Trends, 2012). Over the years, HHS has identified a list of 37 programs that have met the effectiveness criteria of a teen pregnancy prevention evidence-based program and have been found to be effective at preventing teen pregnancies, reducing STIs, and/or reducing rates of associated sexual risk behaviors. Table 5 outlines the 37 programs currently on the HHS list of evidence-based teen pregnancy prevention programs (U.S. Department of Health and Human Services, 2015).

**Table 5. HHS list of evidence-based teen pregnancy prevention programs**

| Program Name  | Program Type        | Evaluation Setting               |
|---|---------------------|----------------------------------|
| 1. ¡Cuidate!  | Sexuality education | After school/community-based     |
| 2. Aban Aya Youth Project   | Sexuality education | Middle school                    |
| 3. Adult Identity Mentoring (Project AIM)   | Youth development   | Middle school                    |
| 4. All4You!   | Special populations | High school, Specialized setting |
| 5. Assisting in Rehabilitation Kids (ARK)   | Special populations | Specialized setting              |
| 6. Be Proud! Be Responsible!  | Sexuality education | After school/community-based     |
| 7. Be Proud! Be Responsible! Be Protective!   | Special populations | Middle school, High school       |
| 8. Becoming a Responsible Teen (BART)   | Sexuality education | After school/community-based     |
| 9. Children's Aid Society- Carrera Program  | Youth development   | After school/community-based     |
| 10. Draw the Line/Respect the Line  | Sexuality education | Middle school                    |
| 11. Families Talking Together (FTT)   | Special populations | Clinic-based                     |
| 12. FOCUS   | Sexuality education | Specialized setting              |
| 13. Get Real  | Sexuality education | Middle school                    |
| 14. Health Improvement Project for Teens (HIP Teens)                                  | Sexuality education | After school/community-based     |
| 15. Heritage Keepers Abstinence   | Abstinence          | Middle school, High school       |
| 16. HORIZONS  | Sexuality education | Health clinic                    |
| 17. It's Your Game: Keep It Real (IYG)  | Sexuality education | Middle school                    |
| 18. Making a Difference!  | Abstinence          | After school/community-based     |
| 19. Making Proud Choices!   | Sexuality education | After school/community-based     |
| 20. Prime Time  | Youth development   | Clinic-based                     |
| 21. Project IMAGE   | Special populations | Health clinic                    |
| 22. Project TALC  | Special populations | After school/community-based     |
| 23. Promoting Health among Teens!   | Abstinence          | After school/community-based     |
| 24. Promoting Health among Teens! Comprehensive Abstinence and Safer Sex Intervention | Sexuality education | After school/community-based     |
| 25. Raising Healthy Children  | Youth development   | Elementary school                |
| 26. Reducing the Risk   | Sexuality education | High school                      |
| 27. Respeto/Protector   | Special populations | After school/community-based     |
| 28. Rikers Health Advocacy Program  | Special populations | Specialized setting              |
| 29. Safer Choices   | Sexuality education | High school                      |
| 30. Safer Sex   | Clinic-based        | Health clinic                    |
| 31. Seventeen Days  | Clinic-based        | Health clinic                    |
| 32. Sexual Health and Adolescent Risk Prevention (SHARP)                              | Special populations | Specialized setting              |
| 33. SiHLE   | Sexuality education | Health clinic                    |
| 34. Sisters Saving Sisters  | Sexuality education | Health clinic                    |
| 35. STRIVE  | Special populations | After school/community-based     |
| 36. Teen Health Project   | Sexuality education | After school/community-based     |
| 37. Teen Outreach Program (TOP)   | Youth development   | High school                      |

Source: U.S. Department of Health and Human Services (2015). Washington, D.C.: *Evidence-Based Programs*.

## Promising programs and interventions

Promising practices are those that utilize characteristics of effective public health interventions, and demonstrate strong quantitative and qualitative positive findings, but do not yet have enough research “to support generalizable positive public health outcomes (Association of Maternal and Child Health Programs, 2015). While these programs have not been formally proven effective by experimental evaluation, they show “Kirby’s 17 Characteristics of Effective Programs,” a tool developed by researchers Kirby, Rolleri, and Wilson (2007) to assist programs in selecting effective curriculum-based programs. Figure 3 below outlines the 17 identified characteristics at a glance:

**Figure 3. Kirby’s 17 characteristics of effective programs**

- 1 Involved people with diverse backgrounds to contribute to the theory, research and education of the curriculum
- 2 Assessed relevant needs and assets of target groups
- 3 Developed and followed a logic model
- 4 Designed activities that are consistent with community values and resources
- 5 Pilot-tested the program
- 6 Focused on clear health goals
- 7 Focused narrowly on addressing specific behaviors leading to the health goals
- 8 Addressed multiple risk and protective factors
- 9 Created a safe social environment for youth to participate
- 10 Included multiple activities to target risk and protective factors
- 11 Employed instructionally sound teaching methods
- 12 Employed activities and teaching methods that were appropriate to the youths' culture, developmental age and sexual experience
- 13 Covered topics in a logical sequence
- 14 Secured support from appropriate authorities
- 15 Provided training, supervision and support to educators
- 16 Implemented activities to recruit and retain youth
- 17 Implemented all activities with reasonable fidelity

\*These 17 characteristics are also extensively considered when determining effective, evidence-based programs (Kirby, Rolleri & Wilson, 2007).

## **Federal funding and programs**

There are several federal funding streams dedicated to sex education programming. The Division of Adolescent and School Health (DASH) within the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC) funds five-year cooperative agreements with State- (19) and Local- (17) Education Agencies (SEAs & LEAs) to build school capacity to provide students with: 1) exemplary sexual health education; 2) linkage to health care; and 3) safe and supportive environments. Nine national organizations are funded to provide assistance to SEAs and LEAs. DASH also supports surveillance of youth risk behaviors (YRBS) and school health policies and practices (SHPPS & Profiles). Over \$3 billion dollars was allocated in the 2015 president's discretionary budget authority (Sexuality Information and Education Council of The United States [SIECUS], 2014a). In 2013, the state of Texas and local Texas organizations received \$609,615 in DASH funding (SIECUS, 2014b).

The President's teen pregnancy prevention initiative (TPPI) funds medically-accurate and age-appropriate programs to reduce teen pregnancy. The U.S. Department of Health and Human Services, Office of Adolescent Health (OAH) administers the grant program, which totaled \$105 million in funding for the 2014 Fiscal Year (FY) (SIECUS, 2014a). TPPI includes two funding tiers. Tier 1 totals \$75 million and provides funding for the replication of evidence-based programs proven to reduce unintended teen pregnancy. Tier 2 at \$25 million provides funding allocated for development, research, and testing of new innovative approaches. For FY 2013, local organizations in Texas received \$4,584,030 in TPPI Tier 1 programming and \$2,823,533 for TPPI Tier 2 Innovative Approaches (SIECUS, 2014b).

A third funding stream, the State Personal Responsibility Education Program (PREP), is administered by the Family and Youth Services Bureau (FYSB), Administration for Children and Families (ACF) and totals \$75 million a year for the period 2014–2019. PREP provides young people with medically-accurate and age-appropriate sex education to help reduce the risk of unintended pregnancy, HIV/AIDS, and other STDs. The state of Texas did not apply for PREP funding in FY 2013 but received Competitive Personal Responsibility Education Program (CPREP) grants for \$8,519,355 (SIECUS, 2014b).

The Title V State Abstinence Education Grant Program (Title V Abstinence-Only Program) allocated \$50 million per a year to states for FYs 2010-2014. The Administration for Children and Families (ACF) administers the program. Title V requires states to provide three dollars for every four federal dollars received. All programs that receive this funding must promote abstinence as their exclusive purpose and may provide mentoring, counseling, and adult supervision to achieve this goal. Programs must be medically-accurate and age-appropriate. In FY 2013, the Texas Department of State Health Services received \$5,114,979 for Title V Abstinence-only programming (SIECUS 2014b).

The final funding stream, the Competitive Abstinence Education (CAE) program reserved \$5 million of dedicated discretionary funding for abstinence-only-until-marriage programs which was included in the final FY 2012 federal appropriations legislation. Texas did not have any grantees from this program in 2013 (SIECUS, 2014b).

## Austin/Travis County interventions

Extensive pregnancy prevention programs exist in the Austin/Travis County service area. Although Travis County has seen a consistent decline in the teen birth rates over the past four years, the teen birth rates continue to be higher than national birth rates (Texas DSHS, 2014; Martin, et al. 2013). The disparity between the number and quality of teen pregnancy prevention efforts and the teen birth rates in Travis County implies that there are additional regional barriers to pregnancy prevention that have not been addressed effectively.

A variety of teen pregnancy prevention interventions are available in community-based, clinic-based, and school-based settings in the Austin/Travis County area. Table 6 below is a chart of Austin/Travis County-based programs specifically targeting teen pregnancy prevention, a brief description of the services offered, and a categorization of the type of programming utilized. HYP has categorized these programs based on the evaluation design, as well as designated them to be either comprehensive education or abstinence education, if applicable. “Comprehensive” is used to describe programming that “explores the context for and meanings involved in sex” and typically includes promoting abstinence from sexual activity, acknowledging teen sexual activity, and lessons on contraception use and STIs. “Abstinence” is used to describe programming that focuses on “discussions of values, character building, and in some cases, refusal skills” and does not include discussions of teen sexual activity or contraception and condom use (Collins, Alagiri, & Summers, 2002).

The programs listed in Table 6 below represent programs and interventions practiced in Austin/Travis County. While these programs and interventions are not the only resources for pregnancy prevention in Austin, they represent well-known pregnancy prevention practices used by the community. Some programs, such as ones provided by community health educators with Planned Parenthood of Greater Texas, provide comprehensive sex education upon request to any community member. Others focus on specific risk factors such as gender (i.e. Gender Matters) and family/community disorganization (i.e. Lifeworks) working with a set population determined through community partnerships.

**Table 6. Teen pregnancy prevention programs in Austin and Travis County**

| Program  | Description   | Implementing Agencies                                     | Service Population  | Funding Source  | Year Began |
|--|---|---|---|---|------------|
| <b>Evidence-based comprehensive programs</b>                                   |   |   |   |   |            |
| <b>PREP: Be Proud! Be Responsible! Be Protected! Be Proud! Be Responsible!</b> | Sexuality education with teen parents utilizing <i>Be Proud! Be Responsible! Be Protected!</i> with adaptations.<br>Sexuality education with homeless, runaway and foster youth utilizing <i>Be Proud! Be Responsible!</i>                                | LifeWorks   | Community-based: Teen parents and homeless, runaway, and foster youth     | ACF Personal Responsibility Education Program Grantee                                       | 2013       |
| <b>PREP: Connections Project</b>   | Sexuality education to foster and juvenile justice <i>Making Proud Choices!</i> curriculum with adaptations   | Cardea Services<br>Planned Parenthood of Greater Texas    | Community-based: Youth in foster care and juvenile justice systems        | ACF Personal Responsibility Education Program Grantee                                       | 2013       |
| <b>PREP: Making Proud Choices!</b>   | Sexuality education to youth utilizing <i>Making Proud Choices!</i> curriculum with adaptations   | Planned Parenthood of Greater Texas<br>EngenderHealth     | School-based: High school students  | ACF Personal Responsibility Education Program Grantee                                       | 2013       |
| <b>REAL TALK Program</b>   | Sexuality education to middle school youth utilizing <i>It's Your Game: Keep It Real</i> and to early high school youth utilizing <i>Reducing the Risk</i> with adaptations   | LifeWorks<br>Planned Parenthood of Greater Texas          | School-based: Middle and high school students                             | Office of Adolescent Health<br>Teen Pregnancy Prevention Tier 1 Grantee                     | 2011       |
| <b>Sisters Saving Sisters</b>  | Sexuality education to female youth utilizing <i>Sisters Saving Sisters</i> curriculum with adaptations   | Planned Parenthood of Greater Texas                       | Community & clinic-based:<br>Female teens                                 | Private donations<br>City of Austin and Travis County Health and Human Services Departments | 2014       |
| <b>¡Cuidate! Peer to Peer Program</b>  | Sexuality education to high school youth utilizing <i>¡Cuidate!</i> curriculum and peer health educators  | Austin/Travis County Health and Human Services Department | High school age Latino/Hispanic youth                                     | Medicaid 1115 Waiver program  | 2014       |
| <b>Project AIM: Adult Identity Mentoring</b>                                   | Project AIM is a group-level youth development intervention designed to reduce HIV risk behaviors among youth by encouraging at-risk youth to imagine a positive future and discuss how current risk behaviors can be a barrier to a successful adulthood | Austin Voices for Education and Youth                     | Community-based: After-school programming; 8 <sup>th</sup> grade students | Texas DSHS Abstinence-Centered Program Grantee  | 2012       |

| Program  | Description   | Implementing Agencies  | Service Population  | Funding Source  | Year Began |
|--|---|--|---|---|------------|
| <b>Promising comprehensive programs</b>                      |   |  |   |   |            |
| <b>Austin Healthy Adolescent Program Sexuality Education</b> | Sexuality education utilizing Big Decision curriculum for middle and high school youth  | Austin/Travis County Health and Human Services Department                              | After school program: Youth in juvenile probation                                       | City and County Health Departments  | 2001       |
| <b>Big Decisions in AISD</b>                                 | Sexuality education curriculum  | Austin Independent School District   | School-based; Students in health class  | AISD Physical education budget  | 2010       |
| <b>Gender Matters</b>  | Newly developed teen pregnancy prevention curriculum with emphasis on gender messages and healthy relationships, undergoing rigorous evaluation to determine evidence base  | EngenderHealth, SafePlace  | Community-based: Youth at a summer youth employment program                             | Office of Adolescent Health Teen Pregnancy Prevention Tier 2 Grantee  | 2011       |
| <b>Get Real</b>  | Sexuality education for youth utilizing Get Real curriculum   | Planned Parenthood of Greater Texas  | School and community-based  | Private donations; Austin/Travis County Health and Human Services   | 2010       |
| <b>Wise Guys and Big Decisions</b>                           | Sexuality education for middle and high school students utilizing the Wise Guys and Big Decisions curricula   | El Buen Samaritano   | School-based: Youth attending an international school or involved in juvenile probation | Michael and Susan Dell Foundation   | 2006       |
| <b>Clinic-based programs</b>                                 |   |  |   |   |            |
| <b>Center for Adolescent Health</b>                          | Provides affordable, specialized, interdisciplinary healthcare including primary care, adolescent gynecology services, STD/pregnancy testing, prevention education, risk-reduction counseling, and social work services   | People's Community Clinic  | Clinic-based: Teens and young adults ages 11-23   | Michael and Susan Dell Foundation; St. David's Foundation; Shield-Ayres Foundation; Triumphant Love Lutheran Church; Trull Foundation | 1993       |
| <b>Tandem Teen Prenatal and Parenting Program</b>            | Interagency collaboration designed to provide medical, mental health, educational/vocational, and social support to low-income young parents and their children, seeking to promote the health and well-being of participating young families and reduce their risk of subsequent unplanned pregnancies | People's Community Clinic<br>Any Baby Can<br>Austin Child Guidance Center<br>LifeWorks | Clinic-based: Low-income teen mothers up to age 17                                      | St. David's Community Health Foundation   | 1997       |
| <b>LARC and STI Testing and Treatment Programs</b>           | Provides low-cost or free long-acting, reversible birth control, including IUDs and birth control implants, and low-cost or free sexually transmitted   | Planned Parenthood of Greater Texas  | Clinic-based: Low income, uninsured   | Federal Funding   | 2013       |

| Program                                     | Description   | Implementing Agencies  | Service Population   | Funding Source  | Year Began           |
|---|---|--|--|---|----------------------|
| <b>Programs not measured/status unknown</b> |   |  |  |   |                      |
| <b>BrdzNBz</b>                              | Free sexual health text messaging service   | Austin/Travis County Health and Human Services<br>Adolescent Pregnancy Prevention Campaign of NC | Community-based: Teens 13-19 residing in Travis County                     | Texas Department of State Health Services Title V Grantee | 2011 (ended in 2014) |
| <b>Our Whole Lives</b>                      | Series of sexuality education curricula developed for use within the Unitarian Universalist Church, equipping participants with accurate, age-appropriate information throughout the course of their lives, comprehensive | Dr. Laura Hancock, Planned Parenthood of Greater Texas   | Church-based: youth involved in partnering Unitarian Universalist Churches | Not funded  | 2012                 |
| <b>Talk First!/¡Hable Primerol!</b>         | Educational workshops to provide parents with the tools and resources to have conversations with their children around sexuality and healthy decision-making, comprehensive   | Planned Parenthood of Greater Texas  | Community-based: Parents   | Private donations   | 2009                 |
| <b>Austin LifeGuard</b>                     | Sexual risk avoidance character and sex education program of Austin LifeCare, a non-profit pregnancy resource center, abstinence  | Austin LifeCare  | Community-based: Middle and high school students                           | Private donations   | 1989                 |
| <b>True Love Waits</b>                      | Youth-based campaign encouraging moral purity by adhering to biblical principles and challenging youth to make a commitment to sexual abstinence until marriage, abstinence   | Mt. Zion Baptist Church  | Church-based   | Church budget   | 1997                 |
| <b>SMART Moves</b>                          | SMART Moves (Skills Mastery and Resistance Training) is a nationally acclaimed comprehensive prevention program that helps young people resist alcohol, tobacco and other drugs and avoid premature sexual activity.      | Boys and Girls Clubs of the Austin Area  | Youth involved in after school program                                     | Unknown –   | Un-known             |

Source: Information gathered from Youth Services Mapping database, each program's corresponding web page, and program contacts at each organization

## Policies

### Texas sex education policies

Although policies regarding family planning and sexual health education are often targeted for macro-level interventions to reduce teen pregnancy, little information is available to suggest that policies impact teen pregnancy. Rather, the majority of research has focused on specific programs and the risk factors those programs address. While more research is needed to explore the effects of policy on teen pregnancy rates, research suggests that policies emphasizing abstinence education are ineffective at reducing teen pregnancy rates (Santelli, Lindberg, Finer & Singh, 2007). Additionally, policy analysis suggests that comprehensive sexual health education and increased contraceptive access may be effective at decreasing teen pregnancy (Tortolero, Cuccaro, Tucker, Weerasinghe & Li, 2011).

#### **The Texas Education Code requires that human sexuality education includes:**

- 1 Presenting abstinence from sexual activity as the preferred behavior for unmarried minors
- 2 Focus on abstinence more than on any other behavior
- 3 Emphasizing the effectiveness of abstinence in preventing pregnancy, STIs, and "emotional trauma associated with adolescent sexual activity"
- 4 Teaching contraception and condom use in terms of human reality rates (Tex. Educ. Code § 28.004, 2011)

The Texas Education Code prohibits schools from distributing condoms in conjunction with human sexuality education and requires that parents are notified and have the right to opt their children out of human sexuality instruction if desired (Texas Educ. Code § 26.010). Texas requires that school districts establish a local school health advisory council (SHAC) to make recommendations as to the appropriate grade levels and methods of instruction for human sexuality education to provide an opportunity for the local community values to be reflected in the district's health education instruction (Texas Educ. Code § 28.004).

In 2009, Wiley and Wilson, researchers at Texas State University, conducted a comprehensive review of all the sex education materials used in all Texas school districts. By invoking the Public Information Act, they were able to obtain material from 990 or 96% of all districts. The results paint a clear picture of what sexuality-related information is being taught in the schools: 94% of schools teach sex education that could be classified as abstinence only, 4% of schools taught abstinence along with contraceptive methods, classifying them as comprehensive sex education or what is commonly referred as "abstinence-plus," 2% of schools taught no sex education (Wiley & Wilson, 2009). The Texas Freedom Network Education Fund conducted a more recent update and found that now at least 25.4% of Texas schools use abstinence-plus programs. The report is based on an analysis of the state's data collected by a Texas Education Agency (TEA) survey of school districts. 677 out of 1,000 school district responded to the survey (Texas Freedom Network [TFN], 2011).

## Texas sexual and reproductive health policies

In regards to health insurance, Texas “has the highest proportion of uninsured individuals of any state” (Hasstedt, 2014). In 2012, there were 5,848,180 women of reproductive age (ages 13-44) in Texas, 3,148,250 of who were in need of contraceptive services (Guttmacher, 2014). Of these women, 393,430 were under 20 years old. Researchers with the Commonwealth Fund ranked Texas 44<sup>th</sup> in the nation in general health system performance, and “in the bottom three states in specific measures of health care access and affordability, and prevention and treatment” (Hasstedt, 2014). In Texas, public funding for contraceptive and reproductive healthcare services may be accessed through three funding streams: the Medicaid federal-state insurance program, the federal Title X family planning program, and the state-run Women's Health Program (Sonfield & Gold, 2012; Texas Women's Health Program, 2015).

Texas' Medicaid program requirement limit options for affordable care: Texas has the second lowest income eligibility ceiling in the U.S., childless adults are ineligible to enroll, and parents' eligibility level is 19% of the federal poverty level. Texas rejected the expansion of state Medicaid in 2012 in favor of implementing its own health insurance marketplace under the Affordable Care Act (Hasstedt, 2014). In 2012, publically-funded family planning services helped women in Texas avoid 55,900 unintended pregnancies, which would have resulted in an estimated 27,700 births and 19,100 abortions (Guttmacher, 2014).

In 2007, Texas was among the half of states that expanded Medicaid eligibility specifically for contraceptive and reproductive health services by creating the Texas' Women's Health Program. In 2011, the Texas legislature enacted major cuts to this program, including a ban on Planned Parenthood participating in the state program. According to researchers at The Texas Policy Evaluation Project, dozens of family planning clinics have had to close, reduce hours or services to accommodate the cuts made in 2011 (White, Grossman, Hopkins, & Potter, 2012). At the end of 2013, the cycle for Title X grant funding came to an end, requiring the Texas Department of State Health Services to reapply for continued funding, and offering an opportunity for nongovernmental entities within the state to apply for funds. The grant was awarded to the Women's Health and Family Planning Association of Texas (Hasstedt, 2014).

Parental consent is not required for minors to purchase nonprescription contraception (e.g., condoms) or to receive information about family planning. Minors must get a guardian's permission to receive prescription hormonal contraception, unless they are on active duty with the armed services, legally emancipated, or over 16 years of age, living on their own, and managing their own finances (Texas Family Code §32.003). Minors do not need parental consent if they wish to receive family planning services at a Medicaid or Title X Family planning source. The constitutional right to privacy provided by Medicaid and Title X covers a minor's access to contraceptives (Project Grants for Family Planning Services, 2015). Recent research suggests that “higher rates of contraceptive use and use of more effective modes of contraception are a major factor” in the recent declines in teen pregnancy and birth rates (Hoffman & Maynard, 2008; Santelli, et al, 2007). Restrictive laws for contraceptive licensing, advertising, or selling are a risk factor for teen pregnancy, while higher levels of state funding for family planning services are a protective factor from early childbearing (Kirby & Lepore, 2007).

Minors can consent to medical treatment related to pregnancy, other than abortion. Eligible young women can receive prenatal care from Medicaid or CHIP. Pregnant young women have the right to refuse this care (Texas Family Code § 32.003).

Pregnant and parenting students have the same rights to access school activities and special services that temporarily disabled students have a right to access. These include the right to:



- Continue going to school, take regular classes, and participate in school activities. This also applies to individuals who have given birth or had an abortion.
- Choose to attend a special program for pregnant or parenting students. Such a program must offer the same opportunities available at their regular school.
- Decline to attend a special program for pregnant or parenting students.
- Be excused for medically necessary absences due to pregnancy or childbirth.
- Not need a doctor's note to continue going to school or engaging in activities, unless all students must have one (Education Amendments of 1972, 2015).

Minors may consent to health and dental care for their children. Pregnant minors and minor parents may receive health services (Texas Family Code § 32.003). Minor parents may also receive public assistance for their children if they meet eligibility requirements for assistance programs under the Texas Human Resources Code (Texas Human Resources Code § 31.0051).

In Texas, a physician performing an abortion on a minor must contact the guardian of the minor at least 48 hours before the procedure to inform them of their intent. Policies that require parental involvement in abortion have been shown to be a risk factor to teen childbearing (Kirby & Lepore, 2007). The physician must also:

Based on his or her good faith clinical judgment, determine if a condition exists that complicates the medical condition of the pregnant minor and necessitates the immediate abortion of her pregnancy to avert her death, or to avoid a serious risk of substantial and irreversible impairment of a major bodily function; and

Certify in writing to the Department of State Health Services and in the patient's medical record that the medical indications supporting the physician's judgment exist (Texas Family Code § 33.003).

Presently there is ban on abortion after 22 weeks from a woman's last menstrual period, physicians who perform abortions must also have admitting privileges to a nearby hospital, and facilities that provide abortion must be the functional equivalent as ambulatory surgical centers. Due to these restrictions almost half of the state's clinics that provide abortion services have closed since 2013 (Hasstedt, 2014).

## Purpose of study

Given that the birth rates in Travis County are higher than the national birth rates, it is imperative to focus energy on examining the causes of high birth rates in Travis County and understand what prevention efforts may be needed to reduce the birth rate. The purpose of this needs assessment is to examine teen pregnancy prevention efforts in Travis County. In order to do so, this needs assessment is guided by the following research questions:

- 1 What are the barriers to teen pregnancy prevention in Travis County?
- 2 What are the strengths in teen pregnancy prevention in Travis County?
- 3 What recommendations does the community have to reduce the teen birth rate in Travis County?

These questions will be addressed using a mixed methods approach to data collection which is described in the following section.





# SECTION

# 2

## METHODS

Establishing a collaborative, multi-disciplinary research team

Qualitative study

Quantitative study



## METHODS

This needs assessment was conducted by a multi-disciplinary collaboration of youth-serving professionals in the Austin and Travis County area, with the support of their organizations. The team used a mixed-methods approach to address the research questions and ultimately, present a holistic picture of teen pregnancy prevention in Austin. The qualitative portion of the study consisted of focus groups and interviews with teens, teen mothers, teen fathers, and parents. The quantitative portion of the study utilized online surveys distributed to service providers, medical providers, and educators in the Austin area.

### **Establishing a collaborative, multi-disciplinary research team**

Beginning in January of 2012, leadership from HYP invited members of the community to join its efforts in conducting this needs assessment by participating on an advisory team. Monica Faulkner, PhD, LMSW, Associate Director of UT's Child and Family Research Institute served as the Principal Investigator for the project. Jeni Brazeal, at that time representing the City of Austin Health and Human Services Department and later EngenderHealth, served as Co-Investigator, facilitating the process of bringing youth-serving professionals together to plan and conduct research. Laura Marra, MSSW with the UT Child and Family Research Institute also served as Co-Investigator, leading the data transcription, coding, and analysis processes.

In total, the advisory team consisted of 34 volunteer members, representing 9 different organizations. Members included practitioners, students, and researchers with backgrounds in social work, public health, health education, case management, healthcare access, parenting support, and youth development. Both direct service and management were represented on the advisory team, and majority of team members had experience working directly with youth. HYP leadership was intentional about wanting this needs assessment to be an opportunity for professional growth, and wanted to bring together people of varying background to broaden the perspectives at the table. A list of team members and their respective agencies is captured in Appendix A.

The advisory team held monthly meetings throughout the process in order to plan and monitor progress. Workgroups were formed at various points throughout the process to address specific parts of the methodology, including literature review, data collection instrument creation, training facilitators, recruiting participants, facilitating focus groups, and data analysis. These workgroups were an effort to allow providers to move in and out of the process as needed to accommodate everyone's varied work commitments. The initial literature review was conducted by a group of undergraduate and graduate research assistants with the Child and Family Research Institute, under the supervision of Dr. Faulkner, Jeni Brazeal, and Kristin McDuffie, MPH with Planned Parenthood of Greater Texas. The data collection instruments were developed through a collaborative process. The teen focus group guide was assessed by volunteer high school students Ashley Dove and Dennis Dove, Jr. to ensure sensitivity, youth-friendliness, and cultural appropriateness for teen participants. A training of facilitators was developed by Jenifer DeAtley, LMSW with EngenderHealth to ensure consistency among focus group facilitators, and all facilitators were required to go through training prior to facilitation.

## Qualitative study

### Sample

For the qualitative portion of this needs assessment, the advisory team recruited focus group participants using purposive sampling, a technique that considers knowledge about a specific population and the study purpose to recruit participants. The advisory team identified youth-serving agencies within Austin and Travis County that provided youth services that overtly or inadvertently address risk and protective factors for teen pregnancy. Members of the advisory team recruited teens, teen mothers, teen fathers, and parents of teens through identified agencies willing to participate. IRB-approved marketing materials were used to assist in the recruitment process.

A total of 16 focus groups were conducted. Figure 4 below demonstrates the breakdown of focus groups and focus group participants by type.

Figure 4. Focus group type and participation



## Pocedures

### Focus group guide

The research team developed four focus group guides (teen, teen mothers, teen fathers, and parents) based on a review of relevant literature and input from advisory team members. The interview guides were examined by youth and the HYP Steering Committee. Based on feedback, the research team made revisions to the language and wording of questions. The guides were finalized by research team members from the Child and Family Research Institute at the University of Texas at Austin. Learning objectives for each focus group type are displayed below in Table 7. Copies of finalized focus group guides can be found in Appendices D-H.

**Table 7. Learning objectives by focus group type**

| <b>Focus group</b>                     | <b>Learning objectives</b>   |
|--|--|
| <b>Teens</b><br>(13-19; non-parenting) | What in their community & their lives helps them to prevent unplanned pregnancy & what is not present that they would like?  |
| <b>Teen Mothers</b>                    | How did they become young parents? (If unplanned) what community supports were they lacking to prevent unplanned pregnancy? (If planned) why did they choose to become a young parent? |
| <b>Teen Fathers</b>                    | How did they become young parents? (If unplanned) what community supports were they lacking to prevent unplanned pregnancy? (If planned) why did they choose to become a young parent? |
| <b>Parents</b>                         | What supports do they see in the community to assist them in helping their child prevent unplanned pregnancy? What barriers do they come up against?                                   |

### Data collection

A data collection plan was developed between March and May 2012. Focus groups guides were created and revised between May and December 2012. During this time, focus group training was also provided to facilitators. Between January and June 2013, focus group facilitator training was completed and 16 focus groups were conducted.

**Figure 5. Focus group data collection timeline**



Informed consent was obtained for all focus group participants over 18 years of age. For participating youth under the age of 18, parental consent and youth assent were obtained. All participants received \$10 gift card incentives for their participation, provided by the youth-serving organization LifeWorks.

### Transcription

All focus group audio recordings were transcribed verbatim by graduate research assistants from the Child and Family Research Institute (CFRI). A transcription guide was created to help maintain consistency among transcribers on formatting, structure, and use of slang. In addition to transcriptions, focus group co-facilitators took detailed notes during the focus groups and provided a summary to the research team within 24 hours of conducting the group.

### Coding

Transcriptions were initially reviewed by CFRI research coordinator and Co-PI Laura Marra and graduate research assistants. A few selected transcripts were individually read by the Co-PI and two experienced research assistants who highlighted relevant text and began identifying key concepts as initial coding categories. Categories were informed by Kirby & Lepore's (2007) review of risk and protective factors affecting teen sexual behavior, pregnancy, childbearing, and STIs as well as focus group guides. Initial coders met and discussed codes and code categories. Codes were operationalized, combined, eliminated, or divided as a result of discussions until a preliminary coding scheme was agreed upon.

Research assistants who had not participated in the initial process went back and coded the selected transcripts using the preliminary coding scheme. Next, the entire team met and discussed the preliminary codes. Revisions were made to eliminate discrepancies and clarify code definitions, and a coding scheme was finalized.

A team of two HYP volunteers was trained by the research Co-PI. To ensure coding was done with consistency and reliability, coders initially worked together to assure similar understandings of codes and code application. The team then coded the remaining transcripts independently. The coders reviewed transcripts they had not originally coded, verifying codes and supplementing codes as necessary. Throughout the process, coders met regularly with the Co-PI to review discrepancies. In addition, CFRI research assistants who had initially developed the coding scheme coded and reviewed Spanish transcripts. The Co-PI monitored code application throughout the process.

### **Data Analysis**

A directed content analysis based on Kirby and Lepore's (2007) review of risk and protective factors affecting teen sexual behavior, pregnancy, childbearing, and STIs was used to evaluate unintended teen pregnancy risk in this study. Conventional content analysis was used to explore teen relationships, perceptions of sex, attitudes and beliefs around birth control, STIs and prevention, sex education, parenthood, and recommendations. Initial data analysis began with a "brainstorming" session with coders, CFRI research assistants, and Co-PIs. Through discussions, the team was able to identify overarching themes in the data for each group of participants. The research Co-PI compiled applied to codes by focus group type into a spreadsheet. Research assistants, Co-PIs, coders, and the PI used the transcripts, focus group notes, discussion notes, and spreadsheets to conduct a final analysis. To check for research subjectivity, team members conducted detailed reviews of the results to ensure consensus. This analysis process resulted in the findings presented in Section 3 of this report.

## Quantitative study

### Sample

The sample for the quantitative study included service providers, educators/school staff, and medical providers in the Central Texas community. Snowball sampling was used to recruit participants using HYP's existing email list serve and network of providers, and the HYP advisory team members. Providers were asked to share the survey link with personal and professional networks. A total of 134 participants completed the online survey.

### Data collection

Researchers and the advisory team developed a survey to better understand the perspectives of those working with youth. The youth-serving professionals were asked to respond to questions about services offered, barriers for their clients in accessing services, barriers for themselves in providing or referring out to services, and clarifying their own attitudes and values as providers. Survey questions were adapted from The National Campaign to Prevent Teen and Unplanned Pregnancy and Guttmacher Institute's Survey of Young Adults 2009 (The Fog Zone) (Kaye, Sullentrop, & Sloup, 2009) and a state assessment sample survey from Advocates for Youth (2009).

Information was collected from service providers, educators/school staff, and medical professionals online via Survey Monkey and in person at the annual HYP Youth Provider Conference. Survey participants consented to take the survey electronically or in person, and if desired, could opt to enter their name into a raffle as compensation for their participation. Raffle prizes consisted of gift cards donated by local restaurants and creative arts studios. Learning objectives for each provider type are listed below in Table 8.

**Table 8. Learning objectives by provider type**

| <b>Provider Type</b>               | <b>Learning objectives</b>   |
|------------------------------------|--|
| <b>Service Providers</b>           | What supports are in place to help them provide information & resources to their service population? What barriers are present?                    |
| <b>Educators/<br/>School Staff</b> | What supports are in place to help them provide information & resources to their students? What barriers are present?                              |
| <b>Medical Providers</b>           | When providing service to an adolescent patient seeking to prevent pregnancy or seeking prenatal care, what services are offered & in what manner? |

### Data analysis

Quantitative data were analyzed descriptively and using SPSS. Tables, charts, and graphs were developed using the data. Survey findings for this portion of the study can be found in Section 4.

# SECTION

# 3

## FOCUS GROUP FINDINGS

Teen focus group findings

Teen parent focus group findings

Parent focus group findings



# FOCUS GROUP FINDINGS

This section summarizes the findings obtained from focus groups with teens, teen parents, and parents.

## Teen focus group findings

Focus groups were conducted with 36 teen participants to provide further insight around factors that impact teen pregnancy from the perspective of teens. Participants were first asked to discuss how people their age define and attribute meaning to relationships, followed by their commentary on teens' perceptions on sex, teen pregnancy, pregnancy prevention services, and the role of adults in supporting healthy sexual decision-making. The factors for early and unplanned pregnancy reported in the focus group were further examined using Kirby and Lepore's (2007) model of sexual risk and protective factors for teen pregnancy and childbearing.

### Teen participant demographics

Prior to participating in focus groups, teens were asked to voluntarily complete a short, anonymous survey with questions about their demographics, attitudes toward sex and childbearing, behaviors, and sex education. Seventy-five percent of teen focus group participants (27) completed surveys. Of those who completed the surveys, 63% identified as female, 37% identified as male, and 0% identified as transgender. The ethnic breakdown shows that 33.3% of respondents identified as Black or African American, 29.6% identified as Hispanic, 22.2% identified as White, and 14.8% identified as Multiracial. All of the participants were born in the U.S. and the average age of respondents was 16.6 years.

### Mixed perceptions of relationships among teens

Overall, teens tended to agree that their peers lack a universal definition for what constitutes a relationship and the meanings they attribute to relationships. Teens discussed feeling naïve or not knowing a whole lot about relationships. As one teen summarized,

“ They [teens] just don't know. They don't have any experience to know. They don't know what they like, dislike. They don't know what they want, don't want.

Teens described relationships generally as more casual and about gaining experience, whether emotional, physical, or sexual. General reasons to be in a relationship included not wanting to be single, going out just to go out, and having fun. Teens expressed that more often for girls there is an emotional investment in a relationship. All teens listed multiple physical and sexual reasons for being in relationships, and sometimes physical and sexual aspects were listed as the only reason to be in a relationship. Physical contact, as defined by the teens, included holding hands, hugging, kissing, or “sucking face.” While teens reported enjoying physical contact in their relationships, some expressed that physical contact of this type alone was not enough and

that they might have an “after-school” relationship with another partner in order to have sex. The following quotes illustrate these findings,

“ Most of the relationships that I have or have had and like the ones that I know that the guys that I talk to want to have are purely sexual and they just want to like have sex.

“ They have that person that they can show to their friends and you know, they do hug and kiss, but then sometimes they don’t give that person what they want, so they [their partners] go find it from somebody else after school when nobody can see them.

Being in a committed relationship was described as being fully dedicated to a person, being honest, caring about someone, being happy, and having a more long-term commitment. A long-term relationship was considered by some teens to be at least three months while others defined long-term as lasting over a year or two. Most teens agreed that being in a committed relationship was not the norm at their age, but that they do see some long-term relationships among their friends,

“ I know a lot of friends who just like sleep with people whenever they can, it doesn’t have to be the same person, but then like on like someone else who’s another good friend she’s like been dating this guy forever and she’s like extremely emotionally invested in him...

“ I just got out of a two year relationship. My best friend just got out of a—a year and a half relationship... Like all of my friends, whenever we date someone it’s typically for quite a while.

### **Sex should be a mutual agreement between two partners**

Teens agreed that the decision to have sex should be a mutual agreement between two partners. Of the respondents who completed the survey, 59.3% reported having had sexual intercourse, including oral, vaginal, or anal sex. Of those who have had sex, 23.6% anonymously shared that they were between the ages of 11 and 14 when they first had sexual intercourse.

Teens discussed sexual urges and desires as a natural part of being human, and described sex as a means to procreate and experience satisfaction. Having sex was often normalized and viewed by teens as something acceptable and unavoidable,

“ We all get the urges that we want to have sex. It happens. It’s just life. It’s a part of being a mammal.

“ It’s in our nature to mate, to have sex, to have intercourse.



Teens also discussed the impulsiveness of their decisions at times. They expressed how other teens do not think about the consequences of their actions. This impulsivity is typical for adolescent development, wherein teens admitted to thinking only about the immediate situation of whether to have sex and not of the possible outcomes, i.e. becoming pregnant.

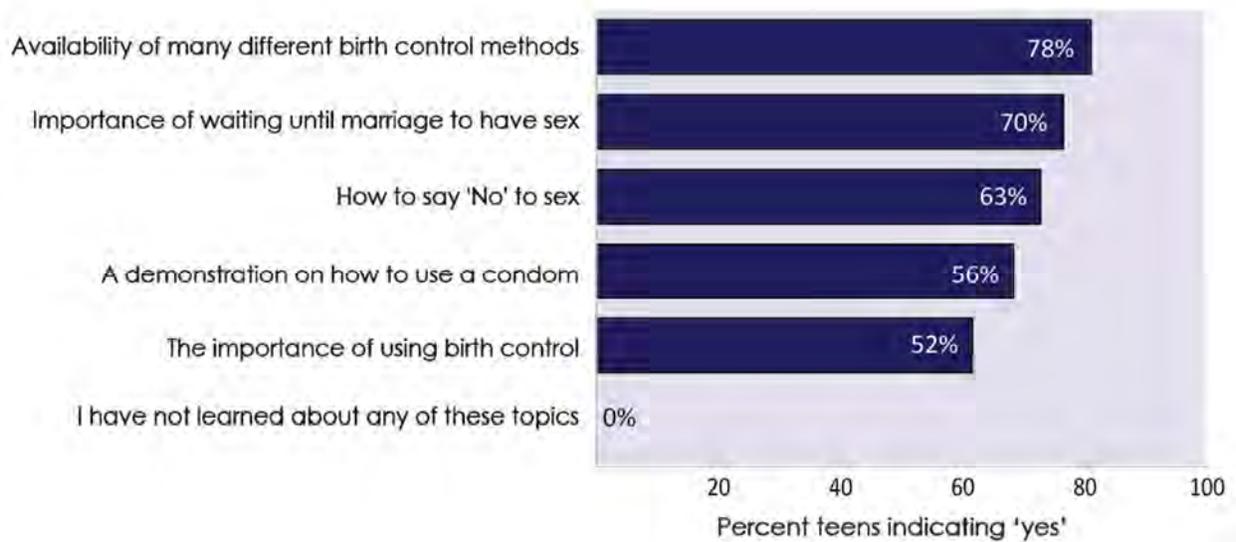
“ The majority of teens are living for now, and now, then, right now they’re not thinking about the future, or tomorrow, next week, they’re thinking about now, today.

“ Not that they don’t really care, it’s just that they don’t really think about the consequences about it, until it happens, and then they’re like, ‘oh, I’m pregnant.’

### Teens’ exposure to sex education topics

Participants were asked on the survey about sex education topics learned, including importance of using birth control if you have sex, condom demonstration, refusal skills, abstinence-until-marriage, and availability of different birth control methods. Figure 6 demonstrates the percentage of youth participants who reported learning about the specific topics listed. Every respondent had learned about at least one of the topics listed and three-quarters of participants had learned about the topics from their parents and in school.

**Figure 6. Percentage of teens indicating exposure to sex education topics**



Some youth shared experiences of being in sex ed classes that were positive and offered information an understandable way, whereas others shared that they felt the information they received was limited or used exaggerated scare tactics,

“ It [sex ed] wasn't like all like talking about literally about sex. They did it in a way you could understand.

“ ...I had a [sex ed] class... I think I was in fifth grade, it was just brief about, you know just, you just learn about hygiene...

“ ...that's kinda how I felt my high school health class was. Was like, all these horrible things will happen to you, so just don't have sex.

A few teens brought up learning about abstinence-until-marriage through school or church, and how these religious beliefs influence their sexual decision-making. Other teens however, did not favor the abstinence-until-marriage message, and wanted more options for teens who do not choose to be abstinent,

“ I guess due to my religion and I mean just my beliefs in general, I've always thought that like—that they always taught me I guess is like getting married is when you have sex, is when you have kids. That's just like how you do things and it's just you have to do them that way because they say, I guess.

“ ...I haven't heard much of like this abstinence stuff... but like I know a lot of people who have and they don't know anything about anything, they're just like, 'oh yeah, I just want to have sex with this person,' so it's like okay I gotta tell you about this stuff because you're always telling me that you have no idea.

“ I know, abstinence—abstinence is like the best way but that's not everyone's choice... and realistically like if that's not something you're going to choose at least you should be able to have other options.

### **Teen decisions around contraceptive use**

Despite 88.9% of teens stating in the survey that it was 'very important' to avoid becoming pregnant right now, 31.3% reported using 'no method' of contraception or 'the withdrawal method' the last time they had sex. This ambivalence around taking action to prevent pregnancy was echoed throughout the survey: 37% somewhat agreed or strongly agreed that it was too much of a hassle to use a condom every time they had sexual intercourse, and 38.5% somewhat or strongly agreed that things just seem to happen to them in life. In regards to teens' sense of responsibility in preventing pregnancy, 50% strongly disagreed with the statement that using birth control was irrelevant and when it was your time to become pregnant it would happen. 76.9% either somewhat agree or strongly agree that pregnancy should be planned. Of those that reported using protection, 56.3% stated they used condoms to prevent pregnancy,

25% used hormonal birth control in the form of pills, patch, or ring, and 12.5% used some other method.

When asked about who makes birth control decisions, teens generally interpreted “birth control” as a hormonal method like the pill, separate from condoms, and more often stated that it was a woman’s responsibility to use birth control. When deciding to use condoms, some teens felt it was a man’s responsibility to decide, while other teens felt it was a mutual decision.

“ ... it’s always been a decision on both, both mine and my partner’s side to use protection of different kinds...

Several teens shared that their parents ultimately decide whether or not they [teens] are able to use birth control due to parental consent laws for minors accessing contraception. A few teens expressed frustration because felt they did not have a decision because their parents were against birth control, and therefore, they had no way to access it. Other teens discussed feeling uncomfortable with asking their parents to help them access birth control when they need parental consent to obtain it,

“ ... my parents are super against it and it really irritates me because I don’t—condoms aren’t one hundred percent sure way to work... It would be an awesome option if Texas allowed teenagers to get birth control like without parental consent...

“ ... I just think that birth control needs to be more readily available without having parents like involved.

Additionally, teens reported feeling pressure in romantic relationships (casual or committed) related to the use of birth control, and more specifically, pressure not to use condoms. Overall, the use of different kinds of birth control for protection was reported by teens as something that is important to them within romantic relationships.



“ ... whenever I slept with someone that I was in a committed relationship with we always used condoms, but like whenever I had like a hook up or something we would never use condoms.

“ But some guys don’t want to do that [wear condoms], you know? ...they’re all like, ‘it doesn’t feel good.’

The most common protective behavior reported by teen participants was the use of condoms during sex. Teens seemed to agree that condom use is a sure way to engage in safe sex. One teen furthered the notion of condom use explaining that until an individual is comfortable in accessing condoms [and birth control], they should abstain from having sex. Another protective factor discussed by teens is their ability to identify when they were not having safe sex and their feelings of unease about it. The following quotes depict how teens view condom use as important,

“ See I think you know you're ready if you have no problem with going to the store and getting condoms and birth control, but if you're ashamed to get those things then you probably shouldn't be having sex.

“ I knew that I wasn't being safe all the time and I really, really didn't like that.

“ ... it's like you can have sex at your own free will, just do it the right way. Don't drink and drive, don't have sex without protection if you're not ready.

Most teens exhibited knowledge of what types of birth control are available to them and where they can access birth control. Teens most commonly discussed using birth control pills and condoms as methods to prevent teen pregnancy. Other contraceptives mentioned included the patch, the Depo-Provera shot, the NuvaRing, and Plan B emergency contraception. Additionally, some teens talked about using “withdrawal” as their primary prevention method. Other teens reported not using any method during sexual activity. In addition, there were teens who responded with a lack of knowledge regarding birth control options. In general, Planned Parenthood was the most common source that teens referred to as a place to go to obtain prevention methods. Teens also reported seeing an OBGYN or personal doctor, or going to basic clinics and wellness centers. They specifically named AK Black (a CommUnity Care Clinic), Round Rock Women's Center, and St. David's Wellness Center as Austin area locations to obtain birth control. Walgreens, Walmart, and other drug stores were identified as places to buy condoms and emergency contraception.

When talking about beliefs and attitudes related to contraceptive use, teens revealed attitudes that may be contributing factors to early and unplanned pregnancies and engaging in unsafe sex. Teens described males having an ambivalent attitude towards birth control use because they are more concerned about pleasure, while females were described as having adverse attitudes towards use of birth control due to unwanted side-effects,

“ I feel like the guys need to be targeted more 'cause I feel like girls definitely get the 'you're the one getting pregnant so you might you need to watch out for it' more than the guys do, and the guys are just like, 'ah screw it, I'll do whatever I want.' And 'cause they feel like they can leave as soon as it happens. And they're like, 'that's your body, now you can take care of that one'

“ Yeah, they’re [girls] just like, ‘if I have a baby, I have a baby, I ain’t getting on birth control, that makes me fat...’

“ I really don’t want to [use hormonal birth control] because I really don’t like the thought of like things just getting inside me and like messing up my cycle, you know.

While teens often normalized sex, they also discussed feelings of embarrassment around obtaining birth control that may put them at greater risk for unintended teen pregnancy. Teens explained that it is “awkward” to buy condoms because then store clerks will know they [teens] are having sex. Teens described buying condoms as being an act that requires “courage,” demonstrating how societal shaming of teen sexual activity impacts their ability to access condoms.

Teens reported that for females, preventing unplanned pregnancy appeared to be the biggest concern; however, for males, preventing STIs was most concerning. As one teen summarized,

“ For guys, it’s more like, ‘Oh I don’t want to get a disease and my penis falls off. For girls, it’s like... ‘I don’t want to have no baby’

STI prevention methods mentioned by teens included using a condom and getting tested. Some teens believed that if an individual is not having sex with multiple partners or knows the person they are having sex with, then that individual is not likely to get an STI.

### Unhealthy gender norms may influence attitudes and behaviors



Teen participant perceptions of sexually active youth conveyed stark gender stereotypes and focused primarily on heterosexual sexual activity. Sexually active male teens were often seen as more popular by their peers, while female teens were often stigmatized for having sex, even if it was just once. Direct quotes below illustrate this point,

“ Well the girls who have sex are sluts and the popular guys all have sex.

“ It’s like your first beer or going fishing with your dad or something like that. It [having sex] is like a stepping stone to becoming a man.

“ Like there are rumors that are going to spread around if somebody hears about it [a girl having sex] even though they may not know the situation. It’s like- it affects your relationships with people in general because you’re going to have a reputation of being somebody who sleeps around even if you’ve only done it once.

“ Something that I've noticed in a lot of high schools is that guys lose it first and guys sleep with a lot more people than girls do. 'Cause even if a girl wants to sleep with a guy like without an emotional attachment thing, there's always that double standard where a girl's like a slut and the guys, like good for him kind of thing.

Teens talked about both males and females displaying permissive attitudes towards having sex and towards talking about sex. Permissive values about sex were also discussed by teens who described that their peers do not worry about the consequences of sex, just their ability to engage in sex.

In looking at gender roles in relation to contraceptive use, 34.6% of teen survey respondents somewhat or strongly agreed that birth control is mainly the responsibility of a woman, while the same percentage somewhat or strongly agreed that it is a man's responsibility to carry condoms.

In addition, teens talked about how “vulnerable girls” may be more likely to be impulsive in their decisions regarding sex. Vulnerable girls were described as those who have recently gone through a break-up or who have low self-esteem and feel unattractive. It is perceived that these teen girls may be easily pressured into having sex because the desire to feel like someone finds them beautiful or attractive may contribute to some teens' impulsivity in deciding when and why to have sex. The following quotes demonstrate this manipulation of vulnerable girls,

“ Find vulnerable girls who like just got out of a break up or they don't find themselves attractive or anything and then they attack.

“ The guy says you're beautiful and then automatically you take off the pants.

## **Risk and protective factors impacting teen pregnancies**

When asked how they would feel if they found out they were pregnant or had gotten someone pregnant, 55.6% of teens reported they would be “very upset;” 2 respondents shared they would be “very pleased” or “wouldn't care;” and 18.5% said they “don't know” how they would feel. While teens agreed that decisions to have sex should be mutual, there were many factors brought up that influence their decisions about engaging in sexual behaviors. The following subsections provide a more detailed look at the influencing factors for teen sexual activity.

### **Individual risk factors for early pregnancy**

Several teens shared that the feeling of being cared for or loved can influence one's decision to have sex. A distinction one teen made, is that being loved by one's own child may be impetus enough to have sex, in hopes of becoming pregnant,

“ They are just trying to get the thrill of how it feels with someone they care about.



*I feel like I would be happier with a kid because a kid's going to love you no matter what, you raise them.*

Also discussed by teens were risk behaviors that may lead to unplanned pregnancies and unsafe sex, such as substance use. 18.3% of teen survey respondents reported that alcohol or drugs were consumed the last time they had sex. Alcohol and drug use were explained by teens as substances that impair one's ability to consent to sex or to "know what they're doing." Moreover, teens explained that when one drinks or smokes it "makes you horny." Teens recognized that substance use decreased one's ability to judge a situation and could increase one's desire to engage in unsafe sex. Teens also suggested that their peers who attend parties engage in more sexual activity than those who do not attend parties, though some teens disagreed with this statement. However, teens did not make a correlation between attending parties and alcohol and drug use.

### Individual protective factors from early pregnancy

Teens discussed the values in their lives that contribute to their motivation to avoid becoming pregnant. The most commonly cited values in teens' lives that serve as protective factors motivating teens to avoid pregnancy are financial stability, personal beliefs about sex and parenting, and religion. Many of the teen participants explored the benefits of being financially and emotionally stable before having a child and caring for "another life,"



*When you're financially, emotionally stable, married, in love, fully committed, everything's good, then you can have a baby. Cause if you don't have good finances, it's only going to cause problems. If you're not in love with the person, it's only going to cause problems. Pretty much, everything is going to cause problems with the kid unless you're fully committed to that person.*



*I feel like you have to be a mature adult and realize what you're setting yourself up for...*

Teens discussed many aspirations and plans for the future before having children. Experiencing and traveling to new places, contributing something creative to the world, and obtaining higher education were three common values that teens gave importance to before deciding to have a child. Teens expressed a desire to explore their options in life and work towards accomplishing their goals before having a child who will occupy their time. In addition, one teen conveyed an ambition to achieve her goals, have children, and then show her children what she has accomplished,



*...I would like to bring something into the world, like not a kid, but like something that I am proud of like a creation, like a book or a movie or something and know that I accomplished it before I have to—not have to, but before I like put my life off and have a kid. I'd like to be able to show my kids that I've, I've done this...*



Teens who identified religion as a protective factor explained that their religion has taught them to wait until they are married to have children and that it has influenced their personal beliefs to avoid pregnancy by practicing abstinence.

### The influence of peers

When asked whether teens were having sex, across all groups there was a collective response, "Yeah!" Teens felt that most of their peers are sexually active, even though the Youth Risk Behavior Surveillance System shows that only around 46% of Texas high school youth report ever having sex (CDC, 2014). Teens believed that at least half if not most teens are having sex by the time they are in eighth grade or high school. While not as frequent, students acknowledged that sixth and seventh graders are having sex, too. Some participants noted that some teens may openly share that they are sexually active, even when they are not,

“ I’ve just noticed a lot I’ve had friends openly say, ‘oh I have a lot of sex,’ but then privately, ‘I’m a virgin.’ It’s like oh. They want it to be seen like they’re having sex but they are not.

“ Like they wanna say, ‘I’ve had sex,’ because they’re embarrassed of it.

In talking about decisions regarding sex, peer acceptance and validation strongly influenced whether or not a teen decided to engage in sex. Abstinence in general was not commonly brought up by teens. However, teens practicing abstinence reported feeling stigma and pressure from their peers about being a virgin, particularly when the majority of their friends were not virgins. They reported feeling awkward and not knowing what to say during conversations about sex. These teens discussed experiencing teasing and ridicule by their peers who have already engaged in sex. As a result of the teasing and ridicule, teens reported feeling pressured and began questioning if they, too, should engage in sex or feeling as though they needed to lie about their virginity in order to “save face.”

“ ... they tease you and all this stuff so you kind of think like, well should I do this? Should I do it just so they’ll stop talking? Should I lie about it?

“ It just makes it uncomfortable because everybody is sitting here and they are talking about this big, huge topic about sex, and you are just sitting there and like, ‘yeah, well, the lunch at school today was really crappy.’

In peer groups where the majority of teens were still virgins, being a virgin was considered more acceptable.

Teens articulated a belief among their peers that having a child is easy, as illustrated by the following quotes,

“ ...I think a lot of people, a lot of kids and teenagers I’ve met sincerely want a kid and sincerely think they can handle it...

“ ...he [my boyfriend] really wanted to have a child with me...he worked at this fast food restaurant, he was like, ‘I have a job now and I can pay for this child for you and me,’ and I was like, ‘nooooo.’

Over a third (38.5%) of teen survey respondents either somewhat agreed or strongly agreed with the statement that their friends have had unplanned pregnancies, yet half of respondents also either somewhat agreed or strongly agreed that using some form of birth control is important to their friends.

### Social media’s impact

Facebook, Twitter, and other social media networking sites were frequently discussed as factors that encourage teen sex and teen pregnancy. Some teens viewed Facebook as an opportunity for casual sex. Other teens discussed how social media has become a part of teens’ sex lives, sharing that teens will post or argue about which of their classmates is a virgin, making it more difficult for some teens to feel okay with their decisions,

“ ...Facebook opens up a lot of opportunities.

“ ...some of the kids they publically put it out on Facebook and fight about how, you know, who said this such and such person was a virgin... social media has a way into people’s sex lives...

Teens also report that they have seen others use social media to make decisions and “get attention” around sex and teen pregnancy. Teens reported seeing some pregnant teens use social media like Twitter and Instagram as a way to post pregnancy pictures, announce their pregnancy, and document the process as the baby develops. In one focus group, members discussed how some pregnant teens use Facebook and Twitter as a means to make a decision about whether or not to keep the baby stating that the teen would post a picture of herself pregnant with the following comment,

“ Like on Facebook & Twitter- 1000 likes and I’ll keep the baby

### The influence of romantic partners

In teens’ romantic relationships, feeling pressured to have sex so they do not lose their partner was a common theme brought up in focus groups. Teens reported that females often feel pressure to have sex with their male partners, and may engage in sex earlier due to a fear that

their male partner will leave them to find a partner who will have sex. The following comment made by one teen illustrates this pressure,

“ They don’t want to lose the person they’re with, so they feel pressure that they have to have sex.

Teens discussed how being in love and being committed are important to a successful relationship. Furthermore, many teens explained that a committed relationship is important to establish prior to having children. In discussing family structure, most teens discussed wanting to be in committed relationships (including, but not necessarily marriage) prior to having a child, though there were a few teens who preferred one-parent families, through the use of sperm donors or adoption.

### Little or no family guidance makes it easy to engage in sex

Teens suggested that when they received little or no parental guidance and supervision, it makes it easy to engage in sex and thus, become pregnant. As one teen mentioned,

“ It’s just really easy to happen if you don’t have, you know, a lot of parental guidance.

Most teens discussed feeling that their parents either do not communicate with them about safe sex options, or if they do, it was often in a way that made teens feel uncomfortable. Teens mentioned that they plan on talking with their own children someday and at younger ages because they feel teens received sex education information too late into their adolescence. Teens who talked about having parents who did communicate with them about sex and birth control mentioned feeling uncomfortable and wanting to ensure that they make the conversation more comfortable when they [teens] talk to their children in the future about sex.



“ Parents like I think they shouldn’t like try like protect you all through life...they don’t tell you about the things that’s out there. Like they’ll tell you about STDs and all that but they won’t tell you like what you can do to deal with stuff. Like honestly the stuff I know I learned it in school from like people my age.

“ ... Don’t get me wrong, my mom did talk to me about sex and stuff like that but like I said, I was never comfortable with it.

Half of teen survey respondents either strongly disagreed or somewhat disagreed that having a child outside of marriage is unacceptable in their families.

Some teens disclosed having parents that were teen parents, and how their parents' experience has influenced their decisions on when they want to be a parent,

“ Also, my mom had me when she was seventeen, so for me it's been I grew up seeing what it does. I mean, my mom gave up a lot for me.

Teens also discussed how younger siblings want to be like or follow the example of their older siblings. Teens felt that when they are sexually active, their younger siblings often see this behavior modeled and think it is okay for them to have sex, too. This is consistent with research conducted by the Guttmacher Institute, which shows that young women with a mother or sister who had experienced teen pregnancy were significantly more likely to experience early pregnancy themselves (East, Reyes, & Horn, 2007).

### Responses by schools toward teen pregnancy

Teen pregnancy was perceived by teens to be an issue at several traditional public schools and one residential school in the Austin/Travis County area. Some teens in the focus groups would name their school and state, “enough said,” implying that their school was known for having a high teen pregnancy rate.

“ I went to three different high schools and at each it was a big issue. And it was all around the city from the North to the East- big issue.

“ You can't even say congratulations anymore, it's like 'you too?'

When discussing peers' attitudes and behaviors towards pregnancy, teens explained that pregnancy has become normalized for them. In school, they see their peers pregnant, excited about it, and sometimes accepted by students, faculty, and staff. Teens explained their peers' attitudes and behaviors in the following ways,

“ If she's pregnant, I can get pregnant.

“ It's a tradition whichever cheerleader drops out of cheerleading because they are pregnant becomes the next homecoming queen.

In these schools with higher rates of teen pregnancy, teens reported more services were often provided to pregnant and parenting teens, particularly when these students' academic performances met standards. Free daycare was a common service mentioned at some middle and high schools to help teens continue to get an education while raising a child. Other services

mentioned included free diapers, free formula, and help with medical bills. Some teens perceived that having too many services and accommodations in their schools may have unintended consequences as illustrated by the quote below,

“ I think it’s gotten into some people’s heads that it’s possible, like easily to have a kid. And [School A] reinforced that a little bit, but you know basically its free daycare as long as you’re passing. And so unfortunately, it’s a little bit of the two extremes to where if you’re passing fine, they’ll take care of you, but if you fail you pretty much have to drop out to take care of your kid. I don’t know. It’s just an interesting stigma that happens because I look at all of the pregnant students at my school and none of them look happy.

On the other hand, some schools were identified as having lower rates of teen pregnancy. In general, these schools were more academically-focused, private, magnet, or in higher socio-economic level neighborhoods compared to most traditional public schools in Austin, and were perceived by teens as discriminating against pregnant and/or parenting teens. For these schools, pregnancy was not seen as an issue, but there was still a stigma present. Teens reported that schools strongly encouraged or asked students to leave if they got pregnant,

“ ...nobody there is pregnant and if you do get pregnant, you’re forced to leave, like you can’t stay there.

“ They have a reputation to keep at these schools.

Because of the stigma at these schools, teens felt that teen pregnancy was more often discussed as a “pregnancy scare.” Teens felt that youth at these schools were more likely to access emergency contraception to prevent unplanned pregnancy or consider terminating a pregnancy than youth at other schools. There was a general sense that teens at these higher socio-economic schools would likely handle their “pregnancy scare” without involving their parents because they had financial resources to access services on their own.

### Media’s mixed influence

In general, teens agreed that most pop stars, songs, TV shows, HBO shows, and movies portray sex as glamorous and negatively influence teens’ decisions about sex,

“ We idolize... Kids idolize pop stars and when they see a pop star doing something it’s like, “oh it’s ok,’ so they do it.

“ Sex sells... It’s entertainment

Teens explained that television shows such as *Teen Mom* and *16 and Pregnant* have colored their perceptions of what it is like to be a teen parent; however, the response to these shows was mixed. On one hand, the shows highlight the reality of being a teen parent, open up discussion around teen sex, and bring more attention to birth control options.

“ ...It's the media, the entertainment. Look at the shows nowadays; *Teen Mom*, *16 and Pregnant*...it's pretty much putting out there that it's ok to be a teenager and pregnant, cause you're going to end up on TV. It's like kind of putting that out there. And it's not right, it's manipulating kids.

Some teens reported feeling disillusioned by teen pregnancy from watching these television shows. For some, the “drama” on these shows was enough to convince them they were not ready to be a parent. For example, one teen stated,

“ I'd be too scared having kids but when I watch the kids, it's like I watch the kids... that's what makes me want to have kids, but when I see the dramas with the baby mamas and baby daddies... I'm just like ok.

However, other teens minimized the shows' emphasis on the difficulties of being a teen parent and focused on the positive aspects of parenthood portrayed. They reported feeling enchanted by the idea of having a baby and being a teen parent. In turn, these teens reported wanting to get pregnant. For example, two teens stated,

“ I watch the deleted scenes... where it's all the good parts (about being a parent).

“ It [*Teen Mom*] makes me want to have a kid!

Finally, teens mentioned that they knew other teenagers who were getting pregnant because they believed they could be on the television show, *16 and pregnant*.



## Teens' advice for future prevention strategies

Teen focus group participants were asked to offer their advice on what teens need to help them prevent early and unintended pregnancies, as well as what adults could do to provide better support for youth.

### Teens want trust, freedom, and open communication

Teens perceived that the majority of adults in their lives view sexually active teens negatively, viewing them as wild and out of control for having or wanting to have sex. Teens discussed not feeling comfortable going to adults with questions for fear of judgment or being shamed. The first piece of advice that teens offered was for adults to be realistic about teens having sex. Within this perspective, teens also discussed the importance of having a trustworthy adult in their lives to guide them through the decision-making process of when to have sex and how to protect themselves,

“ So I think if you are ready to have sex or you think you are, go to an adult or someone you trust who knows about it and can guide you through that process.

Teens felt that parents and other adults in their lives could afford teens more freedom. Teens expressed that when parents and adults trusted teens and gave teens freedom, teens will feel more respect towards them, possibly creating opportunities for dialogue,

“ You want to give them [teens] a little bit of freedom. So that way, they have respect towards you, they don't hate you.

In addition to freedom, teens want open and honest communication from adults in their lives, especially from their parents. Although some teens reported that their parents do communicate with them about STIs and other consequences of having sex, they do not feel that there is enough open dialogue about how teens can handle difficult situations they may encounter. Teens explained that the information they have learned about how to cope and handle difficult situations was learned from their peers at school. Teens want to learn from their parents how to make informed-decisions, but when honest communication is lacking they look to their peers for guidance.

“ ...I just think the biggest thing is that—facilitate those conversations... in a safe place where people, like teens, whether male or female, feel okay to ask serious questions they might not know the answer to without being judged.

A final suggestion that teens had for their parents and other adults in their lives was to begin talking to teens about sex earlier. Many teens believed that parents should begin talking to their children around fourth grade or around ages eight to ten years old. Teens suggested that

dialogue should begin this early because once kids reach middle school they will start to learn about sex from their peers—information that may be misguided.

“ People who’s like teachers, principals, parents, need to educate the kids a lot more earlier than they, you know—because like 8<sup>th</sup> grade is not good enough, there are kids in 6<sup>th</sup> and 7<sup>th</sup> grade that are having sexual relations.

“ ’Cause when you get to middle school, that’s when you start seeing everything. Start knowing everything.

### Sex education

When discussing prevention methods, teens mentioned wanting more information on the following contraceptive methods: hormonal birth control, female condoms, and male condoms. Specifically, teens talked about wanting information on how to properly use these contraceptive methods.

“ I think that they should like show people how to use a condom and stuff.

Teens expressed an interest in peer education – hearing from other young people about relevant topics. In particular, teens expressed an interest in hearing from peers who have dealt with challenging experiences, such as teen parenting, as an integral part of sex education. This exchange of information and experience would provide teens with first-hand knowledge of the realities of parenting as a teen,

“ ...bring in people in that type of experiences ‘cause that the people that have had that have been through those situations and to have them speak in front of people they actually make more of a difference than the parents just telling them no don’t do its bad and stuff and like you’ll die or something I don’t know.

“ ...teens, we take advice better from people our own age than adults. When adults tell us something, we’re just like, oh, you’re just trying to be bitter, or whatever... ‘You don’t know what you’re talking about,’ but when somebody your own age comes up to you and’s like, ‘hey, this is wrong,’ or ‘you don’t need to be doing this,’ they really take in what you say ‘cause, see most teens, your opinion matters.

Another aspect of sex education that teens expressed an interest in was raising awareness of available resources for sexually active teens and raising awareness of the possible consequences of having sex. Teens specifically mentioned wanting to know more about clinics and STIs.

“ Get the word out there. Like let them know about the dangers, as in diseases, pregnancy is not for everybody and just getting it out there, letting people know...letting teenagers know what the consequences of having sex are and what are the... pros and cons of sex.

However, teens also expressed wanting to hear information delivered in a positive way, not just focused on scare tactics,

“ ...I do like the idea of... discussing the kinda like the real life consequences. But I don't think it should be—I think that the health conversation about sex for teenagers should be less about, 'I'm going to scare you into never wanting to have sex ever ever ever!'”

Although less frequent, a few teens mentioned the need for more inclusive sexuality education that addresses the unique needs of youth who identify as sexual minorities, such as lesbian, gay, or transgender youth,

“ ...I don't know, like all these discussions about sexuality and stuff... like a lot of them are very much for like straight people and that's all we talk about.”

“ ...it's like just in general like discussion about sexuality should be more inclusive, especially like I have friends who like don't, who like don't identify with their gender as like the sex they have, like biological sex...”

## Teen parent focus group findings

Focus groups were conducted with 17 young parents: 13 young mothers and 4 young fathers. Based on research done around teen parent relationships and at the advice of youth-serving professionals working with teen parents, mothers and fathers were focus-grouped separately, but were asked the same questions. This allowed for more conversation around their roles within the family. Teen parent participants were asked their perspective on what they'd heard about teen pregnancy before becoming pregnant, what could have helped them prevent early pregnancy, what they did after they found out they were pregnant, what challenges they have faced as young parents, dealing with the social stigma of teen parenting, and how they plan to speak with their children about sex. Teen parents also provided recommendations for future prevention strategies.

### Unplanned pregnancies

Many teen parent participants discussed feeling surprised when they found out they were going to have a baby,

“ Well I was always like, I'm not gonna have a baby right now so it just popped up on me...”

“ I wish I would have known. I wish it would not have just happened out of nowhere like that.”

Some teen parents expressed feeling like they wouldn't be susceptible to early pregnancy, as they believed only a certain type of teen gets pregnant,

“ ‘Cause like I had told myself I would never have kids and so and I wasn't the type, like people put you in a box, you know, there's a type of person who gets pregnant, everyone thinks that way even though they don't want to admit it that's the truth and if you get pregnant you're supposed to be a ho and that's not how I was. I was like really book smart and like you know so I didn't think it would be me.

“ ...it's not going to happen to me. It's only stupid people—and then it happened to me.

When asked what would have helped them prevent an unplanned pregnancy, teen parents suggested having knowledge of and using contraception including condoms, practicing abstinence, having sex education earlier in school, and open communication and guidance from their parents,

“ Knowing like about birth control like people going out there cause—I know now they do the little sex talk in school but I remember I was in middle school and like maybe like in 6<sup>th</sup> grade they did it and then 7<sup>th</sup> and 8<sup>th</sup> grade they just stopped. And then I got to high school...

“ I actually did go to health class... But this was after I had already been having sex. You know what I mean. So this was like a little late.

“ Well I think if my mom would have talked to me about it, I think I would have slowed it down.

### Timing for becoming a parent



Teen parents had several recommendations for things they felt other teens should consider before becoming pregnant. Among these recommendations, being of older age, completing school, and having some sort of economic stability were the most commonly reported pieces of advice. Teen parents suggested that other teens wait until they are older to have a child (suggested ages range from 18-years-old to in the 30's). For those teens who want to go to college, it was also advised that they wait until they finish school before having a child. Finally, economic stability, defined by teen parents as the ability to pay one's bills, being financially “stable,” and perhaps owning a house, was suggested as important to achieve prior to becoming a parent.

## Response to teen pregnancy

### Fathers' involvement

Teen father participants reported that the first action they took upon finding out they were going to be fathers was seeking employment,

“ But once I found out my girl was pregnant, it's like, you gotta motivate yourself to really look for a job... it's like, I got something to live for, I can't play around with my life.

“ I mean, we told our parents and then she went straight to the doctor just to make sure she was really pregnant... and then I tried to look for a job which was the hardest part.

“ I got a job and told myself I needed to man up...



For some of these teen fathers, finding employment was a challenge, even with programs specifically focused on helping young fathers find employment. These teen fathers reported being turned away from employment services for not appearing to be “in need” or for not attending a school considered “at-risk.”

“ ...I know they have programs for teens and dads like to find a job or something but they always told me that I wasn't in need or I didn't go to an at-risk school... I would go to places and they would be like, 'no, you are not at risk.'

Several of the teen mother participants disclosed that the fathers of their children were or are currently incarcerated, forcing them to raise their children as single mothers until the fathers are released.

“ Ok his dad was in prison for violating his probation, mind you, so I was already pissed off that he was there for something so stupid. He went to work instead of class.

“ He [baby's father] wanted to do the same things. Just be out with his friends, drinking and smoking and being in school and doing stupid things. And then he got locked up so and now he's on an 8 year sentence.

### Families' responses and support

Teen parents often talked about feeling fear or worry about having to disclose their pregnancy to their parents. Many teen parents talked about the negative reactions they received from their families when they informed them about their pregnancies. Teen parents talked about their mothers particularly being disappointed or upset about their [teens'] pregnancies, especially those whose mothers were also teen parents. Teen parents shared how negativity from their families impacted their mental health,

“ She [mother] cried when I told her. Out of like hurt and like disappointment because she knew I was better than that because she told me, she experienced it. She didn't want me to go through the same thing so um she was very disappointed in me because I knew better.

“ I got really like depressed about it because my whole family just put me down [by saying], 'oh you messed up your life, you just went downhill, you are not going to be able to go to college, to have a career, and do the things you wanted to do, or like go to prom and stuff like that.' So I got really, really depressed. It took awhile... to accept the fact that I was pregnant and get over it, of being depressed and actually see the positive side of it.

Some teen parents reported having supportive parents of their own or their partner's to help them with transportation, finances, accessing services, and/or emotional support,

“ ... even though she [mom] was mad and upset about it, she still was really supportive and she still helped me how to bath and feed my baby and all of that.

“ ... my mom helps money-wise, but his mom finding support and stuff. My mom is my support, but his mom helps find people organizations that help.

### Unsolicited advice from adults and lack of understanding

Teen parents discussed receiving unsolicited advice from adults regarding pregnancy options, parenting, and child support. Teen parents talked about receiving this advice not only from family members, but from service providers as well. The language used by teen parents when recounting stories of adults giving advice indicated that the teens felt pressure from adults regarding their pregnancy and parenting decisions. Teen parents repeatedly used the word “persuade” when recounting their conversations with adults,

“ My nurse come out she try to, really try to persuade me to put my baby father on child support.

Teen parents explained that people (adults and teens) who are not parents do not understand what it is like to raise children. A parenting difficulty that most teen parents brought up was being exhausted and not getting enough sleep. Teen parents explained how people without children especially do not understand this difficulty of parenting.

“ People who raise their children like they don't get to sleep all day they have stuff to do. People don't realize that though.

Teen parents discussed receiving negative reactions about their pregnancies from different adults in their lives and that adults tended to have more negative comments than positive comments, if anything positive at all. Feeling as though adults “look down” on and pressure them to live their lives “their” (adults’) way was commonly brought up as a stressor among teen parent participants,

“ One of the biggest things that drives me nuts is that they don't have anything positive to say.

“ If you're not doing it their way then you're not doing it right. Because you're young so you don't know.

### Difficulties obtaining services

Teen parents talked about the difficulty they experience when trying to obtain services. Some participants shared that they were told by service providers that they were ineligible for certain services due to their young age, until they reached 18. However, once they have children, teen parents explained that more services become available to them,

“ And it's like with the program you got to be 18 or older for them to actually, to help you—

“ ‘Oh you came here young; you got to be a certain age.’ And then I had the baby and then they start like really helping me out.

Some teen parents expressed disappointment in services they did receive from agencies saying that service providers did not offer guidance or advice on how to take care of their children, which they wished they had received. Teen parents frequently reported having difficulty obtaining childcare services once their child was born. Teen parents shared that utilizing daycare services available at some schools can also be a challenge as schools have academic requirements and may have waitlists,

“ ...you are supposed to reserve get the spot in the daycare... So they have a waitlist of course and um you have to be passing all your classes and everything like that to stay in the daycare...

Some teen parents also found it challenging to prevent a second pregnancy with funding cuts impacting free and reduced-cost birth control access,

“ ...I mean like for her birth control she’s having trouble buying that like where it’s in her price range. She tried to go to [Clinic A] and they’re like something about they lost funding for like free um birth control or whatever... I guess that’s a challenge now just like stay preventing from having another baby.”

## Impact of teen pregnancy

### Relationships with their romantic partner

Teen parents were asked to share how the relationship with their romantic partner was impacted by early pregnancy. For many teen parents, the relationship with their partner became strained once they found out they were pregnant.

“ Like we don’t talk at all, when we go to let’s say the Wal-Mart, it’s all quiet in the truck. It’s like silent, it’s like we don’t talk like we used to. Everything’s changed.

Within their romantic relationships, teen mothers often reported feeling unsupported by their partners. Many teen mothers consistently responded that their partners were “immature,” and had not helped them with household chores or with taking care of their children. In general, teen mothers shared feelings of frustration created by lack of support and help from their partners. Some teen mothers empathized with their partners feelings of exhaustion, but wanted empathy in return for their own exhaustion that accompanies taking care of a newborn baby. The following quotes illustrate these points,

“ ... he was not helping me nothing like, not helping me at all and she was still waking up all night long and I had had enough.

“ I get that he’s exhausted, but he doesn’t understand that I’m exhausted too.

Teen father participants discussed relational challenges accompanying learning to co-parent with their partner, feeling as though the mother of their child wanted “control” over how to parent. One father shared that his partner won’t let him see his child, despite the financial support he continues to provide.

“ Like she just felt as a mom like she should always have control of the baby and like only she could take care of the baby and I’m not allowed to take the baby out... like that kind of hurt our relationship but now our relationship is stronger because like we talked about it and now she is okay with it.

“ I still give her [baby’s mother] money, but she won’t let me see him [baby]. The thing is that I don’t want to be like, ‘nah, I ain’t gonna give you no money.’

Several teen fathers reported strain on their relationship brought on by the parents of their partner, referring to them as “instigators” and sharing that they feel the parents try to get too involved in their relationship,

“ Because to me, it feels like she’s [partner’s mother] in the relationship with me... I understand that she’s her mom, you know, but don’t try to put your two cents in everything that we do.

“ See, I want my baby mama to live with me, but her mom don’t let her. See what I’m saying, she’s still trying to control her life...

Although not reported by many, there was one response from a teen parent that provided information related to race and ethnicity being a contributing factor to teen pregnancy. One female teen discussed that being married to an individual of Mexican ethnicity influenced her to become pregnant because her partner’s culture normalized teen pregnancy, another female participant agreed with this sentiment.

“ I’m married to a Mexican ... in Mexico they believe that it’s normal, it’s normal for them... For their younger girls to get pregnant like that.

### Peers and social life

Teen parents talked about the difficulties they experience when it comes to being able to still hang out with their friends after they have a baby, and finding out who their true friends are as they are becoming a parent.

“ I told a girl that I considered my best friend. And then as soon as I told her it didn’t even take her five minutes I think to tell everybody. And then everybody knew so I stopped talking to her because I considered her my friend, but she wasn’t really my friend.

Most teen parents explained that eventually they were not able to hang out with their friends anymore and instead became friends with other teens who had children. Teen parents shared feeling more understood by other teens with children because they can do the same kinds of things together and realize that just “hanging out” with friends or going out downtown are not plausible options.

“ I want to do things with people who have kids because they understand the kinds of things I like to do.

“ I got to be serious because I have someone to provide for, and all the fun stuff they [friends] do I can’t really do, or I don’t care to.

“ I lost all my friends. So I don’t really have any friends.

In addition, teen parents discussed the social stigma that often accompanies early parenthood. Several teen parents referred to experiences of name-calling for becoming pregnant, and expressed frustration that people didn't understand what they were going through as young parents,

“ People think that people got pregnant just for fun or like to have attention.

“ Yeah, that's what a lot of people think—that once you become pregnant and starting having family your life is ruined and you can't be anybody anymore.

“ You can't just talk bad about them [teen parents] because you don't know what they was going through in the situation for her to become pregnant.

### The responsibilities and realities of teen parenting

Both teen mothers and fathers reported that they wished they had known how much responsibility is required to take care of a baby and that they had been prepared for the difficulties of parenthood. Teen fathers in particular expressed that if they had known about the challenges and realities of young parenthood, they may have made different choices,

“ I feel like if we would have known what we got ourselves into, we never would have been in this mess.

Teen mothers disclosed feelings of anger and depression about being pregnant. When talking about anger, several teen mothers acknowledged feeling angry for the entirety of their pregnancies,

“ The first time I found out I was pregnant I was pissed, I mean I was upset the whole 9 months, like I didn't even get over it.

Only when their babies were born did they express feelings of happiness and excitement. However, along with the happy feelings, teen mothers discussed also feeling depressed prenatally and postnatally.

“ Young moms especially don't know about postpartum depression and they're like the number one target to have postpartum depression, they have so much of a cause... resentment [is] a big one, everyone telling [you] because of this kid you are not going to follow your dream. Everyone tells young moms that.

Teen parents discussed the challenges that they experience as young parents. One challenge that many teen mothers were able to relate to was feeling overwhelmed by the responsibility of having to care for a newborn baby. Teen mothers explained that they would also cry when their babies were sick and crying or when their babies were inconsolable. The emotional strain of having a newborn baby to take care of was a shared sentiment among the teen parents,

“ I would cry all the time at nighttime I could not get any sleep because he would just wake up in the middle of the night and just cry.

“ I wish I would have realized that literally how exhausting it gets, like you think like oh wake up at every whatever is not too bad, you don't realize that after two months of getting nothing but two hours sleep at a time you are past the point of sanity.

Teen parents talked about the need for parenting classes for young parents. Teen parents discussed taking parenting classes in order to learn about child development, better their parenting skills, and prepare them for what to expect raising their child,

“ ...I think that young people should have some kind of advocate that teach, gives them classes to go to on like people that are going to prep them up like and like teach about your baby.

“ ...I will make time to like go to parenting classes because I am only 16 going on 17 and I don't know what to do...

“ ...everybody should take them [parenting classes] because there's always something you can learn.

Financial strain was commonly brought up by both teen mothers and fathers as they discussed the challenges of trying to pay bills while earning minimum wage. Being able to afford formula, diapers, and other daily necessities was stressful for the young parents, especially when their children have special needs, such as requiring a specific feeding formula. Many teen parents reported utilizing WIC and food stamp services to afford to pay for these daily needs, however even enrolling in these services proved to be a challenge for some,

I enrolled myself in WIC and then Medicaid.

“ ...I tried to get food stamps, but they said my mom makes too much...

Teen parents expressed a desire to filter out the negative influences in their lives and focus on turning their situation into a positive,

“ This situation is permanent you no longer have an option. You're a parent let's figure out how to make this a good situation not bad this and bad that. Let's figure out how to make this a positive thing. Like how to make this child's life easier and better and not have to hear negative people all the time.



### Talking with their children about sex

Teen parents discussed wanting to build relationships with their children in which there will be trust and open communication, specifically when it comes to talking about sex.

“ I want her to tell me everything and come to me... so I want her to trust me and be able to talk to me about anything... no matter if it is sex, if she wants to be on birth control.

“ Things come fast at your life. We fathers now because we lived that fast life. So now we have to look out for the little ones. School them through life, you know? Show ‘em the ropes. Then give them positive choices on how to live life when they get older you know.

“ We’re going to be telling our kids much more than our fathers, who weren’t there to tell us.

Teen fathers expressed more comfort around talking to sons, and wanting the mother to communicate with their daughters about sex. Teen mothers on the whole expressed a desire to talk to their children about sex regardless of gender or sex.

## Teen parents' advice for future prevention strategies

“ At school [if] they would talk to us about preventing pregnancy, instead of preparing for pregnancy, I think that would have helped a lot.

Teen parents suggested that teens should be provided with comprehensive sexuality education, including accurate information about how and where they can access birth control methods. Teen parents talked about not knowing that they could go to clinics for condoms without having to obtain permission from their parents. Letting other teens know what is available to them so that they can practice safe sex was a recurring theme.

Teen parents expressed wanting to have conversations with their children that they felt they weren't able to have with their parents. Teen parents also want to be able to share their experiences as teen parents with their peers as well in order to tell them how difficult it is to be a teen parent. Some teen parents also volunteered to go into schools and speak with other teens about the realities of young parenting.

“ What we're going through right now, we're going to share this with our child in the future.

“ I'll go to schools and talk to kids.

## **Parent focus group findings**

Focus groups were conducted with 20 parents in the Travis County community, in both English and Spanish, to understand parents' perspectives on how youth learn about sex, the messages they send about the ideal timing for parenthood, how they support their children in preventing early and unintended pregnancy, community supports they are aware of in helping their child prevent pregnancy, and barriers present to accessing services.

### Parents as educators

When asked how young people learn about sex, parent focus group participants brought up peers, school, partners, media, the internet, “participating in it,” and parents, with many participants sharing that parents have the most influence over what their children learn.

Several parents discussed the importance of not forbidding their children from having sex, as teens can sometimes be rebellious and that may push them into wanting to have sex. These parents discussed the need to trust and respect their children to help them make healthy choices,

“ No les digas, ‘no tengas sexo,’ porque van a tenerlo. [Don't tell them, ‘don't have sex,’ because they're going to have it.]

“ Es correcto eso que si todos analizamos la misma pero a veces nosotros venimos de un país allá en que todo es esto y esto y esto. Y ya siempre tenemos en la mente que ‘no, tú no te vas a ir allá porque no.’ Y a veces si les quitamos la opción, a lo mejor no van a hacer absolutamente nada no más está abriendo la puerta para que ellos se extiendan. Pero la mente de uno dice no vas a hacer. Entonces, allí es cuando viene lo ‘Si mi papa no me deja, y mi mama no me deja ir, voy a hacer esto’ [Everything in our respective countries is like this, this, and this. So in our heads, we think ‘no, you’re not going there because I said so.’ So we take options away, maybe they won’t do anything [bad] and are just extending themselves. But we automatically negate their choice and options. So that’s where, ‘well if mom and dad say no, I’m going to do what I want’ comes from.]

“ A veces le digo a mi niño grande, tú vas a terminar primero tus estudios y después hasta si quieres te compro un condón y se ríen. Eso es lo que me gusta porque, como que se va una escalerita porque me tienen confianza y cosas así. [Sometimes I tell my oldest son, you are going to finish your studies first, and after that if you want, I’ll even buy you a condom and they laugh. But I like this approach, it’s a stairway to building trust and things.]

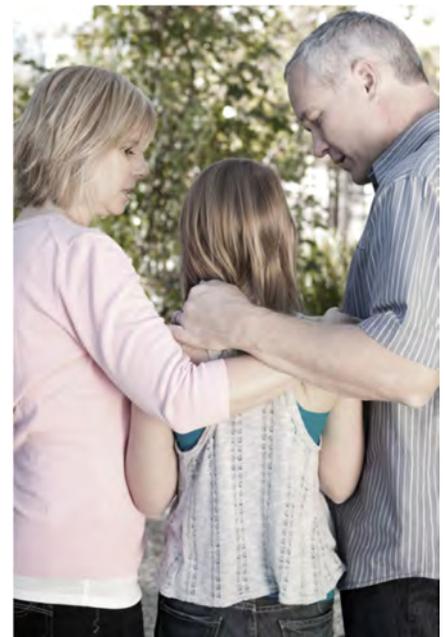
“ Y eso es, me alegra porque hemos jugado y le das confianza... y respetas a los niños, verdad. Y personas quieren poner un leash muy cortito. Entonces, pero después no hemos hablado en realidad de relaciones verdad. [And that is, I’m happy because we have played and give them trust... and you respect the children. People want to use a very short leash. But then we haven’t really talked about the realities of relationships.]

Parents discussed the influence they feel they have over their child’s decision-making, and the responsibility they have to communicate with their children about sex,

“ Introduce them to some things that are safe, talk to them about safe sex, talk to them about sex period.

“ It’s our responsibility to teach them what the pros and cons of sex is, really, like it’s not all flowers and happiness and everything because there’s bad parts to it too. They need to know the difference between wrong and right when it comes to sex...

“ Pues simplemente hacer lo que a uno no nos enseñaron. Enseñarles a los hijos. Explicarles lo que pasa en realidad. Simplemente protégete, si tú lo vas a hacer protégete. Eso. [Simply doing what they didn’t teach us. Teaching our kids. Explaining to them the reality. Simply use protection, if you are going to do it, use protection. That’s it.]



Many parents expressed uncertainty or discomfort in knowing how to talk with their child, when to begin, or what to say. Parents brought up barriers to communicating with their children, including embarrassment, cultural differences, and feeling like their children are more informed than they are.

“ ... por ejemplo, yo a mi niña—no sé en qué edad sería la edad correcta de empezarle a hablar. [For example, between me and my daughter—I don’t know what age is the correct age to begin talking.]

“ ... es muy importante que nosotros los padres seamos más abiertos con los hijos y es los hispanos que no lo hacemos. Nos da pena... [It’s very important for us parents to be more open with our children, and Hispanics do not. We’re embarrassed to...]

“ Y por eso ahora me interesa mucho aprender porque sé que las niñas saben, ojala no, pero a veces pienso, saben más que yo. Y no, no debe ser así. [So now I’m interested to learn because I know my daughters know, I mean, I hope not, but sometimes I think they know more than I do. And no, that shouldn’t be the case.]

Parents discussed recognizing that communication with their children around sex needs to happen earlier,

“ ...Y esa falta de darnos cuenta de que es importante prevenir por que no prevenimos hablar, hablar antes de que tengan su periodo verdad debería ser lo ideal y no esperar que ya tengan su menstruación. [We don’t realize how important prevention is, not preventing the sex-talk. Ideally, we should talk to them before their period/puberty starts and not wait after.]

“ ...a veces yo le digo la niña mira hija esto, y esto, “¡Ay mami! Eso ya lo sabía. Mi amiga me lo dijo.” Y yo me quedo [Gruñendo]. Y yo me siento culpable, ¿sabe porque? Porque yo me tuve que haber educado más sobre eso y desde más pequeña hablarle a ella enseñarle a ella, a las dos. No dejar que las compañeras les enseñen. Muchas veces si les dicen cosas que en la escuela les han enseñado pero muchas veces es puro mugrego pura basura.. [Yes, because sometimes I tell my daughter, look here, “Ah, mom! I already know that. My friend told me.” I just get irritated. And I feel guilty. You know why? Because I should have educated myself more on the subject and have talked to her at a young age, both girls. Not let their peers/girl-friends teach them. Most of the time their friends share with [my daughters] the material they’ve learned in school but most of the time it’s garbage.]

Parents expressed interest in educational opportunities to learn more about talking with their children and to stay current on information. Parents were also interested in learning when to begin talking with their children and information on age-appropriate topics,

“ ...I don’t care what stage or what age you are in your life, you can always learn something, you know, and I’m still learning, I learn something new every day... we need to be updated because stuff changes—all the time more modern.

“ Pero la verdad uno de papa debe de informarse. Aha y poderles hablar porque mejor consejo que uno de padre. [Truthfully, parents should educate themselves, and be able to talk {to their children} because what better advice than from a parent.]

“Pues solo así, pues solo ser algún mensaje o invitarle a los padres a una reunión. Porque habremos muchos padres que ni tiempo damos para una plática como esta, esto yo creo que eso es muy importante para nosotros los padres pero no todos los padres damos tiempo para venir a escuchar estas pláticas.” [Only like this, if there’s a message or parents are invited to a meeting. There might be a lot of parents that do not set time aside to meet for a discussion like this, but it’s important for us as parents to set time to come and listen to these discussions.]

Several parents disclosed their own history of teen pregnancy, and the desire to talk with their children about sex to protect them from becoming teen parents themselves, repeating the cycle of teen pregnancy.

### **Community Resources to Support Their Children**

The majority of parents struggled to identify resources available within the community to help their children prevent teen pregnancy. Parents who were able to identify resources primarily identified family planning clinics or school-based resources, such as Communities In Schools.

Parents discussed the importance of involving their children in extracurricular activities to help them prevent pregnancy, but it was also noted that parents didn't feel like Austin had enough opportunities for activities for their kids or feeling a sense of community.

“ Yo pienso como él dijo de que mantenerlos ocupados a ambos hijo/hija en cualquier actividades que les gusta sea religioso o sea natación o sea deporte. [Like he said, I think we should keep our kids occupied in whatever activities they like, be it religious or swimming or sports.]

Parent participants brought up wanting support from schools and churches in teaching their children about sex,

“ ...they don’t have sex education in school anymore. And I think that’s what helped a lot of people when I was growing up.

“ En las iglesias a veces [hay] muchos retiros para jóvenes...si. Y te llevan –como se llama, pasas tres, viernes, sábado y domingo y como se llama, te hablan mucho. Y también tienen temas de la sexualidad y la familia y eso ayuda. [Churches have youth retreats, and they take {teens} to spend Friday, Saturday, and Sunday to talk. They cover topics like sexuality and the family, and that helps.]

Parents identified a number of barriers involved preventing them from accessing services, including awareness of available resources, health insurance, transportation, hours of operation, language barriers, and the belief that some providers have a “god complex” where they do not offer services or information to everyone. This perception may be due to funding limitations on

who can receive services. The most common barrier identified by parents was being able to get their children to open up to them,

“ ... you don't want to be like a parent that is failing to give their child what they think they need, but I can tell you, I don't care how close you are with your child... they are not going to tell you everything.



Parents were very interested in seeing open dialogue around sexual health in the community,

“ Yo diría mas este, yo no sé el tema un tabú como dicen. Y las Iglesias en lugar de, no todas, pero en lugar de estar diciendo que es un tema um, pues ya saben lo que dicen [I would say it's a topic that's taboo as they say. And the churches, instead of, not all, but instead of saying that it's um [taboo] well you know what they say].

“ Es de educar más que todo a la gente” [Above all, it's about educating the community].

## Parents' advice for future prevention strategies

Parents made suggestions about ways to educate their teens on the consequences of having unprotected sex, talk to their teens about sex, and provide teens with accurate information about sex.

Overall, parent recommendations were quite similar to those made by teen and teen parent participants, including more open communication in the community about sexual health, increased and earlier parent-child communication about sex, parental guidance and supervision to reduce opportunity for sex, and educational opportunities for parents on how to talk with their children.

In addition, parents also wanted to see churches get more involved in sexual health and opportunities for youth to come together and learn about sexual health,

“ Si me gustaría que en la comunidad hubiera no se al mejor un salón, una reunión así como se juntan las amigas que fueran los amigos que les dieran clases... clases de sexo o como simplemente como comportase a ver si entre todos captan el mensaje que les están dando.” [I would like the community to round-up teens like a friend hangout, both girls and boys, so they can receive classes... classes about sex or simply taught how to behave, we'll see if they capture the message.]

In most parent focus groups, parents expressed interest in public service announcements and community-wide media campaigns targeted at getting more information out about the consequences of sex, bring awareness to available resources, and encourage parent-child communication around sexual health.

“ Entonces una imagen más publicó de las consecuencias del sexo, de los embarazos, las enfermedades, todo eso que sea más público. [A more public image {public service announcements} about the consequences of sex, the pregnancies, the illnesses, all that should be more public].

One parent participant noted that teen pregnancy is often spoken about negatively, and that marketing campaigns should be more positive so as not to shun and stigmatize young parents.



# SECTION

# 4

## SURVEY FINDINGS

Survey participants

Survey findings

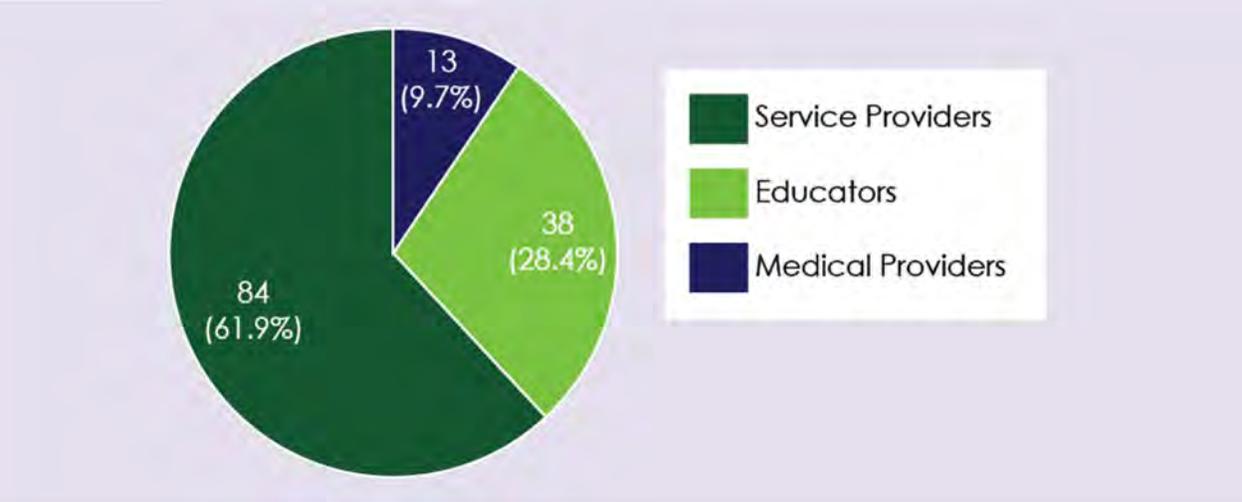


# SURVEY FINDINGS: YOUTH SERVING PROFESSIONALS

## Survey participants

Before discussing content related to teen sexual health findings, a description of participants is presented. A total of 134 participants completed the online survey. The majority of participants were service providers (62%) and educators/school staff (28%). See Figure 7 below for a breakdown of participation by provider type.

Figure 7. Survey participation by profession (N=134)



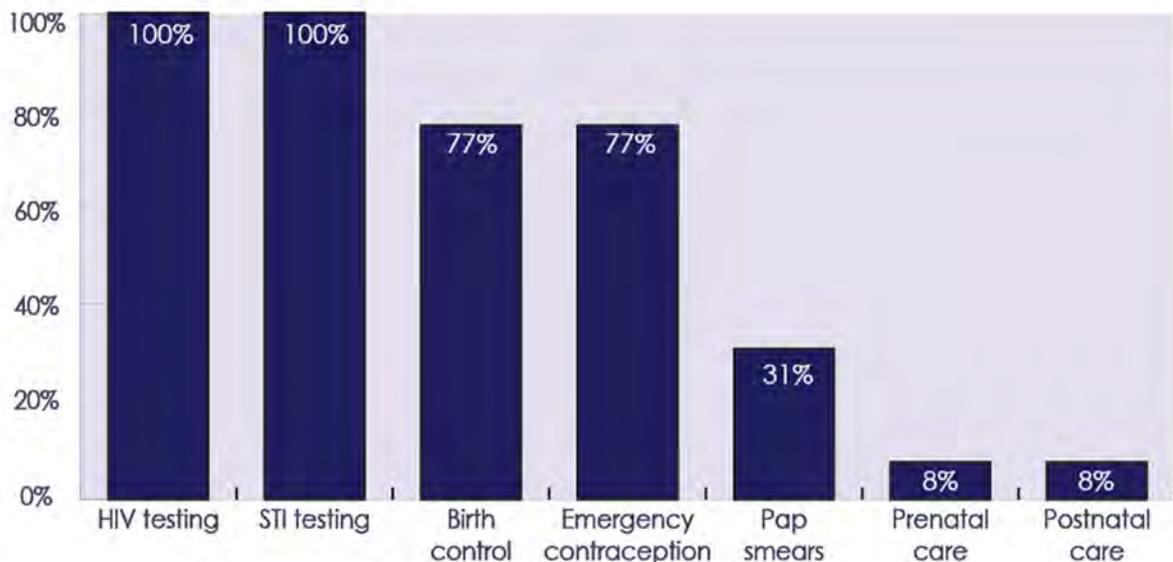
## Medical providers

A total of 13 medical providers participated in the online survey, representing about 10 percent of all survey participants. The majority (85%) worked in a clinic. About 40% of the medical providers had a registered nursing (RN) degree and 50% had specialized in OBGYN.

## Medical services

Medical services offered to teens by responding medical providers focused on HIV and STI testing as well as birth control and emergency contraception. Prenatal and postnatal care services were provided by one participant. Figure 8 shows the percentage of medical providers providing sexual and reproductive health services,

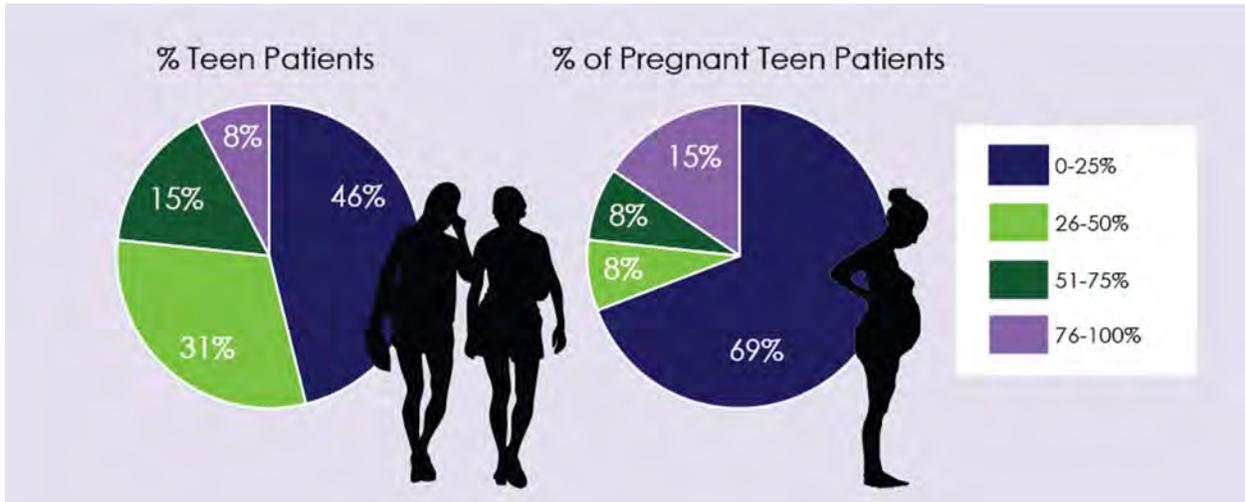
**Figure 8. Medical provider services for teen patients (N=13)**



## Respondents with teen patients

The majority of medical providers (10 of 13) reported that less than 50% of their patients were teens. Out of all teen patients, 70% of providers also reported less than 25% of their patients being pregnant. Figure 9 below shows the percentage breakdown of teen and pregnant teen patients to medical provider respondents.

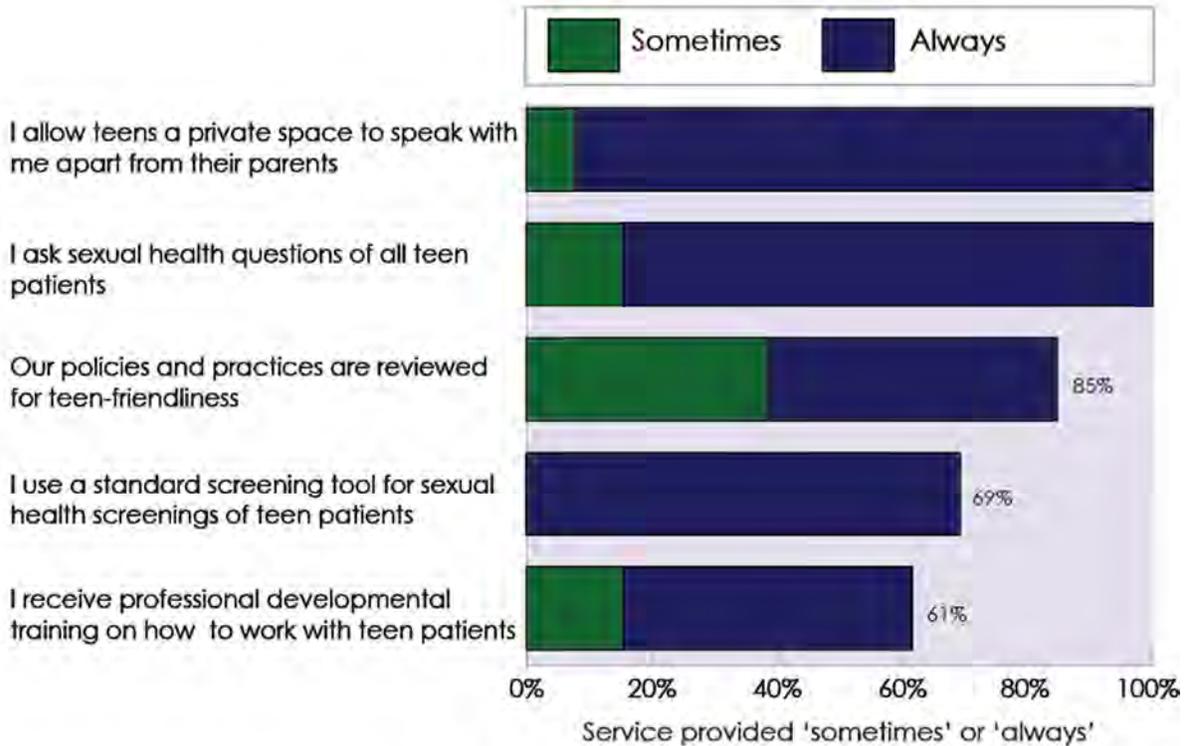
**Figure 9. Medical providers: Percent of teen and pregnant teen patients (N=13)**



**Policies and procedures**

In terms of teen-friendly sexual health policies and procedures, medical providers indicated they almost always allow teens an opportunity to have a private conversation separate from their parents as well as ask teens questions about their sexual health. However, 38.5% of the medical providers indicated that they never receive professional training on how to work with teen patients.

**Figure 10. Medical providers' teen sexual health policies and practices (N=13)**



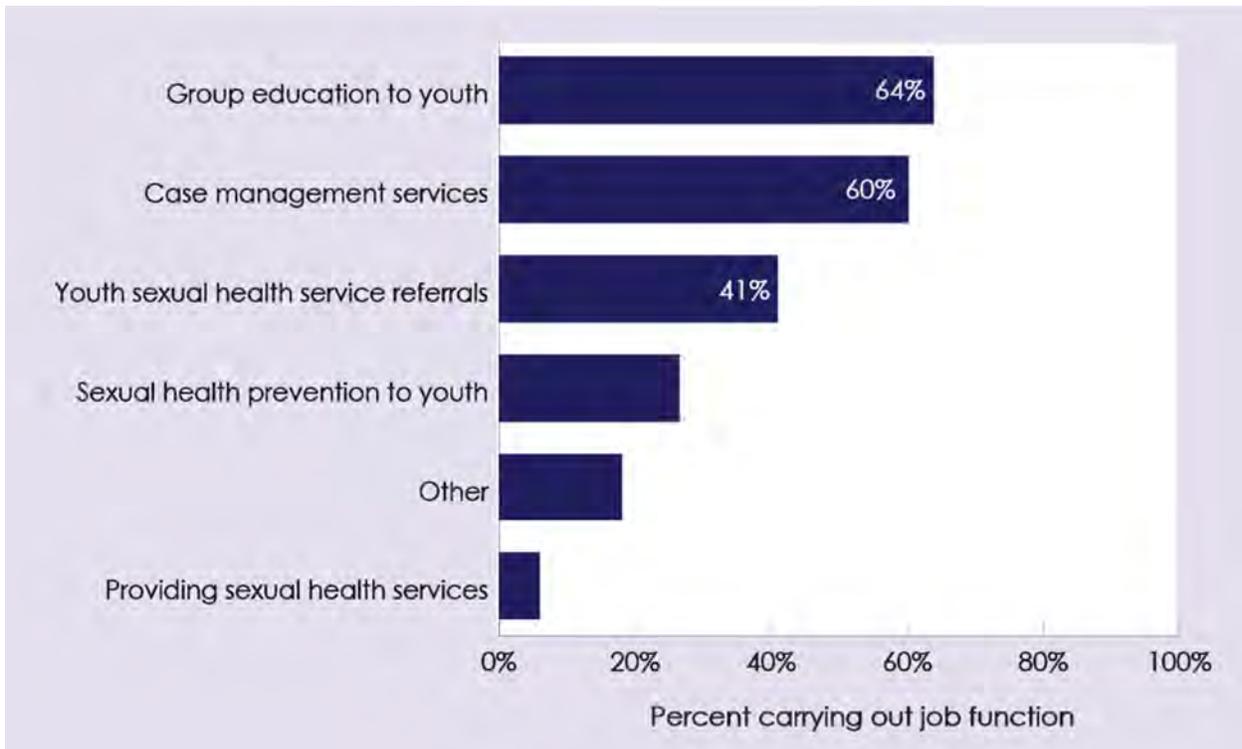
## Service providers

Eighty-three service providers responded to the survey, accounting for more than half (61%) of the respondents. This higher response rate is likely due to the recruitment strategy for this survey.

## Job functions

The majority of respondents provided case management services (60%) and group education to youth (64%). Forty percent of the service providers indicated they made referrals for sexual health services, while 26.5% presented preventative sexual health material to youth. Only 6% of the service providers provided sexual health services to youth. Other job functions reported include mental health counseling, substance abuse prevention, and program administration. Figure 11 demonstrates the breakdown of job functions among service provider respondents. This breakdown of job functions will not add up to 100%, as some jobs include multiple functions.

**Figure 11. Service provider job functions (N=83)**



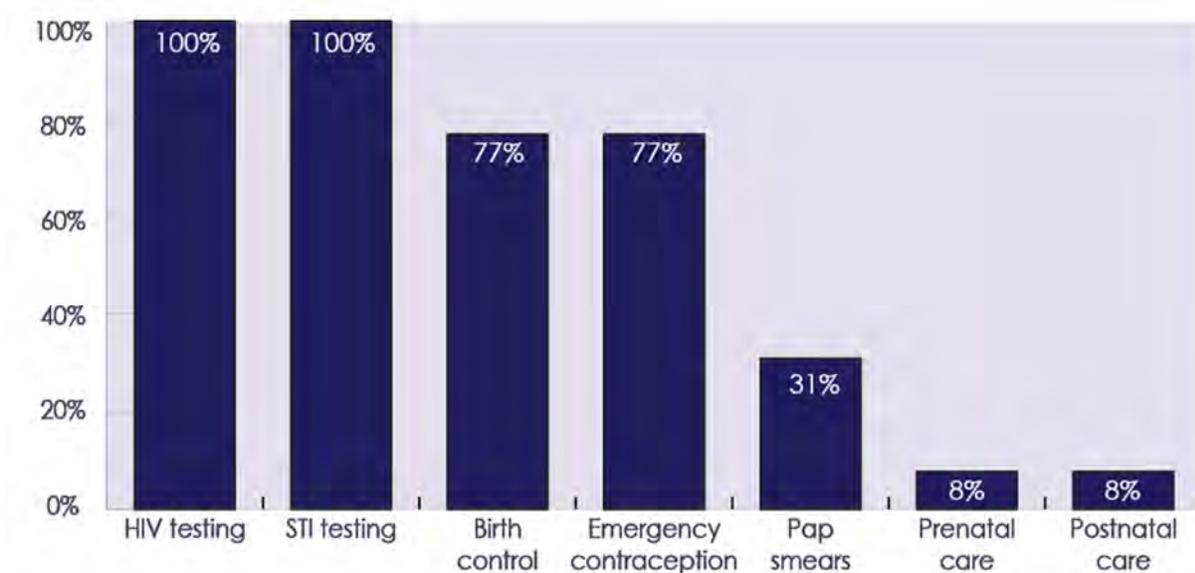
### Agency sexual health services

Respondents were also asked to report on types of agency services offered to youth. About half (54%) of the service providers indicated their agency directly addressed teen sexual health services. Case management services (teens, teen parents, and pregnant teens) and health education were the most common types of sexual health services delivered. Other services delivered include mental health counseling, academic enrichment, GED education, youth development, substance abuse prevention/treatment, and housing services.

**Figure 12. Addressing teen sexual health within providers' service agencies**



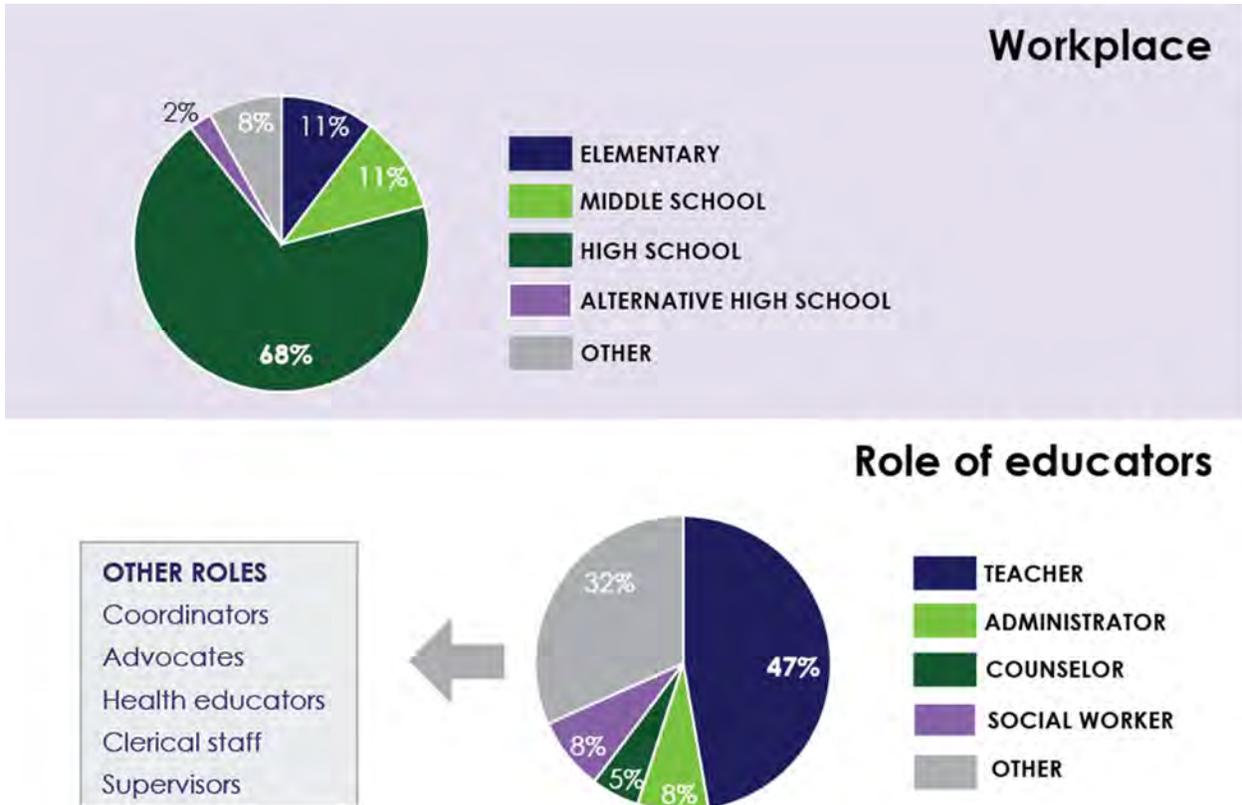
**Figure 13. Sexual health services for teens within providers' service agencies**



## Educators and school staff

Thirty-eight educators and school staff members responded to the survey, with a variety of roles including teachers, administrators, school social workers, school counselors, and afterschool program coordinators. Educator respondents were located at elementary, middle, high, and alternative school campuses, as well as in the central office of their school district. Figure 14 below demonstrates the percentage breakdown of respondents for roles in their schools and school settings.

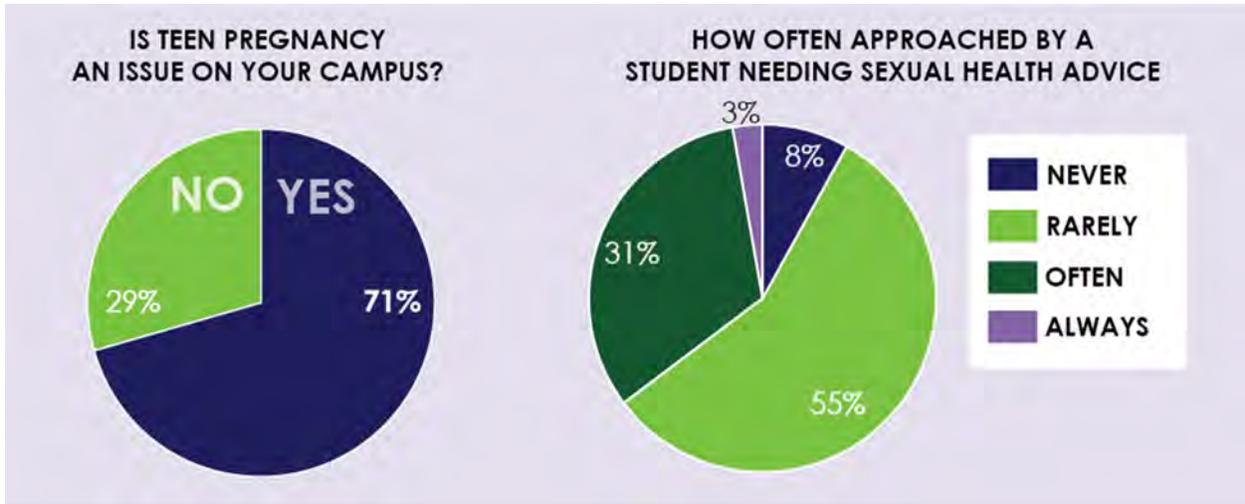
Figure 14. Educators' workplace settings and roles



### Teen pregnancy on school campuses

Sixty-three percent of educators responded that they felt teen pregnancy was an issue on their campus, however, only 44% felt that there are supports in place at schools to help if the educator identified a student needing sexual health information. When asked how often educators and school staff are approached by a student needing sexual health advice, 31% of respondents reported often, and 55% responded rarely. Only 8% of respondents said they are never approached about sexual health advice from students.

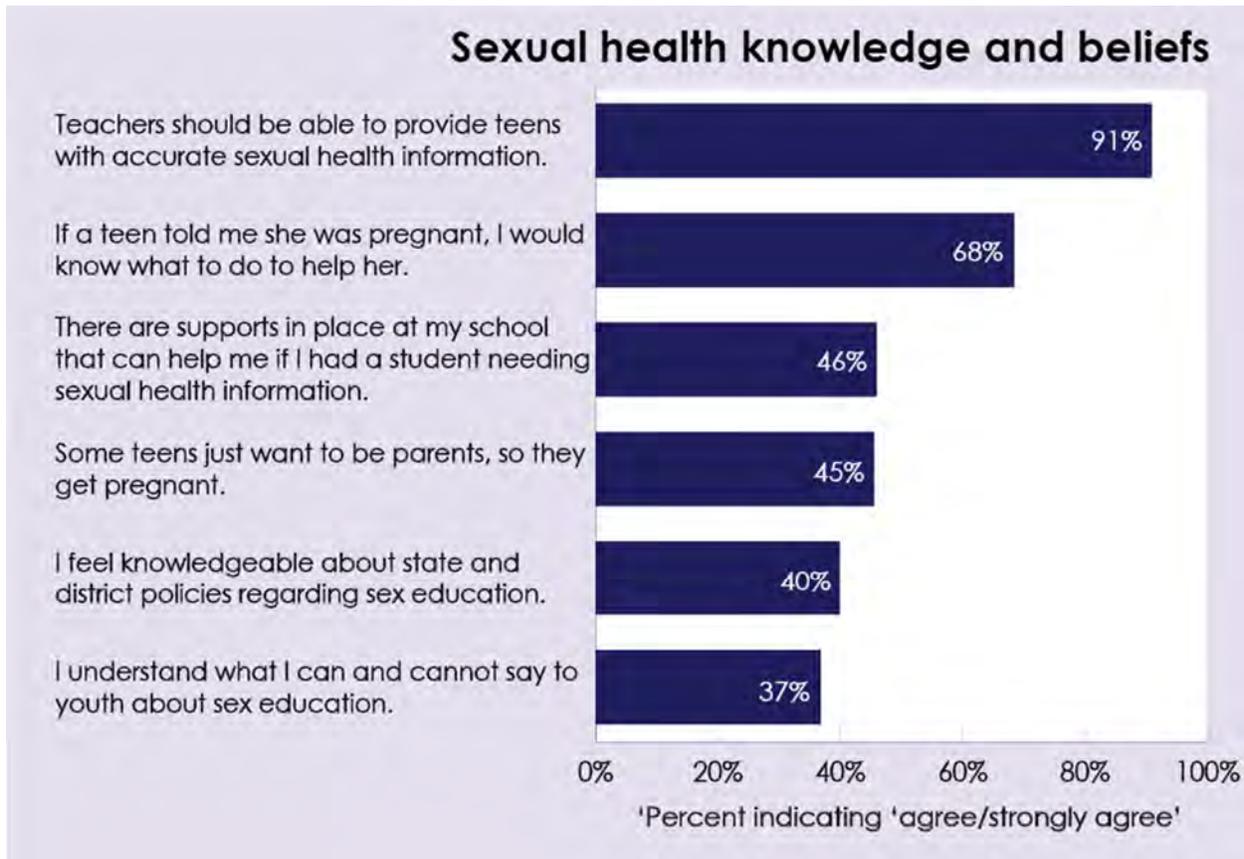
**Figure 15. Educators' views of teen pregnancy and sexual health needs at schools**



### Sexual health education in schools

Educators were asked to assess the sex education offerings at their schools—Figure 16 below demonstrates the percentage of respondents who agreed with the following statements.

**Figure 16. Sexual health education in schools**



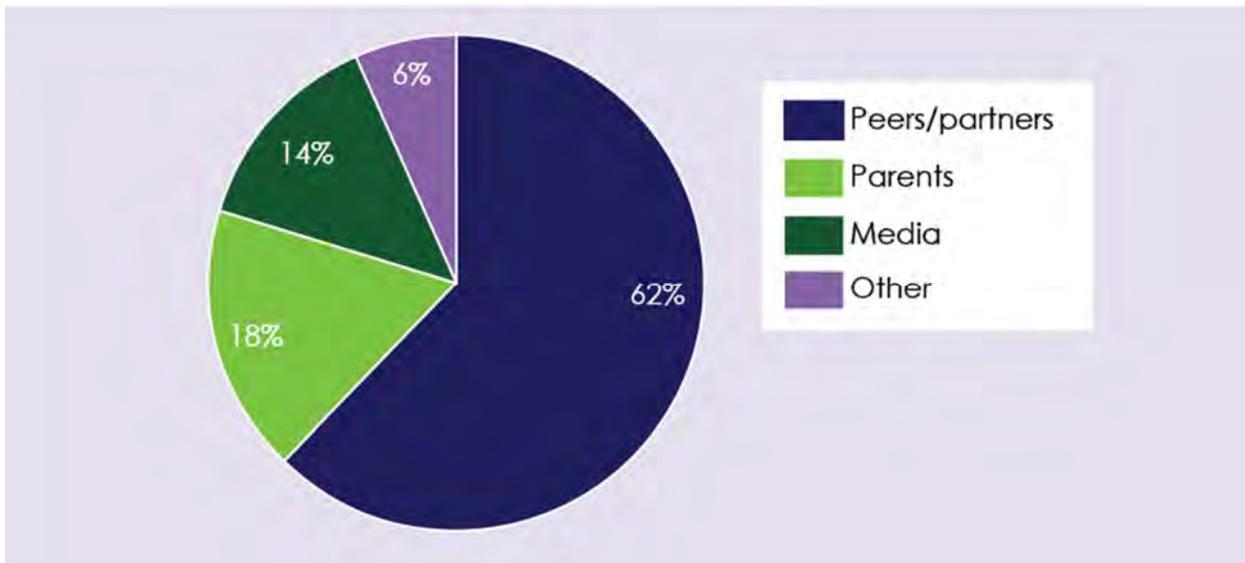
In looking at local school district and statewide policies around human sexuality education, discussions of contraception are not prohibited, however policy does not allow for contraceptive devices to be *demonstrated* or *disseminated* (Austin Independent School District [AISD], 2010). This misconception among educators that simply talking about contraception is not allowed demonstrates a need for professional development around state laws and district policies for discussing sexual health information with students.

## Survey findings

### Teen decisions around sex

All providers (medical, service, and education) were asked to rate who they feel most influences teens when it comes to sexual decision-making. Figure 17 shows the breakdown of provider responses. Over 62% of providers indicated that peers/partners had the most influence on teen sex decisions. Approximately 18% of providers indicated parents were most influential, while 14% indicated the media was most influential.

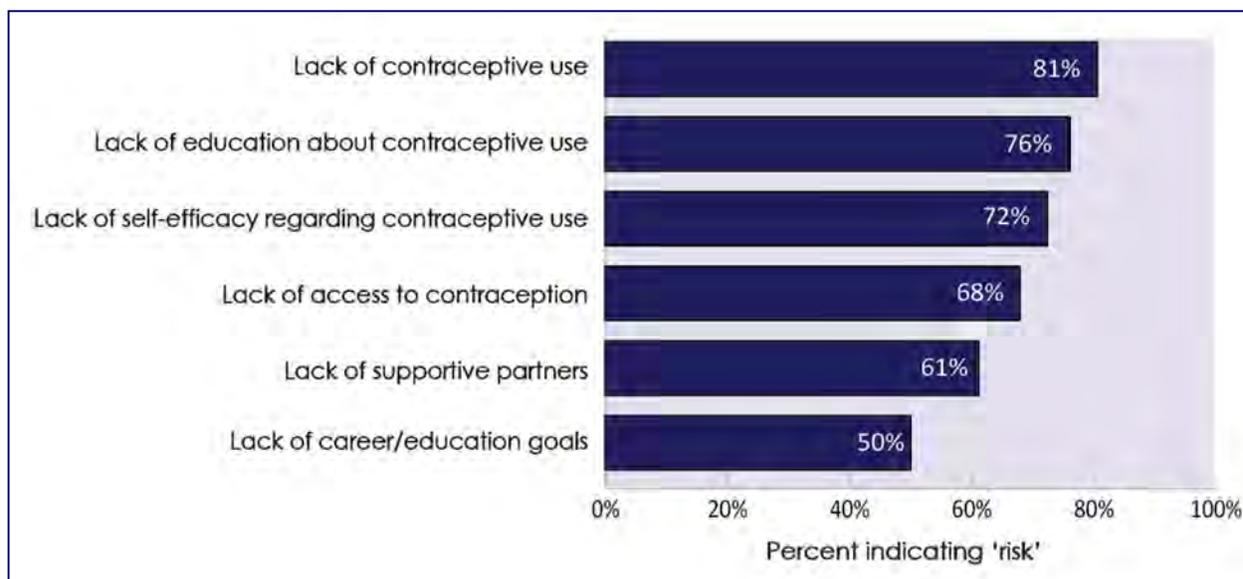
**Figure 17. Teen influences for sexual decision-making**



### Identified risks for unintended teen pregnancy

All providers were asked to identify risks for unintended teen pregnancy. Figure 18 shows the percent of providers across all provider types that agreed or strongly agreed that the following risks are risks that Austin and Travis County youth are encountering. Lack of contraceptive use (81%), lack of education about contraceptive use (76%), and lack of self-efficacy regarding contraceptive use (72%) were identified as the top three risks for unintended teen pregnancy among all providers. Additional risks identified by providers included lack of communication and negotiation skills for condom and contraceptive use, lack of parental support, exposure to false/misleading information, and lack of knowledge on pregnancy/parenting.

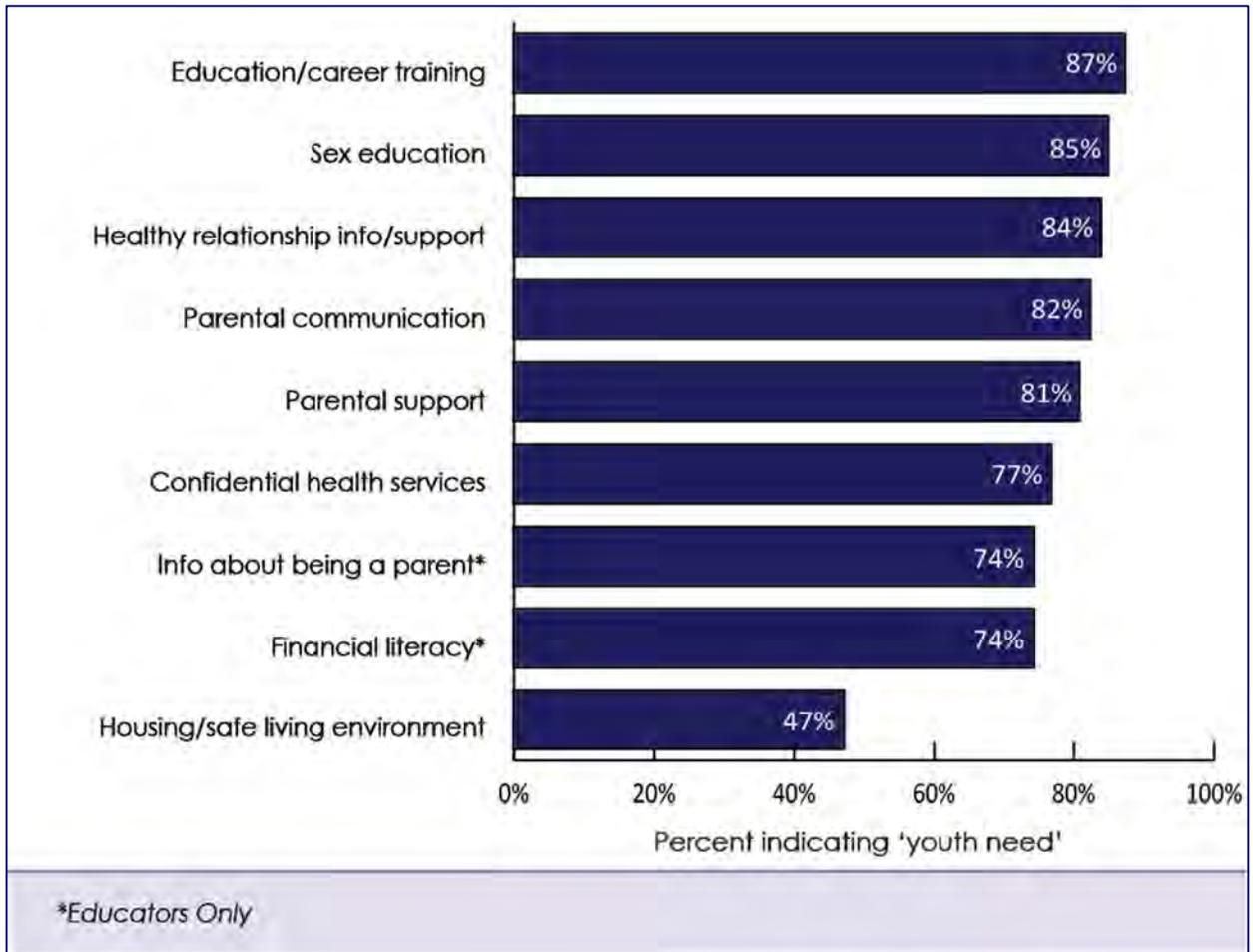
**Figure 18. Identified risks for unintended teen pregnancy (N=126)**



### Youth sexual health needs

Providers were asked to identify what they felt youth need in order to prevent pregnancy. Vast majority of respondents felt that sex education, confidential health services, parental support, parental communication, safe living environments, information and support on healthy relationships, education and career training, information on being a parent, and financial literacy are always a need. Figure 19 demonstrates the percentage of respondents across all provider types that identified the following services to be “always a need.”

Figure 19. Identified pregnancy prevention needs across all provider types (N=126)



## OTHER IDENTIFIED PREGNANCY PREVENTION NEEDS



Accurate information on anatomy, contraception, parenting, STIs, and decision-making

Education and information on healthy relationships

Parental support/engagement and caring adults

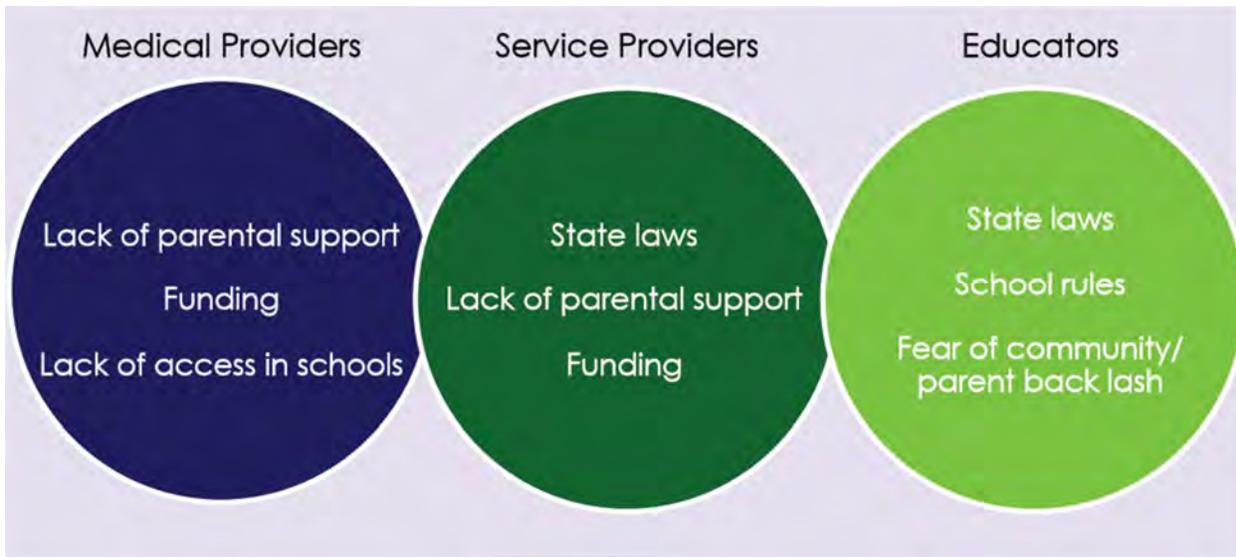
Basic necessities: safety, housing, food, and clothing

Mental health services

## Barriers to providing and accessing services

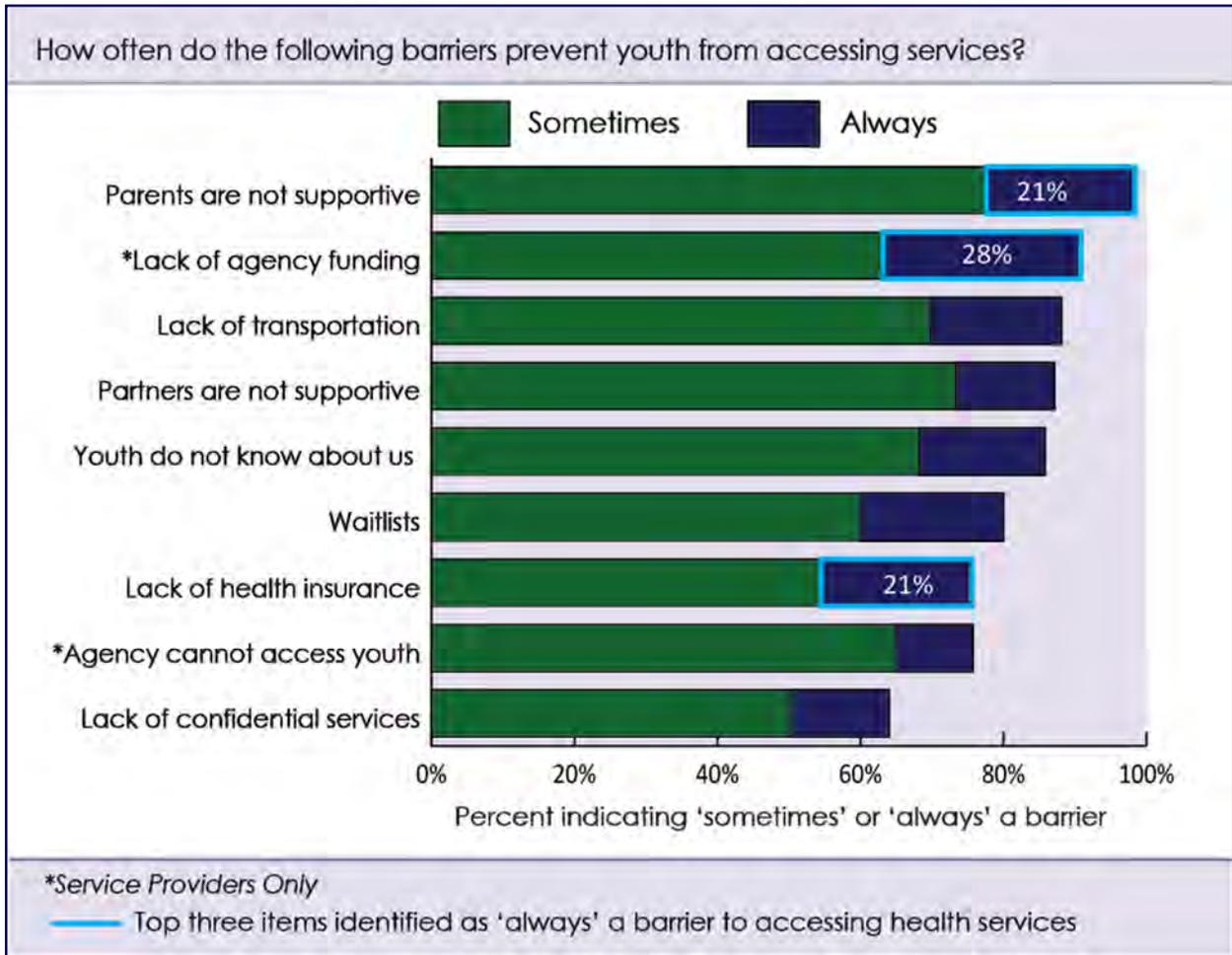
Providers assessed the barriers that prevent them (providers) from providing resources and information to teen clients, students, or patients. State laws were identified as a barrier by approximately 50% of participants across all provider types. Funding and lack of parental support were more frequently identified as barriers by medical and service providers. Figure 20 below shows the top three barriers identified by each provider type.

**Figure 20. Top barriers to providing resources and information to teens by provider type**



Providers were also asked to assess barriers that prevent youth from accessing their services. Providers most often identified lack of supportive partners, supportive parents, transportation, knowledge of services, and agency funding as being the most common barriers faced. Figure 21 shows the percentage of providers who indicated the following barriers as being sometimes or always a barrier for their teen clients/students, as well as additional access barriers identified by provider respondents.

**Figure 21. Barriers for teens accessing services, across all provider types**



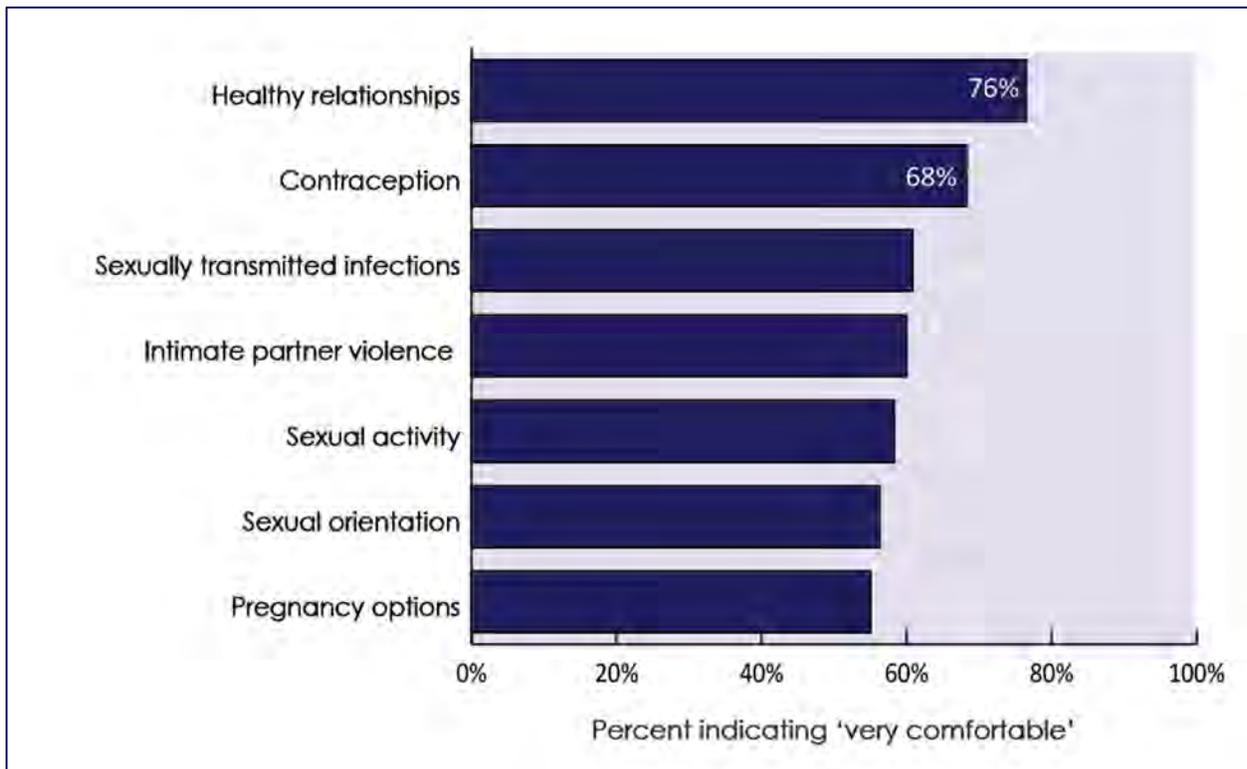
**OTHER IDENTIFIED ACCESS BARRIERS**

- Age • Location • Finances • Confusion • Culture
- Policies • Embarrassment • Education • Fear
- Reporting • Funding • Misinformation • Time
- Truancy • Religion • Beliefs • Schedule • Stigma
- Shame

## Level of comfort discussing sexual health topics with teens

Providers were asked to rank their comfort level in discussing particular sexual health topics with teens on a five-point Likert scale (1-very uncomfortable, 2-not comfortable, 3-neutral, 4-somewhat comfortable, 5-very comfortable). On average, providers reported feeling between somewhat to very comfortable discussing sexual health with teens. Providers as a whole felt most comfortable discussing healthy relationships and contraception, and less comfortable discussing STIs, intimate partner violence, pregnancy options, and sexual orientation. Educators reported lower levels of comfort in most areas, compared to medical and service providers.

**Figure 22. Comfort discussing sexual health topics with teens, across all provider types**



# SECTION

# 5

## DISCUSSION

Risk and protective factors

Limitations and future research



# DISCUSSION

## Risk and protective factors

The following discussion of our findings explores which findings have been previously supported by Kirby and Lepore's (2007) analysis of research identifying risk and protective factors that affect teen sexual behavior, pregnancy, childbearing and sexually transmitted disease. Some of our findings were not supported by this specific study, but may be important within the context of the Central Texas community.

### Individual



Over half of our teen sample said they used condoms at last intercourse, while only 25% of teen sample reported using some type of hormonal birth control method. 31.3% mentioned using withdrawal or no method. Our teen participants discussed their attitudes towards sexual activity, birth control, condoms, pregnancy, and parenting. In general, our sample of teens were in support of contraceptive use, but mentioned concerns about a loss of pleasure from condom use and hormonal birth control side effects; both of these issues have been identified as risk factors of teen pregnancy (Kirby & Lepore, 2007). A portion of our teen sample seemed to have ambivalent attitudes about pregnancy, as in they didn't care whether or not it happened, which has also been shown to be an associated risk of teen childbearing (Kirby & Lepore, 2007). Our teen parent sample discussed how they didn't perceive pregnancy as a risk and were surprised by their pregnancy. A greater perceived risk of pregnancy has shown to be a protective factor (Kirby & Lepore, 2007). Teen parent participants often spoke

of the financial, social, emotional and mental strain their pregnancies and childbearing had on themselves, their partners, and their families. Knowing about these consequences of teen pregnancy and parenting has been shown to be a protective factor against teen pregnancy and childbearing (Kirby & Lepore, 2007). An interesting insight gathered from the teen parent focus groups was what they recommended financial, emotional, and relationship stability as important considerations in regards to pregnancy timing. However, our providers did not identify a lack of future goals/career plans as an important risk factor. Future orientation has a protective association towards teen pregnancy and childbearing (Stewart, 2003; Kirby & Lepore, 2007).

In most cases, when the participants discussed gender differences they used language that was heavily informed by a gender binary and in most cases, only discussed heterosexual relationships. Teens and teen parents often discussed conflicting ideas around sex. Teens discussed their perceptions of their peers' attitudes towards sexual activity, remarking on gender differences by noting that boys seemed to be supported by their peers to engage in sex while girls were ostracized. It has been documented that adolescent boys tend to have more permissive views on sex, a risk factor, and this could be a result of this sexual double standard that exists to support their sexual activity (Kreager & Staff, 2009). Kirby and Lepore (2007) identified the belief that boys will gain respect if they have sex as a risk factor. Our teen participants also discussed the stigma they felt around abstinence or being abstinent. Some discussed the desire to be seen as abstinent, while others discussed the pressure they felt to have sex. While perceiving the personal and social benefits of abstaining from sex is protective, conversely, research has also shown the belief that one will gain respect from peers for having sex to be a risk factor (Kirby & Lepore, 2007). Teens also discussed differences in gender responsibility for use of contraception, noting that boys were expected to provide condoms and girls were expected to be responsible for their own hormonal birth control. Previous research has suggested that greater perceived male responsibility in preventing pregnancy may be a protective factor for using condoms and contraception; however, the binary breakdown of responsibility reported by the youth reflects more stereotypical gender roles, which is more likely to be a risk factor for use of protection and teen childbearing (Kirby & Lepore, 2007).

### **Peers and romantic partners**

Our teen sample believed that most of their peers were sexually active. Associating with sexually active teens has shown to increase risky sexual behaviors (Kirby & Lepore, 2007). Several times within the teen and teen parent focus groups it was mentioned how prevalent teen pregnancy was among teens' friends and classmates in school. Having a good friend who has been pregnant or gotten someone pregnant, and having friends who are also teen mothers are identified risk factors (Kirby & Lepore, 2007).

Our provider participants cited unsupportive partners as a barrier to accessing their resources, and our teen participants also discussed their partner's attitudes towards sex and birth control, revealing experiences with pressure from their partners to have sex or get pregnant, and discussing their partner's support or lack of support for birth control; both factors have significant associations with risky sexual behavior and teen childbearing (Kirby & Lepore, 2007).

### **Family**

Teens, teen parents, parents and providers all recommended that greater, open, and honest communication about sex and birth control was important to preventing teen pregnancy, but greater communication between parent and child was mentioned most often. The level of comfort in talking about sex with their children varied among our parent participants. A parent's confidence and skill at talking about sex has shown to influence unhealthy adolescent sexual behaviors (Guilamo-Ramos & Bouris, 2008). This is an important protective factor to consider that is supported by our participants (Kirby & Lepore, 2007). Only half of teen survey respondents either strongly disagreed or somewhat disagreed that having a child outside of marriage is unacceptable in their families. Adolescents' perceptions of their parent's views on sexual activity

and early childbearing does not have sufficient evidential support, but it may be an important finding to consider within the context of our community (Kirby & Lepore, 2007).

### **Community and environmental**

Teen, teen parent, and provider participants discussed the difficulties in accessing contraception and reproductive health services in our community. Our teen participants cited laws that require minors to receive consent before accessing reproductive services as a barrier, while a good portion of our providers considered state laws to be a barrier to providing resources and information to teens. Restrictive laws regarding licensing, advertising, or selling of contraception has been identified as a risk factor of teen pregnancy, and parental involvement legislation for reproductive services have been identified as a teen childbearing risk (Kirby & Lepore, 2007).

Teen parents discussed how schools and adults in their community often had negative reactions to their pregnancies. Teen participants discussed how certain local schools pressured and or asked pregnant students to leave the school which could be a violation of Title IX education amendments (Education Amendments of 1972, 2015). Our participants also recommended that sex education happen earlier, and use approaches that are comprehensive, inclusive, and when possible, peer led. Previous research has been inconclusive on sex education timing, content, and type



of facilitator, but more recent research needs to be conducted. Only 3% of educators and school staff survey respondents felt that the present sex education taught in schools was meeting the needs of youth, with 40% reporting that they feel students receive sexual health information too late. Some participants, both teens and providers, discussed the perception that the services for teen parents may in some way promote teen pregnancy since the benefits of these services are clearly apparent in the school and social environment. This perception, coupled with the high incidence of teen pregnancy and childbearing, may indicate a normalization of teen pregnancy within in the Central Texas community. Texas is ranked number one in the country for repeat teen pregnancy, with 22% of teen births being repeat births (CDC, 2013). Within our sample, some of our teen participants had been pregnant and several of our teen parent participants had multiple children at the time of the focus group.

Our findings highlight some of the individual, peer, family and community factors that may contextualize the current status of teen sexual health in Texas. Participants reported two interesting paradoxical situations that teens and teen parents are faced with today: a stigmatization around both teen sexual activity and abstinence, and a stigmatization and

apparent normalization of teen pregnancy. These polarized messages informed teen attitudes and teen parent experiences with providers, their schools, and families. HYP proposes 9 recommendations to address our findings.

## Limitations and future research

HYP conducted this needs assessment to determine the barriers and strengths related to teen pregnancy prevention in Travis County. Recommendations on how to reduce the teen birth rate in our community were also gathered from our participants. The HYP Needs Assessment Collaborative was largely unfunded with the exception of a few in-kind donations, and was conducted by community members and local professionals on a volunteer basis. Due to the unfunded and volunteer-based nature of this project, the timeline for the needs assessment was extended on multiple occasions. Several limitations came to fruition in research coordination, data collection, and analysis.

Surveys for providers were disseminated electronically and physically, with providers self-selecting the type of provider survey they would take; this may have varied the provider responses since different questions and options for answer selection were available to the participant depending on the type of provider survey chosen. A survey for teen participants which measured demographics and attitudes, beliefs, and behaviors around birth control and pregnancy was only disseminated to some but not all teen focus groups. No survey collecting demographic data or recording attitudes, beliefs, or behaviors was developed for teen mothers, teen fathers, or parents. There is also a possibility that participants in the parent groups may have been teen parents as well, as parent ages and the ages of their children were not disclosed at the focus groups. Future research should more uniformly collect data from these groups so that researchers can compare the demographics, experiences, and views of these different groups.

Purposive sampling was used to recruit a non-probability sample of focus group participants. This method is a limitation and subject to potential bias because participant selection is conducted based on the researcher's judgment of who would be able to provide rich information. For example, teen fathers were underrepresented in our sample. Programs for teen fathers are not numerous or widely available in our community, making recruitment difficult due to our chosen method of sampling. Purposive sampling was utilized due to collaborative participation of several organizations that work with our targeted populations and lack of funding for community-wide recruitment strategies. The views reflected in our findings may not reflect the views of the larger Central Texas community who do not receive services from certain organizations within Travis County. Furthermore, provider surveys were dispersed among those who had been involved in HYP activities or were recruited by involved collaborators utilizing a snowball method. HYP experienced difficulties recruiting educators and school staff within the complex school system and medical providers who don't often make their email addresses public. Future research should utilize random sampling if possible to capture the views of the larger community.

Teen parents and teens who were pregnant were included in some of our teen focus groups because participants were not required to disclose if they had been pregnant or given birth prior to the focus group. Previous experience with pregnancy and birth may influence the attitudes, beliefs, and behaviors of teens. Some teen parent participants may also have had

multiple children at the time of the focus group, and gathering this information may have been useful in creating a more comprehensive snapshot of our sample.

Some technical issues occurred during data collection. Two parent focus group audio files were lost due to recording issues, but data from these focus groups were included from the comprehensive notes of trained note-takers who accompanied the focus group facilitators. Focus group facilitators and note-takers all attended a two hour training on focus group facilitation, but focus group facilitators did not always maintain the line of questioning provided by the guides and often improvised to engage our participants in discussion. While this may vary our results, it did at times provide rich insight from our participants.

As mentioned in the discussion of our findings, focus group guides did not elicit discussion of LGBTQQIA (lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual) issues around teen pregnancy. Our teen participants were only asked to identify their gender with the



limited choices of male, female, or transgender. Sexual orientation was not directly asked of our participants. The questions in our focus group guides were developed intentionally using language that did not imply sex or gender. Participants discussed teen sexual activity and pregnancy primarily in the context of heterosexual relationships. This is an important limitation. LGBTQQIA youth have been found to be at greater risk of many social and environmental risk factors that may influence teen pregnancy prevention efforts (Kirby & Lepore, 2007). In accordance to our first recommendation, adopting a gender-transformative approach, having our participants discuss sexual orientation and expression and gender identity and expression in the context of teen sexual behavior and pregnancy would have aided efforts to make the Central Texas community more inclusive of sexual minorities. There are also limits to a gender-transformative approach: while it does encourage the restructuring of gender norms, it does not specifically address the unique needs of LGBTQQIA

youth. HYP recognizes this limitation but believes utilizing a gender-transformative approach is an important, research-based first step to encourage inclusivity in our community. Furthermore, HYP recommends a separate needs assessment within our community to fully identify and address the needs of this population.

Parents, providers, and teens expressed concern and uncertainty about state laws and regulations within our findings. Teen pregnancy interventions such as school-based sex education or creating access to reproductive health services have been widely studied on the individual level (Kirby & Lepore, 2007). Far less investigation of these interventions has been conducted on the population level. HYP recommends further investigation of how relevant state laws and policies influence state and local county pregnancy and birth rates. This research can better inform Travis County teen pregnancy prevention advocacy efforts on the policy level.



# SECTION

# 6

## RECOMMENDATIONS

Working with youth

Working with caregivers

Improving policies

Conclusion



# RECOMMENDATIONS

Based on these findings, Healthy Youth Partnership has identified three areas in which youth-serving professionals and policymakers can affect changes in attitudes and behaviors that contribute to teen and unplanned pregnancy; working with youth, working with parents and guardians, and improving policies. To fully address these three areas HYP proposes the following:

|                         |   |
|-------------------------|---|
| Working with youth      | <p>Adopt a <b>gender-transformative approach</b> to break down rigid, binary concepts of gender and gender stereotypes, and build in inclusive approaches for more advanced conversations around gender identity, gender expression, and sexual orientation.</p> <p>Provide <b>educational and occupational opportunities</b> that address realistic pathways for youth to achieve adult status.</p> <p>Implement <b>youth-driven services</b> that involve peer educators.</p> <p>Prioritize developing <b>teen-friendly policies and practices</b>, requiring or encouraging staff to participate in professional development around building trust and rapport with youth.</p> |
| Working with caregivers | <p>Provide caregivers with <b>direct education</b> on how to talk to their children about sex, utilizing a <b>sex-positive approach</b>.</p> <p>Develop <b>community marketing campaigns</b> that focus on challenging caregivers to talk to their teenage children about sex and learn to become more comfortable with the notion that their teenage children are sexual beings.</p>   |
| Improving policies      | <p>Advocate for statewide and local school district policies that <b>encourage real, open, and honest communication</b> around topics of sexuality and sexual health.</p> <p>Advocate for <b>funding dedicated to holistic approaches</b> to positive youth development and sexual health.</p> <p>Advocate for policies that provide <b>support for teen parents</b>, both prenatally and postnatally.</p>  |

## Working with youth

The following recommendations are suggested as approaches to incorporate into existing youth programming or as new programming is being developed.

### Adopt a gender-transformative approach

Focus group questions did not specifically address gender, biological sex, or sexual orientation, however teen focus group participants as a whole expressed rigid ideas of gender norms in their environments, as demonstrated by the following quote,

“ It’s a double standard between girls and guys. Guys, they see him like, ‘oh, he’s a player,’ you know, he has all these girls, but for girls it’s ‘she’s ho.’

This feedback obtained during the needs assessment confirms the need to incorporate a gender-transformative approach into sexual health education. By doing so programs are better able to address the harmful gender constructions that impact risky sexual behaviors and attitudes of youth. Rottach, Schuler, & Hardee (2009) offer this definition:

*“Gender-transformative approaches... actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender-equity objectives. Gender-transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers or traditional leaders.” (p. 8)*

Beliefs and attitudes that support more stereotypical gender roles are risk factors for initiation of sex, number of sex partners, use of condoms, use of contraception, and teen childbearing (Kirby & Lepore, 2007). Research has shown that adolescent males who hold traditional attitudes toward masculinity are at an increased risk for contributing to an unintended pregnancy due to less consistent use of condoms and more sexual partners. Moreover, these young men are more likely to believe that a pregnancy validates their masculinity, have less belief that males have a shared responsibility to prevent a pregnancy, engage in less intimate relationships, and are less likely to access healthcare. Research concludes that adolescent females who hold traditional views of femininity are also at a greater risk of unintended pregnancy, are less likely to use condoms consistently, and are at greater risk for HIV. These young women are more likely to accommodate the interests and desires of men and are at greater risk of relationship violence and coercion (Pleck, Sonenstein, & Ku, 1993; Stewart 2003; Jewkes & Morrell, 2010).



By integrating discussions of gender into programs and curricula and engaging youth in developing awareness of socially constructed gender norms, programs can begin to address the unhealthy relationship dynamics driving negative health impacts, create more equitable relationships among young men and women, and improve the overall health outcomes of youth.

HYP recognizes that a gender-transformative approach in itself may not meet the needs of youth who identify as lesbian, gay, bisexual, transgender, queer, questioning, intersex, or asexual (LGBTQQIA). This needs assessment did not produce significant findings around the unique needs of LGBTQQIA youth, however research supports that sexual minority youth are at greater risk of early initiation of sex, increased frequency of sex, increased number of partners, reduced condom use, teen pregnancy, and STI transmission (Kirby & Lepore, 2007). In addition to the research-based gender transformative approach, programs should seek to build in inclusive approaches to meet the needs of these youth.

**Recommendation 1:** HYP recommends adopting a gender-transformative approach to take the first step in helping to break down rigid, binary concepts of gender, and build in inclusive approaches for more advanced conversations around gender identity, gender expression, and sexual orientation.



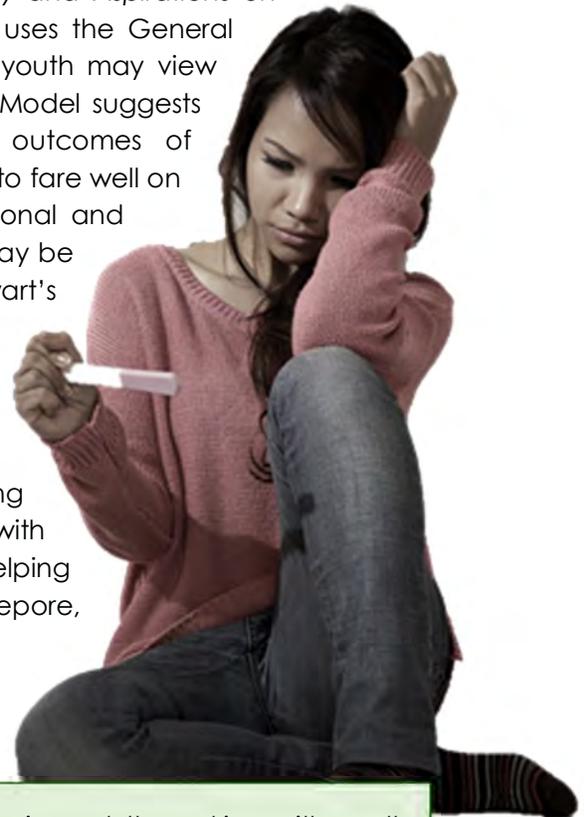
## Address pathways to adulthood

Focus group participants varied in opinions around teen pregnancy, adulthood, and the ideal timing for parenthood. Some teens expressed a desire to explore their options in life and work towards accomplishing their goals before having a child, which can be a strong protective factor for delaying onset of sexual activity, and delaying pregnancy and childbearing. Some teens expressed views of early childbearing as an entry into adulthood. Other teens perceived that social encouragement (such as being voted homecoming queen) and access to services and accommodations made for teen parents at some schools may encourage teens to have a child. Some teens perceived that their peers believe parenting will be easy, as illustrated by this quote:

“ I don't think that most teenagers realize that a baby is more than a baby that it's actually a human being that is going to grow up and be a person just like them.

In *The Mommy Track: The Consequences of Gender Ideology and Aspirations on Age at First Motherhood* (2003), researcher Jennifer Stewart uses the General Resources Model to provide one explanation for why some youth may view parenthood as entry into adulthood. The General Resources Model suggests that economic and interpersonal resources impact the outcomes of individuals. In this case, children raised in poverty are less likely to fare well on standardized tests, which may impact their view of educational and occupational opportunities available to them. Childbearing may be seen by these youth as a way to obtain adult status. Stewart's research suggests that “educational and occupational aspirations are predictive of higher age at first birth” and that youth will delay childbearing if they “perceive they have viable alternatives” to attaining adult status (Stewart, 2003).

Supporting the academic achievement of youth, reducing emphasis on standardized testing, and connecting youth with extracurricular activities may serve as protective factors in helping youth delay initiation of childbearing (Stewart, 2003; Kirby & Lepore, 2007).



**Recommendation 2:** HYP recommends that programs and caring adults working with youth address realistic pathways for youth to achieve adult status through educational and occupational opportunities.

## Increase youth-driven services in our community

Teen focus group participants expressed wanting to hear information coming from other teens, particularly when it comes to health education. Teens noted that they felt the media glamorized sexuality and in some cases, teen childbearing, and expressed wanting to hear real experiences from people similar to themselves. In particular, teens expressed interest in wanting to hear from parenting teens about the realities of parenting at their age. Teen parent participants shared that they feel others do not understand the realities of their situation and also expressed an interest in wanting to share their stories with others- through the schools and with their own children- as a way to help prevent others from encountering similar challenging situations.

“ ...bring in people in that type of experiences ‘cause that the people that have had that have been through those situations and to have them speak in front of people they actually make more of a difference than the parents just telling them no don’t do its bad and stuff and like you’ll die or something...

Peer education programs have been shown to successful in that people tend to identify with their peers and view peers as credible sources of information (Turner & Shepherd, 1999). Research supports that “people are more likely to hear and personalize a message that may result in changing their attitudes and behaviors if they believe the messenger is similar to them in lifestyle and faces the same concerns and pressures” (Sloane & Zimmer, 1993). In addition, peer education programs benefit those serving as peer educators, as “participating in the practice of health promotion and the role of community leadership helps peer educators perceive themselves as growing, both personally and professionally, from their education and training experience” (Sloane & Zimmer, 1993).

Currently, there is only one sexual health peer education program being implemented in the Austin community, through the City of Austin Health and Human Services Department, focusing on the Latino population (see Table 6 of this report). Other peer education programs previously implemented in the community, such as the former youth-serving agency YouthLaunch’s *No Kidding: Straight Talk from Teen Parents* program and Planned Parenthood’s Teen Peer Health Education program have ended due to lack of sustainable funding and an increased focus on evidence-based interventions. HYP advises programs seeking to implement peer education programs should also consider funding challenges and limitations for this type of work, and think creatively about sustainable funding structures.

**Recommendation 3:** HYP recommends that organizations and programs seeking to develop new programs or restructure current programming and consider the possibility of youth-driven services, especially those working with teen parents as peer educators.

### Build trust with youth who utilize community services

Teen and teen parent focus group participants both expressed feeling overwhelmingly negative reactions from adults around sexuality and childbearing, and discussed not feeling comfortable seeking advice from adults in their lives in fear of judgment. This is illustrated by the quotes, "...they don't have anything positive to say," and "they look down on me a lot." Teens expressed wanting parents and other trusted adults in their lives to be realistic about teens having sex, give teens freedom to make their own decisions, be honest and frank in communication, and to start talking about sexuality with kids before they enter middle school.

**Recommendation 4:** HYP recommends that youth-serving agencies prioritize developing teen-friendly policies and practices, requiring or encouraging staff to participate in professional development around building trust and rapport with youth participants, and working with caring adults (such as mentors or foster parents) to support them in building trust with the youth in their lives.



## Working with caregivers

The following recommendations are suggested as approaches to incorporate into programming for caregivers on how to provide information about sex to their teenage children.

### Encourage caregiver/child communication through direct education & media campaigns

Teens recognized that without parental support and guidance they would be more likely to make risky decisions about sex, and expressed a desire for parental support and guidance to avoid making such decisions. Teens want to know how to navigate through complicated decisions and learn values and skills from their parents about making their own decisions within the context of peer and romantic relationships, not just hear a lecture about what they should or should not do. Teen, teen parent, and parent focus group participants expressed difficulty around having open conversations about sex. Teen and teen parent focus group participants and provider survey respondents felt that teens are receiving information on sexual health too late, and that communication around healthy sexuality should begin earlier, before the child enters puberty.

Providing caregivers with knowledge about how to communicate with their children about sex has been shown to increase their comfort and confidence around having these conversations. Based on these results, educating caregivers has the potential to “help young people establish individual values and make healthy decisions,” delay initiation of sex, and increase use of condoms if they choose to have sex (Kitchen & Huberman, 2011).

The commonly reported barrier parents face of teens not wanting to open up to them may be addressed by educating parents and caregivers to use a “sex-positive approach” when talking with youth. Williams, Prior, & Wegner (2013) offer this definition of a sex-positive approach:

*“A sex-positive approach means being open, communicative, and accepting of individuals’ differences related to sexuality and sexual behavior. Sex positivity is not about having frequent sex or condoning sexual activity per se...a sex-positive approach is about allowing for a wide range of sexual expression that takes into account sexual identities, orientations and behaviors; gender presentation; accessible health care and education; and multiple important dimensions of human diversity...because human sexuality and its expression are so diverse, it is important that the topic of sex can be discussed in an open, respectful, and nonjudgmental manner.” (p.273)*

By focusing on remaining open, respectful, and nonjudgmental, a sex-positive approach may help bridge communication between caregivers and teens, who often report feeling that adults look down on them and refuse to acknowledge them as sexual beings.

**Recommendation 5:** HYP recommends providing caregivers with direct education on how to talk to their children about sex so that they can make informed decisions, utilizing a sex-positive approach to bridge parents and their children and to begin creating foundations for healthy sexuality earlier in life.

A suggestion made for supporting and educating caregivers was to create community marketing campaigns that provide useful educational tools and information for talking with one's teenage child about sex. Previous research has shown mass media campaigns to be effective in facilitating parent-child communication about sex. In particular, the U.S. Department of Health and Human Services national campaign, the *Parents Speak Up National Campaign* (PSUNC) launched in 2007, has been shown to be effective in increasing parent-child communication (Davis, Evans & Kamyab, 2013). This type of intervention has also been shown to be effective on the state-level (Evans, Davis, Umanzor, Patel, & Khan, 2011). Teen and parent focus group participants expressed feeling uncomfortable having conversations with each other about sex; however, both groups of participants acknowledged the importance of having such conversations.

**Recommendation 6:** HYP recommends community marketing campaigns that focus on challenging caregivers to talk to their children about sex and learn to become more comfortable with the notion that their teenage children are sexual beings.

Community marketing campaign strategies may include social media, webcasts, podcasts, mobile/text message marketing, direct mail flyers, email bulletins, and special events such as attending health fairs and school-based events for parents.



## Improving policies

The following policy recommendations are for adolescent sexual health education.

### Create space for real, open, honest discussions in schools and public places

A theme throughout the focus groups, among teens, teen parents, and parents, was the desire to be able to have conversations about sexual health in public places, such as school classrooms. In Texas, most policies about adolescent sexual education focus on emphasizing abstinence and consequences only (Texas Education Code §28.004); however, teen and teen parent participants repeatedly talked about wanting to receive real and honest information about sex. Participants expressed a deep desire to be able to communicate with trusted adults about sex, to receive information about their options for safe sex, and to be provided with information on the different ways to access birth control.

Policies should include the support of comprehensive sex education in schools and in the community, which are defined as programs that stress abstinence but also provide information about contraceptives and condoms.

**Recommendation 7:** HYP advocates for statewide and local school district policies that encourage real, open, and honest communication around topics of sexuality and sexual health.

### Fund services that support teen pregnancy & childbearing prevention

In the provision of social services, funding is a constant obstacle to overcome. Services that support delaying pregnancy and childbearing need sufficient funding to serve the youth of Travis County, including sex education, extracurricular activities, and access to contraception. Teen parent focus group participants talked about how more funding for programs might encourage teens to access services if they knew there were sufficient services available. Parent participants discussed how extracurricular activities serve as a protective factor for their children, but some didn't feel that there were enough opportunities for youth to get involved.

Medical and service providers commonly identified funding as a barrier for providing information and services to their youth clients. Funding restrictions dictating who can be served and what services may be offered were cited as additional barriers.

Programs also need funding to appropriately advertise their work to the community, and increase awareness of available resources for families.

**Recommendation 8:** HYP advocates for funding dedicated to holistic approaches to positive youth development and sexual health to meet the diverse needs of youth in delaying initiation of childbearing.

## Fund services that support teen parents

Teen parent focus group participants discussed programs for teen parents needing more funding to provide services such as daycare, financial support, and access to contraceptives to prevent repeat births.

“ ...When people are just like you know, being negative and negative and they don't think well once you decide to keep the baby that's it you're keeping the baby you know so like if that's what you really want to do people should support you in that and if you don't have people around supporting you it becomes stressful.”

Teen parent focus group participants expressed appreciation for the support they received from service providers and other adults in their lives; however, they also mentioned that medical providers often did not take the time to have open conversations with them about all of their options if a teen did become pregnant. Parents of teenage children also expressed seeing a need in the community for more supportive services for teen parents. The focus groups with teens revealed a drastic disconnect in how teens perceive services offered to teen parents, demonstrating the need to clarify why services are offered and how services are being utilized in order to reduce the stigma surrounding teen parents in schools.

**Recommendation 9:** HYP advocates for policies that provide support for teen parents, both prenatally and postnatally.

HYP believes service providers could enhance services to teens and teen parents by developing a regular review process for teen-friendliness of policies that includes teen input, seeking out professional development for working with teens, and developing partnerships for referrals for prenatal and postnatal services.

Teen parent focus group participants expressed a desire to receive emotional support from their own parents. Some teen parents mentioned that their parents assisted them financially in caring for their baby. However, emotionally, a greater number of teen parents felt judgment, shame, and misunderstanding from their parents and the parents of their partner. Teen parents, and teen mothers in particular, discussed stress and depression associated with early childbearing. Focus group participants also discussed wanting to have parenting classes and resources made available to them. Given that these services exist within our community, such as through the TANDEM program partnership between Austin Child Guidance Center (mental health services) and Any Baby Can (parenting classes and resources), service providers, educators, and other youth-serving professionals should develop referral systems to connect young parents with mental health and parenting supports.



## Conclusion

HYP conducted this needs assessment to determine teen pregnancy prevention barriers and strengths in Travis County, and collect recommendations from our participants on how our community can better support youth in preventing pregnancy. Our key finding is Travis County teens are receiving mixed messages about sex and pregnancy and they feel judged no matter what they choose. As a community we need to LISTEN to youth, and recognize youth as experts in adolescence, CLARIFY through open, honest communication throughout the lifespan of the child and TRANSFORM messages, policies and practices to ensure every child, every voice is heard and valued. Based on our findings, HYP has developed recommendations around improving our work with youth, working with caregivers, and improving policies to address teen pregnancy and childbearing in our community. This report is intended to serve as a source of support and information for local community members, youth-serving professionals, and stakeholders in an effort to improve the well-being of adolescents throughout our community and beyond.



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# **APPENDIX A**

Needs assessment advisory workgroups and organizations

## Needs Assessment Advisory Workgroups and Organizations

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**Supporting Organizations:**

SafePlace  
American Youthworks  
Boys and Girls Clubs of Austin

Goodwill Industries of Central Texas  
Travis County Health and Human Services  
and Veterans' Services

## **APPENDIX B**

Glossary of terms

## Glossary of Terms

**Abstinence education:** a broad term for sexual health education that has the exclusive purpose of teaching abstinence from, or delaying, sexual activity. Abstinence education will often focus on values, character building, and refusal skills. Abstinence education focuses on setting a moral standard for sexual activity within a marriage, and promotes messaging that sex and childbearing out-of-wedlock is likely to have harmful psychological and physical consequences.

**Birth control (methods):** See Contraception

**Causality:** a statistics term used to show that one thing led to another. It explains that one event happened *because of* another thing. This is similar to the idea of cause and effect, and answers the question “why?” For example, if a researcher is curious about the causality behind the fear of heights, they might discover that having fallen and broken a bone was a common reason for, or cause of that fear.

**Comprehensive sexuality education:** a broad term for sexual health education that will often include discussions and skill-building around a wide range of sexual health topics including delaying sexual activity, contraception and condom use, decision-making, relationships, negotiation and refusal skills, and STI prevention. In some cases, comprehensive sexuality education is also called “abstinence plus” education.

**Contraception:** methods used to prevent pregnancy. Also referred to as contraceptive methods. There are various methods of contraception recommended for use by adolescents, both hormonal and barrier. Hormonal methods include birth control pills, patch, vaginal ring, injection or shot, certain intrauterine devices (IUDs), and emergency contraceptive pills like Plan B. Barrier methods include condoms (male and female), spermicides, and diaphragms. Each of these methods has a different level of effectiveness at preventing pregnancy. Condoms are also effective at reducing risk of sexually transmitted infections (CDC, 2015).

**Correlation:** a way to describe a relationship between two things. A positive correlation means that the more of one thing there is, there will also be more of the other thing, (for example, the hotter it is outside, the more people use air conditioning). A negative correlation says that as one thing goes up, the other thing goes down (for example, the more time spent on a computer, the less time a person spends outside).

**Evidence-based program:** programs that have been evaluated using rigorous research designs and have been found to be effective using these advanced research methods. Such research designs include experimental and quasi-experimental design, which assign an independent variable and measures the resulting dependent or responding variable. For sexuality education, the independent variable is often participation in a set number of hours of sexuality education and the dependent variable is knowledge, attitudes and behavior related to pregnancy prevention. Experimental design includes a treatment group and a control or comparison group to evaluate the effectiveness of each program on reducing teen pregnancy rates, reducing STI rates, delaying sexual initiation and other risk factors and sexual behaviors (Advocates for Youth, 2012).

**Focus group:** a group discussion focused on explaining people’s perspectives on a specific topic. A focus group is led by a researcher and is usually limited to no more than 8 people.

**Gender norms:** society's expectations of how people should behave based on their biological sex. To have rigid gender norms means that people have firm and inflexible ideas of how a person should behave based on their sex. In this needs assessment, a rigid gender norm discussed by participants was that teen females who are sexually active are labeled as “sluts” by their peers, while teen males who are sexually active are not.

**Gender transformative approach:** an approach to programming that actively tries to have participants examine, question, and change rigid gender norms and the imbalance of power between genders. This can be accomplished by bringing awareness to the idea of gender norms, having participants critically examine how rigid gender norms might impact them negatively, and challenging or addressing power relationships, how resources are distributed, and how responsibilities or duties are shared between genders (Rotach, Schuler, & Hardee, 2009).

**Internal locus of control:** "A locus of control orientation is a belief about whether the outcomes of our actions are contingent on what we do (internal control orientation) or on events outside our personal control (external control orientation)" (Zimbardo, 1985). Internal locus of control places the person experiencing an event as the person in the driver's seat; rather than things just happening to them, they see themselves as contributing to their situation. They believe that when something happens to them, it is in response to something they did. They have a sense of responsibility for what happens in the external world.

**LGBTQQIA:** an acronym used to represent individuals who identify as Gay, Lesbian, Bisexual, Transgender, Queer, Questioning, Intersex, or Asexual. Also commonly used are LGBT, LGBTQ, or GLBTQ, among others. This acronym is commonly used to reflect gender and sexual minority identities. Identifiers such as these exist to help make sense of the complexity of gender and sexual diversity, and are not fixed definitions, meaning they may not be used in the same way from person to person. For more detailed information about gender and sexual diversity and identities, visit PFLAG's National Glossary of Terms, available at <http://community.pflag.org/glossary>.

**Mixed methods approach:** This is an approach that combines qualitative and quantitative methods. Mixed methods approaches attempt to account for shortcomings of each of the two approaches. By using both qualitative and quantitative methods together, researchers are able to fill gaps and answer questions using a mixture of techniques.

**Promising program:** Promising practices are those that have not gone through as rigorous of an evaluation as an evidence-based program, but have demonstrated effectiveness in positively affecting the knowledge, attitudes, or behaviors of the youth participants that have been served by the program.

**Protective factors:** circumstances or influences that encourage one or more behaviors that might prevent unhealthy outcomes, such as unplanned pregnancy or sexually transmitted infections. Protective factors may also be circumstances or influences that discourage behaviors that might lead to the unhealthy outcome (Kirby & Lepore, 2007).

**Purposive sampling:** participants are selected based on knowledge of the population and the purpose of the study. Purposive sampling focuses on specific characteristics of a group that are considered most helpful in answering research questions. Researchers choose the sample being

studied, and therefore it is not representative of the greater population (Lund Research Ltd, 2012). This needs assessment used purposive sampling for focus group and survey participants.

**Qualitative data:** information that is largely based on words or observations. For example, qualitative data can be collected from a video recording, or a focus group discussion. Strengths of qualitative data are the variety of possible responses or discoveries, the ability to examine something in greater depth, and the ability to use an individual's own words (Minichiello, et al, 1990). This needs assessment gathered qualitative data through focus groups.

**Quantitative data:** information that is largely based on numbers or counts. Quantitative data can come from yes/no questions, rating scales, records of how often a person engaged with a specific behavior. For example, a score on a test and the number of hours studied are both quantitative data. Strengths of quantitative data are the ability to use statistics during analysis and the ability to use the same measurement technique on more than one individual (Minichiello, et al, 1990). This needs assessment gathered quantitative data through surveys.

**Risk factors:** circumstances or influences that encourage one or more behaviors that might lead to unhealthy outcomes, such as unplanned pregnancy or sexually transmitted infections. Risk factors may also be circumstances or influences that discourage behaviors that might prevent the unhealthy outcome (Kirby & Lepore, 2007).

**Sample:** A sample is a group of individuals chosen to represent a larger population when it is unreasonable to include all people. For example, if a researcher wanted to learn about what it is like to be a parent, it would be impossible to talk to all parents in the world. Instead, they would speak with a smaller group of parents in order to build an understanding of what it is like to be a parent.

**Self-Efficacy:** refers to an individual's belief in his or her capacity to execute behaviors necessary to produce specific performance attainments (Bandura, 1977). Self-efficacy is confidence in your ability to control your own motivation, behavior, and social environment.

**Sex-positive approach:** an approach to programming and communication that means being open, communicative, and accepting of differences in people's sexual identities, orientations, and behaviors (Williams, Prior, & Wegner, 2013). A sex-positive approach focuses on not judging a person's expression of their sexuality as long as it is consensual and healthy.

**Sexually Transmitted Infections (STIs):** Sexually transmitted infections (STIs for short), also known as sexually transmitted diseases (STDs) are infections typically spread through sexual behavior or contact. STIs are caused by bacteria, viruses, or parasites. Depending on the type of infection, it may be spread or transmitted through direct skin-to-skin contact or through body fluids such as blood, vaginal fluids, semen, pre-ejaculate (commonly called pre-cum), or breastmilk. Commonly known STIs include Chlamydia, Gonorrhea, HIV (Human Immunodeficiency Virus), and HPV (Human Papillomavirus).

**Snowball sampling:** a technique used to gain contact with individuals of a similar group by asking for referrals and references. A snowball sample begins with one individual that gives a researcher the name and contact information of a similar person to speak with. Once the researcher has gathered data with that person, they ask to be referred to another person. This technique can be useful for research about sensitive topics or people who are less likely to talk with a researcher out of fear of exposure. For example, a person who is researching life

satisfaction of movie stars might have greater success using a snowball sampling technique to contact new movie star participants than if they were to approach them on the street without a friend's introduction (Lund Research Ltd, 2012).

**Social determinants of health:** the social, physical, and emotional “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (Healthy People 2020, 2014). The social determinants of health are shaped by economics, social policies, and politics, and affect people's access to and the availability of resources.

# APPENDIX C

Teen survey

**5. How old are you?**

- 12 years old or younger
- 13 years old
- 14 years old
- 15 years old
- 16 years old
- 17 years old
- 18 years old or older

**6. What is your gender?**

- Female
- Male
- Transgender

**7. Are you Hispanic or Latino?**

- Yes
- No

**8. What is your race? (Select one or more responses.)**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

**9. Have you ever had sexual intercourse? (sexual intercourse is defined as the act of engaging in sexual behaviors with someone else, including oral, vaginal, or anal sex)**

- Yes
- No

**10. Were you born in the United States or somewhere else?**

- In United States
- Somewhere else

**11. If you have had sexual intercourse, how old were you the first time?**

- I have never had sexual intercourse
- 11 years old or younger
- 12 years old
- 13 years old
- 14 years old
- 15 years old
- 16 years old
- 17 years old or older

**12. If you have had sexual intercourse, did you drink alcohol or use drugs before you had sexual intercourse the last time?**

- I have never had sexual intercourse
- Yes
- No

**13. If you have had sexual intercourse, what method(s) did you or your partner use to prevent pregnancy the last time you had sex? (Select as many as apply.)**

- I have never had sexual intercourse
- No method was used to prevent pregnancy
- Birth control pills, patch, or ring
- Condoms (male or female)
- Depo-Provera (or any injectable birth control), Implanon (or any implant), or any IUD
- Withdrawal
- Some other method (such as spermicide, sponge, etc)
- Not sure

**14. Thinking about your life right now, how important is to you to avoid becoming a parent?**

- Very important
- Somewhat important
- A little important
- Not at all important
- Don't know

**15. If you found out today that you were pregnant or you had gotten someone pregnant, how would you feel?**

- Very upset
- A little upset
- A little pleased
- Very pleased
- Wouldn't care
- Don't know

**16. Have you learned about the following topics? (Check all that apply)**

- The importance of using birth control if you have sex
- A demonstration on how to use a condom
- How to say 'no' to sex
- The importance of waiting until marriage to have sex
- The availability of many different types of birth control methods
- I have not learned about any of these topics

**17. Where have you learned about the above topics? (Select as many as apply.)**

- I have not learned about any of the above.
- From my parents/guardians
- At school
- At church
- At a community organization (such as GENaustin, Boys & Girls Clubs, Big Brothers Big Sisters, etc)

**18. Please check the box that most applies.**

|  | <b>Strongly Agree</b>    | <b>Somewhat agree</b>    | <b>Neither agree nor disagree</b> | <b>Somewhat disagree</b> | <b>Strongly disagree</b> |
|--|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| It is too much of a hassle to use a condom every time you have sex.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| Using birth control is morally wrong.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| It doesn't matter whether you use birth control or not; when it is your time to get pregnant it will happen. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| It is mainly a woman's responsibility to make decisions about birth control.                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| It is mainly a man's responsibility to carry condoms.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| In my life, things just seem to happen to me.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| In life, I think I take many more risks than other people my age.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| In my family, it is not acceptable to have a child outside of marriage.                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| Many of my friends have unplanned pregnancies.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| Most of my friends think using birth control is important.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| I have all the information I need to avoid an unplanned pregnancy.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| It is OK for an unmarried adult female to have a child.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnancy is something that should be planned.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |
| Every pregnancy is a blessing.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/> | <input type="checkbox"/> |

## **APPENDIX D**

Focus group guide: Teens

## Focus Group Guide: Teens

### Introduction

1. Review consent form/ assent form
2. Introduce yourself and the note taker
3. Thank the participants for agreeing to participate in today's discussion. Let them know that you will be asking them some questions about relationships between young men and women, and their ideas about teenage pregnancy. Explain that what you learn from them today will help shape programs and services for youth.
4. Explain the taping process: Tell participants that you will be taping today's discussion. This will help you to remember what they said later on. Let them know that if there is anything that they want to say that they do not want recorded to let you know and you will turn the tape recorder off. Also explain that they don't have to answer any questions that they do not want to answer in the conversation today. Finally, tell them that the one ground rule of this conversation is that nothing that gets said in this room will leave this room, that way everyone can all be comfortable sharing their ideas and opinions.
5. Ask participants if they have any questions.

### Questions

**NOTE:** These questions are a guide. Prompting questions may be asked to elicit further responses from the group if more discussion is needed.

- 1. Tell me about what kinds of relationships young people have.**
  - a. What does it mean to be in a relationship?
  - b. Do teens have more than one relationship at a time?
- 2. Are teens your age having sex?**
  - a. How do you and your friends make decisions about sex? Who decides about birth control? Who decides when to have sex?
  - b. How does sex impact relationships?
- 3. A lot of teens in our community become parents at a young age. When do you think is the ideal time to become a parent?**
  - a. Do you think teens are ready for parenthood? Why or why not?
  - b. What things do you want to do before becoming a parent?
  - c. What do you think about teen pregnancy at your school?
- 4. What do teens need to prevent pregnancy?**
  - a. What types of contraception are available for teens having sex?
  - b. How comfortable are teens getting birth control?
  - c. Where can teens get birth control? (If clinics are not mentioned- ask if they know about any health clinics they can go to)
  - d. What else would you like that would help teens to stay healthy and prevent pregnancy?
- 5. How can adults support you in making healthy choices?**
- 6. What else would you like to share about teenage pregnancy?**

**Thank you for your time!**

## **APPENDIX E**

Focus group guide: Teen mothers

# Focus Group Guide: Teen Mothers

## Introduction

1. Review consent form/ assent form
2. Introduce group facilitator and note taker
3. Explain audio/taping
4. Invite any questions from teens

## Questions

**NOTE:** These questions are a guide. Prompting questions will be asked depending on the participant's responses.

- 1. Think back to before you got pregnant. How did people at your school talk about teen pregnancy and teen parents?**
  - a. What were your friends' thoughts & feelings on teen pregnancy?
  - b. What were adults saying?
- 2. What could have helped you to prevent getting pregnant at your age?**
  - a. Did you talk to your parents about sex and preventing pregnancy? What did you talk about?
  - b. Did you learn about sex at school or in a community program? What did you learn?
  - c. Did you know about using condoms and birth control? What did you know?
- 3. What did you do after you found out you were pregnant?**
  - a. Who did you tell first? How did they respond?
  - b. Did you get help from any services in the community? Which ones?
  - c. Did you have difficulty getting what you needed from the services in the community?
- 4. What challenges have you faced as a young mother?**
  - a. What do you wish you would have known before you got pregnant?
  - b. Has your relationship with your child's father been what you expected?
- 5. As a mother, how do you plan to talk to your child about sex?**
  - a. Would you do anything different from your parents?
  - b. When would be the ideal time for your child to become a parent?

**Thank you for your time!**

## **APPENDIX F**

Focus group guide: Teen fathers

# Focus Group Guide: Teen Fathers

## Introduction

1. Review consent form/ assent form
2. Introduce group facilitator and note taker
3. Explain audio/taping
4. Invite any questions from teens

## Questions

**NOTE:** These questions are a guide. Prompting questions will be asked depending on the participant's responses.

- 1. Think back to before you became a father. How did people at your school talk about teen pregnancy and teen parents?**
  - a. What were your friends' thoughts & feelings on teen pregnancy?
  - b. What were adults saying?
- 2. What could have helped you to prevent becoming a father at your age?**
  - a. Did you talk to your parents about sex and preventing pregnancy? What did you talk about?
  - b. Did you learn about sex at school or in a community program? What did you learn?
  - c. Did you know about using condoms and birth control? What did you know?
- 3. What did you do after you found out your partner was pregnant?**
  - a. Who did you tell first? How did they respond?
  - b. Did you get help from any services in the community? Which ones?
  - c. Did you have any difficulty getting what you needed from the services in the community?
- 4. What challenges have you faced as a young father?**
  - a. What do you wish you would have known before your partner got pregnant?
  - b. Has your relationship with your child's mother been what you expected?
- 5. As a father, how do you plan to talk to your child about sex?**
  - a. Would you do anything different from your parents?
  - b. When would be the ideal time for your child to become a parent?

**Thank you for your time!**

## **APPENDIX G**

Focus group guide: Parents

## Focus Group Guide: Parents

### Introduction

1. Review consent form/ assent form
2. Introduce group facilitator and note taker
3. Explain audio/taping
4. Invite any questions from parents

### Questions

**NOTE:** These questions are a guide. Prompting questions will be asked depending on the participant's responses.

- 1. How do you think young people learn about sex?**
  - a. Who has the most influence over what your child learns about sexuality?
  - b. At what age does this influence change and who do you think it changes to?
  - c. What role do you think parents should play in their child's sexual health education?
- 2. A lot of teens do become parents at a young age in our community. When do you think is the ideal time to become a parent?**
  - a. How ready are teens for parenthood?
- 3. What do you do help your child prevent an unintended pregnancy?**
  - a. Do you talk to your child about relationships and sex? If so, how and how often?
  - b. Do you feel comfortable talking with your child about birth control? Why or why not?
  - c. What barriers do you face when trying to communicate with your child about sex?
- 4. What resources in your community do you know about that can help your child prevent an unintended pregnancy?**
  - a. How can someone connect with these community resources?
  - b. What barriers do that you face when trying to connect with (or help your child connect with) these resources?
  - c. What other skills or resources do parents need to help their teen prevent pregnancy?

**Thank you for your time!**

## **APPENDIX H**

Focus group guide: Parents Spanish

## Guía de Grupo de Enfoque: Padres

### Introducción

1. Revise la forma de consentimiento/forma de asentimiento
2. Introducir el facilitador del grupo y tomador de notas.
3. Explicar la grabación de audio.
4. Tome preguntas de los padres.

### Preguntas

**Ojo:** Estas preguntas son una guía. Preguntas adicionales dependiendo de las respuestas de los participantes.

- 1. ¿Cómo cree que los jóvenes aprenden sobre el sexo?**
  - a. ¿Quién tiene la mayor influencia sobre lo que su hijo aprende acerca de la sexualidad?
  - b. ¿A qué edad cambia esta influencia y quién cambia influencia?
  - c. ¿Qué papel cree que los padres deben desempeñar en la educación de salud sexual de sus hijos?
- 2. En nuestra comunidad, muchos jóvenes se hacen padres a una edad joven. ¿Cuándo crees que es el momento ideal para ser padre?**
  - a. ¿Qué preparado están los adolescentes para la paternidad?
- 3. ¿Qué hace para ayudar a su hijo a evitar un embarazo no deseado? ¿Habla con su hijo sobre las relaciones y el sexo? Si es así, cómo y con qué frecuencia?**
  - a. ¿Se siente cómodo hablando con su hijo sobre el control de la natalidad? ¿Por qué si o por qué no?
  - b. ¿Qué obstáculos enfrenta al intentar comunicarse con su hijo sobre el sexo?
- 4. ¿Qué recursos en su comunidad conoce que puede ayudar a su hijo prevenir un embarazo no planeado?**
  - a. ¿Cómo se puede conectar alguien con estos recursos de la comunidad?
  - b. ¿Cuáles son los obstáculos que se enfrentan al intentar conectar con (o ayudar a su hijo conectar con) estos recursos?
  - c. ¿Qué otras habilidades o recursos necesitan los padres para ayudar a sus hijos a prevenir el embarazo no planeado?

**¡Gracias por su tiempo!**

# APPENDIX I

Survey: Service providers

UT IRB STUDY NUMBER: 2012-11-0039

Approval Date: 12/18/12

Expires: 12/17/13

## Survey: Service Providers

**PLEASE READ THE FOLLOWING INFORMATION ABOUT THIS SURVEY. AFTER YOU HAVE FINISHED READING THIS SURVEY, CLICK THE LINK AT THE BOTTOM TO BEGIN THE SURVEY.**

### **Identification of Investigators and Purpose of Study**

You are invited to participate in a research study, entitled "Travis County Teen Pregnancy Prevention Needs Assessment." The study is being conducted on behalf of the Healthy Youth Partnership and is supervised by Dr. Monica Faulkner of the School of Social at The University of Texas at Austin. Dr. Faulkner can be reached at One University Station, Austin, TX, 78712, (512) 471-7191 or mfaulkner@mail.utexas.edu. The purpose of this research study is to examine the service needs in Travis County regarding teen pregnancy prevention. Your participation in the study will contribute to a better understanding of the barriers and needs in Travis County related to teen pregnancy prevention services. You are free to contact the principal investigator at the above address and phone number to discuss the study. You must be at least 18 years old to participate.

### **If you agree to participate:**

The online survey will take approximately 10 minutes of your time. You will be asked questions about your job, your knowledge of teen pregnancy prevention and your ideas regarding teen pregnancy prevention.

### **Risks/Benefits/Confidentiality of Data**

There are no known risks to participating in this online survey. There will be no costs for participating, nor will you benefit from participating. You will not be asked for any personal identifying information.

### **Participation or Withdrawal**

Your participation in this study is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time. Withdrawal will not affect your relationship with The University of Texas in any way. If you do not want to participate either simply stop participating or close the browser window. If you do not want to receive any more reminders, you may email us at mfaulkner@mail.utexas.edu.

### **Contacts**

If you have any questions about the study or need to update your email address, contact the principal investigator, Dr. Monica Faulkner of the School of Social Work at The University of Texas at Austin. Dr. Faulkner can be reached at One University Station, Austin, TX, 78712, (512) 471-7191, or mfaulkner@mail.utexas.edu. This study has been reviewed by The University of Texas at Austin Institutional Review Board and the study number is 2012-11-0039.

### **Questions About Your Rights as a Research Participant**

If you have any question about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the Office of Research Support by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu. If you agree to participate, click on the "next" button below to begin the survey.

**1. What services does your agency provide (check all that apply)?**

- Health education for youth
- Health services for youth
- Health education for parents
- Abstinence based sex education
- Evidence based programs for teen pregnancy prevention
- Case management services for teen parents
- Case management services for pregnant teens
- Case management services for teens
- Other (please specify): \_\_\_\_\_

**2. Which of the following are part of your job functions (check all that apply)?**

- providing case management services
- providing group education to youth
- presenting to youth regarding sexual health prevention
- providing referrals to youth for sexual health services
- providing sexual health services
- Other (please specify): \_\_\_\_\_

**3. Does your organization directly address sexual health with teen clients?**

- No
- Yes, in what ways?: \_\_\_\_\_

**4. Where do you refer teens for sexual health services?**

- Planned Parenthood
- People's Community Clinic
- Lone Star Circle of Care
- City/County Health Clinics
- Private Providers \_\_\_\_\_

**5. Regarding the youth with whom you work, how would you rate the following items in terms of what youth need?:**

|  | Never a need             | Sometimes a need         | Always a need            |
|--|--------------------------|--------------------------|--------------------------|
| Sex education                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confidential health services             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parental support                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parental communication                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Housing                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Healthy relationship information/support | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Education                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**6. What do you believe are your service population's greatest needs?**

**7. Which of the following are barriers that prevent youth from accessing your services?:**

|   | Never a barrier          | Sometimes a barrier      | Always a barrier         |
|---|--------------------------|--------------------------|--------------------------|
| Lack of transportation  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of confidential services   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of agency funding for additional services                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Waitlists   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of health insurance  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents are not supportive  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Partners are not supportive   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Agency cannot access youth due to external rules (e.g. school rules, etc) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Youth do not know about us  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**8. What else might prevent people who could use your services from accessing them?**

**9. What factors put young people that you work with at greatest risk for unintended pregnancy (check all that apply)?**

- Lack of contraceptive use
- Lack of access to contraception
- Lack of self-efficacy regarding contraceptive use
- Lack of supportive partners
- Lack of education about contraceptive use
- Lack of career/education goals
- Other (please specify):

\_\_\_\_\_

**10. What supports are in place to help you provide information and resources to support teens in preventing unintended pregnancy (check all that apply)?**

- Referral guides
- Access to youth in schools
- Relationships with other agencies providing services
- Parent support
- Other (please specify):

\_\_\_\_\_

**11. What barriers prevent you from providing teens with information and resources they need to prevent unintended pregnancy (check all that apply)?**

- Time
- Education materials
- Funding
- Confidentiality
- Health literacy
- Communication
- Lack of access in schools
- Lack of parental support
- State laws
- Other (please specify): \_\_\_\_\_

**12. On a scale of 1-5, please rate how comfortable you feel discussing the following with teen clients:**

|                                 | Very uncomfortable       | Not comfortable          | Neutral                  | Somewhat comfortable     | Very comfortable         |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sexual activity                 | <input type="checkbox"/> |
| Contraception                   | <input type="checkbox"/> |
| Sexually transmitted infections | <input type="checkbox"/> |
| Healthy relationships           | <input type="checkbox"/> |
| Intimate partner violence       | <input type="checkbox"/> |
| Pregnancy options               | <input type="checkbox"/> |
| Sexual orientation              | <input type="checkbox"/> |

**13. When it comes to teens' decisions about sex, who is most influential?**

- Parents
- Friends
- Media
- Teachers
- Siblings
- Religious leaders
- Other (please specify): \_\_\_\_\_

**14. How much do you agree or disagree with the following statements?**

|   | <b>Strongly Agree</b>    | <b>Somewhat agree</b>    | <b>Somewhat disagree</b> | <b>Strongly disagree</b> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| It would be much easier for teens to postpone sexual activity and avoid pregnancy if they were to have more open, honest conversations about these topics with their parents. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents believe they should talk to their kids about sex but often don't know what to say, how to say it, or when to start.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It is important for teens to be given a strong message that they should not have sex until they are at least out of high school.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It is important for teens to be given a strong message that they should not have sex until they are married.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to encourage teens to postpone sex.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to provide teens with information about birth control,  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to provide teens with information about postponing sex and birth control or protection.                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Federal funding should primarily support those programs that have been proven to change behavior related to teen pregnancy  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| This community needs more efforts to prevent teen pregnancy.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reducing teen pregnancy is a very effective way to reduce the high school dropout rate and improve academic achievement.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Religious leaders and groups should be doing more to help prevent teen pregnancy.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Teens should be able to access birth control without their parents' consent.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Teens should be able to access emergency contraception without their parents' consent.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents need more education to be able to talk with their children.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## **APPENDIX J**

Survey: Educators and school staff

UT IRB STUDY NUMBER: 2012-11-0039

Approval Date: 12/18/12

Expires: 12/17/13

## Survey: Educator

**PLEASE READ THE FOLLOWING INFORMATION ABOUT THIS SURVEY. AFTER YOU HAVE FINISHED READING THIS SURVEY, CLICK THE LINK AT THE BOTTOM TO BEGIN THE SURVEY.**

### **Identification of Investigators and Purpose of Study**

You are invited to participate in a research study, entitled "Travis County Teen Pregnancy Prevention Needs Assessment." The study is being conducted on behalf of the Healthy Youth Partnership and is supervised by Dr. Monica Faulkner of the School of Social at The University of Texas at Austin. Dr. Faulkner can be reached at One University Station, Austin, TX, 78712, (512) 471-7191 or mfaulkner@mail.utexas.edu. The purpose of this research study is to examine the service needs in Travis County regarding teen pregnancy prevention. Your participation in the study will contribute to a better understanding of the barriers and needs in Travis County related to teen pregnancy prevention services. You are free to contact the principal investigator at the above address and phone number to discuss the study. You must be at least 18 years old to participate.

### **If you agree to participate:**

The online survey will take approximately 10 minutes of your time. You will be asked questions about your job, your knowledge of teen pregnancy prevention and your ideas regarding teen pregnancy prevention.

### **Risks/Benefits/Confidentiality of Data**

There are no known risks to participating in this online survey. There will be no costs for participating, nor will you benefit from participating. You will not be asked for any personal identifying information.

### **Participation or Withdrawal**

Your participation in this study is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time. Withdrawal will not affect your relationship with The University of Texas in any way. If you do not want to participate either simply stop participating or close the browser window. If you do not want to receive any more reminders, you may email us at mfaulkner@mail.utexas.edu.

### **Contacts**

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### **Questions About Your Rights as a Research Participant**

If you have any question about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the Office of Research Support by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu. If you agree to participate, click on the "next" button below to begin the survey.

**1. What is your role at your school?**

- Teacher
- Administrator
- Nurse
- Social Worker
- Counselor
- Other (please specify):  
\_\_\_\_\_

**2. What type of school are you at?**

- Elementary
- Middle
- High
- Alternative campus
- Other (please specify):  
\_\_\_\_\_

**3. Is teen pregnancy an issue on your campus?**

- Yes
- No
- Other (please specify):  
\_\_\_\_\_

**4. How often have you been approached by a student needing sexual health advice?**

- Never
- Rarely
- Often
- All the time

**5. How would you describe sex education at your school (check any that apply)?**

- Students receive information too late
- Sex education relies on scare tactics
- We are not allowed to talk about contraception
- We are not allowed to talk about pregnancy options
- Abstinence is emphasized
- Sexual orientation is assumed to be heterosexual
- Sex education is comprehensive
- Sex education is enough to meet the needs of youth

**6. Regarding teens at your school, how would you rate the following items in terms of what youth need?:**

|  | Never a need             | Sometimes a need         | Always a need            |
|--|--------------------------|--------------------------|--------------------------|
| Sex education                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confidential health services             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parental support                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parental communication                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Housing                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Healthy relationship information/support | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Education                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**7. What do you believe are your teens' greatest needs related to sexual health services?**

**8. Which of the following are barriers that prevent youth from accessing your services?:**

|                               | Never a barrier          | Sometimes a barrier      | Always a barrier         |
|-------------------------------|--------------------------|--------------------------|--------------------------|
| Lack of transportation        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of confidential services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Waitlists                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents are not supportive    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Partners are not supportive   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Youth do not know about us    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**9. What else might prevent teens from accessing sexual health services?**

**10. What factors put students at your school at greatest risk for unintended pregnancy (check all that apply)?**

- Lack of contraceptive use
- Lack of access to contraception
- Lack of self-efficacy regarding contraceptive use
- Lack of supportive partners
- Lack of education about contraceptive use
- Lack of career/education goals
- Other (please specify): \_\_\_\_\_

**11. What barriers prevent you from providing teens with information and resources they need to prevent unintended pregnancy (check all that apply)?**

- Lack of health insurance
- Time
- Education materials
- Funding
- Confidentiality
- Health literacy
- Communication
- School rules
- Lack of parental support
- State laws
- Fear of parent/community backlash
- Other (please specify): \_\_\_\_\_

**12. How much do you agree with the following statements:**

|   | Strongly disagree        | Disagree                 | Neutral                  | Agree                    | Strongly agree           |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| I feel knowledgeable about state and district policies regarding sex education.                                 | <input type="checkbox"/> |
| I understand what I can and cannot say to youth about sex education.  | <input type="checkbox"/> |
| There are supports in place at my school that can help me if I had a student needing sexual health information. | <input type="checkbox"/> |
| If a teen told me she was pregnant, I would know what to do to help her.  | <input type="checkbox"/> |

**13. On a scale of 1-5, please rate how comfortable you feel discussing the following with teen clients:**

|                                 | Very uncomfortable       | Not comfortable          | Neutral                  | Somewhat comfortable     | Very comfortable         |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sexual activity                 | <input type="checkbox"/> |
| Contraception                   | <input type="checkbox"/> |
| Sexually transmitted infections | <input type="checkbox"/> |
| Healthy relationships           | <input type="checkbox"/> |
| Intimate partner violence       | <input type="checkbox"/> |
| Pregnancy options               | <input type="checkbox"/> |
| Sexual orientation              | <input type="checkbox"/> |

**14. When it comes to teens' decisions about sex, who is most influential?**

- Parents
- Friends
- Media
- Teachers
- Siblings
- Religious leaders
- Other (please specify): \_\_\_\_\_

**15. How much do you agree or disagree with the following statements?**

|   | Strongly Agree           | Somewhat agree           | Somewhat disagree        | Strongly disagree        |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| It would be much easier for teens to postpone sexual activity and avoid pregnancy if they were to have more open, honest conversations about these topics with their parents. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents believe they should talk to their kids about sex but often don't know what to say, how to say it, or when to start.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It is important for teens to be given a strong message that they should not have sex until they are at least out of high school.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It is important for teens to be given a strong message that they should not have sex until they are married.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to encourage teens to postpone sex.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to provide teens with information about birth control,  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to provide teens with information about postponing sex and birth control or protection.                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Federal funding should primarily support those programs that have been proven to change behavior related to teen pregnancy  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| This community needs more efforts to prevent teen pregnancy.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reducing teen pregnancy is a very effective way to reduce the high school dropout rate and improve academic achievement.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Religious leaders and groups should be doing more to help prevent teen pregnancy.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Teens should be able to access birth control without their parents' consent.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Teens should be able to access emergency contraception without their parents' consent.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents need more education to be able to talk with their children.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## **APPENDIX K**

Survey: Medical providers

UT IRB STUDY NUMBER: 2012-11-0039

Approval Date: 12/18/12

Expires: 12/17/13

## Survey: Medical Providers

**PLEASE READ THE FOLLOWING INFORMATION ABOUT THIS SURVEY. AFTER YOU HAVE FINISHED READING THIS SURVEY, CLICK THE LINK AT THE BOTTOM TO BEGIN THE SURVEY.**

### **Identification of Investigators and Purpose of Study**

You are invited to participate in a research study, entitled "Travis County Teen Pregnancy Prevention Needs Assessment." The study is being conducted on behalf of the Healthy Youth Partnership and is supervised by Dr. Monica Faulkner of the School of Social at The University of Texas at Austin. Dr. Faulkner can be reached at One University Station, Austin, TX, 78712, (512) 471-7191 or mfaulkner@mail.utexas.edu. The purpose of this research study is to examine the service needs in Travis County regarding teen pregnancy prevention. Your participation in the study will contribute to a better understanding of the barriers and needs in Travis County related to teen pregnancy prevention services. You are free to contact the principal investigator at the above address and phone number to discuss the study. You must be at least 18 years old to participate.

### **If you agree to participate:**

The online survey will take approximately 10 minutes of your time. You will be asked questions about your job, your knowledge of teen pregnancy prevention and your ideas regarding teen pregnancy prevention.

### **Risks/Benefits/Confidentiality of Data**

There are no known risks to participating in this online survey. There will be no costs for participating, nor will you benefit from participating. You will not be asked for any personal identifying information.

### **Participation or Withdrawal**

Your participation in this study is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time. Withdrawal will not affect your relationship with The University of Texas in any way. If you do not want to participate either simply stop participating or close the browser window. If you do not want to receive any more reminders, you may email us at mfaulkner@mail.utexas.edu.

### **Contacts**

If you have any questions about the study or need to update your email address, contact the principal investigator, Dr. Monica Faulkner of the School of Social Work at The University of Texas at Austin. Dr. Faulkner can be reached at One University Station, Austin, TX, 78712, (512) 471-7191, or mfaulkner@mail.utexas.edu. This study has been reviewed by The University of Texas at Austin Institutional Review Board and the study number is 2012-11-0039.

### **Questions About Your Rights as a Research Participant**

If you have any question about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the Office of Research Support by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu. If you agree to participate, click on the "next" button below to begin the survey.

**1. Please check off all degrees and licenses that you have:**

- MD
- RN
- FNP
- PA
- BSN
- PhD
- MPH
- Other (please specify):  
\_\_\_\_\_

**2. What is your area of specialization (check all that apply)?**

- OB/GYN
- Pediatrics
- Family practice
- Other (please specify):  
\_\_\_\_\_

**3. Do you...?**

- Work at a clinic
- Work in private practice
- Other (please specify):  
\_\_\_\_\_

**4. Does your practice or clinic accept Medicaid or CHIP?**

- Yes
- No
- If yes, in what ways?: \_\_\_\_\_

**5. Do you receive Title X funding?**

- Yes
- No
- Other (please specify):  
\_\_\_\_\_

**6. Approximately what percentage of your patients are teens?**

- Less than 25%
- 26% to 50%
- 51% to 75%
- 76% to 100%

**7. Approximately what percentage of your teen patients are pregnant?**

- Less than 25%
- 26% to 50%
- 51% to 75%
- 76% to 100%

**8. How often do the following occur within your practice?:**

|  | Never happens            | Sometimes happens        | Always happens           |
|--|--------------------------|--------------------------|--------------------------|
| Our policies and practices are reviewed for teen-friendliness.                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I receive professional development training on how to work with teen patients. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I ask sexual health screening questions of all teen patients.                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I use a standard screening tool for sexual health screening of teen patients.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I allow teens a private space to speak with me apart from their parents.       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**9. At what age do you start speaking to teens about sex?**

- Before age 12
- 12
- 13
- 14
- 15
- 16
- 17
- 18

**10. What sexual health services do you provide to teens?**

- HIV testing
- STI testing
- Pap smears
- Birth control prescriptions
- Emergency contraception
- Prenatal care
- Postnatal care

**11. Regarding your teen patients, how would you rate the following items in terms of what youth need?:**

|  | Never a need             | Sometimes a need         | Always a need            |
|--|--------------------------|--------------------------|--------------------------|
| Sex education                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confidential health services             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parental support                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parental communication                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Housing                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Healthy relationship information/support | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Education                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**12. What do you believe are your teen patients' greatest needs related to sexual health services?**

**13. Which of the following are barriers that prevent youth from accessing your services?:**

|                               | Never a barrier          | Sometimes a barrier      | Always a barrier         |
|-------------------------------|--------------------------|--------------------------|--------------------------|
| Lack of transportation        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of confidential services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Waitlists                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of health insurance      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents are not supportive    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Partners are not supportive   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I do not serve teen patients  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Youth do not know about us    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**14. What else might prevent people who could use your services from accessing them?**

**15. What factors put young people that you work with at greatest risk for unintended pregnancy (check all that apply)?**

- Lack of contraceptive use
- Lack of access to contraception
- Lack of self efficacy regarding contraceptive use
- Lack of supportive partners
- Lack of education about contraceptive use
- Lack of career/education goals
- Other (please specify): \_\_\_\_\_

**16. What barriers prevent you from providing teens with information and resources they need to prevent unintended pregnancy (check all that apply)?**

- Time
- Education materials
- Funding
- Confidentiality
- Health literacy
- Communication
- Lack of access in schools
- Lack of parental support
- State laws
- Other (please specify): \_\_\_\_\_

**17. On a scale of 1-5, please rate how comfortable you feel discussing the following with teen clients:**

|                                 | Very uncomfortable       | Not comfortable          | Neutral                  | Somewhat comfortable     | Very comfortable         |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Sexual activity                 | <input type="checkbox"/> |
| Contraception                   | <input type="checkbox"/> |
| Sexually transmitted infections | <input type="checkbox"/> |
| Healthy relationships           | <input type="checkbox"/> |
| Intimate partner violence       | <input type="checkbox"/> |
| Pregnancy options               | <input type="checkbox"/> |
| Sexual orientation              | <input type="checkbox"/> |

**18. When it comes to teens' decisions about sex, who is most influential?**

- Parents
- Friends
- Media
- Teachers
- Siblings
- Religious leaders
- Other (please specify): \_\_\_\_\_

**19. How much do you agree or disagree with the following statements?**

|   | <b>Strongly Agree</b>    | <b>Somewhat agree</b>    | <b>Somewhat disagree</b> | <b>Strongly disagree</b> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| It would be much easier for teens to postpone sexual activity and avoid pregnancy if they were to have more open, honest conversations about these topics with their parents. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents believe they should talk to their kids about sex but often don't know what to say, how to say it, or when to start.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It is important for teens to be given a strong message that they should not have sex until they are at least out of high school.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It is important for teens to be given a strong message that they should not have sex until they are married.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to encourage teens to postpone sex.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to provide teens with information about birth control,  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The primary message of sex education programs should be to provide teens with information about postponing sex and birth control or protection.                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Federal funding should primarily support those programs that have been proven to change behavior related to teen pregnancy  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| This community needs more efforts to prevent teen pregnancy.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reducing teen pregnancy is a very effective way to reduce the high school dropout rate and improve academic achievement.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Religious leaders and groups should be doing more to help prevent teen pregnancy.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Teens should be able to access birth control without their parents' consent.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Teens should be able to access emergency contraception without their parents' consent.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parents need more education to be able to talk with their children.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |