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Piloting *Families Talking Together* in the Bañado Sur, Paraguay:
An assessment of the feasibility of a parent-focused adolescent pregnancy prevention program

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Abstract

Piloting *Families Talking Together* in the Bañado Sur, Paraguay:
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By Brianna Keefe-Oates

Background: Adolescent health is paramount to guaranteeing long term health and opportunities. In Paraguay 16% of adolescents of low socioeconomic status become pregnant before they reach 20 years of age. These pregnancies can hinder their educational and social development and progress. Due to the conservative nature of Paraguayan politics, sexual education is not taught comprehensively in schools, and so alternative strategies to reduce adolescent pregnancies need to be taken. Parent-child communication about pregnancy prevention has been found to be effective in other countries and could be effective here. This study assesses the acceptability and feasibility of implementing a parent-focused intervention, *Families Talking Together*, in Asunción and provides recommendations for adaptation.

Methods: The intervention was modified for Paraguay and subsequently implemented in the Bañado Sur, Asunción. Focus groups were conducted with parents who participated in the intervention while individual interviews were conducted with key informants and adolescents. The data were analyzed to understand reactions to the intervention and possibilities for adaptation.

Results: The intervention was generally well received by all parties, however parents still reported struggling to discuss sexual and reproductive health topics with their children after the intervention. Key informants and adolescents discussed the pressures that adolescents feel to have sex at an early age and the lack of sexual education as two reasons for the high adolescent pregnancy rates. All participants enjoyed the discussions in the intervention and accompanying materials regarding love and healthy relationships; these were topics that participants said were not often discussed.

Discussion: *Families Talking Together* could be further adapted for the Bañado Sur to encourage parent-child communication regarding sexual and reproductive health. Parents' difficulty in addressing these issues even after the intervention suggests that prior programming needs to focus on family strengthening, healthy communication skills and skill-building for adolescents before parents would benefit from the Families Talking Together intervention.

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Chapter 1: Introduction

Introduction and Rationale

Adolescent health is paramount to guaranteeing long term health and opportunities. The literature on adolescent health now recognizes it as a sort of "point of no return," one of the last great opportunities to establish good health practices and prevent conditions that can affect a person's quality of life in the long term. Sexual and reproductive health consistently emerge as a top priority in adolescent health because adolescent pregnancies have long interrupted boys' and girls' progress towards higher education and healthy lives (Sawyer et al., 2012).

In order to prevent these unplanned pregnancies, researchers have focused on identifying risk and protective factors that could be targeted in interventions for adolescents. While many of these are individual factors, research has shown that familial influences, particularly the extent to which children feel connected to their parents, can also help prevent risky behaviors that lead to unplanned pregnancies (Guilamo-Ramos et al., 2007; Jaccard, Dodge, & Dittus, 2002; Douglas Kirby, 2007; Douglas Kirby & Miller, 2002; Levine, 2002; Markham et al., 2010). Specific research surrounding parent-teen communication has shown that when parents have conversations with their children about sex and contraception before they are sexually active, age at sexual initiation increases and the frequency of sexual relations decreases. Though much of this research has been US focused, literature from elsewhere in Latin America has also shown that communication with parents has a protective effect against adolescent pregnancies (Atienzo, Walker, Campero, Lamadrid-Figueroa, & Gutiérrez, 2009; Campero, Walker, Atienzo, & Gutierrez, 2011; Campero, Walker, Rouvier, & Atienzo, 2010; Guijarro et al., 1999).

Many barriers exist to improving parent-child connectedness and increasing communication with adolescents about sensitive issues such as sexual and reproductive health

topics. Often parents cite being embarrassed to speak about the topic, fearing it might encourage their children to engage in risky behaviors, or their own lack of knowledge as reasons that they do not engage in such conversations (Guilamo-Ramos & Jaccard, 2008; Guilamo-Ramos et al., 2007; Jaccard et al., 2002). New evidence-based interventions are being replicated in the United States to begin empowering parents to discuss sexual and reproductive health with their children. These same interventions could also be adapted and applied to settings in Latin America to address adolescent pregnancies (Akers, Holland, & Bost, 2011; Atienzo et al., 2009; Guilamo-Ramos, Bouris, et al., 2011; Guilamo-Ramos, Jaccard, et al., 2011; Villarruel, Cherry, Cabriales, Ronis, & Zhou, 2008; Wight & Fullerton, 2012).

Problem Statement

In Paraguay students from lower socioeconomic classes are disproportionately affected by unplanned pregnancies. Paraguay has a large proportion of young people, with 22% of the population classified as adolescents, defined as those between the ages of 10 and 19 (UNICEF, 2010). Paraguay is also an unequal society, with the Gini Coefficient, a measure of income inequality, ranking it as the 16th most unequal country in the world ("CIA - The World Factbook: Paraguay," 2012). This inequality affects health statistics as well; pregnancies among adolescents ages 15 to 19 vary by socioeconomic status with 16% of low income girls reporting an adolescent pregnancy in 2008 compared to 5% of high income girls youth (Centro Paraguayo de Estudios de Poblacion, 2009). Unwanted pregnancies also affect women of low socioeconomic status disproportionately: in a 2008 survey, women of low socioeconomic status reported more unwanted pregnancies than their counterparts of higher socioeconomic status (Centro Paraguayo de Estudios de Poblacion, 2009). These indicators reflect a need for more interventions to prevent adolescent and unwanted pregnancies, especially in low-income communities.

Since 2008, the Paraguayan government and civil society have debated mandating sexual education in schools, but opposition from conservative groups in the country has made it difficult to agree on an appropriate curriculum (Consorcio Latinoamericano contra el aborto inseguro, 2011; "Ministro paraguayo defiende reforma de sistema educativo," 2011). Despite 80% of Paraguayan adolescents reporting learning about reproductive health at school, the adolescent pregnancy rate remains high (CEPEP, 2009). Education in the schools may be limited due to conservative influences; certainly it does not appear to have helped prevent adolescent pregnancies. It is thus important to find alternative ways to give youth information and skills that will help protect themselves from unwanted pregnancies.

Increasing parent involvement in their child's sexual and reproductive health education is particularly important in Paraguay due to the lack of proper sexual health education in schools. However current education about sexual and reproductive health in the home is also sparse. In a qualitative study of youth in Paraguay, researchers found a lack of communication between parents and teens. Findings also revealed that when there was discussion around reproductive and sexual health topics, the discussion was often negative (Andes & Cisneros Puebla, 2009). This study recommended implementing interventions for younger youth because evidence shows it is necessary to educate teens while they are young. Curricula for younger teens are also age appropriate and less controversial than curricula for older youth.

The study presented here aimed to implement and assess a pregnancy prevention program focused on encouraging parent-teen communication about sexual and reproductive health among parents and their young teens. The study was carried out in the *Bañado Sur,* a marginalized neighborhood on the outskirts of Asunción, Paraguay's capital city.

Purpose Statement and Research Questions

The purpose of this study was to assess the feasibility and acceptability of the parent-focused Families Talking Together pregnancy prevention intervention.

Research questions include:

1. How did key stakeholders in Asunción react to the *Families Talking Together* intervention?
2. What is the best way to deliver the intervention in the *Bañado Sur* and similar communities in Paraguay?

Specific Aims:

1. Implement an intervention designed to increase communication between parents and children about sexual and reproductive health in order to prevent adolescent pregnancies.

2. Assess the acceptability and adaptability of the FTT intervention from the perspective of adolescents, their parents, and youth development and health professionals.

3. Establish recommendations to inform adaptations of the intervention in the future.

Significance Statement

Little research has been conducted in Paraguay on sexual and reproductive health interventions. Given the conservative nature of the country and lack of sexual health education in schools, working with parents to transmit sexual health messages could be effective in helping decrease the adolescent pregnancy rates. This study is set in the *Bañado Sur*, a marginalized neighborhood in Asunción. The participants in this study provide valuable insight surrounding parent-child communication and adolescent sexual health in low socioeconomic communities in Paraguay where adolescent pregnancy rates are highest. The findings from this study will not only help adapt the *Families Talking Together* intervention for the Paraguayan context, but will

also provide useful information on the best techniques for designing parent-focused prevention interventions that could affect adolescent risk behaviors in Paraguay.

Chapter 2: Review of the Literature

Sexual and Reproductive Health in Paraguay

In Paraguay 22% of the population is between the ages of 10 and 19 (UNICEF, 2010). For Paraguayan youth who want a better future, it is important that they stay healthy and are able to continue in the school system for as long as possible. An adolescent pregnancy can endanger a girl's health and prevent her, and at times her partner, from continuing their education. While there is limited data about adolescent sexual and reproductive health (SRH) in Paraguay, the evidence suggests that adolescents are not receiving the information they need to prevent pregnancies and keep themselves healthy. New interventions need to be piloted in Paraguay that can help address the multiple components that are attributed to high adolescent pregnancy rates.

Adolescent pregnancy in Paraguay

According to a 2008 reproductive health survey, the adolescent fertility rate in Paraguay was 63 per 1000 adolescents; however the percentage that adolescents contributed to the overall fertility rates increased from 10.5% during 1987-1990 to 12.8% in the 2005-2008 time period. This indicates that more adolescents were becoming pregnant relative to the general population. These adolescent pregnancies can affect a girls' educational opportunities in the future: a 2008 survey showed that 55.3% of the female adolescents who were in school when they became pregnant had to stop their studies. Only 11.9% of them had returned to school when surveyed (Centro Paraguayo de Estudios de Poblacion, 2011). These adolescent pregnancies can also have serious effects on a woman and her child's health: in 2008 Paraguay had the highest adolescent maternal mortality rates in Latin America ("Paraguay ocupa primer lugar en muertes por embarazo juvenil," 2008).

While overall 11.6% of Paraguayan adolescents age 15-19 years old in 2008 were pregnant or had a child, this varied enormously depending on age and socioeconomic level. The percentage of pregnant teenagers increased with age, with 10.5% of 17 year olds, 19.1% of 18 year olds and 23.7% of 19 year olds reporting having a child or being pregnant in 2008. The burden of these cases tends to fall on those with low socioeconomic status: 16.4% of low income youth reported an adolescent pregnancy compared to 5.1% of high income youth (Centro Paraguayo de Estudios de Poblacion, 2011). Unwanted pregnancies are also more prevalent among women of low socioeconomic status: in 2008, women of low economic status reported more unwanted pregnancies than their counterparts of higher socioeconomic status (CEPEP, 2009). Among girls 15-19 years old, there were also important differences in contraceptive use: While only 61.2% of girls of low socioeconomic status reported using contraception during their first sexual relation, 86.8% of girls of high socioeconomic status reported using contraception (CEPEP, 2011). These indicators reflect a need for more programs to prevent adolescent and unwanted pregnancies and educate about contraceptives, especially in low-income communities.

Table 1. Key pregnancy and contraception indicators of women in Paraguay according to Socioeconomic status

Socioeconomic status	**% of Adolescents 15-19 with a child or pregnant**	**% of adolescents 15-19 using contraception during their first sexual relation**	**% of unwanted pregnancies among all women 15-49**
Low	16.4	53.7	33.0
Medium	11.5	71.2	32.4
High	5.1	82.6	24.1

Source: CEPEP 2009, 2011

When planning programs to prevent pregnancies, it is important to understand the patterns in sexual activity among youth so that measures can be taken to prevent risky behaviors before they start and potentially lead to an unplanned pregnancy. In the 2008 Paraguayan reproductive health survey, while 12.6% of 15 year olds were sexually active, 42.1% of 17 years olds were sexually active, with the percentages increasing steadily each year. This suggests that it is

important to reach girls when they are young, before they begin to have sex. Another important risk factor to consider is who the girls' sexual partners are: 34.1% of girls 15-19 years old in 2008 reported having their first sexual relationship with a man 6 or more years older than them. This suggests that there could be aspects of coercion linked to these sexual encounters due to the power dynamics in a relationship with a teenage girl and adult man. It also suggests that being with a significantly older man is a risk factor for becoming sexually active (CEPEP, 2011).

A cross-sectional survey with students from private and public high schools in Asunción and Lambaré, a town near the *Bañado Sur*, found that 42% of students reported having ever had sex. There was a significant difference ($p<.001$) between females reporting having sex (27%) compared to males (56.5%). Though some of this difference could reflect the pressures on males in Paraguayan society to have sex, it could also reflect the reluctance of females to admit they had had sex. Another significant statistic is that more students from public schools reported being sexually active (47%) than students in private schools (30%) which could also reflect the influence of socioeconomic status on sexual initiation (Macchi, Benítez Leite, A, Nuñez, & Ortigoza, 2008).

Sexual health education

Education about sexual health and pregnancy prevention in Paraguay is limited. Since 2008 the Paraguayan government and civil society have been debating mandating sexual education in schools. Unfortunately, given the conservative nature of some groups in the country including the Catholic Church, it was hard to agree on an appropriate curriculum and the law, the *Marco Rector,* has yet to be approved. (Consorcio Latinoamericano contra el aborto inseguro, 2011; "Ministro paraguayo defiende reforma de sistema educativo," 2011)

In a survey of youth in Asunción in 2006, 53.3% of students reported that schools were one of their main forms of information about HIV/AIDS while 47% reported friends as being one of their most important sources of information. Notably, parents were not listed as one of the sources of information (Macchi et al., 2008). Additionally, 80% of Paraguayan adolescent females surveyed in 2008 reported learning about reproductive health in schools (CEPEP, 2011). In a qualitative study of SRH among youth in Asunción, adolescents also mentioned that their peers were the main way they received information (Andes & Cisneros Puebla, 2009). Despite these reports of education through schools and peers, the amount of girls aged 15-24 reporting having had sexual relations has increased in Paraguay and the adolescent pregnancy rate remains high (CEPEP, 2009). This indicates that pregnancy prevention interventions need to be improved in order to address the current situation in Paraguay. Part of this problem may be that simply receiving information is not enough to prevent pregnancies. Instead, teenagers need to learn how to take the information they are receiving and apply it in a manner that will actually prevent pregnancies.

In a qualitative study with youth in Paraguay, researchers discovered a lack of communication between adolescents and adults about sex, sexual relations and protection. The majority of the time when adolescents discussed communication with their parents and other adults they cited the adults' attitudes as negative and judgmental. A lack of communication and knowledge of how to communicate was also evident when adolescents were asked about discussing these topics with their partners, particularly when their relationship with someone from the opposite gender wasn't serious. This lack of communication also included a general attitude of negativity by parents towards any kind of romantic relationship. When adolescents have to hide these relationships from their parents they have less physical space to "date" and are more at risk

of having sexual relations in precarious places, which can contribute to unsafe sex (Andes & Cisneros Puebla, 2009). With these findings the authors suggest that sexual health education needs to be focused on a younger population of youth (ages 11-14) where efforts can be made to delay sexual initiation. Additionally, they suggest increasing communication between older adolescents and their parents, schools and medical providers about family planning (Andes & Cisneros Puebla, 2009). Rather than simply giving adolescents information in schools, interventions need to focus on other factors that contribute to risky behaviors and try to use all avenues to teach adolescents how to make healthy decisions.

Risk and Protective Factors for Adolescent Pregnancies

In order to prevent adolescent pregnancies it is first important to understand some of the underlying factors that contribute to those pregnancies. Though many risk and protective factors are specific to individuals (i.e. attitudes towards contraceptives, drug and alcohol use), some of these factors are also structural or environmental (Kirby, 2007). Cultural and familial influences, unfriendly youth services, and a lack of education can also contribute to low contraceptive and condom use and early sexual initiation (Bearinger, Sieving, Ferguson, & Sharma, 2007). Understanding these factors that can contribute to unplanned pregnancies will help public health professionals design interventions to reduce the risks and support protective factors that contribute to healthy behaviors. In the case of Paraguay, where sexual health education is difficult to implement in schools, it is important to focus on factors that are influenced by social and environmental factors such as parents and families.

Focusing on risk factors in developing countries

Though there is little research in Paraguay about specific risk and protective factors, evidence from other developing countries can help us understand the best way to encourage

healthy SRH behaviors. Unfortunately, much of the research conducted in developing countries about risk and protective factors in adolescent SRH has focused on individual factors that put the adolescent at risk rather than social or ecological factors. These social and ecological factors include adolescents' relationships with their families and, specifically, their parents. These relationships are often referred to as "family connectedness." The majority of research on family connectedness has been performed in high income, Western countries, however some research has found evidence for family connectedness as a protective factor among youth in Latin American countries.

Several studies performed in developing countries found that living with both parents, living at home, having a father present, and having parents who were in a stable marriage/union appeared to have a protective factor on SRH outcomes. However these studies did little to understand how a parent's influence, through their relationships or communication with their children, affected adolescent behavior (Mmari & Blum, 2009). In their article about the SRH of adolescents globally, Bearinger and colleagues stressed the need to address the social contexts of adolescents' lives that could act against safe sex. Additionally, they encouraged using evidence based sex education curricula to start changing these social and structural factors (Bearinger et al., 2007). Before doing so, it is important to understand those social and ecological factors that influence risk and protective factors.

Parental influences on sexual and reproductive health as risk prevention

Though there is little research from the developing world on the topic, research in the United States and other high-income countries have shown that parent-child connectedness, and the degree by which this bond is both mutual and sustained over time, can serve as a protective factor against risky sexual behavior (Lezin, 2004). Recently, family connectedness, which

includes measures of parental closeness, satisfaction with the parental relationships, and parent involvement, has been found to be protective against early sexual initiation, increased frequency of sex and pregnancy (Markham et al., 2010).

The quality of parent-child connectedness is determined from a very early age. This can make it difficult to design interventions that target all aspects of parent-child connectedness when the child is an adolescent. However, parental communication and monitoring/control are two factors that contribute to parent-child connectedness and have been found to have an effect on adolescent SRH (Lezin, 2004). There is ample evidence showing that parent-adolescent communication about sex is protective against the adolescent ever having sex and early sexual debut. Additionally, some evidence has been found that ever communicating with youth about SRH encourages condom use, decreases the frequency of sex and decreases pregnancies. Several longitudinal studies have found that parent-adolescent communication about sex appears more protective for females than males. However, because the frequency and content of communication about SRH is hard to measure, few longitudinal studies have been able to draw consistent conclusions about the quality of communication and SRH outcomes (Markham et al., 2010).

Articles that have studied the association of parental monitoring and SRH outcomes have concluded that there is "sufficient evidence" that parental monitoring could increase contraceptive and condom use and be a protective factor against early sexual debut. Two separate longitudinal studies found that monitoring also had an effect on contraction of an STI. The association between monitoring and sexual initiation is one that has shown mixed results. In some studies, monitoring was found to be protective against sexual initiation while in others it was found to be a risk factor when the monitoring became overcontrol. Across groups, there was more evidence to

support parental monitoring as protective for females compared to males, with overcontrol being identified as a potential risk factor for males (Markham et al., 2010).

The literature about parent-child connectedness in Latin American countries is limited. One study of female adolescents in Ecuador considered the influence of families on early pregnancies. Parental separation or divorce and poor parent-daughter communication were found to be associated with adolescent pregnancies ($p<.02$) while non-pregnant adolescents were found to report higher levels of communication and connectedness ($p<.02$) (Guijarro et al., 1999). In Mexico, Atienzo et. al. found that secondary school students frequently reported discussing sexual relations with their parents. Among sexually active survey participants, 68.1% reported having their first discussion with their parents prior to first sexual intercourse. Adolescents reported discussing biological aspects, risks and prevention more often with their mothers, but 63.5% still wanted more information from their parents about sexuality, pregnancy and birth control. Participants reported differences in what they discussed with their parents depending on the gender of both the parents and participants and whether the student was already sexually active. This suggests that more research must be conducted about the way different genders communicate about sexual risks when designing interventions (Atienzo et al., 2009). The researchers also found students who had discussed prevention and risks with their parents before their first sexual intercourse were twice as likely to report condom use at first intercourse. The authors of this study use this data to argue for an increase in parental communication before the student begins having sex, which means starting the conversation early.

Evidence-Based Interventions to Decrease Risky Sexual Behaviors

In order to improve reproductive health outcomes for adolescents, researchers and practitioners have begun to develop interventions focused on decreasing risky sexual behaviors by

improving knowledge, skills, attitudes and behaviors that protect against unplanned pregnancies, STIs and HIV. Though there are many programs that exist to offer SRH interventions through different mechanisms including schools, community-based programs, parent-based programs and media campaigns, many are not evaluated and thus there is no way of knowing if they achieved their goals.

To ensure that the goals of behavior change are achieved, the interventions must be rigorously evaluated. In many reviews of evaluations, authors consider the interventions rigorously evaluated if the study included intervention and control groups and the changes are measured over time. Douglas Kirby (2007) identifies 14 characteristics that can help classify the strength of the study, including the quality of the research design itself, the indicators measured and analysis and dissemination of results. There has been a push to replicate those interventions that have been found effective during a "rigorous" study in order to have a bigger impact on adolescent reproductive health outcomes (Kirby, 2007). Kirby conducted a systematic review of evidence based interventions in order to understand which interventions had an effect on youths' knowledge, skills, attitudes and behaviors. Many interventions focus on increasing knowledge about SRH, but recently there has been a push to begin to focus on programs that can actually demonstrate reductions in risky behaviors or teen pregnancies.

The disadvantage to these evidence based interventions is that they are often evaluated in research settings, where participants are paid or given something in return for their time participating in the study. Additionally, those who implement the intervention tend to be experts in group facilitation. Unfortunately, without incentives and expert facilitators, replicating these interventions in schools and communities can be more difficult, though not impossible. Thus it is

important to identify which interventions are appropriate and how they can be replicated or adapted with fidelity so that they achieve their goals and are suitable for the setting.

The effectiveness of sexual and reproductive health interventions

In his 2007 report, *Emerging Answers*, Kirby reviews over 80 interventions that have been rigorously evaluated. Not all programs that aimed to change behaviors showed proven results. Only about half were successful in delaying sexual initiation, reducing the number of sexual partners, increasing condom use, increasing the use of other contraceptives or decreasing a combination of sexual risks. The programs typically reduced risky sexual behavior modestly, by about one-third. At the same time, none of the programs resulted in earlier sexual initiation, a criticism sometimes made against SRH prevention interventions or educational curricula (Kirby, 2007). More recently, Kirby and colleagues reviewed effective curriculum-based STI, HIV and sex education programs for adolescents, and found that most of the 55 programs were effective in delaying sexual initiation and increasing condom use, suggesting that teaching adolescents about abstinence and protection using curriculum-based programs is an effective way to decrease risky behaviors. Only one abstinence-only program showed negative results, suggesting that only focusing on abstinence is not effective in reducing sexual risk behaviors among youth (Douglas Kirby & Laris, 2009).

With his research, Kirby (2007) established a list of 17 characteristics of effective interventions. He found that programs that directly address STI/pregnancy prevention must have a strong, clear message. When designing the program, Kirby notes that effective programs were typically designed by individuals with varied expertise in curriculum development and SRH, assessed the needs and assets of the youth who were targeted, used a logic model approach when

developing the curriculum, ensured that activities were appropriate given the resources and community values, and conducted pilot projects to test the program.

Evidence based interventions in developing countries

Most of the interventions reviewed in *Emerging Answers* and other systematic reviews were developed and evaluated in the United States, but there are few SRH education programs in developing countries that have shown consistent effectiveness. A 2003 systematic review of developing country interventions found that many were successful in increasing knowledge and improving attitudes, but were less effective in changing behavior (Speizer, Magnani, & Colvin, 2003). Additionally, some evaluations did not measure behavior change, focusing instead only on changes in knowledge and attitudes.

By 2007, the number of developing country interventions had grown to such an extent that Kirby and colleagues were able to review 83 studies that measured the impact of sex and HIV interventions on sexual behaviors, and found that a number of programs were effective across cultures and countries. When replicated and implemented as intended, interventions were equally likely, if not more likely, to be effective in developing countries compared to the US and other developed countries. Similarly to the US, skills-based programs were found to be more effective at changing behavior than knowledge-based programs (D Kirby, Laris, & Rolleri, 2007). These programs were also more likely to change behavior positively if they incorporated the 17 characteristics that Kirby identified in his 2007 publication, *Emerging Answers*.

In a separate review of school-based programs in developing countries, Kirby and colleagues concluded that school-based curricula that include four-fifths of the "Seventeen characteristics" identified in *Emerging Answers* were reliable and should be implemented elsewhere (D. Kirby, Obasi, & Laris, 2006). Additional research has focused on community

based HIV/AIDS prevention interventions that have been shown to be effective in developing countries; many of these same messages and techniques can be applied to pregnancy prevention as well. Those effective interventions typically focused on youth who were served by existing organizations which were accepted by the community and where HIV/AIDS had a logical fit within the organization (Maticka Tyndale, 2006).

Few programs from Latin America have been rigorously evaluated but some have shown promise. Once again, most of these programs have improved knowledge and attitudes about contraceptives and HIV but few have shown a measured difference in behaviors or health outcomes (Cáceres, Rosasco, Mandel, & Hearst, 1994; Gallegos, Villarruel, Loveland-Cherry, Ronis, & Yan Zhou, 2008; Martinez-Donate et al., 2004). Two successful school-based interventions in Mexico and Chile have shown effectiveness in delaying sexual initiation and affecting risk behaviors (Martinez-Donate et al., 2004; Silva & Ross, 2003): The Teenstar program in Chile, which focused on fertility awareness, showed a marked decrease in pregnancies among the intervention group. In Mexico, "Planeando tu Vida," showed an increase in contraceptive use (Cabezón et al., 2005; Pick de Weiss, 1994). Only two interventions, the Chilean "Decision Adolescente Responsible" (Responsible Adolescent Decisions) and two programs in Mexico, involved parents in any way in the intervention (Cabezón et al., 2005; Campero et al., 2011). Though intensive programs have many benefits, in a practical setting attrition is often a drawback to these programs, making it important to find shorter interventions in Latin America that have been proven effective.

Justifications for parent-child connectedness interventions

Curriculum based interventions for youth have often been the focus of pregnancy prevention interventions. These programs are generally implemented in group or school settings

and only focus on youth. However, evidence has shown that it is important to also focus on parent-child connectedness and communication. In 2002, Jaccard, Dodge and Dittus developed a conceptual framework outlining the barriers and facilitators to parent-child communication about SRH. The authors began by outlining the justifications for increasing this type of communication. First, communication is important because it enables parents to discuss the concepts that they feel are appropriate for their children and are consistent with their values. Secondly, parents can individualize the message for their own children and families, something that cannot be done in group based interventions targeted towards teens (Jaccard et al., 2002). In addition, as the research on protective factors shows, parent-child communication, monitoring and supervision help to prevent adolescent sexual risk behaviors, thus preventing unplanned pregnancies. Using this framework, one way change adolescent risk behaviors without presenting controversial topics in schools is to equip parents with the tools to address SRH issues with their children as they see fit.

Jaccard and colleagues explain that barriers to communication include a lack of knowledge and skills to communicate effectively. Additionally, poor cooperation between the two parties, efficacy of communication, and fear that by discussing these themes parents could encourage sexual activity inhibit parents from discussing these important issues. Environmental constraints such as finding the right time and place for these discussions also contribute to the list of barriers. Most importantly, many parents are embarrassed to discuss these issues with their children or are worried their children might not listen to them.

Evidence has also shown that mothers are more likely to talk to their children when they feel they have the proper knowledge, believe that their discussion will help their child mature, do not feel anxious about the discussion, have higher self-esteem and believe that they are

responsible parents if they discuss these issues with their children (Guilamo-Ramos & Jaccard, 2008). In their conceptual framework Jaccard and colleagues suggest that interventions need to help parents become more effective communicators, giving them the necessary skills rather than simply encouraging them to communicate. Though some parent-based approaches have been criticized in the past because of the potential for parents to communicate incorrect information, the authors point out that effective interventions will appropriately convey knowledge that the parents need. In their review of adolescent reproductive health interventions in developing countries, Speizer, Magnani and Colvin only found one intervention that specifically targeted parents, but their findings revealed the need for more multicomponent programs that address multiple risk and protective factors to adolescent SRH. This includes designing interventions that focus on parents, targeting them because of their power to influence their adolescents (Speizer et al., 2003).

Parent focused interventions

In 2002 Kirby and Miller conducted a systematic literature review to analyze interventions that promoted parent-teen communication about sexuality. Interventions, primarily from the US, ranged from multi-session programs that targeted both parents and teens, to mass media campaigns, to programs targeting teens but involving parents through meetings or homework assignments. Other interventions were home-based, using written and visual media to encourage parent-child communication. Though many of these interventions increased parent-child communication about sex, most of them did not measure sexual health outcomes of the adolescents over time, while others were not proven to have an effect on outcomes (Douglas Kirby & Miller, 2002). Though there have been more instances since then where sexual health outcomes were measured, most parent-focused programs to improve communication have

continued to do just that: improve communication and communication skills. Few have been shown to effectively prevent risky behavior (Akers et al., 2011; Wight & Fullerton, 2012). Though some intensive programs have been proven to affect adolescent behaviors, Kirby and Miller are careful to note that these programs do not always reach a large quantity of parents and adolescents because of their intensive nature. In order to have a greater effect it is important to look at those intervention techniques that can reach a large audience (Douglas Kirby & Miller, 2002).

The literature on parent-focused programs in Latin America is similar. One intervention in Mexico combined adolescent education with sessions to encourage parent-adolescent communication. Parents who participated in the intervention reported more general and sexual-risk communication with their adolescent as well as more comfort communicating. However because this was part of a larger intervention, it is difficult to determine whether the communication itself affected the adolescent behavior (Villarruel et al., 2008). Another Mexican intervention focusing on parent-adolescent communication was found to be effective in reducing risk behaviors, improving knowledge, and increasing adolescent access to contraceptives. In the intervention group, the program delayed sexual initiation, increased knowledge of emergency contraceptives and improved access to condoms. It was not shown to increase parent-adolescent communication, but this could be due to the difficulties of measuring communication (Campero et al., 2011). These results show that it is not simply parent-child communication that needs to be addressed in order to decrease risky behaviors among youth but there needs to be a focus on improving communication skills and encouraging monitoring and supervision.

Families Talking Together as an effective and practical intervention

Paraguay's high adolescent pregnancy rates, specifically in low income communities, reveal the need for targeted interventions that can have an effect on risky sexual behaviors in adolescents. The literature has found that risk and protective factors contributing to SRH outcomes in adolescents not only include individual factors but also familial and environmental factors. The conservative culture in Paraguay is resistant to sexual health education curricula in schools but parents can also have a strong influence on their children's behaviors. By empowering parents to discuss SRH topics with their children, those risk behaviors could be mediated. However it is not only through communication that parents can influence their children's behaviors; the parent-connectedness literature reminds us that proper monitoring and supervision as well as how parents model and communicate their values about sexual behavior can also have a strong effect on adolescent behavior (Akers et al., 2011; Douglas Kirby & Miller, 2002; Wight & Fullerton, 2012). Implementing a parent-focused intervention in Paraguay requires adapting an evidence-based curriculum that is appropriate for the culture and gives parents the tools to improve parent-child connectedness and reduce risk behaviors in their children.

One promising program is *Families Talking Together (FTT).* FTT is a parent-focused intervention that includes an emphasis on both monitoring and supervision, and parent-adolescent communication. The program has appeal because it is a relatively short intervention and thus can reach more audiences in a smaller amount of time than some intensive interventions can. FTT was originally developed for Latino and African American parents in New York to increase parent-teen communication about sexual health. Through a randomized clinical study design the intervention was proven to be effective in reducing risky behaviors by targeting mothers and encouraging them to increase communication about sexual health, monitoring and supervision of their adolescent.

FTT originally targeted mothers of young adolescents ages 11-14 in health clinic waiting rooms. An "interventionist" would work with mothers for 30 minutes while their child was being attended by a physician. The interventionist would encourage communication about sexual behavior and proper monitoring and supervision of their adolescents. The mothers were then sent home with intervention materials and exercises to practice the skills with their children. They received follow-up calls to support their skill-building. The intervention targeted younger adolescents, with the hope of delaying sexual initiation in this young population. The intervention was found to be effective in delaying vaginal sexual intercourse and decreasing the frequency of sexual intercourse. There was also an apparent delay in oral sex as well, although not at the expected level of statistical significance (Guilamo-Ramos, Bouris, et al., 2011).

The intervention was then adapted for a group-based setting. This intervention was tested against an evidence-based intervention that targeted only youth, and a combination of the two interventions where adolescents and their parents were both targeted. The adolescents whose parents participated in FTT reported higher levels of parent-adolescent communication and significantly lower levels of risky sexual behaviors. No significant differences in adolescents' sexual behaviors between the three interventions were found, suggesting that the parent-only intervention was just as effective as the more intensive youth-focused intervention (Guilamo-Ramos, Bouris, et al., 2011; Guilamo-Ramos, Jaccard, et al., 2011). FTT is unique in that it is relatively brief and focuses on mothers of young adolescents who are in seventh and eighth grade, allowing mothers to learn how to communicate information that they think is appropriate for their son or daughter. Giving parents tools to communicate about SRH while also giving them more control over what and when their child learns about SRH topics could be an effective way to educate adolescents and prevent adolescent pregnancies in Paraguay.

Chapter 3: Methods

Study Site

Paraguay, the second poorest country in South America after Bolivia, consists of 6.5 million people. The country, small and landlocked, relies principally on agriculture to support its economy. With a per capita GDP of 3, 625 US dollars, Paraguay is also an incredibly unequal society. It ranks as the 16th most unequal country in the world with a GINI coefficient of 53.2 and 34.7% percent of the population living below the poverty line ("CIA - The World Factbook: Paraguay," 2012; UNICEF, 2010). Despite the poverty and inequality, it is an under-researched country that is often shadowed by its neighbors in the Southern Cone.

The poverty and inequality in Paraguay is reflected in the study site itself. The majority of this research was conducted in what is traditionally referred to as the *Bañado Sur*, a neighborhood officially recognized as part of "Republicano," Asunción, Paraguay. The *Bañado Sur* is a settlement that has existed on the banks of the *Rio Paraguayo* for sixty years. Participants originally settled there when they had moved from the countryside to the city or when increased poverty and housing costs pushed them out of other poor neighborhoods of Asunción (Navarro & Perrotta, 2003). Until the early 2000s the area was not recognized on official maps of Asunción however pressures from community organizers have recently forced its recognition as part of the municipality. Despite its official recognition, many still do not officially own the land they live on. The government began to give "occupation rights" to inhabitants of the *Bañado* but these rights only serve to organize the neighborhoods politically; the government still has the right to take the land away if it ever desires (Navarro & Perrotta, 2003).

The lack of formal recognition reflects the general marginalization of the community. The *Bañado* is often described by inhabitants and even more frequently by outsiders as a place characterized by violence, drug and alcohol addiction. Most workers earn less than the official Paraguayan "Minimum Wage" of about 1, 600,000 *Guaranies* ($355 US Dollars) per month. The *Bañado* is situated near one of the municipal garbage dumps and thus one of the most common sources of income is collecting and selling recyclables from the landfill. Other sources of income include domestic service and agricultural work (Zibechi, 2008).

In this environment, teen pregnancy and school dropout rates are high. To combat these rates, a community-based non-governmental organization, *Mil Solidarios*, provides after school programs and financial incentives for middle and high school students to encourage them to stay in school and continue on to higher education. M*il Solidarios* operates three facilities in the *Bañado Sur* to support the community and encourage educational achievement. Two of the facilities offer after school enrichment activities to students age 11-18 and monthly stipends for those who meet established educational requirements. The site that serves 6^{th}-8^{th} graders and 12^{th} graders is referred to as *RAPE,* another site, referred to as *Santa Librada*, serves students in secondary school. The third site is referred to as *CAFA (Centro de Atención Familiar)* or the Center for Family Development. This site serves as a community center and supports women who have children and are continuing their high school education. Women age 15-45 attend weekly meetings and come to the center for homework help. These women are also given a small stipend to help curb the costs of attending adult schools (Bello, 2012).

Mil Solidarios served as the main partner during this research as part of an on-going relationship with Emory University and Dr. Karen Andes, a professor in the department of Global Health at the Rollins School of Public Health. Dr. Andes has worked with organizations in

Asunción for nine years and supervised two other graduate student projects in the *Bañado Sur*. In previous years, graduate student research has revealed the need for more sexual health education for parents and children involved in *Mil Solidarios*. These experiences not only supported the need for reproductive health education but also proved that the partnership would provide mutual benefits. While the research would provide *Mil Solidarios* with a curriculum they could use with parents, *Mil Solidarios* could facilitate access to parents and their children who live in the *Bañado Sur*, and connect me with key informants who worked with the population. These connections would allow me to conduct formative research about the feasibility of a parent-focused pregnancy prevention intervention in marginalized areas in Paraguay.

Intervention: Families Talking Together

The *Families Talking Together* (FTT) intervention addresses many of the worries about pregnancy prevention that other Emory students identified when in the *Bañado Sur*. I translated and adapted the FTT facilitation protocol to be used in Paraguay using the clinical training materials developed and shared by the FTT team from New York University. The guide was then revised by a volunteer at *Mil Solidarios* who teaches parent education classes at *RAPE* and later implemented with three different groups of parents.

The adapted intervention in the *Bañado Sur* consisted of two one and a half-hour sessions with parents to implement the curriculum, along with a third follow-up session. The first session focused on the importance of discussing SRH with adolescent children, presented the current statistics of teenage sexual initiation and pregnancy and discussed the pressures adolescents face to have sex.

The second session focused on skill-building. A facilitator from *Mil Solidarios* or myself lead discussions about the social reasons that adolescents had sex, and parents then practiced

discussing these topics with their children through role-playing activities. At the end of the session, parents were given a set of FTT materials: one for themselves and one for their adolescents. They were asked to commit to giving their children the materials and talking about the subject with them.

During the third meeting, the parents who attended discussed their challenges and their children's reactions to the materials. They also participated in a focus group to give feedback on adaptations to the materials.

Research Design

This project used qualitative methods to understand how the intervention was accepted in the *Bañado* as well as its feasibility and potential for adaptation. In order to assess these aspects the project began with an exploratory phase including focus groups with adolescent mothers and key informant interviews. The intervention was then implemented, and subsequently interviews and focus groups were conducted with adolescents and parents in order to assess their reactions to the intervention and the potential for adaptation. These methods were used to understand parents', adolescents', and key informants' perspectives of the causes of and trends in adolescent pregnancy among marginalized populations in Asuncion, the acceptability of FTT, and recommendations for program adaptation. Qualitative methods allowed a better understanding of the community's perceptions and provided a platform for unanticipated themes to arise. This was particularly important because of the exploratory nature of the project.

Exploratory phase

Before implementing the intervention, I conducted preliminary focus groups with adolescent mothers who attended CAFA to understand their history of communication about SRH with their parents and families. Data from this focus group aided in adapting the intervention to

incorporate relevant themes in the *Bañado Sur*. These preliminary focus groups also helped determine the appropriate age to administer an intervention such as FTT to adolescents. Additionally, a meeting was held with an advisory committee at *Mil Solidarios* to inquire about the staff's opinion about the appropriate age to begin these conversations. Both the adolescent mothers and *Mil Solidarios* staff agreed that talking about SRH was appropriate with adolescents twelve years and older.

Key informant interviews were also conducted with professionals who could comment on their experiences working with parents and their children. While focus groups and interviews with parents and children presented the detailed personal experiences of community members in the *Bañado Sur*, the key informants contributed their expertise in certain components of the topic and provided a general overview of teen pregnancy in the *Bañado Sur* and in Asunción.

Intervention implementation

After discussions with an advisory committee from *Mil Solidarios* I recruited mothers who had adolescents 12 to 18 years old to participate in the FTT intervention. Though the original FTT program targeted adolescents 11-14 years old, the project in Paraguay was designed to pilot the materials rather than measure the effectiveness of the intervention (materials can be found at http://www.clafh.org/files/Teen_Sex_Spanish.pdf and at http://www.clafh.org/files/TheBasics_spanish.pdf). Mothers of older adolescents were also recruited in order to have a large enough sample size to reach saturation and receive varied feedback about the intervention.

Assessment

In order to assess reactions to the intervention and understand ways in which the intervention could be adapted for the community, I conducted focus groups with parents. Focus

groups provided an opportunity for parents to share their experiences talking to their children and allowed them to compare and contrast techniques that they used to communicate. These discussions also allowed the groups to think together about the best way to implement the intervention in the *Bañado Sur* in the future and suggest adaptations. I also conducted individual interviews with adolescents 12 years of age or older whose mothers had participated in the intervention. Interviews were the most appropriate data collection method in this case because though participants were not asked any direct questions about their sexual habits, discussing sexual and reproductive health can be a sensitive topic especially for teenagers. Additionally, participants may feel more comfortable sharing their thoughts and feelings in a confidential setting rather than surrounded by peers in an environment such as a focus group.

Study Methods

Method 1: Preliminary focus groups

Exploratory focus groups were conducted with the CAFA adolescent mothers to understand the experiences of pregnant teens and their exposure to sexual health education and parental communication before their pregnancies. Discussions with these participants served to better understand the appropriate age to target SRH education as well as to identify the issues that most influenced adolescent pregnancies, providing information on where to target prevention efforts.

Sample, Setting and Recruitment

Females ages 15-19 who had a child and attended the *Mil Solidarios* CAFA high school support program were identified as potential focus group participants. Participants were recruited through the center's director who briefly explained the project purpose and invited the potential participants to attend the focus group on a predetermined day. During this time I was also present

if the potential participants had any questions about the research project or wanted more details about the focus group. Adolescents who were invited and chose to participate returned to the center on the scheduled day to participate. Two focus groups were conducted with five participants each. The discussions were conducted at the CAFA center where the high school support program normally took place. The discussions were conducted in a separate, detached room in order to ensure confidentiality.

Procedures

The participants were informed of the procedures and content of the discussion when they arrived for the focus group discussion. After the participants gave oral consent I led the discussion using a semi-structured focus group discussion guide (found in Appendix 1). The discussion focused on several topics, the first being the history of communication with the participants' parents and other adults about SRH before they became pregnant. The discussion then focused on where the adolescents received their information about SRH and the age at which they thought parents should begin to discuss SRH with their children. A research assistant was present during the second discussion in order to track the conversation for transcription purposes, but was not present for the first discussion. One focus group lasted slightly over half an hour while the other lasted 50 minutes.

Method 2: Key informant interviews

Though parents and their children contributed to the assessment of the intervention by giving their perspective, key informant interviews helped to understand overall trends in adolescent sexual health. The key informants, who were professionals experienced in implementing interventions, also gave valuable feedback on how to adapt and implement FTT. The purpose of the interviews was to understand the informants' perceptions of the most pressing

issues in adolescent sexual health in Paraguay, as well as their opinions on sexual education and the feasibility of a parent-based sexual education program such as FTT.

Sample, Setting and Recruitment

Potential key informants were identified during the first five weeks of the project by establishing relationships at *Mil Solidarios*, the *Instituto Nacional de Salud*, and CEPEP (*Centro Paraguayo de Estudios de la Poblición*—Paraguayan Center of Population Studies). After identifying seven possible key informants at *Mil Solidarios*, I invited them to participate in interviews which were conducted at the *Mil Solidarios* facilities. I also identified one key informant, a doctor and public health practitioner, at the *Instituto Nacional de Salud* who was asked to participate and also accepted. Through relationships with researchers at CEPEP, I was able to contact and interview two key informants who were doctors. Key informants were chosen so that they would have specific expertise in a variety of issues in adolescent health and reproductive health. The doctors offered a medical perspective of the state of adolescent health in low-income populations and were also experienced in implementing interventions. The key informants from *Mil Solidarios* included program directors, psychologists, social workers and a parent educator who presented and coordinated parent meetings. These informants had seen many cases of adolescent pregnancies and worked directly with families. They saw how parents could be effective in talking to their children and how adolescents might be influenced by their parents' or guardians' advice.

Procedures

Each interview lasted between 45 minutes and 1 hour and followed a semi-structured interview guide found in Appendix 2. I conducted the interviews in the homes or offices of the key informants depending on their preference. The first part of the interview focused on the key

informants' perspectives of what adolescents knew about SRH and family planning methods. The latter half of the interview focused on the key informants' opinions of the feasibility and acceptability of a parent-based sexual education program such as FTT in Paraguay.

Method 3: Intervention implementation

Sample, setting and recruitment

Participants were recruited to participate in the intervention from two different *Mil Solidarios* sites. The first site was at *Mil Solidarios* RAPE, where parents meetings are held weekly for parents whose children attend either *Santa Librada* or RAPE. The meetings are overseen by a volunteer parent educator and segmented by students' grade level into three classrooms led by volunteers. I consulted with the parent educator prior to project implementation and she and the *Mil Solidarios* staff thoroughly supported the intervention. During the parent meetings the intervention was presented to parents and they were invited to participate. Participation was completely voluntary and parents were informed that their participation would have no effect on their children's standing with *Mil Solidarios*. The intervention was then offered during the regular parent meetings. The intervention was implemented with two different groups at RAPE, first with the group that had been attending meetings for 2-3 years, then subsequently to the rest of the parents. At RAPE a total of 41 women and 3 men participated in at least one of the three intervention sessions. Nine women and 2 men completed the entire intervention series at this site. Attempts to contact mothers who did not attend the third session, a debriefing session, were made with varying success.

A group of mothers who attended the high school support classes at CAFA and had children ages 12-18 at the high school support site were also recruited to participate. At this site, the opportunity to participate in the intervention was presented during a normal site meeting and

participants were asked to return at a set time and date to participate if they qualified and wanted to participate. The research assistant called them on their cell phones to remind them of the meetings the day before each meeting took place. Thirteen women at CAFA participated in at least one of the intervention sessions and 4 women completed the entire intervention series.

Procedures

The curriculum was implemented with the first group of parents at RAPE by myself with support from the parent educator who helped lead the discussion and translated or clarified words in Guaraní for parents who needed that clarification. After watching the implementation of the curriculum, two parent educators facilitated the intervention at RAPE with the third group of parents while an assistant researcher took field notes. The FTT sessions at the CAFA site were conducted by me with my research assistant present. I collected field notes during the sessions with the help of a research assistant and a fellow RSPH student who was also conducting research in the area.

Method 4: Focus groups with mothers

Sample, setting and recruitment

Focus groups were conducted with the mothers after the intervention to understand their reactions to FTT and solicit their advice about ways in which the intervention could be adapted and improved. Parents who participated in the intervention were invited to participate in the focus groups, which were conducted during the third intervention session. Focus groups with parents were held at the same facilities where they attended intervention sessions in private classrooms in order to ensure confidentiality.

Procedures

The focus groups were conducted immediately after the third intervention discussion. A research assistant accompanied me during the focus groups to take notes for transcription purposes and to translate anything discussed into Guaraní. The topics for the focus group discussions for mothers followed a semi-structured guide (found in Appendix 3), which focused on the participants' reactions and responses when discussing SRH with their children and their feedback on the intervention itself. At the *Mil Solidarios RAPE* site one focus group included six participants while the other included four. At the CAFA site, the focus group included four participants. Each focus group lasted between fifty and seventy minutes.

Method 5: Individual interviews with adolescents

In order to understand adolescents' relationships with their parents and significant others as well as to assess their reactions to the intervention materials and post-intervention discussions with their parents, I conducted individual interviews with them. Individual interviews allowed the adolescents to share their thoughts on the subjects without influences from their peers or parents.

Sample, Setting and Recruitment

After mothers who participated in the intervention gave consent, I made contact with their adolescent children while they attended classes at *Mil Solidarios* and invited them to participate in an interview. Adolescents were recruited to participate if their mothers had attended at least the first two intervention sessions and they were present at the *Mil Solidarios* centers. All of the adolescents agreed to participate, however one girl asked not to be recorded during the interview. During that interview I took notes instead. A total of 17 adolescents (10 girls and 7 boys) were interviewed. There were 12 adolescents I interviewed whose parents also participated in the focus groups were interviewed in addition to 5 other adolescents whose parents only attended the first two intervention sessions. This allowed me to ask them not only about their lives and previous

communication with their parents, but also their perceptions of the educational materials their mothers brought home.

All interviews took place at the two *Mil Solidarios* centers *(*RAPE and *Santa Librada)* that focus on youth development and secondary education. After approval from the *Mil Solidarios* site director, students were called out of class and asked to participate. *Mil Solidarios* staff provided a private room to conduct the interviews.

Procedures

Before the interviews, the discussion guide (found in Appendix 4) was piloted with the research assistant to ensure that the questions were understandable and culturally appropriate and then approved by *Mil Solidarios* administration. The interviews with the adolescents centered around communication about SRH issues with parents and other community members, perceptions of parental monitoring and supervision and the adolescents' reactions to the FTT materials. The adolescents were first asked briefly about their relationships with their family and significant others and their history of communication with their parents about relationships and sexual health. They were then asked whether they had received the FTT materials from their parents and how their parents had presented them with the materials. Finally, adolescents were asked about their preferences in how they receive information about SRH. Interviews lasted between 15 and 45 minutes, with most lasting between 20 and 25 minutes.

Data preparation and analysis

Preparation

All focus groups and interviews were conducted in Spanish, one of the two official languages of Paraguay. During most focus group discussions a research assistant helped take notes for transcription purposes as well as translate any words from Guaraní, the other official

language, to Spanish. All focus groups and interviews apart from the aforementioned individual interview were recorded and transcribed verbatim. I transcribed the majority of the focus groups and interviews, de-identifying the content while transcribing. When portions of the recording were unclear, I listened with my research assistant who translated any phrases from Guaraní and helped verify the transcription. All Guaraní phrases were translated to Spanish and included in the transcriptions in square brackets. In order to speed up the transcription process and ensure appropriate translation of Guaraní to Spanish I sent three of the focus groups and two individual interviews to a professional transcriber. I then verified and de-identified those transcripts myself. All transcripts were verified a second time and edited if necessary. The data was analyzed in Spanish in order to stay as close as possible to the original language and meaning. The segments presented in this document were translated to English during the write-up process.

Analysis

The focus groups and interviews were analyzed thematically in order to understand my original questions and identify other themes that arose in the data (Hennink, Hutter, & Bailey, 2011). I chose not to include the adolescent mother focus groups in the analysis because they primarily informed program implementation and contributed little to the understanding of parent-child sexual health interventions.

All analysis was performed using MAXQDA10 software (VERBI Gmbh, 2011). Initially, I applied four structural codes (current situation, materials, reactions to the intervention, modifications) to each transcript in order to segment the transcriptions into different topic areas. I then conducted focused readings of several transcripts from adolescent and key informant interviews as well as one focus group to identify common themes and definitions that would apply to all three types of data. Reading through another focus group transcript and several more

interview transcripts confirmed that the original codes remained relevant, and identified several additional codes representing recurrent themes in this second set of transcripts. The codebook includes the 4 structural codes and 14 thematic codes. The thematic codes consisted of sexual and reproductive health themed codes including: contraceptives, sex, biological reproductive health, pregnancy and STIs. The codebook also includes codes that refer to more social themes: romantic relationships, parent-child relationship, love, trust, peers, gender, monitoring, and violence (see Appendix 5).

After all transcriptions were coded, I was able to focus the analysis on four main themes: Current sources of information and influences on adolescent sexual health, Reactions to the intervention, *Families Talking Together* materials, and Modifications and recommendations for parent focused pregnancy prevention interventions. Using the coded segments, I analyzed each type of data separately and then triangulated the results in order to understand how the perspectives of parents, key informants and adolescents converged or diverged.

Ethical Considerations and Data Management

The research protocol was reviewed by Emory University's Institutional Review Board and approved in an expedited review process. Three amendments were made to the research protocol while in the field; each one of those amendments were reviewed and approved by Emory IRB. All participants were consented during an informed consent processes. During the adolescent mother focus groups, a consent form was read aloud and participants were given a written copy of the form. If they agreed to participate (which they all did), they gave oral consent. Paraguayan law considers minors emancipated when they become sexually active, thus the adolescent mothers were treated as such during the consent process (Scholl, Rosen, Aguilar, Romero Rossi, & Gonzalez, 2005).

In the intervention groups, mothers received a consent form and the researcher explained the research protocol to them. They then gave written consent for themselves and their children to participate in the focus groups and interviews. Adolescents who were interviewed gave informed written assent before participating in an interview. Key informants were given the option of remaining anonymous or allowing themselves to be identified in the research. If they allowed themselves to be identified they signed a written consent form. All participants were informed that even though they signed the consent form, they were free to end their participation at any point in time. In this data all participants are de-identified to maintain confidentiality.

A research assistant or parent educator who spoke Guaraní was present during all the intervention sessions and focus groups to translate anything that the participants or I said if translation was necessary. The research assistant, who was present during the focus groups, completed the FHI Research Ethics Training Curriculum. Recordings and identifiable data were kept in a password protected file that only I had access to. Once the recordings were transcribed and the transcripts verified, the recordings were destroyed.

Data Quality and Limitations

Several limitations were identified while implementing the intervention component of the research. Parenting sessions were encouraged for all parents of *Mil Solidarios* students, however they were not required. Thus the sample of parents who participated included those parents who were most willing and able to attend to the parenting sessions. Many of these parents had attended previous parenting sessions where they had discussed effective communication with their children. Therefore the parents who participated may have been more aware of the issues we discussed than typical parents in the *Bañado Sur*. Additionally, though many parents attended several sessions, few attended the whole session series including the focus group. This difficulty

in achieving consistent attendance is addressed in the Results section, however it is also important to note because the parents who attended all the sessions and focus groups were those who were most enthusiastic and open to discussing SRH with their children.

I made every effort to encourage parents who spoke Guaraní more than Spanish to participate in both the intervention and the focus groups. Nevertheless, some participants might have chosen not to return for the focus group because they did not feel comfortable with a facilitator who only spoke Spanish. While implementing the intervention and conducting the focus groups, there was always a facilitator or assistant present who spoke Guaraní, however, most of the intervention was presented in Spanish and the materials were in Spanish. Thus, language barriers may have dissuaded some participants from participating fully.

Chapter 4: Results

The key informant interviews, focus groups and adolescent interviews all discussed common themes relating to Families Talking Together and sexual health education such as sources of information about sexual and reproductive health, reactions to the intervention and materials, and possibilities for adaptations in the future. This chapter is separated into four sections: Current Sources of Information and Influences on Adolescent Sexual Health, Reactions to the Intervention, *Families Talking Together* Materials and Modifications and Recommendation. Some of these sections rely heavily on the data from one group of participants because those discussions focused heavily on one theme, while other sections contain equal contributions from all types of participants.

Current Sources of Information and Influences on Adolescents' Sexual Health

The key informant interviews concentrated heavily on the informants' perceptions of where adolescents received their information about sexual and reproductive health and the causes of early sexual initiation and pregnancy. Adolescents were also asked where they received information about SRH; those discussions frequently led to discussions about the pressures and influences on adolescents to have sex. Although the parent focus group discussions did not concentrate on how their children received information, the theme also emerged during these conversations.

Influences on knowledge and actions

All participants discussed societal and cultural pressures to have sex as one of the strong influences on adolescents' behaviors. Many key informants believed adolescents felt pressure to

have sex early, but that the pressures were different for boys and girls. While boys might feel a cultural or societal pressure, girls felt the pressure from their boyfriends and other peers. Key informants and parents both mentioned that boys in Paraguay are expected to be "macho," which can be is demonstrated by having many girlfriends. This expectation encourages boys to feel as if they need to have sex early. In the boys' case, many key informants and several parents and adolescents said that both families and peers apply this pressure.

Girls in Paraguay are expected to be docile, and often times their parents do not allow them to have boyfriends when they are teenagers. Yet this does not prevent pressure; many key informants and girls discussed how boys and other peers will pressure them to have sex. Girls and key informants mentioned in their interviews that boys use the idea of a "prueba de amor," or proof of love, to pressure them, telling girls that if they really loved them, they would have sex with them.

> *And they say to you, "you have to show me that you love me," and all those things. Or the boyfriends try to sweeten you up, [the girls] say that's how he loves you, and then they can take you anywhere. You have to be aware of what they're saying"*
> *--13 year old girl*

Several girls told me stories about when they themselves had been pressured by their boyfriends or friends. One 13 year old girl told a story about when she had been pressured to have sex by her boyfriend, and a separate instance where several male friends had asked her why she was still a virgin. A 15 year old girl said there had been a man in her neighborhood following around several girls trying to convince them to go to his house and have sex. One girl also echoed an opinion that many other key informants had stated, saying that if a girl has a boyfriend, once they are in a relationship it is expected that they have sex.

A little less than half of the boys acknowledged pressures on them to have sex, however they never said so spontaneously. I began to ask the boys what kind of pressures to have sex they

experienced after many participants, including key informants, parents and female interviewees, mentioned this pressure. While one of the boys said he didn't think there was any pressure, two boys said that they might be called gay if they didn't have sex, and one boy even said that boys could be pressured by both their friends and girlfriends.

> *Interviewer: It's the girlfriends who pressure them?*
> *Respondent: Sometimes the two kids pressure each other, him and her. Sometimes my friends say, "No because we're too young" and sometimes the girls….my girlfriend was broken up with because of that, she told him she still didn't want to do it and he (her old boyfriend) broke up with her.*
> *I: Ok. That's interesting because at the end of these materials they discuss the pressures to have sex. From your point of view, what are some of the pressures on boys to have sex?*
> *R: For boys, if their girlfriend makes them, or his friends start to say he's gay, homosexual, all of that.*
> *I: His friends will tell him that?*
> *R: Yeah, sometimes. That pressure, or the girl will leave him. She'll tell him she's going to leave him if he doesn't do it.*
> *--15 year old boy*

In addition to cultural norms and peer groups, the media was also viewed as an influential factor in early sexual debut. Key informants believed explicit material on television made adolescents think they should have sex early. One group of parents discussed the presence of sex in TV shows as well. They said they had difficulty shielding their children from this influence because of its constant presence.

> *My 8 year old son asked me about sex because on TV now you see butts, breasts and sex. I didn't know what to tell him so I evaded his question. It's worse now than the internet.*
> *--Mother*

Key informants also mentioned the influence of the internet, where adolescents could easily access pornographic material. Though the adolescents themselves didn't directly mention porn, several of them said they had learned about SRH on the internet, and one girl said that she sometimes chatted with people who would mention sex and had asked her if she was a virgin.

Sources of information

The first step to helping adolescents make informed, healthy choices is giving them the proper information about SRH. Both adolescents and key informants were asked where

adolescents learned about SRH topics. The parent discussion guide did not include a question specifically pertaining to this topic, however it did come up in the focus group discussions. The main sources identified by the three groups were through schools, peers and parents.

Schools

All participants agreed that schools were one of the main sources of information about SRH for adolescents. However different groups of interviewees perceived the quality of that information differently. Almost all of the adolescents, except one of the youngest boys, reported learning about SRH in school. Many said there had been similar discussions at *Mil Solidarios.* They reported learning about STIs, HIV and contraceptives, and occasionally reproductive health topics such as menstruation. When I asked one of the older girls who reported learning about contraceptives in school whether she knew where she could actually access contraceptives, she said no. On the other hand, two boys who reported learning about condoms said that they and their friends went to the Centros de Salud (Health Centers) to get them.

In response to these sexual health lessons, the students said that adolescents would giggle, become embarrassed, or not pay attention during sexual health classes. When the adolescent interviewees were asked about what they personally thought of those lessons they generally expressed interest in the topics and said that they paid attention. One girl said that she sometimes felt silly during the lessons because she didn't know much about the topics while other kids did. Another girl said that a lot of kids laughed and joked about the lessons because they weren't really ready to have sex with anyone.

> *Interviewer: And where did you learn about STIs?*
> *Respondent: At school, and here at Mil Solidarios they sometimes tell you about them.*
> *I: Uh huh, y what kinds of things do they tell you?*
> *R: That I have to protect myself, I mean, that the guy has to use condoms and I have to take pills so I don't get pregnant.*
> *I: And when they talk to you about that what do the kids think?*
> *R: Well they laugh. Because some of them aren't ready to sleep with anyone. They take it as just a joke.*

> *I: And what do you think when they speak about these things in the school or here at Mil Solidarios?*
> *R: Well that I have to do everything that they tell me so I don't get sick or anything. Because there are some that have the disease and no one wants them anymore, they have to get treatment and those kinds of things.*
> *--Sarita, 14 years old*

Parents also reported that their children learned about SRH topics in school and at *Mil Solidarios.* Some parents agreed that their children received plenty of information about SRH in school, citing lessons on condom use and menstruation that their children had recounted to them. On the other hand, many parents also believed that the education in the schools was not thorough, nor did it focus on the emotional side of sex. One mother was surprised that when she sat down to discuss the FTT topics with her daughter, her daughter asked her about AIDS:

> *Parent: We were talking, and she asked me, for example, how does someone get infected with AIDS and all that…*
> *Interviewer: She didn't know how?*
> *P: No, she still didn't know, and I said to her, "But they still haven't taught you that in school?" and, "Yes, yes they teach us" but she was asking me again … because she wanted to know. So we kept talking.*
> *--Focus Group Discussion*

Key informants were more critical of the information that was presented in the schools. The older key informants who had more experience working in sexual health overwhelmingly pointed out the failures of the sexual education curriculum. One doctor said that although the school health curriculum discusses STIs and pregnancy, it does not discuss how to prevent pregnancy. Others stated that teachers were supposed to present SRH lessons but were often too embarrassed to present them thoroughly. The younger group of key informants, all staff at *Mil Solidarios*, thought that students did receive information about contraceptives and condoms in school, but the problem lay in the practice. They said that students were taught about contraceptives at school but weren't taught how to use them. Several of the key informants also believed that schools needed a more rights-based approach to sexual education and should teach students how to resist pressure.

Key informants also mentioned that teenagers received information from health centers or directly from workshops that *Mil Solidarios'* staff presented focusing on the consequences of early sexual initiation and how to use condoms. At the same time, they admitted that they couldn't focus wholeheartedly on sexual education because of the controversial nature of the topic in the country.

> *At school they receive very little information. I'm not sure if you're heard what the Marco Rector for sexual education is, but it has been stopped by the House of Representatives and the senators who are in reality a group of conservative politicians. But we…the little information that the kids receive in schools combined with a little bit of what we tell them, which isn't very open either, but we have had workshops about those things with them, about sexuality, diseases. That's all the information they have.*
> *--Mil Solidarios staff member*

One staff member said that when she talked to her students she focused on discussing healthy relationships and respect between partners. Several of the professors said they discussed topics individually with students when the subject arose, but one staff member admitted that she was also a little embarrassed to talk about the topic or probe too much when discussing sex and relationships with her students.

The older key informants who worked at regional and national levels discussed the controversial nature of sexual education and parental resistance to implementing a national sexual education curriculum. However, in the *Bañado Sur* parents were very open to the idea of sexual education and even asked that there be more sexual education at *Mil Solidarios.*

Parents

About two thirds of adolescents reported that they had discussed SRH topics with their parents. One third also expressed at the beginning of the interviews that they had very good relationships with their mothers and trusted them. This suggests that parents and adolescents who have stronger relationships are more likely to discuss SRH topics.

The content of these conversations differed between boys and girls. All of the girls said that their parents told them to "*cuidarse*" or "take care of themselves," meaning in this context to take measures not to get pregnant. However none of the girls reported that their parents spoke to them specifically about contraceptives or condoms.

> *Interviewer: And your mom, you said you speak with her a bit, she just tells you to take care of yourself?*
> *Respondent: Yes, to take care of myself so that I don't get pregnant.*
> *I: Has she spoken to you about different ways to take care of yourself?*
> *R: No, she just tells me that [to take care of myself](laughter).*
> *--17 year old girl*

It was more common for the parents to tell them to wait to have sex, to continue in school, and to be sure not to get pregnant so that they could keep studying. Only one girl mentioned that her father had discussed HIV/AIDS with her. Most of the girls reported talking to their mothers about SRH, but several whose fathers played an active role in their lives also reported discussing the topics with them.

Fewer boys reported discussing these topics with their parents. Those boys who reported having conversations said that their mothers told them to protect themselves for two reasons: because they could impregnate a girl or they could get an STI. The two boys who specifically told me they had good relationships with their mothers also said their mothers spoke to them about condoms. One boy, whose mother had been less explicit when speaking with him, told him not to impregnate anyone because he would be considered a bad person in his neighborhood for impregnating a girl so early. Two boys' mothers told them that impregnating someone could mean that they would have to take on an extra responsibility early and perhaps drop out of school. One boys' aunt and uncle told him to be careful of STIs and another boys' mother talked to him about AIDS because she had a friend who died of the infection.

Some key informants said that parents don't speak to their children about SRH, however many parents in the focus group discussions reported discussing these issues with their

adolescents before the intervention was implemented. Several others admitted that they had never talked to their children before the intervention. Key informants and parents alike believed this lack of communication was due to parents' embarrassment. In addition, all of the parents in two of the focus groups noted that their parents had never discussed SRH with them, and thus it was very hard for them to discuss it with their sons and daughters.

At the beginning of the FTT intervention, parents participated in an activity where they were asked what they thought was the main reason they didn't talk to their children about SRH topics. In the front of the room there was a piece of paper with seven choices; parents were asked to place a sticker next to the choice that most applied to them.

Why haven't you talked to your child about sex?

- ☐ I'm embarrassed/my son or daughter will be embarrassed (10 stickers)
- ☐ I feel uncomfortable because I had sex at an early age (5 stickers)
- ☐ I don't feel prepared to talk to him/her (4)
- ☐ If I talk to them about this, they'll think about it more (3)
- ☐ I don't know enough to talk to him/her (2)
- ☐ My son/daughter will learn about this somewhere else (1)
- ☐ It won't make a difference (0)

Some parents stated that they already discussed these topics with their children, in which case they were instead asked why they thought other Paraguayan parents didn't talk to their children about SRH topics. The most commonly chosen reason was "I'm embarrassed/I think my son or daughter would be embarrassed," followed by "I feeling uncomfortable discussing these issues because I had sex at an early age" and "I don't feel prepared to talk to my son or daughter." Several parents were afraid that if they discussed the topic their child would start thinking about it more. One mother said that she thought her child would learn about the topic somewhere else. It is important to note that one of the choices that parents were given was "I don't talk to my child about sex because it won't make a difference," however not a single parent marked that option.

When asked how the adolescents felt when their parents talked to them about these topics, most of the interviewees said they didn't frequently ask questions or engage in conversation if their parents discussed these topics. The adolescents did say that they felt "fine" or a little embarrassed when their parents talked to them but most said they knew their parents were talking to them for their own good. When asked who they preferred to talk to about sex and protection, a little less than half of the participants said they preferred talking to their mother or the main female caregiver. One boy said he preferred talking to his father because he was a man and understood him. Another girl expressed at the beginning of her interview that her grandmother had influenced her decision not to have sex:

> *[My grandmother] tells me not to have sex before I'm fifteen because I could get pregnant. And I say, "Ok". And once I was going to do it, but then I remembered my grandmother, and I didn't do it.*
> *--14 year old girl*

There were several adolescents who said at the beginning of the interview that they didn't talk about these subjects with anyone. However, two of these same girls later said that their mothers had discussed pregnancy with them previously and told them not to get pregnant. Only two boys said they had never talked to anyone, and one girl said she didn't talk to her family about relationships in any way.

Peers

Key informants and adolescents said that peers did provide a certain amount of information about sexual and reproductive health but key informants did not think it was very comprehensive. Several female adolescents told me that they had discussed sex with their friends who had already had sex but in most instances they would just listen to their friends' stories. The few boys who mentioned they talked to their friends said they talked about their girlfriends and sex occasionally but it was usually jokingly.

Interviewer: Do you friends talk much about sexual relations?
Respondent: Yes, in all truth they do, when someone mentions it they do talk, but it's always a joke, nothing serious.
--16 year old boy

The key informants said adolescents often received poor information from their friends, which perpetuated myths about pregnancy. The doctors, Mil Solidarios staff and girls recounted many myths that they had heard from other adolescents, including inaccurate information about the rhythm and withdrawal methods and the common belief that a girl cannot get pregnant the first time she has sex. One staff member said adolescents will listen to the advice and anecdotes from their friends and then combine all of those anecdotes to come up with ideas about sexual health that are not accurate. Another Mil Solidarios staff member said that sometimes girls will take their friends' incorrect advice about contraceptives and self-medicate, which can lead to unplanned pregnancies.

They speak very little with their parents, and everything else they learn from friends. With their friends, it's all about who knows, who heard something, who saw it, who told who, and all that. This is the information that they get, in reality they mix it all together. They mix it all together and sometimes they come to their own conclusions. I think this is what they do…and well, then someone gets pregnant, or they create all these myths.
--Mil Solidarios staff member

Further information that adolescents need to prevent unplanned pregnancies

Contraceptive use was a concern for key informants when considering unplanned pregnancies. Though some recognized that adolescents might know what kinds of contraceptives are available, most informants agreed that adolescents do not always know how to properly use the contraceptives. Another issue that several informants brought up was access. It is difficult to access contraceptives in the *Bañado* because though they are available at pharmacies, youth are embarrassed to go to pharmacies where people might know them and they might be judged for using contraceptives. In addition, contraceptives can be bought over the counter from pharmacists who are not always medically trained. If the girls do not receive proper information about how

and when to use the contraceptives they can have an unplanned pregnancy. For example, injectable hormones are one of the most common forms of birth control in Paraguay but key informants noted that some pharmacists give the injection at the wrong time during a woman's menstrual cycle, putting her at risk of having an unplanned pregnancy.

> *The girls, often because they are misinformed or educated by their friends, they self-medicate. For example, they go to the pharmacies, this is something very natural for them, they go to the pharmacies and any pharmacist will give them the injectable [hormonal injection]. But a friend tells them that they have to take pills after they have sex. So she'll go and take another pill, and there's a double medication there, right? And apart from that they have other pills that they are taking during some days. So, it's a huge risk, that the adolescents also have such a lack of information.*
> *--Mil Solidarios staff member*

Key informants and parents agreed that adolescents not only need more accurate information about SRH but they also need to improve their psychosocial skills so that they are empowered to make healthy decisions. The parents also expressed enthusiasm for more thorough sexual health education in schools and further discussions about the more emotional parts of sex and love. Many key informants also mentioned that it was important for parents to have trusting relationships with their children and help them build their self-esteem, as well as teach them self-control to help their children make healthy decisions and resist the pressure to have sex early.

Most of the key informants stressed the need to help girls improve their self-esteem so that they did not feel as if they had to have sex to be popular or gain attention from males. They also believed it was important to talk to both genders about mutual respect, caring for one's body and the fact that abstinence was also an option. Finally, several key informants believed that there should be more education on healthy communication between partners so that couples can better negotiate sex and contraceptive usage.

> *So, for example, if she wants him to use a condom, she might tell him once. But she won't tell him twice because she's afraid he will get mad. That's disrespecful towards her, because she needs to protect herself. But she doesn't…fight for her rights. So if she doesn't fight for her rights, who's going to fight? So we…we teach them that she has to take care of herself, and if he doesn't want to use a condom there has to be a negotiation. In the best way possible, but she has to negotiate that.*

> *Because it's unacceptable that [she doesn't use one] because he doesn't want to, that's unreasonable for us.*
> *--Doctor specializing in reproductive health*

Reactions to the Intervention

All three groups of participants were asked about their impressions of the intervention. The parent focus groups focused primarily on this topic because they had directly participated in the intervention. At the beginning of each focus group parents were asked how the discussions with their children went, what they talked about, and how they felt when discussing the topics. Adolescents were also asked whether their parents talked to them after the intervention and how they felt about those discussions. Almost all of the 12 parent-adolescent pairs that participated in the focus groups and interviews reported similar events when talking to each other. There was only one case where a mother reported giving her child the materials and talking to him while he said she had never talked to him about the intervention or the topics. While some parents had discussed these topics with their children before the workshop as well, about half had not. Only two of the ten key informants had actually been present during intervention implementation however all key informants were given a brief synopsis of the intervention and asked for their opinions as well.

Adolescents' Perspectives

Half of the sixteen adolescents reported that their parents engaged them in some kind of conversation about sexual and reproductive health (SRH) after the intervention. On the other hand, about a third of adolescents said that although their parents gave them the materials and mentioned that they came from the parent workshop, they did not give a detailed explanation about what we discussed at the workshop. Instead, they simply told the adolescents that they had to read the material. Several parents talked to their children about this subject for the first time

while two adolescents also reported that their parents gave them the materials and talked to them about sex and relationships for the first time ever. However some parents seemed to still be reluctant to discuss the topics: two adolescents reported that their parents didn't give them the materials or tell them anything about the workshops. These two parents were some of the older parents at the workshops and had lower literacy abilities, which could have affected their confidence in discussing the topics. On the other hand, it could be that they didn't discuss the workshops because they didn't receive or feel comfortable with all the information from the intervention.

> *Interviewer: Did she tell you anything about what she talked about at Mil Solidarios?*
> *Respondent: No, when she goes to Mil Solidarios she doesn't tell me anything….nothing about that… She goes, listens and then, when she gets home she forgets. She doesn't know how to explain it and all that.*
> *I: Oh, ok. Have you ever talked to your mom about sexual relations or how to keep yourself safe?*
> *R: About that kind of thing, no. That's how she is, she's not one to give advice and things. My mom, she studied until first grade, she didn't finish school. She hardly knows how to sign her name and things…she's not one to guide me or anything.*
> *--17 year old girl*

Topics of parent-child discussions

Many of the discussions that took place after the intervention focused on the social issues that were discussed during FTT. Almost half of the nine girls reported that their parents talked to them after the workshop about waiting to have sex. The parents of these girls and two other boys also talked to their children about the importance of knowing their partner well before having sex and told them to consider the consequences of having sex before doing it. These messages were mentioned by both parents who had discussed SRH topics with their children in the past and parents who were discussed SRH topics with their child for the first time.

Parents reported focusing on psychosocial issues as well as concrete SRH issues, however it was more common for the parents to focus on the psychosocial topics. Half of the fourteen parents said they talked to their son or daughter about love, love at first sight, and healthy

relationships. These topics were discussed during the intervention and also addressed in the materials. Several parents said that they talked to their children directly about sex, while a greater number said they just discussed relationships and topics surrounding boyfriends or girlfriends. For example, one parent talked to her daughter about whether she was allowed to have a boyfriend and another mother discussed her son's relationship with his girlfriend. Only a fifth of parents reported talking directly about birth control with their children and the same amount said they talked specifically about pregnancy.

Due to the nature of a focus group, it was at times hard to distinguish whether parents had ever discussed these topics or whether they were new topics that they discussed after the intervention. Many parents said that they had discussed pregnancy in the past with their children. It is possible that they discussed this topic again after FTT but did not explicitly state this as one of the topics they discussed with their children because they already mentioned it at an earlier point in the focus group discussion. Parents were clear in noting that the topics of love and love at first sight were new topics that they discussed with their children as a result of the intervention and the materials.

Reactions to discussions

When parents reflected on how their children responded when they discussed the intervention topics with them, most of the 14 parents said that their children listened to them when they spoke but didn't respond or ask any questions. About a quarter of the adolescents told their parents they had already received information on SRH in school and seemed to dismiss the information that their parents gave them. A third of parents also said their children became embarrassed when they began to address the topic. Though most parents said they tried to at least say something to their adolescents about the topic, several parents reported simply giving their

children the materials but not engaging in any kind of conversation. On the other hand, three parents were able to engage their children in conversations related to the topic. These conversations included the adolescents telling their parents about instances of themselves or their friends being pressured to have sex or engage in other risky behaviors at school. Two girls who engaged in these conversations also asked their parents about pregnancy prevention and myths about pregnancy.

About half of the parents also admitted that they found it difficult to talk to their children for the following reasons: it was hard to find the time, they felt embarrassed or their children said they knew everything already.

> *Parent 1: For example, my daughter is 14 years old, she's about to turn 15 and….truthfully it was hard to talk about…about intimate things with her. But I was obligated to tell her because I'm her father, I'm with her and…first I had difficulties talking but after a while I couldn't hold back and I started to…to talk to her in her room.*
> *Moderator: About which topics?*
> *P1: About sex….and all the things we talked about….sex…her friends…for two weeks now her friends have been inviting her to go to the mall, "Tell your dad you're going to do your homework at school." Imagine that. And she told me everything…*
> *M: She trusts you doesn't she?*
> *P1: Yes, and she told me…dad it's like this. And I told her, "Don't do that," there will be an opportunity for her to go out…but [I told her] to wait for the moment, that she needs to think first before she does things. Because…her friend, the one that goes to the Mall alone, they go to walk around, she already has a boyfriend, I've seen it with my own eyes. But I can't all of a sudden take my daughter's friends from her.*
> *--Focus group discussion*

One mother expressed her worry that her son was just humoring her rather than actually listening to what she had to say. On the other hand, when asked how they felt talking to their children, the mothers in one group said they felt good talking to their children because they knew they were helping prepare them for their future. One mother said she felt as if her conversation opened up the opportunity for conversations in the future.

> *Moderator: And how did you feel speaking to your children?*
> *Parent 1: Myself, I feel good, because I know I'm preparing my child for his future…if he isn't aware of things, "I talked to you, I talked to you and you were always telling me that you knew, but I am always going to talk to you" I tell him. I feel sometimes, there are days that he complains, but I still insist and now he knows, "I already learned that in school" he tells me. But I still keep explaining about…about love and this 'love at first sight,' that, for example, I continued to tell him, "In school for example they didn't explain this*

topic to you, they told you how you had to protect yourself, how to use a condom, but not about love" I tell him. "Look, listen here" I tell him.
Parent 2: Yeah, they don't teach them anything, of that part…
P1: "That it's not just love at first sight, seeing that girl or that emotion, that momentary part, they didn't tell you that" I tell him. That's what I was able to explain to him so that he understood. That part interested me a lot. There are a lot of things like using protection that they're always telling you, and they also have that in the health book, but this part I was reading and it interested me. He wasn't paying attention but "Look right here at this, listen to me" "Yes mom, yes mom" "Look at me, I'm speaking to you, I need your attention for just 5 minutes," I told him on Sunday.
--Focus group discussion

Adolescents were also asked about their thoughts and feelings after talking to their parents about this subject. Several adolescents who said their parents hadn't talked to them in the past reported not quite knowing what to think and not responding or engaging in conversation with their parents. These adolescents also reported that they felt a bit uncomfortable or didn't like talking about this topic. The embarrassment was not just among adolescents whose parents had never talked to them: one girl whose father had spoken to her in the past about this subject said that she was also sometimes embarrassed when he talked to her. But at the same time, adolescents recognized their parents' efforts. The majority, including those kids whose parents had never talked to them, said they knew their parents were talking to them to protect or take care of them in hopes that they would take care of themselves in the future.

What did they like most about the intervention?

Parents were asked which parts of the intervention they learned from and enjoyed the most. In every parent focus group, participants said they didn't expect the workshop to focus on topics such as love and love at first sight. They had not considered talking to their children about healthy relationships and respect within a relationship before this intervention. The intervention helped them realize these were important topics to bring up with their children when thinking about making the decision to have sex.

Parents also discussed how important it was to have a good relationship with their children so that their children trusted them and felt comfortable confiding in them.

> *In reality, what's really important is communication. Trying to establish trust with your child. Because all the materials talk about the way in which you speak to your child, how to get close to them, how to talk to them.*
> *--Mother*

Parents who regularly attended the *Mil Solidarios* parenting classes said that previous workshops had discussed how to communicate effectively with their children, yet those workshops had never addressed how to discuss SRH topics with their children. The FTT materials mention several different ways to start talking to children, and these materials and the workshop helped them consider how they could improve communication about SRH with their own children. One technique parents noted that they used was to take advantage of a situation when an SRH issue came up (for example, on TV or in the community) and take that time to discuss the issues directly.

In every focus group parents also mentioned the difficulty of supervising their children properly. While many parents said that FTT helped them think about monitoring and supervising their children, they also expressed concern that their children could easily lie to them and be somewhere or doing something they weren't supposed to.

Other topics that parents enjoyed discussing were STIs; they said that often when SRH was discussed in the community pregnancy was the only topics of conversation. Finally, parents also enjoyed the role-playing exercises during the intervention.

Overall benefits of the parent education sessions

While discussing the intervention, parents also commented generally on the benefits of attending the regular workshops at *Mil Solidarios*. Several parents said that parents who do not attend are often dismissive of their value. In the FGDs, participating parents believed that those

parents who did not attend were missing out on valuable education about how to communicate with their children. The parents also recognized that the adolescents appreciate their participation in the meetings. One participant said that one student whose mother does not attend the sessions always approaches the participant to ask what topics were discussed. Another daughter frequently accompanied her mother to the workshops because she said she found them interesting while a mother said her daughter always asked her what they discussed in the workshops.

The parents and several key informants noted that the ongoing workshops have helped parents open up more and have improved their communication with their children. One mother added that she liked the parent workshops because she had formed friendships and a support system through the workshops.

> *Parent 1: For me it's very important, it will always be important. Because it helps me, I can help my sons and daughters.*
> *Parent 2: Before it was hard for me to speak like this, openly, I learned this in the past year in the workshops that they presented, with games and all that. It was really hard for me to speak before in a group and these workshops have helped me a lot.*
> *P1: And also to speak to the teachers and my children and all of that, it was hard for me to go…I was always behind my son, but to speak [to the teacher] to say, "this is happening" and explain to them also. Generally I would get really nervous, now it's different.*
> *P2: When you come here it's different, it changes.*
> *P1: I can speak better, I can ask why this and that, in my house too, it's different.*
> *--Focus group discussion*

Parents also saw the value of FTT itself because they believed that these discussions could help their children make better decisions in the future.

Key informants' perspectives

All the key informants believed that it was important to work with parents to encourage communication between them and their adolescents. The *Mil Solidarios* staff said that it was important to offer parents this kind of education because they tended to be poor, young, and have little formal education of their own so they needed support when raising their children. Several staff members mentioned that some parents blame their children for the fact that they were not

able to improve their lives and get the education they wanted, while other parents were struggling to ensure that their children did not follow the same path they did. Three key informants also said that they believed the intervention had to be longer or start at a younger age because these topics take time and practice. Based on her own experiences implementing the parent workshops, where she has recently begun seeing changes in the parents, one founding coordinator at *Mil Solidarios* noted that change takes time.

> *Yes, at the personal and institutional level we have to be conscious that education has its own process. It's not that I talk to them about one thing today and they learn it right away, no, we have to persevere on this road to education…So we have seen the results in many parents after 4, 5, 6 years. We've seen changes in the relationships that they have with their children, and we hear and see this both in the parents and our kids. Because our kids come and say, "Professor, now I can talk to my mom, and my dad too," their relationships are improving. But this change took four years, it wasn't over night. So we have to be patient, tolerant, perseverant, tolerant.*
> *--Mil Solidarios staff member*

Key informants were also asked about the disadvantages of implementing FTT. Most of the seven key informants from *Mil Solidarios* said that it would be hard to get the information across to parents with written materials because of the low literacy rates in the *Bañado*. Others discussed the problems with attendance at the parent meetings; although they are said to be mandatory, only about 10% of parents go to any one meeting. Several *Mil Solidarios* staff said this was precisely because of the acute poverty in the *Bañado.* Some parents worked all day and came home tired or had chores that they had to do in the evening, or they did not have childcare while they attended the meetings. Others said that parents were struggling every day to survive and were not thinking long-term about how these meetings could benefit their families. As will be seen in the Modifications section, there were many suggestions about how FTT could be implemented in the *Bañado* so that it would be easier for parents to access the intervention.

Families Talking Together Materials

During the intervention parents were given a pamphlet for themselves and another pamphlet to give to their adolescent children (Center for Latino Adolescent and Family Health, 2011a, 2011b). The parent pamphlet was 10 pages long and discussed why, how and when a parent should talk to their adolescent. The 8-page adolescent pamphlet focused on healthy relationships and misperceptions about sex and pregnancy. Parents were told to use these materials to begin discussing SRH topics with their children. In the focus groups and individual interviews I asked both parents and adolescents whether they used the materials, which topics most called their attention, and whether they thought they or others would use them in the future. Key informants were also asked their opinions of their materials, though most had not thoroughly reviewed the materials and thus gave only their initial impressions.

Use

While the parent materials appeared to be useful in teaching, and parents said they liked them, the adolescents did not seem to use the material as much as their parents. Almost all of the 16 adolescents said their parents had given them the materials and more girls than boys said that they had read the pamphlet. While half the girls said they had read the materials, only one boy said he had actually read it and two boys said they glanced at it quickly. The adolescents who received the materials but did not read them cited being too busy or distracted when their parents had given them the materials. Many adolescents said they didn't have time in the week to read the materials, and several of them said they were watching TV or doing something else when their parents gave them the materials. Most of the adolescents said their parents told them that they received the pamphlet at *Mil Solidarios* and that the adolescents had to read it. Only a couple of adolescents said their parents elaborated on the topics contained in the material. While some of

the girls said they thought their friends might read the material if they received it, none of the boys were certain that their friends would read the pamphlet.

On the other hand, the parents believed the parent and adolescent materials were useful in facilitating discussion with their children because it gave them ideas of how to approach the topics and what exactly to discuss. Almost all of the 14 parents said they gave the materials to their children; those who didn't said that they didn't have time or were embarrassed. One mother decided that her daughter was still too young for the materials, stating that she would give her daughter the pamphlet when she was 12 or 13. Similar to the adolescents' reports, only three parents reported actually discussing the materials with their children. Those parents focused on discussions about love and love at first sight. Other parents said they gave their children the materials, but didn't know if their children read them. Several parents also said that their children didn't appear to want to talk after reading the materials, and one mother said that her son wanted his mother to briefly tell him what was in the materials rather than having to read them himself. There were a few younger parents who really appreciated the materials and said they would continue using them as a guide for how to talk to their children about SRH issues.

Parents and key informants were unsure if other parents would use the materials, yet at the same time they felt they were useful and should be used during the intervention. Some parents thought that their peers might simply throw the materials away due to disinterest. On the other hand, another small group of parents noted that some adults in the community had difficulty reading and thus would not be able to use the materials

> *Moderator: Should the materials still be distributed to the parents, or should the workshop be presented in a different format?*
> *Parent 1: No, it's good because sooner or later they will read it.*
> *Parent 2: But you could have, for example, a presentation, or a video, so that in that moment they could see it, and then you could go on explaining. It's more…*
> *P1: You learn more.*
> *Parent 3: Acting…*

> *P3: You absorb the information more. Because let me tell you, here in our country, it's hard to get people to read, maybe they'll read a* popular [*popular magazine] …*
> *--Focus group discussion*

Key informants were also concerned that the low literacy levels in the *Bañado* would lead to few parents actually reading the materials, however they thought it was important to still give them out so parents felt like they had received something at the workshops. Several key informants thought parents could also give the materials to their children or ask their children to read to them.

Content

Parents and adolescents who read the materials both said the topics that most interested them were the discussions of love and relationships. Almost all of the girls who read the materials said one of the most memorable topics in the pamphlet was the discussion of the idea of love and love at first sight. Many of the girls said they didn't believe in love at first sight, that though some of their friends said they were "in love" the girls didn't really believe that they were. The girls liked that the material discussed what it meant to be in love, including needing to have a good relationship to really be in love.

> *Respondent: Something else that called my attention was this part that says…that teens want to have sex because they have a boyfriend and want to have sex, they want to have sex because for them that is love. And love is, for example, from my point of view it's when two people get married and they love each other. Then they can do everything they want because they are married and are conscious of their actions.*
> *Interviewer: Right, the materials discuss this a lot, how love doesn't have to be sex.*
> *R: They are two different things.*
> *I: Yes, and what do other girls think about this, about love and sex?*
> *R: Well, normally the girls, if they have a boyfriend, no matter what, they're thinking about it, thinking about having sex.*
> *I: So, when a someone has a boyfriend or girlfriend this means that they're going to have sex?*
> *R: Well, most people I know, lots of people, I'm talking about teenagers, they have a girlfriend or boyfriend and no matter what they say they're going to have sex…it's just about protecting themselves they say. "I'm going to have sex with him, you just have to protect yourself," they say.*
> *--14 year old girl*

The three boys who mentioned the focus of love in the materials also seemed doubtful that it existed in adolescent relationships. One boy was interested in the topic because he thought that

some adolescents said that they were in love but didn't actually mean it. Another boy said that he didn't think any of his friends were thinking about love, only sex.

The key informants who had read the materials and parents in all focus groups said they liked the focus on the emotional and social parts of these topics, such as love and mutual respect, and the importance of these aspects in a relationship before having sex. They appreciated this focus because they did not believe it was covered in schools. About two thirds of the parents who specifically mentioned that they liked this focus said that they took the opportunity to discuss those subjects with their children after the intervention using the materials.

Pressures to have sex were also mentioned in the materials and appeared to resonate with some the girls. With about half of the nine girls, our discussion about love and respect lead to a discussion about being pressured to have sex. In contrast, boys only discussed the pressure to have sex when I brought it up in reference to the materials.

Adaptations

Over the course of the discussions with adolescents and key informants it became clear that most of the content in the FTT materials was relevant to Paraguay, however the materials would need to be tailored to fit the culture and literacy levels in the *Bañado Sur*. The only part of the materials that key informants identified as culturally irrelevant was a section that discussed waiting to have sex until marriage. In Paraguay, many couples do not formally marry, and thus this section does not have as much meaning in the context of the culture.

The adolescents also pointed out several sections of the materials that did not make sense to them because of the vocabulary that was used, suggesting that adaptations will have to be made to use this material in the future in Paraguay. Key informants had many suggestions about how those adaptations could be made, including using community leaders, local experts and public

health students to work together to adapt the materials. Key informants also recommended simplifying the materials so that they were more accessible to people with various literacy levels. Parents suggested that in order to accommodate adults who didn't read as well, more time should be allotted during the sessions to discuss and explain the content. This way, those who couldn't read could at least understand the topics included in the materials. One mother suggested using a PowerPoint or videos to explain the content so that everybody would understand the materials right away.

Modifications and Recommendations for Parent-focused Pregnancy Prevention Interventions

After implementing the initial FTT sessions, the logistical challenges and successes of the program were clear. Consistent attendance and literacy levels were two challenges that *Mil Solidarios* staff had warned me about and indeed were two of the biggest challenges in implementing the sessions. A significant portion of both the key informant interviews and focus group discussions were targeted towards discussions about how to improve FTT and how to disseminate materials about sexual health education in general. These conversations helped me understand how FTT could be more successful in Paraguay, as well as best practices in other programs that could help guide adaptations for FTT in the future.

At the end of the individual adolescent interviews I also asked interviewees how they preferred to learn about sexual health. These findings suggest that girls and boys prefer different forms of education, which is important when planning programming. The adolescents' reactions to their parents' discussions were also relatively positive, suggesting that parent-child education could be effective, especially when supplemented with education from other sources such as school-based education.

Group vs. Individual Sessions

The original FTT intervention was designed to be an individual intervention for parents waiting for their children at health clinics. The intervention was then adapted to be a group-based intervention. I asked parents and key informants whether it was preferable to implement the intervention individually or in a group setting. Almost all the participants preferred a group setting. *Mil Solidarios* staff who worked closely with parents all said that the group setting allows parents to share their experiences, learn from each other and receive support from the group. One of the doctors also believed that in group settings the parents would see that all the parents were going through similar challenges raising their children. In this setting, they wouldn't feel singled out as they would if they were approached individually.

> *I think it would work better in a group….individually you only think about what you know and what the person is telling you, but in a group one can learn much more about others' experiences too. Because the way in which I raise my child is never the same as the way someone else raises their children, nor do I communicate in the same way with my children as someone else does. It's always different, and I think with this variety there can be a lot of learning too.*
> *--Mil Solidarios staff member*

Two of the three groups of parents also preferred the group format, mainly because they enjoyed hearing other parents' opinions. In addition, they said that for parents who couldn't read, it was better to do FTT in a group format so that they could share their opinions and listen while the materials were being reviewed. On the other hand, several parents noted that due to the shy culture in Paraguay, some parents don't like to open up in public, so it might be more effective to reach these parents individually. One group said they might be open to someone approaching them in a clinical setting. A mother who had experience in outreach in the community said that she thought it would be effective to start in a group setting and then visit parents individually afterwards, when they felt more comfortable with the facilitator of the intervention.

Though overall key informants and parents recommended a group setting, key informants did see some value in conducting the intervention in a clinical setting or individually by going to families' houses and meeting with parents. One *Mil Solidarios* coordinator thought it would be more effective to go to houses because few parents went to the clinics. Even at CEPEP, where the doctors said that mothers bring their adolescents, they did not receive a large amount of mother-daughter pairs in a day. Two key informants said that parent receptiveness would depend on their personalities; some simply wouldn't be interested in a one-on-one approach. A *Mil Solidarios* staff member pointed out that parents who come up with excuses not to attend the parent meetings would do the same with an interventionist who came to their house. Often, she said, parents avoid these discussions because they feel they might not understand the topics, or are illiterate and do not want to admit that they can't read the materials.

One suggestion from a key informant was to present the intervention using a multi-dimensional approach. First, she recommended a publicity campaign using posters and community radio to announce the information. Then, she recommended visiting individual houses to begin speaking with parents. Finally, the parents could come together in a group and share their experiences, allowing for the support that group-based education provides.

Ideal candidates to present the material and facilitate sessions

Both parents and key informants emphasized the importance of having an FTT facilitator who had in-depth knowledge about sexual health. Several key informants and many parents also mentioned the value of having a facilitator who had "charisma" and could gain trust with participants. Parents said that the facilitator didn't necessarily need to have children if they had sufficient knowledge, yet they thought some parents wouldn't listen to a facilitator who was

young and didn't have children. Key informants agreed, saying it is incredibly helpful to have facilitators who are parents themselves, as participants then know they have shared experiences.

Several parents said that having an authority figure present the topics would encourage other parents to heed their advice. In two focus groups, participants suggested that religious leaders would be appropriate presenters because they have are respected in the community, yet one mother disagreed, saying they could at times be condescending or hypocritical. Key informants thought that parents would be open to authorities who are familiar with the topic, such as promotoras or doctors, as facilitators; this sentiment was echoed in two parent groups.

Everyone agreed that the facilitator should be bilingual (in Spanish and Guaraní) so that they could switch between the two languages, and so that Guarani-dominant parents would feel more at ease. While one *Mil Solidarios* staff member said she thought that a peer educator, such as another mother, would be an appropriate and effective facilitator, two key informants thought it was helpful to have a facilitator who wasn't from the community. One *Mil Solidarios* staff member explained that participants might not want to open up to someone they see all the time in the community. This person could make them uncomfortable when they think of how they opened up or might share their information with other people in the community.

generalmente ellos se abren más a una persona que viene de afuera y por muy poco tiempo, a una persona que trabaja aquí y que está aquí y que la van a ver el resto de la vida, veradd?

> *Generally they open up more to someone who's from outside, and here for very little time, tan someone who works here, and is here, and who they'll see the rest of their lives.*
> *--Mil Solidarios Staff*

Outreach: Best ways to improve attendance

One of the biggest challenges to conducting the FTT intervention is that the sessions build on one another, making it important for parents to consistently attend the sessions. Unfortunately,

less than half of all the parents who began the FTT workshop completed the sessions while others joined one of the later sessions after having missed the first one. Many key informants and parents said that this was because parents are busy with their children and work, making it difficult to attend meetings consistently.

I asked both key informants and parents why they thought some parents didn't come and the best way to encourage parents to attend the workshops. While some focus group participants acknowledged that many parents didn't attend because they didn't have time, they also said that those parents were missing out on valuable information. One mother noted that other parents didn't normally come to the meetings because they thought the topics would always be the same, making the meetings repetitive and boring. Parents who did attend, however, expressed how much they benefitted, because they felt their relationships with their children had improved.

Some parents also seemed resentful that other parents did not attend as consistently as they did. In one focus group parents suggested imposing a sanction of some sort, but thought that even with a sanction, it might be difficult to encourage parents to attend. The *Mil Solidarios* staff did not champion this approach because they do not want youth to suffer if their parents do not attend. Two focus groups and several key informants noted that more parents would attend if there were food, prizes or some kind of recognition, such as a certificate, at the end. Both parents and key informants thought that community outreach would be the best way to encourage attendance, possibly through announcements about the intervention at schools and other community organizations, or by presenting the intervention itself at these venues. Parents recommended against sending flyers home with children as they tended to lose them. Another recommendation from a focus group and several key informants was to publicize meetings through the radio or actually present the information on the community radio station. In one focus group however,

parents said they didn't listen to the radio often. Another recommendation from both key informants and parents was to call parents and remind them about the meeting.

Finally, one of the most popular suggestions among parents and key informants was to conduct the intervention in various neighborhoods. The facilitator could work with one mother to invite other mothers in that neighborhood to her house where the facilitator would then present the materials. This would make it easier for the parents to attend because the workshop would occur closer to home than the *Mil Solidarios* center. Though one MS staff member was in favor of this idea, she also worried that parents might get distracted if their children or other non-participating family members were present.

Best practices and further ideas for presenting FTT in the Bañado

I also asked about best practices in presenting materials such as FTT. A third of key informants emphasized the importance of interactive workshops where mothers were not simply listening while a facilitator spoke. Two key informants also suggested that the intervention include more than the three sessions because though the allotted amount of time might allow parents to learn the information, it doesn't necessarily give them time to put the lessons into practice. One mother also noted that many people in the Bañado like to read short stories called "populares" which are written at basic reading levels and contain many visuals. She suggested using these as a type of educational material.

Additional topics suggested during FTT

I asked key informants and parents what should be added to the existing FTT workshop for parents. Most key informants focused predominantly on what adolescents needed to know; however one key informant noted that parents also needed to learn more about family planning methods so that they could counsel their children on methods.

Parents suggested there be more discussion about how to encourage fidelity and healthy relationships among adolescents. One woman in particular shared her concern about domestic violence, and her belief that adolescent girls need to learn to be independent and do what they want in the relationship rather than what the man wants. This is a point that the doctors emphasized repeatedly. In one focus group, parents requested that *Mil Solidarios* offer more sexual and reproductive health workshops so that their children could continue learning.

Other techniques to educate parents and children about sexual health

Many participants had additional ideas on how to improve sexual health education for both parents and children that did not necessarily fit into the FTT curriculum. Almost half of key informants suggested facilitating discussions between parents and children by doing workshops with both groups. Three key informants also suggested an intervention involving both parents and children together, potentially by holding separate workshops and then bringing them together for discussion and role-playing activities. A *Mil Solidarios* staff member thought the workshops could encourage parents and children to read the materials together both during the workshop and afterward. Another staff suggestion was to conduct a workshop for mothers, who would then present what they learned to their children in the form of socio-dramas. Parents in one focus group also supported these ideas because they were enthusiastic about talking to their children at the end of the intervention, but found it very difficult to discuss the topics at home with their children. They said they would have liked to practice talking with their children during the intervention.

> *For example, I would like each child to participate with their mother. That would be great. Both of them could participate, the kids could participate to hear what they think, they could talk and participate with us in the meetings. This would be great, see, because right now you come [home], you know everything you're going to say but then you get scared.*
> *--Parent*

Another idea was to hold sexual health education workshops with girls and boys separately, and then bring them together to discuss relationships. At the very least, the key informant suggested, the adolescents could role-play situations that would prepare them for real discussions in the future. Another *Mil Solidarios* staff member suggested a broader community-based approach that would target the whole community, including young people who might have children in the future.

The two doctors from CEPEP discussed their experience in working on a past project called *Espacio Joven*. The program focused on two separate age groups: an intervention with younger adolescents addressing topics such as abstinence, self-esteem and their changing bodies and an intervention with older adolescents focusing on contraceptives, condom negotiation and romantic relationships. During the *Espacio Joven* project, CEPEP trained peer educators to present sexual education and facilitate discussion with their peers. While they were both positive about the project, they noted that it was sometimes difficult to continue the program because as youth grew up, they often left their neighborhoods or got pregnant and could no longer continue as peer educators. One *Mil Solidarios* staff member also thought that peer education was a good idea; she noted she didn't know of peer education projects on sexual health in Paraguay but had seen other groups of successful peer educators focused on issues of drug addiction and HIV/AIDS.

Two key informants, one from CEPEP and one from *Mil Solidarios,* suggested that the first way to improve sexual education was to educate school teachers themselves. School teachers are supposed to present sexual health education, however key teachers often do not feel comfortable or are not well enough trained to present the information.

The CEPEP doctors also discussed a model they used to present sexual health education workshops at schools, usually when invited by administrators or teachers to discuss sexual and reproductive health. They have implemented an interactive model by asking students to submit questions anonymously to a question box before the workshop starts. The doctors then answer the questions and are careful to include the essential topics of health education in those discussions.

Adolescents' preferences for sexual health education

Adolescents were asked who they preferred to talk to about sexual health, and who they preferred to talk to them. Boys and girls appeared to have different preferences. Almost all girls said they preferred to talk with their mothers or friends, noting that they liked discussing these topics with people they trusted:

> *Interviewer: And to receive information like that about sex and how to protect yourself, in what form do you like to receive this information? For example here we have written materials, but it could be in presentations, or you could speak individually to your mom, through videos, the internet. What form do you like the most?*
> *Participant: I want it to come only from my mom.*
> *I: From your mom? Why from her?*
> *P: Because I trust her more and I know she's going to give me the best [information]…Because sometimes in the internet or somewhere else they could show you a lot of bad things too.*
> --13 *year old girl*

When talking to adolescents, I did not always specify that I wanted to know who they would like to receive information from, rather than simply who they liked to talk to about the subject. However I believe that is how they construed the question because we had just discussed where they received information about sexual health. Most girls said they preferred to speak to their friends and mothers, whereas the three boys who discussed this said they preferred to hear from a professor or other expert. Several boys were even resistant to discussing the topic with their mothers.

Finally, I asked adolescents how they preferred to receive SRH information. In some cases, I had to give examples such as pamphlets, videos, presentations or information on the

internet, and interviewees would tell me which they preferred. There was little difference by gender: two girls said they still preferred their mother to give them information while two boys preferred videos, and one boy noted that whenever they show a video in school everyone listens. A quarter of the adolescents preferred "charlas," when a teacher presented the material and three stated a preference for written materials. Adolescents had widely varying opinions on how they preferred to learn about these topics, which suggests it is important to approach the subject with multiple media and presentation techniques so that all students are able to engage in the material. The differences in preference and gender are also important to consider when adapting or creating pregnancy prevention interventions.

Chapter 5: Discussion

The *Families Talking Together* intervention is a brief, parent focused intervention that encourages parent-child communication and improved parental monitoring and supervision in order to prevent adolescent pregnancies. The intervention was implemented and followed by key informant interviews, parental focus group discussions and interviews with adolescents in order to assess the intervention's effectiveness in Paraguay. These qualitative data, triangulated to better understand the current situation of sexual health education and the reactions to the FTT intervention, provide valuable information about sexual and reproductive health interventions in Paraguay. The data not only provide feedback on how the FTT intervention can be adapted to better serve populations of low socioeconomic status but they also reveal further areas for intervention in order to improve adolescent sexual and reproductive health in Paraguay.

Families Talking Together was well received in the *Bañado Sur* by both parents and key informants; however the results have shown that this intervention alone may not be able to improve communication among Paraguayan parents and children. The parents who attended the FTT sessions were an extraordinary group who faced difficult circumstances in their daily lives but still took the time to attend parent education sessions and invest in their own education to improve the lives of their children. Even many of these parents, who were enthusiastic about discussing SRH topics with their children, found it difficult to begin these conversations after the FTT intervention. Due to the lack of general communication about relationships and SRH in Paraguay, I believe these families were not nearly as prepared to talk to their children about these topics as the New York families who participated in original intervention. Parents in Paraguay

acknowledged that they never received education in school about these topics, and their own parents never discussed these topics with them.

The societal norms in Paraguay discourage this kind of communication about SRH, and the lack of real world examples about how to approach these subjects leave parents struggling to communicate with their adolescents. FTT may not be able to singlehandedly improve parent-child communication about sexual and reproductive health, however parents, adolescents and key informants still found the content useful in Paraguay. Coupled with other, more intensive communication interventions, FTT could play an important role in encouraging sexual and reproductive health communication once parents have improved general communication skills.

Adapting the FTT intervention for the Bañado Sur

The FTT intervention received positive feedback about its content, but the data collected also reveal that FTT still needs to be adapted for Paraguayan culture. Participants offered many ideas for how FTT could be adapted as well as additional suggestions for sexual health education interventions. ETR Associates, one of the leading evidence based intervention research groups, has compiled a brief guide to adapting evidence based pregnancy prevention interventions (Firpo-Triplett & Fuller, 2012). Though the guide is focused on interventions targeting adolescents, it provides useful guidance on which kinds of adaptations could be successful while maintaining the fidelity and effectiveness of FTT. These adaptations are characterized by color: red means that the adaptation should only be implemented with "extreme caution," yellow signifies that the adaptation is "sometimes acceptable" and green indicates that the adaptation is "always appropriate." With the guidance of the adaptation guide, the adaptations that were recommended by participants in Paraguay are classified below into these three categories.

Green light adaptations

A green light adaptation is one that does not threaten the fidelity of the intervention but instead makes it more relevant to the population that the intervention serves. In the case of FTT, there are several adaptations that will have to be made to ensure that the intervention fits the Paraguayan context. For example, the materials themselves used Spanish words and phrases (such as "El amor es una calle de dos direcciones" on page 3 of the adolescent materials) that were not similar to vocabulary used in Paraguay, making several pieces confusing to the readers. Additionally, key informants pointed out that the materials' images must be adapted so that they resonate with the target population. Finally, the statistics concerning teen pregnancies and knowledge and attitudes must reflect the Paraguayan situation. These suggestions regarding materials, vocabulary and statistics are adaptations that the authors of the guide believe are important and should be made in accordance with local language and culture.

The adaptation guide also approves the idea of making the interventions more interactive in order to appeal to different learning styles, another suggestion also mentioned during interviews and focus groups. Due to low literacy levels, parents and key informants were concerned some written materials might not appeal to parents in the Bañado and instead suggested showing videos or Powerpoint presentations to better illustrate the topics of FTT. Further innovations that are more interactive and rely less on reading abilities will need to be made for this population.

Yellow light adaptations

Yellow light adaptations involve modifying the content or pedagogical components of the intervention. The adaptation guide recommends proceeding with caution with these changes and consulting a behavior change or curriculum expert when necessary. Parents and key

informants had many such suggestions regarding ways to supplement the original curriculum with more topics or more in-depth focus on some key topics. Given the large differences in culture and educational background of the participants in Paraguay compared to the original population, some of these changes could improve FTT in Paraguay but must be considered thoroughly before implementation.

One suggestion by key informants was to lengthen the intervention. They believed the three sessions weren't enough to communicate all the themes and also encourage participants to practice what they had learned. Though parents did not directly comment on this, those who participated in the *Mil Solidarios* parenting meetings regularly expressed how the meetings had helped them communicate better with their children, showing the value of having sessions that last longer than a few weeks. However, if the intervention were to be longer, further topics or reinforcement activities would have to be added. One drawback that must be considered is that elongating an intervention could then affect retention of the participants for the entire program (Firpo-Triplett & Fuller, 2012).

Key informants also expressed the need to educate parents further about family planning and the proper use of contraceptives. Key informants believed this lack of knowledge about how to properly use birth control was incredibly important because adolescents are becoming pregnant due to the improper use of birth control methods, especially hormonal injections. An additional session about family planning could easily be added into the curriculum because FTT already has a set of materials that provide information about birth control. Once again, the adaptation guide warns against adding too many additional topics or activities that could reduce retention during the course of the program. If the intervention is to be replicated at *Mil Solidarios* or another organization that already has a standing parent meeting, these activities could simply be presented

at another meeting. However, if FTT is presented as a standalone intervention in the community, the interventionists will have to seriously consider and assess whether it is appropriate to add this as an additional session.

Red light adaptations

The adaptation guide warns against what are considered "Red Light Adaptations" which include shortening a program or eliminating certain components of an intervention. During the focus groups and interviews most of the suggestions surrounding the adaptation of FTT were to enhance the curriculum, rather than take anything away, thus there are few red light adaptations to be considered for FTT.

One key component the guide warns against is reducing or eliminating opportunities for skills practice. Though the implementation of FTT in the *Bañado* did include practicing the skills called for in the original intervention protocol, a key component of this skill building was practicing communication skills when parents went home and saw their children. Based on the reports from the focus groups and adolescent interviews, few parents actually practiced these skills and addressed SRH topics with their children. Instead they simply handed the youth the written materials, or briefly discussed the topics but did not thoroughly cover the material. This could be because parents did not have enough time between the second session and booster session (generally 1-2 weeks in each group) to start discussing the topics with their children. But parents also expressed that they still felt embarrassed discussing the topics with their children. This indicates that parents may not have received the real skills based practice the protocol calls for because they themselves did not take time individually to practice those skills at home.

In order to improve these skills and increase the amount of skills based practice, parents and key informants suggested conducting part of the workshop with the adolescents present or

working separately with adolescents and parents and then bringing them together to practice their skills in a supportive environment. This is not part of the original FTT intervention, and thus may need further exploration as well as a curriculum development expert in order to add this component to the original FTT curriculum and include another session to improve skills practice.

Important practical considerations for proper implementation

Parents and key informants extensively discussed best practices for recruiting and retaining parents for FTT. Though these topics are not mentioned in the adaptation guide, they are important topics to take into consideration when adapting FTT for Paraguay. Many parents and key informants agreed the best way to reach parents would be to go into the community and offer sessions in neighborhoods so that parents didn't have to travel far. Though participants did see some value in offering the intervention, or parts of the intervention, individually as is done in the clinic based FTT intervention, most people preferred the intervention in a group format. The intervention should be implemented as a group because discussing these topics together allows parents to share their experiences and know that the issues they face are common struggles for other parents as well.

When recruiting parents to participate, techniques for recruitment could vary between going house to house and inviting parents; using the radio to disseminate information and calling them to invite them. The facilitator must be bilingual in Guaraní and Spanish and must show that they have comprehensive knowledge about the subject. Possible facilitators that fit these criteria could be doctors or health promoters. It was also suggested that the facilitator should have children of her/his own so that parents could feel as if the facilitator understood the parents' concerns and struggles.

Implications for Designing Future Interventions

While the data primarily focused on the best way to implement FTT, it also gave insight into the kind of information adolescents do or do not receive about SRH as well as typical communication in the community about those topics. These results show that parents and adolescents are reluctant to discuss these topics together. Adolescents also lack comprehensive sexual education in schools and other educational centers. Finally, adolescents feel pressure from multiple sources to have sex. Coupled with a lack of communication and comprehensive education from schools and community centers, this pressure can put adolescents at an increased risk of an adolescent pregnancy.

The societal pressures to have sex in Paraguay influence adolescents differently depending on their gender. Not only do girls and boys experience different pressures, they also receive different messages from their parents about sexual and reproductive health. These two separate sets of information and expectations for boys and girls can cause deep divides between genders and create different perceptions and expectations of what relationships should or could look like. When different expectations about sex and relationships exist, communicating those expectations and reaching a consensus can be difficult.

After a long dictatorship, Paraguay is only now becoming a democratic country. This history, where many were silenced for speaking up, has nurtured a culture where communication is difficult. In this environment, trying to cross gender barriers and encourage mothers to talk to their sons, fathers to talk to their daughters, and partners to talk to each other about sensitive topics such as sexual and reproductive health can appear a large feat. However just beginning the conversation, and encouraging an open discussion about relationships, gender, and expectations, could begin to open the way for sexual and reproductive health discussions. Given these gender

differences and the communication barriers, in order to truly improve education and parent-child communication about SRH and reduce adolescent pregnancies in marginalized areas of Asunción, the following techniques could be used in interventions:

1. *Present lessons on parent-child communication that focus on familial relationship-strengthening and healthy communication strategies while children are still young.*

During the implementation and data collection process many parents admitted that they found it difficult to begin conversing with their children about sensitive issues. Key informants and parents both expressed how helpful the years of parent education classes at *Mil Solidarios* had been in improving their communication and relationships with their children. These experiences are proof that parents in the *Bañado* need long-term support in order to improve their relationships with their children. For parents who do not attend the *Mil Solidarios* classes already, interventions could be implemented with them to focus on communication and family strengthening. When done early, these interventions do not have to focus specifically on SRH; instead they could be the first step to establishing open lines of communication between parents and children. Using this model, when children reach the age when their parents need to address romantic relationships and SRH, the families will already have established norms around communication, making it easier to address difficult topics.

2. *Offer parents intensive skills-based interventions that prepare them to discuss these issues with their children.*

Though FTT is advantageous because it is a short intervention and can reach many parents, the participants in the intervention still had difficulties broaching the topic with their children. In order to feel comfortable discussing this information, they need further coaching and practice. Adolescents were generally positive about their discussions with their parents because

they knew they were talking to them for their own good but they also felt uncomfortable discussing these issues. One possibility could be to implement longer interventions that allow for more time and role plays to practice skills. As mentioned earlier, participants (parents and key informants) also suggested implementing an intervention that actually facilitated a discussion between the two parties in order to help them communicate. This would provide both parents and adolescents a safe environment to practice the skills that they learned.

3. Focus on negotiation skills in interventions for both parents and their children.

The gender biases in Paraguayan society put pressure on youth to have sex early. While boys are pressured by society and peers to begin having sex early, girls often then feel this pressure from their boyfriends or male peers. Parents and key informants were also concerned that the media's influence on adolescents encouraged them to start thinking about sex at an early age. Yet none of the youth I talked to said that they had ever been taught how to resist these pressures. Interventions can help alleviate these pressures by both teaching youth how to resist those pressures and changing their perceptions of sex. The literature surrounding pregnancy prevention and sexual health emphasize the importance of skills based interventions that empower youth with the skills to resist pressures and make healthy decisions. Interventions with adolescents could be implemented to focus on these skills, and parents could learn how to encourage their children to develop healthy refusal and negotiation skills.

4. Focus on healthy romantic relationships.

All three groups of participants thoroughly enjoyed the discussions in the interventions and materials regarding love and healthy relationships. Emphasizing these important aspects of teen relationships could help adolescents view sex in a different light. In parent focused interventions, participants should be encouraged to discuss positive relationships and encourage

"innocent" romantic relationships that are supervised so that adolescents can understand that there is more to a romantic relationship than sex. Teens could be encouraged to discuss and analyze these topics during health classes so that they can recognize healthy and unhealthy relationships.

5. Consider gender differences when designing interventions

Throughout the data gender differences could be seen in the ways that parents discussed SRH with their children and the way adolescents perceived the topics. Key informants frequently discussed the importance of improving girls' self-esteem to empower them to make their own choices. Parents seemed to believe it was easier to talk to girls about the consequences of pregnancy, but they were not very explicit in the ways that they discussed prevention of pregnancies. On the other hand, parents seemed to address STIs more frequently with boys, and were also more explicit in their discussions about condom use. Though boys still need to understand the consequences of pregnancy and girls still need education about STIs, the parents' perception of how these different issues affect their children and what topics might get through to their children are interesting and must be taken into account.

There were also gender differences in how boys and girls preferred learning about SRH: girls appeared to be much more open to the idea of their mothers or peers giving them information while boys preferred more passive ways such as hearing about information in a presentation. This could be because boys feel more uncomfortable discussing the topics with people they know, making it even more important to begin to change the communication norms surrounding sexual health. By changing these norms, they could feel more comfortable receiving information from multiple sources. On the other hand, girls may feel more comfortable receiving information from friends or family members because they feel uncomfortable receiving the information in a group

setting where they might feel pressure from peers about sex. Segregated interventions for boys and girls could help alleviate some of this embarrassment.

Starting with Communication and Family Connectedness: recommendations for other evidence-based interventions

The results from this study show that further interventions need to be implemented with parents to encourage communication between all parties and improve parent-child connectedness even before they begin discussing sexual and reproductive health. Two such interventions, endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Registry of Evidence Based Programs and Practices, could be replicated in Paraguay (National Registry for Evidence Based Programs and Practice, 2013). These two programs have both been found to be effective in improving parent-child connectedness through a variety of measures in the United States and have been replicated in Latin America.

The first intervention, the Family Strengthening Program, is better known as *Familias Fuertes* in Latin American countries (NREPP, 2012c). This version was created in collaboration with the Pan-American Health Organization and contains videos with Spanish-speaking actors (Pan-American Health Organization). During my study, several higher level health officials mentioned that there are plans to implement this intervention in certain parts of Paraguay. This intervention is targeted to families with youth ages 10-14 and includes sessions for parents and children separately and together. The intervention's aims are to enhance parent-child bonding, manage anger and family conflict, and instruct parents on the risk factors for substance abuse. It has been found to be effective among US populations in decreasing substance use and aggressive behaviors while also improving school engagement and academic success.

The second program, Active Parenting Now, is for parents of children 2-12 years old (NREPP, 2012b). It also has a separate module for parents of teens called Active Parenting for Teens: Families in action (NREPP, 2012a). The original program is designed to teach parents effective communication techniques and ways to improve their children's self-esteem. It was found to improve parental reports of their children's behaviors and improve parent-child relationships. The teen version includes components for both parents and teens, and uses videos, role playing and other activities to involve parents and children. Participants in the evaluation of this intervention reported greater familial and school attachment, improved self-esteem and improved attitudes towards alcohol use. These interventions have also been translated into Spanish and used with Hispanic families in the US.

Though these programs do not directly address SRH outcomes, many of the risk and protective factors that they aim to target are similar to those that could cause poor SRH outcomes among teens. These programs are designed to focus on self-esteem, family strengthening and parent-child communication which are also topics that the participants in this *Families Talking Together* study identified as important building blocks to improve parent-child connectedness and prevent adolescent pregnancies. Though both of these interventions have been translated and used in Spanish, it is important to note that not all cultures and countries that speak Spanish are alike. This research on *Families Talking Together* reveals that even with translated materials, there are cultural norms that must also be taken into consideration when replicating an intervention. Implementing one of these programs successfully in Paraguay will still require background research and a feasibility assessment similar to the one performed with FTT. However when appropriately piloted and adapted, these interventions could serve as predecessors for the FTT intervention. Parents and their children could learn how to effectively communicate and

strengthen their relationships, making it easier for parents to discuss sexual and reproductive health with their children when the time comes.

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Appendix 1: Adolescent Mother Focus Group Discussion Guide

Families Talking Together Paraguay
Adolescent Mothers Focus Group Guide: Spanish Version

Research question: What is the appropriate age to begin discussing sexual and reproductive health with adolescents in Paraguay?

Specific Domains: Before implementing FTT researchers want to understand—

1. **The information that adolescent mothers had about sexual and reproductive health before getting pregnant**
2. **How adolescents perceived communication with their parents about sexual and reproductive health issues before getting pregnant**
3. **How adolescent mothers perceive parental monitoring and supervision**
4. **Where adolescents receive information about sexual and reproductive health**
5. **The age at which adolescent mothers believe that other adolescents should receive information about sexual and reproductive health in order to prevent an adolescent pregnancy**

Familias Hablando Unidas Paraguay
Guía de grupos focales con madres adolescentes

I. **Introducción—explicación sobre el proyecto y aseguramiento de anonimidad**

a. Aseguramiento de confidencialidad: "Hoy vamos a hablar sobre tus experiencias a cerca de tus conocimientos sobre la salud sexual y reproductiva y la comunicación con tus madres sobre estos temas. Con tu permiso, voy a grabar la conversación para que capte todo lo que dicen y puedo escucharlo otra vez si necesito para recordarme de los temas de que hablamos. Les invito a escoger un nombre ficticio para usar durante la discusión; no vamos a usar sus propios nombres durante la grabación, así que todo lo que dicen será anónimo. También, pedimos que mantengan la confidencialidad de esta sesión y que después, nadie comenta sobre esta conversación a personas ajenas. Así todos nos sentiremos más cómodos para hablar abiertamente sobre los temas. ¿Estamos de acuerdo?

b. Ok, queremos escuchar todas sus opiniones sobre este tema. No hay una respuesta correcta, así que por favor, digan todo lo que ustedes piensan.

c. Por favor, les pido que cada persona primero pase y diga su nombre ficticio, y cuantos años o meses tiene tu hijo/a.

II. **Para abrir: Preguntas sobre la sociedad en general** "Ok, primero les voy a pedir un poco sobre su comunidad."

a. Dominios: Percepciones de Monitoreo y Supervisión,

i. ¿En tu barrio, los padres cuidan mucho a sus hijos? ¿Cómo se ve que un padre o una madre está cuidando mucho a su hijo?

1. ¿Cuáles son algunas reglas que tienen los padres para los hijos?

ii. ¿Qué ustedes creen sobre las reglas que ponen estos padres?

iii. ¿Qué hay de diferencia entre los adolescentes que reciben buena atención de sus padres y los que no reciben buena atención?

III. **Acceso a la información;** *percepciones de comunicación con los padres*

"Ahora les voy a pedir sobre lo que piensan sobre algunos temas sobre la salud sexual. En particular, me interesa saber sobre el embarazo y la prevención del embarazo y qué han escuchado de cómo prevenir un embarazo."

a. ¿Cómo los jóvenes aprenden sobre la salud sexual y reproductiva? ¿De dónde?
    i. ¿Dónde habían aprendido ustedes del sexo antes de embarazarse?
    ii. ¿Cómo aprenden cuidarse de un embarazo no-deseado?
    iii. ¿Con quiénes hablan de estos temas?
    iv. ¿Cuántos años tenían cuando empezaron a aprender sobre estos temas?
b. ¿Es común que los padres hablen con sus hijos sobre el sexo y cómo cuidarse?
    i. ¿Qué piensan los adolescentes cuando sus padres hablan de eso?
c. ¿Qué les habían dicho tus madres u otros adultos sobre la salud sexual antes de embarazarse?
    i. ¿Tus sugerencias les ayudó? ¿Ustedes hicieron caso a lo que dijeron? ¿Por qué? ¿Por qué no?
    ii. ¿Cuántos años tenían ustedes cuando les empezaron a hablar de estos temas?
d. ¿Qué es la mejor forma de enseñar a los jóvenes cómo cuidarse de las enfermedades y un embarazo no-deseado?
    i. ¿Cómo les gusta a ustedes aprender de estos temas? ¿En la escuela? ¿Por charlas de doctores? ¿De los padres, amigos?

IV. **Edad necesario/adecuado de hablar sobre la salud sexual**

a. ¿A qué edad creen que los padres deben empezar a hablar con sus hijos sobre estos temas? ¿Por qué?

Yo ya no tengo preguntas para ustedes, pero quiero agradecer su participación. ¿Alguien quiere decir algo más? ¿Tienen algunas preguntas para mí?

Appendix 2: Key Informant Interview Guide

Families Talking Together Paraguay
Key Informant Interview Guide: Spanish Version

Research Question: What are the most important topics in adolescent sexual health and what is the best way to implement a program surrounding these parent-adolescent communication about topics?

Specific Domains:

1. **Current sexual and reproductive health needs for adolescents**
2. **Sources of information about sexual and reproductive health for adolescents.**
3. **Best practices for implementing parent-focused interventions surrounding sexual and reproductive health.**

I. Introducción

Hola, gracias por ofrecer a participar en esta entrevista. Yo le voy a estar haciendo algunas preguntas sobre la salud sexual adolescente. Si no quiere contestar ninguna pregunta, no hay problema, solamente hay que avisarme. (Leer Informed Consent) Tiene algunas preguntas?

II. Perspectivas de los adolescentes.

a. Primeramente, me puede contar un poco sobre tu trabajo con adolescentes?
    i. Por cuánto tiempo has trabajado con ellos?
    ii. Cuáles edades?
    iii. Qué tipo de población?
b. ¿Cuáles son los temas que vos ves como los más importantes de la salud de los adolescentes?
    i. Como son los servicios de salud para adolescentes?
    ii. Por qué crees que estos son los temas más importantes?
    iii. Cuáles son los temas importantes en la salud sexual de los adolescentes?
c. Ahora me interesa saber, de tu punto de vista, lo que saben los adolescentes sobre su salud. Cuánto saben los adolescentes de estos temas de la salud sexual que mencionaste?
    iv. ¿Por qué saben y por qué no lo saben?
    v. ¿Dónde aprenden de estos temas?
    vi. ¿Cuáles conocimientos tienen los adolescentes del aborto médico?
    vii. Hay adolescentes que se hacen abortos?
        1. ¿Cuáles son las técnicas más comunes que se ha visto?
        2. ¿Has trabajado con algunos adolescentes que se lo han hecho aunque sea ilegal?
            a. ¿Por qué lo hicieron? ¿Cómo reaccionaron después?
            b. ¿Cuales servicios hay para adolescentes que intentan abortar el feto? ¿Qué opinas de esos servicios?
        3. ¿Cual tipo de información necesitan saber los adolescentes para que puedan mejor prevenir un embarazo no-deseado?

a. ¿Qué tipo de cosas deben aprender los adolescentes sobre el aborto?
b. ¿Cuáles cosas todavía deben saber los adolescentes sobre la planificación familiar?
c. ¿Cuál es la mejor forma de aprender de estas cosas? ¿Dónde aprenden de estos temas hoy en día?
    i. ¿Dónde deben aprender estas cosas?
    ii. ¿A qué edad deben aprender? ¿Por qué?

III. **Familias Hablando Unidas:** Lo que yo estoy haciendo aquí es una evaluación de un programa titulado, "Familias Hablando Unidas". Este programa hace 3 talleres con madres de adolescentes, enseñándoles técnicas de cómo hablar con los adolescentes sobre la abstinencia, la prevención del embarazo y las ITS. Usa los siguientes materiales para enseñar a los padres y a los hijos.

a. ¿Qué opinas de un programa así?
    i. ¿Cuáles son algunas ventajas de un programa así?
    ii. ¿Cuáles son algunas desventajas o desafíos de implementar un programa así?
    iii. ¿Cuáles son los temas que usted crees que se deben tratar los padres/madres con sus adolescentes?
    iv. ¿Cuál es la mejor manera de ofrecer estas técnicas a los padres?
        1. ¿En grupo?
        2. ¿Individual?
        3. ¿Quién es el mejor/la mejor tipo de persona para presentar un programa asi?
        4. ¿Los materiales escritos funcionan con las poblaciones con que trabajas?
        5. Hay dos maneras de hacer esta intervención—de forma grupal con dos a tres horas de talleres o individual, lo que dura más o menos media hora. ¿Cuales son algunas ventajas o desventajas de hacerlo de cada forma desde tu perspectiva?
            a. ¿Cuál cree que funcionaría mejor para la población con que trabaja?
            b. Para tu organización, ¿cuáles recursos tienen para implementar un programa así?
            c. ¿Cuáles otros recursos necesitarían para implementar un programa así?
            d. ¿Cuáles serían algunos desafíos de implementar el programa con tu organización?
        6. Te interesaría usar el taller en tu organización en el futuro?

Ya yo no tengo más preguntas para usted, pero quiero saber ¿si quiere agregar algo? ¿Tiene algunas preguntas para mí? Muchas gracias por su tiempo y participación en el programa.

Appendix 3: Parent Focus Group Discussion Guide

Families Talking Together Paraguay
Parent Focus Group Guide: Spanish Version

Research question: How appropriate is the FTT intervention for improving parent-teen communication about sexual and reproductive health in Paraguay?

Specific Domains: After the implementation of the intervention, researchers want to understand:

1. **How parents communicated with their children in the past about sexual and reproductive health topics.**
2. **How parents understand what it is like to be an adolescent.**
3. **Parents' confidence in communicating with their child**
4. **Parents' current perceptions of their relationship with their child**
5. **How the materials contributed to the knowledge of sexual and reproductive health topics**
6. **How the materials and intervention contributed to the discussion of sexual and reproductive health**
7. **The perceptions of the acceptability of the intervention and ways to improve it in Paraguay**

Familias Hablando Unidos Paraguay
Guía de grupos focales con madres/padres

I. Introducción

a. Aseguramiento de confidencialidad: "Hoy vamos a hablar sobre sus experiencias hablando sobre el sexo con sus hijos. Con su permiso, voy a grabar la conversación para que capte todo lo que dicen y puedo escucharlo otra vez si necesito para recordarme de los temas. Les invito a escoger un nombre ficticio para usar durante la discusión; no vamos a usar sus propios nombres durante la grabación, así que todo lo que dicen será anónimo. También, pedimos que mantengan la confidencialidad de esta sesión y que después, nadie comente sobre esta conversación a personas ajenas. Así todos sentiremos más cómodos para hablar abiertamente sobres los temas. Estamos de acuerdo?

b. Ok, yo voy a estar preguntándoles sobre sus conversaciones con sus hijos sobre la salud sexual y los materiales que leyeron. Queremos saber de las experiencias y opiniones de todos, así que por favor no tengan vergüenza en contestar, al mismo tiempo si no quieren contestar una pregunta no tienen que contestar. Para empezar, voy a pedir que cada persona pase por la sala y se presente con el nombre que le gustaría ser identificado, y por favor díganos una cosa que dijeron a sus hijos sobre lo que habían aprendido durante el programa de Familias Hablando Unidos.

II. Para abrir: preguntas leves sobre la sociedad en general:

"Ok, quiero entender un poco más sobre la comunidad aquí"

a. ¿Es común hablar con los hijos sobre el sexo? ¿Por qué creen que algunos padres no hablan sobre el sexo?
b. Voy a pedir que cada uno diga la edad de su hijo/hija y qué dijeron a ellos después de participar en FHU.

III. Comienzo de la discusión sobre los temas de la intervención

A. Confianza sobre la comunicación; Historia de comunicación; Contribución de los materiales e intervención a la discusión

1. ¿Habían hablado con su hijo sobre el sexo o la salud sexual antes de participar en "Familias Hablando Unidas?
   a. ¿Cuándo y cómo fue?
   b. ¿Cómo se sintieron mientras que estaban hablando con Ellos?
2. Cuando fueron a la casa después de estas sesiones, ¿cómo ustedes usaron los materiales?
3. Cómo les fue cuando les hablaron y les mostraron los materiales?
   a. ¿Fue fácil hablar sobre los temas? ¿Por qué, por qué no?
   b. ¿Cuál técnica usaron? ¿Por qué?
4. ¿De qué hablaron con sus hijos mientras leían los materiales y las actividades?
   a. ¿Qué fue el tema en que más enfocaron o hablaron?

B. Mejorar su relación con ellos; Confianza sobre la comunicación

5. ¿Cómo se sintieron hablando con él/ella?
6. ¿Cómo ustedes creyeron que ellos respondieron/sintieron?
   a. ¿Cómo reaccionaron a los materiales que recibieron?
7. ¿Algo les sorprendió sobre su conversación?

C. Dominios: Entender lo que es ser adolescente en Paraguay, saber más información sobre la salud reproductiva y sexual.

8. ¿Cuáles son algunas de las cosas que aprendieron durante las sesiones de Familias Hablando Unidas?
   a. ¿Cuáles cosas nuevas aprendieron sobre los adolescentes?
   b. ¿Cuáles cosas nuevas aprendieron sobre la comunicación?
9. ¿Cuál parte de las sesiones les gustó más? ¿Por qué? ¿menos?
   a. ¿Había una actividad en particular que disfrutaron?
10. ¿Cuál parte de la sesión les hizo pensar en la situación de su hijo más?
    a. ¿En cuál parte de la sesión pudiste pensar en una situación parecida con su hijo/a?

IV. Aceptabilidad del programa; Cierre

a. ¿Cuáles sugerencias daría a otras madres que quieren hablar con sus hijos sobre estos temas?
b. ¿Cómo se podría mejorar la sesión?
c. ¿De cuáles temas quisieran saber más?
d. ¿Qué diría a otra mama sobre este programa?
e. ¿Cuáles tipos de mamás creen que usarían los materiales?
f. ¿Cómo reaccionarían otras madres a este programa?
   i. ¿Vendrán si es ofrecido otra vez?
   ii. ¿Creen que son útiles las sesiones?

g. ¿Cuál es la mejor manera de ofrecer este programa a las mamás? ¿Cómo se puede animarlas a venir?
   i. ¿Dónde? ¿Quién lo debe enseñar? ¿Cómo? (¿En grupo o individual?)
   ii. ¿Cuáles son algunos formas de ofrecer el programa que no se debe hacer?
   iii. ¿Cuáles son algunas razones que los padres no vienen a las reuniones y talleres?
      1. ¿Cómo podemos ofrecer el programa para que sí vienen?

Ya yo no tengo más preguntas para ustedes, ¿pero quiero saber si ustedes quieren agregar algo? ¿Tienen algunas preguntas para mí? Muchas gracias por su tiempo y participación en el programa.

Appendix 4: Individual Adolescent Discussion Guide

Families Talking Together Paraguay
Adolescents Focus Group/Individual Interview Guide: Spanish Version

Research question: What are adolescents' perceptions of parent-teen communication both in general and after their mothers received the FTT intervention?

Specific Domains: After the implementation of the intervention, researchers want to understand:

1. **How adolescents perceive parental monitoring and supervision**
2. **How adolescents perceive communication with their parents about sexual and reproductive health issues**
3. **How adolescents reacted to the FTT materials their mothers brought home**
4. **The key themes that the adolescents learned from the FTT materials**
5. **The reaction of the adolescents to their discussions with their mothers**
6. **How adolescents think the intervention may assist them in discussing these issues with other adults, such as service providers**

Familias Hablando Unidos Paraguay
Guía de grupos focales con adolescentes

I. **Introducción—explicación del proyecto y aseguramiento de confidencialidad**
   a. Aseguramiento de confidencialidad: "Hoy vamos a hablar sobre sus experiencias de comunicar sobre algunos temas con sus madres. Les invitamos participar en esta reunion para hablar con nosotros por mas o menos una hora sobre estos temas. Con su permiso, voy a grabar la conversación para que capte todo lo que dicen y puedo escucharlo otra vez si necesito para recordarme de los temas. Les (Te) invito a escoger un nombre ficticio para usar durante la discusión; no vamos a usar sus propios nombres durante la grabación, así que todo lo que dicen será anónimo. También, pedimos que mantengan la confidencialidad de esta sesión y que después, nadie comente sobre esta conversación a personas ajenas. Así todos nos sentiremos más cómodos para hablar abiertamente sobre los temas. Estamos de acuerdo?
   b. Ok, queremos escuchar todos sus opiniones sobre este tema. No hay una respuesta correcta, así que por favor, digan todo lo que ustedes piensan.
   c. Por favor, cuéntame un poco de ti, ¿Qué te gusta hacer en tu tiempo libre? ¿Quiénes viven en tu casa? ¿De dónde son tus amigos? ¿En quién confías en tu vida? ¿Tienes un/a novio/a?

II. **Para abrir: Preguntas sobre la sociedad en general** "Ok, ahora te voy a pedir sobre lo que piensan sobre algunos temas sobre la supervisión y comunicación con los padres."
   a. Dominios: Percepciones de Monitoreo y Supervisión, percepciones de comunicación con los padres
      i. ¿Tu padre/madre le permite tener novio/a?
      ii. ¿Qué opinas de esto?
      iii. ¿Tu padre/madre te pone reglas? ¿Cómo te sientes cuando te ponen estas reglas?

iv. ¿En su barrio, los padres cuidan mucho a sus hijos? ¿Cómo se ve que un padre o una madre está cuidando mucho a su hijo?
    1. ¿Cuáles son algunas reglas que tienen los padres para los hijos?
v. ¿Cómo son los hijos de los padres que los cuidan mucho?
vi. ¿Qué ustedes creen sobre las reglas que ponen estos padres?
    1. ¿Los hijos que tienen muchas reglas se portan mejor/hacen mejores decisiones? ¿Por qué o por qué no?

III. Discusión sobre *Familias Hablando Unidos*

a. Reacción a los materiales

i. ¿Ustedes vieron los materiales que llevaron sus padres a casa verdad?
ii. ¿Qué tal les gustaron, o no les gustaron?
iii. Ok, ¿que aprendieron de estos materiales? ¿Cuáles partes te llamó la atención?
iv. ¿Creen que otros adolescentes leerían estos materiales?

b. Reacción a la discusión con sus madres sobre la salud reproductiva y sexual; lo que aprendieron sobre el tema; Aceptabilidad del programa

i. Antes del taller, tu mamá te había hablado de este tema?
    1. ¿Qué te había dicho?
    2. ¿Cómo te sentiste?
ii. ¿Cuando tu madres les empezaron a hablar sobre la salud reproductiva y sexual esta vez, que pensaron?
iii. ¿Cómo se sintieron cuando empezaron a hablar con ustedes?
iv. ¿Qué aprendieron cuando ella les habló?
v. ¿Ustedes creen que los adolescentes hacen caso a los padres cuando les hablan de esto?
    i. ¿Ustedes mismos le gusta escuchar lo que tienen que decir los padres?

c. Actitudes acerca de la comunicación con sus padres sobre la salud reproductiva y sexual.

i. ¿Dónde aprenden los jóvenes sobre la salud sexual/cómo prevenir el embarazo?
ii. ¿Con quienes hablan sobre el sexo los jóvenes?
iii. ¿Qué les dicen esta gente sobre el sexo?
iv. ¿Qué piensan cuando se habla sobre esto (con cada grupo mencionado)?
v. ¿Es común que los padres hablan con sus hijos sobre el sexo?
    1. ¿Qué les dicen normalmente?
vi. ¿Qué piensan los adolescentes cuando sus padres hablan de eso?
vii. ¿De qué forma te gustaría recibir información así?

II. Aceptabilidad del programa; Cierre

a. ¿Compartirían ustedes los materiales con sus amigos?
b. ¿Qué dirían ustedes a un amigo suyo sobre los materiales que vieron?
c. ¿Cuáles sugerencias darías a tus hijos o hermanitos/primitos cuando tenga la edad apropiada sobre estos temas? ¿Cuáles reglas pondrían a tus hijos/as?
d. ¿En el futuro que te gustaría hacer?

Ya yo no tengo más preguntas para ti, pero quiero agradecerte tu tiempo. ¿Tienes algo más que quieres decir? ¿Tienes algunas preguntas para mí?

Appendix 5: Codebook

Love	Any mention of love in a romantic way between partners. Includes love being used as a pressure (proof of love, *prueba de amor*). Also includes discussions about what love is and references to the materials where the definition of love is discussed.
Trust/Confianza	Refers to discussion of people trusting or confiding in one another. Could include parents trusting their children, adolescents trusting their parents or friends or adolescents confiding in their parents, friends, or another trusted person.
Peers	Any reference to adolescents' relationships or interactions with other peers, does not include romantic relationships. Does include how their peers influence them, how they interact with peers, information they gain from peers, perceptions of peers' actions and beliefs. Peers can include siblings.
Gender	Any mention of the differences between girls and boys, or things that are specific to boys or girls. Also includes mentions of gender roles in sex and relationships. Includes discussions of homosexuality.
Reproductive health	Reference to biological reproductive health issues. Includes mentions of anatomy, menstruation and biological changes during adolescence.
STIs	Any time any sexually transmitted infections, including HIV/AIDS, are mentioned.
Monitoring	References to the ways in which parents monitor their children's actions. Includes any rules that exist for the adolescents, if parents regulate where they go, and any communication about where the adolescent is or is going.
Contraceptives	Any mention of techniques (including condoms, pills, or injections) used to prevent pregnancy or STIs. Includes any ideas or myths that participants mention about how people get pregnant or how pregnancy can be prevented. Includes any mention of protecting oneself (*cuidarse).*
Relationships	Discussion of boyfriends and girlfriends and male/female relationships that are romantic, meaning they are referring to boyfriends/girlfriends or liking/loving someone.
Information	Any reference to where adolescents receive information about sexual and reproductive health issues. Includes discussions about teachers presenting sexual education in schools and any mention of where adolescents prefer to receive information. Includes communication with other people (not parents) about advice that they received. This only refers to instances where they received new information, could include influences by media.
Pregnancy	References to pregnancy among adolescents, including reasons they get pregnant and attitudes towards adolescent pregnancies. This does not include discussion about contraceptives but does include discussions surrounding abortion.
Sex	Any mention of sex or communication about sex. Includes pressures to have sex and reasons adolescents have sex
Materials	Mention of the FTT materials that parents used or gave their children during the intervention (does not include discussions of other materials or types of information. Includes reactions to the FTT materials, parts that parents/adolescents/KIIs found interesting, and how parents and their children communicated about the materials.
Modifications	Any suggestion to modify any part of the intervention, improve it, or do an intervention that may be similar. Includes kids saying how they like to receive information. Also includes what parents think other parents might think of FTT and mentions of similar interventions that have been effective
Reactions to intervention	Any time someone mentions their opinion of the intervention that does not suggest a modification. Can also include mentions of how FTT intervention affected them. In the case of adolescents, this includes how the materials might have affected them or what they thought of the content.

P-C Relationship	Any time there is mention of parent/child communication and/or the quality of the relationship. This could also refer to other parent-child relationships, not just personal relationships mentioned. Includes when parents are reacting to the intervention and mention the quality of relationship with their child. Includes communication they have with their child if the communication is directly about relationships, STIs, pregnancy, contraceptives or reproductive health.
Current situation	This is a structural code referring to the situation before the implementation of FTT. Includes discussion of adolescent knowledge, attitudes or practices towards sexual and reproductive health (including STDs, HIV, pregnancy), where they get this information, and and mention of current romantic relationships. This includes when parents and kids communicate and adolescents tell their parents about their "current situation" if it includes sex/relationships/SRH. Includes communication between adolescents about perceptions of others and sex (including advice they give/would give to others).
Violence	Any mention of violence between parents, in a relationship, or between kids. This includes sexual violence, including rape.