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SHORT REPORT

Adolescent perspectives on addressing teenage pregnancy and sexually transmitted infections in the classroom and beyond

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ABSTRACT

Sex education both in and beyond the classroom has been shown to have the potential to ameliorate negative sexual health outcomes for adolescents. School-based sex education and sexual health services targeting young people should be informed, in part, by teenagers themselves. Semi-structured interviews were conducted with 41 young people aged 13–22 years in a mid-sized midwest US city to inform such programme development. Analysis employed both top-down and bottom-up approaches to coding. Four themes emerged regarding sex education activities in and out of school: the need for knowledge of current activities aimed at prevention; information-seeking behaviours; personal views on how to address teenage pregnancy and sexually transmitted infections (STIs); and the ideal place to address these issues. Current activities were seen as ineffective or non-existent. Many participants indicated they would not engage actively in information-seeking unless they were affected personally by the issues. Participants' suggestions of how to address the issues included improving school services, introducing media campaigns and having peer or trusted-adult educators. Participants identified the need for services that offered confidentiality, a non-judgemental approach and a comfortable space to meet. Through direct engagement with youth, this research makes recommendations for interventions to address teenage pregnancy and STIs.

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Background

Teenage pregnancy and sexually transmitted infections (STIs) can have adverse effects on young people and are important public health concerns. The USA has the highest rate of teenage pregnancy in the developed world (Sedgh et al. 2015). Rates of Chlamydia, gonorrhoea and syphilis are on the rise in the USA, with half of newly diagnosed STIs occurring in individuals aged 15–24 years (CDC 2017). Long-term health consequences can be serious, including infertility and an increased vulnerability to HIV infection (CDC 2017). Factors that have been found to influence teenage pregnancy and STI rates in young people include a lack of comprehensive sex education; cultural attitudes and norms as they relate to young people's sexuality (e.g. stigmatisation of this issue and perceptions of peer behaviours); and a general

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lack of access to appropriate services and information (Hall et al. 2016; Santelli et al. 2017; Jaramillo et al. 2017; Lindberg and Maddow-Zimet 2012; Donaldson et al. 2013; Lindberg, Maddow-Zimet, and Boonstra 2016; Yarger et al. 2017; Kirby, Laris, and Rolleri 2007; Kirby 2008; Haberland and Rogow 2015; Marcell et al. 2017; Beltz et al. 2015; Kohler, Manhart, and Lafferty 2008).

Public support for comprehensive sex education varies, as do local and state policies, which may act as a significant barrier to adequate and appropriate information provision (Hall et al. 2016; Demby et al. 2014). In 2014, fewer than half of US high schools covered all 16 sex education topics that are considered essential (Guttmacher Institute 2017). Due to cultural attitudes and norms, stigma and silence surround teenage sexuality. School-based sex education can be a controversial topic in the USA, with a significant proportion of people supporting an abstinence-only model. This support can be partly attributed to the mistaken belief that giving young people information will encourage sexual activity; however, research has found that providing appropriate information means teenagers are more likely to make healthy sexual choices (Kirby 2008; Kohler, Manhart, and Lafferty 2008; Lindberg and Maddow-Zimet 2012; Santelli et al. 2017).

Numerous public health professionals have advocated against abstinence-only approaches, which commonly neglect to provide important information, and thus often fail to provide adequate guidance to young people (Santelli et al. 2017; Haberland and Rogow 2015; Hall et al. 2016; Jaramillo et al. 2017). Furthermore, it has been argued that abstinence-only programmes reinforce harmful stereotypes, promote stigma, do not support the rights of adolescents and are not inclusive of minority groups (Santelli et al. 2017). There has been an ongoing decline in the receipt of comprehensive sex education for US teenagers, and rates of parental communication on the topic remain at a steady, but relatively low level (Lindberg, Maddow-Zimet, and Boonstra 2016; Guttmacher Institute 2017). Due to the lack of guidance and support, many young people may be at a heightened risk of contracting an STI or becoming unintentionally pregnant.

Whilst school-based sex education may be the mainstay of interventions to address teenage pregnancy and STIs, a range of programmes are needed to reach all young people in need (Salam et al. 2016; Demby et al. 2014; Ewan et al. 2016; Goesling et al. 2014; Denno, Chandra-Mouli, and Osman 2012; Donaldson et al. 2013; Plastino et al. 2017; Fisher et al. 2010, 2012; McCarthy et al. 2015; Gupta et al. 2015). In particular, digital and social media are likely to play a large part of the future of providing information about sex to adolescents (Hall et al. 2016; Guse et al. 2012). The use of digital and social media for sexual health promotion has the benefits of inclusive access for all youth, privacy, confidentiality, efficiency, flexibility, availability, affordability, quality of life improvement and stigma reduction (Minichiello et al. 2013; Simon and Daneback 2013). A variety of services can potentially be provided in this way – education, STI testing and screening management, online counselling and support groups (Minichiello et al. 2013). For programmes that address teenage pregnancy and STIs to be effective, it is necessary to engage the target population in a way that is appropriate and meaningful to them (Ewan et al. 2016; Pound, Langford, and Campbell 2015, 2016). Interventions aimed at addressing teenage pregnancy and STIs are unlikely to result in change if they do not take account of what young people themselves perceive as important, and do not provide services in a manner agreeable to youth (Ewan et al. 2016; Pound, Langford, and Campbell 2015, 2016).

The research discussed in this paper examines young people's perceptions and awareness of current community activities associated with teenage pregnancy and STIs, and personal views on how these issues could be better addressed. The study site was a US midsize Midwestern city in a largely rural area; sites such as this lack local research that addresses the unique situation of adolescents as it relates to sexuality and sex education (Blinn-Pike 2008). Furthermore, little research asks young people themselves what their views are on the topic (Pound, Langford, and Campbell 2016). Rates of STIs are significantly higher in the city studied, when compared with national and state rates (Tibbits, Taylor, and Rasetshwane 2013). Rates of Chlamydia and gonorrhoea in this city are particularly concerning, and African American and Hispanic/Latino youth are disproportionately affected by these (Tibbits, Taylor, and Rasetshwane 2013). In terms of teenage pregnancy, racial and ethnic disparities are more strongly marked in the city compared with national and state data, with Hispanics/Latinos and African Americans having significantly higher rates than other ethnicities (Tibbits, Taylor, and Rasetshwane 2013).

Methods

All study protocols were approved by the University of Nebraska Medical Center Institutional Review Board (IRB). Recruitment of participants was guided by the fact that the rates of teenage pregnancy and STIs are higher in particular geographic regions of the city studied, especially amongst African American and Hispanic/Latino ethnic groups. Efforts were made to ensure that homeless and/or former wards of the state were included as participants. Although there is lack of knowledge regarding the issue of teenage pregnancy and STIs among homeless adolescents and/or wards of the state, there is anecdotal evidence to suggest that these may be of even greater concern in this population. Finally, gender equity was sought, as the issues of teenage pregnancy and STIs broadly affect both girls and boys.

An over-arching aim of the study was to address the issues of teenage pregnancy and STIs at a community level. It was thus felt appropriate to enlist the help of community-based organisations involved with young people in specific geographical locations (i.e. the areas most affected by teenage pregnancy and STIs). Community-based organisations were selected for their ability to help with recruitment, particularly to achieve the participant demographic goals of homeless youth, former wards of the state, and African American and Hispanic/Latino youth.

Youth organisations helped identify young people for participation, schedule interviews, and, where necessary, obtain signed parental consent forms. For homeless youth and young people who might be put in greater danger if seeking parental consent, such as gay or lesbian youth, the requirement for parental consent were waived by the IRB. Ultimately, however, the sample was a purposive sample of convenience (Kerlinger 1986).

In order to meet the inclusion criteria, participants had to be between 13 and 24 years old, residing in the city studied and accessing the services of a community-based organisation partnered with the team for the purposes of the project. An incentive of a USD 25 gift card or cash, determined by the organisation, was provided to each participant.

A qualitative approach to data collection was determined to be the most appropriate method, given that the aim of the study was to document in-depth the insights of young people, particularly with regards to current and future programmes to reduce the risk of teenage pregnancy and STIs. Data were therefore collected through semi-structured

interviews, which were audio-recorded and transcribed before coding. The average length of the interviews was 33 minutes and they lasted from 17 to 64 minutes. A narrative enquiry approach was chosen as, through the participants' sharing of personal experiences, we could gather rich descriptive data. Questions asked covered participants' views of how (and how not) and where issues of teenage pregnancy and STIs could be addressed. Older participants were asked to reflect on their teenage years and how and where to address these issues for teenagers today based on their own experiences. Pseudonyms were assigned to participants to protect confidentiality and anonymity.

Data analysis was undertaken in two phases ad used NVivo 10 software. The first phase of analysis employed a top-down approach. This involved using codes pre-defined by the research questions and study aims. Three researchers analysed the interview data for statements that conformed to these codes. To ensure reliability across coders, all three researchers coded the same interviews and compared their results. The team achieved agreement of 98–100%, indicating that the researchers had near identical interpretations of the codes, and thus there was consistency in analysis. A second, bottom-up phase of data analysis was more in-depth in character. In this phase, themes were coded based on participants' statements. Bottom-up coding ensured a more complete exploration of the issues and facilitated the discovery of more in-depth information that reflected participants' experiences. Again, to ensure reliability across coders, all three researchers coded the same interview and compared their results. Themes from both phases of analysis closely aligned and were therefore combined in the reporting of results.

Results

Forty-one participants aged between 13 and 22 were interviewed. Of these, 23 were girls (56.1%), and the average age was 17.6 years. In terms of race and ethnicity, 19 participants (46.3%) identified as Caucasian, 11 as African American (26.8%), 9 with more than one race (22.0%), 1 as Native Hawaiian (2.4%) and 1 as 'other' (2.4%); 12 participants (29.3%) identified ethnically as Latino/a. The majority of participants were in middle or high school or college (n = 30, 73.2%), and there was a significant proportion of participants who were former wards of the state (n = 17, 41.5%; see Table 1 for details). The four themes that emerged from the data were: knowledge of current activities aimed at prevention; information-seeking behaviours; personal views on how to address the issues of teenage pregnancy and STIs; and the ideal place to address these issues.

Current programmes and services

Regarding knowledge, awareness and perceptions of current programmes and services, participants had a variety of perspectives, with some strong areas of consensus. Many participants made statements that indicated that teenagers are not being engaged in or are unaware of issues related to teenage pregnancy and STIs, and the majority of participants talked about the stigma related to these issues; 'They don't really talk about [STIs]' (Tom, 16 year old African American); 'Let's say someone did have STDs, I'm pretty sure they wouldn't want to talk about it, because that would be embarrassing for them.' (Sofia, 17 year old Latina)

Most participants in the study did not know of any programmes addressing teenage pregnancy and STIs (see Table 2), and awareness of such programmes was frequently

Table 1. Participant demographics ($N = 41$).

	n (range)	% (mean)
Gender		
Female	23	56.1%
Male	18	43.9%
Age	13–22	17.6
Race		
Caucasian	19	46.3%
African American/Black	11	26.8%
More than 1	9	22.0%
Native Hawaiin	1	2.4%
Other	1	2.4%
Latino/a (yes)	12	29.3%
In School?		
Yes	30	73.2%
Middle (% of yes)	3	10.0%
High (% of yes)	22	73.3%
College (% of yes)	5	16.7%
No	11	26.8%
Living Situation		
With Parents/Home	24	58.5%
On Own	6	14.6%
With Friends	5	12.2%
With Relatives	3	7.3%
No stable Place	2	4.9%
Various	1	2.4%
Former Ward of State	17	41.5%
Interview Length (minutes)	17–64	33

Table 2. Activities/Organisations to address teenage pregnancy and STIs as reported by participants.

Activity	Total *n*	Preg *n*	STIs *n*
No activities/'I don't know'/'not much'	27	11	16
Human Growth & Development/Child Development classes in school	27	16	11
Free clinics/Heath Centres	12	6	6
Community-Based Organisations	10	4	6
Presentation at school by outside person	3	3	0
Free condoms at school	3	1	2
Counsellor at school	3	3	0
Condom/Birth Control Commercials	3	1	2
Posters in school	3	3	0
Christian celibacy programme	2	1	1
School nurse	1	1	0
SMS (texting) Services	1	1	0
Classes outside of school	1	1	0
Health Fairs	1	1	0
Billboards	1	1	0
Condoms from friends	1	1	0
Flyers around town	1	0	1

Note: Counts are of number of times mentioned; some participants mentioned multiple items, thus these numbers are not of out of 41 participants.

associated with school sex education classes. However, some participants indicated awareness of the activities provided by local community-based organisations; 'So they try to get the youth involved in things. And then once we do get involved in those things, they will kind of educate us and give us more details all in one setting.' (Lucy, 14 year old multi-racial)

A number of young people described the need for more sex education classes and class time. Participants' perceptions of sex education within a school environment indicated that classes were not mandatory and were also becoming less accessible; "I asked my counsellor, 'cause I was like, 'I wanna take that class. Do you have it?' and she said, 'They got rid of it because so many girls got pregnant, so it was just… not a use' (Jane, 16 year old multi-racial) . The education that was provided was also seen as having significant limitations. Some young people mentioned the potential discord between what teenagers believe is relevant to their lives and what sex education is allowed to teach; 'Like in some health class there's stuff they can and can't talk about in health to get out there and really show you what you – what's really out there' (Jennifer, 20 year old multi-racial).

Ineffectiveness was also an issue; 'They just say don't get pregnant, because you're not going to be able to take care of the kid. But really, um, that really doesn't push someone's mind to say no.' (Alberto, 16 year old Latino); 'I think that's a big reason why most teens come out like come pregnant and stuff, because they don't get the information they need' (Suzanne, 16 year old African American). Further evidence of the ineffectiveness of sex education was demonstrated by the general lack of recall amongst participants when asked what they had been taught about pregnancy and STI prevention.

Information seeking

Results revealed that most teenagers would only try to find information if they were actually experiencing the issues; '…these kids – the only time that they're going to seek out information about it is when it, when it happens to them. Then that's too late' (Juan, 22 year old Latino); '… it's very unlikely that they're gonna seek information, because they're not gonna care. I mean, I didn't care' (Sharon, 21 year old African American). The reasons given for this included the perception that teenagers 'didn't care' unless it was happening to them personally, and the stigma surrounding the issue leading to embarrassment or shame. Although it was generally felt that teenagers might not seek out information until it was too late, participants gave ideas about where adolescents might go for information (see Table 3 for sources of information). The most common speculation was school-based programmes; however, some participants pointed out that teachers were not necessarily the easiest to talk to about such issues; 'They really just don't care. It's not affecting their life; it's affecting yours. And they're just like okay, whatever' (John, 17 year old white).

The perceived benefits of using the Internet included privacy, and an abundance of information; 'It tells you more' (Jorge, 16 year old Latino). Going to friends for advice was seen as safe, but potentially problematic due to unreliability. Healthcare professionals were generally seen in a good light, providing medically accurate information and maintaining much-valued confidentiality. Although parents were mentioned by 13 (31.7%) participants and were sometimes seen to provide sound guidance, having such conversations was commonly viewed as uncomfortable for both parents and children; "I don't think a parent is ever really comfortable with telling their teen, like, 'Hey, you need to do this if you're gonna have sex' (Brenda, 15 year old African American). Parents' main role as identified by several participants was to enforce boundaries and rules for their children.

Table 3. Sources for seeking information on pregnancy and STIs.

	Total	Pregnancy	STIs
Source	*n*	*n*	*n*
School-based sources	38	25	13
School	*16*	*10*	*6*
Teachers	*12*	*10*	*2*
Human Growth & Development	*8*	*4*	*4*
School Counsellors	*2*	*1*	*1*
Internet (almost all google)	25	15	10
Friends	22	17	5
Doctor/Nurse/Clinic/Pharmacy/Health Fair	17	11	6
Parents	13	10	3
TV/News	8	7	1
CBO	6	4	2
Brochures/Books/Flyers	6	3	3
Adults other than parents/teachers	5	4	1
Church	1	1	0

Note: Counts are of number of times mentioned; some participants mentioned multiple items, thus these numbers are not of out of 41 participants.

Personal views to address teenage pregnancy and STIs

Participants had a variety of ideas about the ways in which teenage pregnancy and STIs could be addressed. One comment that every participant made was simply to have more discussion of the issue in a school environment, peer-to-peer, at home and in the media: 'Just talk to [us] about it more'. School in particular was seen as the most significant area where improvements could be made. One specific reason that was frequently given for this was the ability to engage more youth as the majority of young people go to school on a regular basis; 'I think probably within school it would be more – it would capture more of the students because they'll be like – they'll hear about it more constantly…' (Isabella, 18 year old Latina).

Participants suggested that sex education needed to be comprehensive, accurate, reaching all teenagers, and with more time dedicated to it. Other potential interventions were starting sex education earlier, having 'awareness days', training adults who were not teachers to provide advice, STI testing in schools, after-school programmes, and having separate programmes for boys and girls. In terms of the delivery of the programmes, participants stated that they should be: 'comfortable'; not 'boring'; should not 'sugar coat things'; should potentially provide incentives (e.g. food/gift cards) to attend; and have peer-educators, especially young people who had experienced teen pregnancy or STIs themselves: 'Maybe bring in some teen moms… or even people that have STIs and how it maybe ruined their lives or affected them' (Melissa, 22 year old white).

A view held by many was that a programme needed to have 'a good feeling to it. Like, making it seem comfortable or making it seem like it's something that isn't going to be boring' (Valerie, 18 year old Latina). Another way of addressing the issues mentioned by several participants was the provision of condoms; 'Definitely handing out condoms would help a lot with that' (Jay, 19 year old white).

Regarding the provision of information, some suggested that young people should be able to receive this in a manner that is both private and confidential, and the use of new technology was seen as the best approach. Participants listed a number of potential social media tools for getting messages across including Facebook, Twitter, Instagram,

video games, phone apps and websites. Messages sent out should include general education about the issues and prevention methods, along with the location of services. A number of participants also talked about the necessity for parents to talk to their children; 'Don't be afraid of what your kid is gonna say to you. Like you're the parent. Talk to them at home' (Jennifer, 20 year old multi-racial); 'Just let them know that if they don't listen to [the parents], then they're gonna probably regret it' (James, 21 year old African American).

Finally, one participant mentioned the need for better role models and leadership in her community; 'Like for me personally, I don't think African Americans are good at leading kids in the right directions about sex and other stuff… They need to be more strict to their kids especially. Being a proper role model' (Portia, 15 year old African American).

Ideal place to address teenage pregnancy and STIs

The final topic explored in the interviews concerned the characteristics of an 'ideal place' for information and services related to teenage pregnancy and STIs. Responses to this suggested that, unlike sex education, it should *not* be in a school. Whilst schools might offer a convenient location, confidentiality and privacy could not be maintained and other students might become aware of who is accessing services. Moreover, schools may feel the need to inform the young person's parents; 'School tells everything to your parents' (William, 16 year old Latino).

In contrast, an ideal place was would be a service that covers all areas of need – information, contraception provision, counselling, testing and access to health professionals who can help with teenage pregnancy and STIs. Crucially, the employees of such a service need to be non-judgemental and welcoming. Peers were seen as being potentially beneficial in this respect: 'Somewhere that you feel comfortable and you're not feeling like there's somebody always watching you or they're saying oh, well, we're going to tell your parents… somewhere where you could just easily talk to somebody or express how you're feeling…' (Lucy, 14 year old multi-racial); 'To a teen […], you can express it more because it's life, and you feel like you're going through it too at the same time' (Camille, 19 year old Latina multi-racial).

Participants wanted the geographical location of a service be discreet and somewhat hidden. However, this needed to be set against convenience. Some participants also described the physical appearance of such a place, highlighting the need for it to be comfortable and inviting.

Discussion

This study has documented youth perceptions of teenage pregnancy and STIs in a Midwestern US midsized city. The paper reports on the findings as they relate to current programmes and services, and young people's own ideas of how best to address the issues in order to inform future interventions. The results identified strong areas of consensus but also diverging perspectives. Given the purposive sampling utilised, the findings are not representative of all young people locally; however, the results may hold relevance in situations similar to those investigated (c.f. Pound, Langford, and Campbell 2016). The requirement for parental consent for most youth in this study

could have limited the opinions and views expressed to those youth whose parents were comfortable participating in such a research study. The particular location of this study, and the relatively high representation of African Americans, Latinos/Latinas and former wards of the state, add new insight into how to address teenage pregnancy and STIs among vulnerable populations.

Many young people in this study felt that most youth would not seek out information on pregnancy or STIs unless they had a personal experience with the issue. Participants supported addressing the lack of preventative information-seeking through calls for sex education to be more comprehensive, be required for all young people, and delivered in a 'sex-positive' way without stigma – a finding very much in line with other research in the field (Hall et al. 2016; Santelli et al. 2017; Jaramillo et al. 2017; Lindberg and Maddow-Zimet 2012; Donaldson et al. 2013; Lindberg, Maddow-Zimet, and Boonstra 2016; Yarger et al. 2017; Kirby, Laris, and Rolleri 2007; Kirby 2008; Haberland and Rogow 2015; Marcell et al. 2017; Beltz et al. 2015; Kohler, Manhart, and Lafferty 2008; Demby et al. 2014; Guttmacher Institute 2017; Pound, Langford, and Campbell 2015, 2016).

Outside the classroom, participants called for sexual health services to be confidential, non-judgemental and comfortable; services which are not may limit access to care (Guttmacher Institute 2017; Pound, Langford, and Campbell 2015, 2016). Finally, young people advocated the creation of community-wide social media campaigns and the development of a pool of lay peer and adult health educators as trusted sources of information. Service providers, policymakers, community-based organisations and other sexual health groups can use this evidence to develop culturally appropriate responses which address the recommendations provided by the young people in this study.

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