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Kathryn Standish Date

Associations between parent-female adolescent sexual and reproductive health communication and first sexual and reproductive healthcare seeking experiences amongst low income women in suburban areas outside of Atlanta, Georgia.

By

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Chapter 1: Introduction

Context and Problem

Adult and adolescent women's autonomy over their sexual and reproductive health (SRH) care is vital to women and society's overall wellbeing. Unintended teenage pregnancies can have short and long-term adverse health effects, as well as negative social and financial implications for the individual and the community (Nove, Matthews, Neal, & Cambacho, 2014; CDC, 2019a). Teenage mothers who carry to term may be at a higher risk for health complications such as delivery complications and maternal mortality than women aged 20-30 (Nove, Matthews, Neal, & Cambacho, 2014). Teenage mothers are also more likely to experience financial hardship than mothers who deliver at a later age (Wall-Wieler, Roos, &Nickel, 2016; Hoffman & Marynard, 2008, and are less likely to finish high school than teenagers who do not become pregnant (Perper, Peterson, & Manlove, 2010; CDC, 2019a). Limited educational advancement and economic insecurity can have harmful effects on mother and baby (Hoffmann & Maynard, 2008).

Teen pregnancies in the United States remains higher than other developed regions and are largely underreported (Wall-Wieler, Roos, & Nickel, 2016; Potter, Trussell, & Moreau, 2009; Finer & Henshaw, 2006). Female adolescents in Georgia are disproportionately affected. Sexual education and SRH related policies have been affected by the deep rooted religious and cultural norms in The South. Sexual education is mandated to be taught in Georgian schools, however the information provided does not need to be medically accurate, does not need to discuss condom or contraception, can promote religious values, and is not required to be age or culturally appropriate (Guttmacher, 2020). Restrictive SRH policies are rife within the United States and are particularly so in the South. Georgia, for example, is one of six states that legally allows

pharmacists and medical professionals to refuse family planning services, such as contraceptives counseling and care, due to personal moral or ethical beliefs (NARAL, 2020). Cultural norms and restrictive policies are reflected in SRH outcomes among female adolescents in Georgia. Adolescents have a higher unintended pregnancy rate and higher STI rates in Georgia compared to the national average (Guttmacher, 2014; US Department of Health and Human Services, 2014).

Use of contraception, access to teen friendly SRH services and counseling can reduce teen pregnancies and influence other adolescent SRH outcomes (UNFPA, 2014). Non-use, as well as misuse of contraception is a large contributor to unintended teenage pregnancies (Bell, Gifford, Rashid, McDuffie, & Knight, 2020; Potter, et al., 2009, Manlove et al, 2004). Female adolescents who utilize no method of birth control in their first year of becoming sexually active are 85% likely to become pregnant compared to 6-9% of adolescents who use birth control (Trussel, 2011). In a 2017 study that explored female adolescent's (15-19 years) contraceptive use found that of the 42.4% of participants that reported being sexually active only 31% had ever used an oral contraceptive in the last 3 months, 12.6% had used another hormonal method, and (Abma & Martinez, 2017). While this is a slight increase from previous years, more is needed to be done to increase contraceptive use among female adolescents in the United States to help decrease unintended pregnancies.

Studies have shown parents play a significant role in reducing adolescent unintended pregnancies (Widman, et al., 2016; Flores & Barroso, 2016) and can also hold the greatest influence over a female adolescent's SRH outcomes (Lantos, et al., 2019; Somers& Surman, 2004). Studies have also shown parents are the preferred and trusted source for SRH information amongst adolescents (Albert, 2012). According to The National Campaign to Prevent Teen and

Unplanned Pregnancy's national survey, parents (41%) hold the greatest influence over a female adolescent's sexual and reproductive health decisions, more than friends (20%) or the media (9%) (Albert, 2012). One study found that nine out of ten teens reported open communication with their parents would help them avoid teen pregnancy (Albert, 2012). Studies have shown parent-teen discussions regarding sexual and reproductive health are positively associated with sexual and reproductive health service use, however more research is needed to examine the content of the discussions and its association with SRH service use (Hall, Moreau, & Trussell, 2012) (Lantos et al., 2019).

Objectives and Aims

This study aims to assess the impact of parent-female adolescent (parent-adolescent) SRH discussions on female adolescent's first sexual and reproductive healthcare seeking experience amongst low income women in suburban areas outside of Atlanta, Georgia. The specific aims of this study are:

1) To examine the circumstances which facilitate the initiation of parent-adolescent SRH discussions.
2) To explore the content of parent-adolescent SRH discussions.
3) To assess the association between the content of parent-female adolescent sexual and reproductive health discussions and female adolescent's first sexual and reproductive healthcare seeking experience amongst low income women in suburban areas outside of Atlanta, Georgia.

Chapter 2: Literature Review

Unintended Pregnancies

Adult and adolescent women's autonomy over their sexual and reproductive health care is imperative for her and society's overall wellbeing (Yazdkhasti, Pourreza, Pirak, and Abdi, 2015). Although unintended pregnancies can fall under a spectrum of intention, clarification between unintended pregnancies and mistimed pregnancies is typically assessed by women's responses to survey questionnaires. For example, in a 1998 Pregnancy Risk Assessment Monitoring System (PRAMS) survey, women were asked "Thinking back to just before you got pregnant, how did you feel about becoming pregnant?" If the participant responded wanted at a later time, the pregnancy was classified as mistimed, if the participant responded she did not want to become pregnant currently, or in the future, it was labeled as unwanted (D'Angelo, Gilbert, Rochat, Santelli, & Herold, 2004). D'Angelo et al., (2004) clarified the way in which a survey assesses pregnancy intendedness can influence responses from participants. PRAMS used a single question in a mail-in survey (as well as a follow-up phone call) to ascertain pregnancy intendedness, whereas the National Survey for Family Growth (NSFG) used a series of questions during face to face interviews (D'Angelo, et al., 2004). Pregnancy intention measurements can vary extensively depending on the study's setting and population (Gipson, Koeing, & Hindin, 2008). For example, retrospective cross-sectional studies rely on mothers' memory recall regarding their feelings at the time of their pregnancy (Gipson, et al., 2008). This can pose a problem, as women may have changed their opinions or attitudes associated with their pregnancy at the time (Gipson, et al., 2008; D'Angelo, et al., 2004). However, retrospective designs are typically the study of choice, as prospective studies pose their own issues, especially as studies attempt to capture a woman's intention in the future, which may likely change (Gipson, et al.,

2008). For the purposes of this paper, unintended pregnancies will be defined as unwanted (not wanted at any time) or mistimed pregnancies (wanted at a later time) (Gipson, et al., 2008).

Unintended pregnancy health implications

Unintended pregnancies can have negative life consequences such as adverse mental and physical health effects, financial strain, and constricted life choices (Yazdkhasti, et al. 2015; Herd, 2016; Finer, Lindberg, & Desai, 2018). Unintended pregnancies can lead to an increased risk of depression, anxiety, and decline of psychosocial conditions (Abajobir, Maravilla, Alati, & Najman, 2016). Compared to women with intended pregnancies, women who carry unintended pregnancies to term are more likely to experience depression during pregnancy, post-partum, and the first 7 years after birth (Herd, 2016; Abajobir, etl al. 2016). Studies conducted in the United States found a significant association between pregnancy intentions and timing of antenatal care. Women who deliver an unintended pregnancy to term are more likely to delay prenatal and antenatal care, which can delay diagnosis of health complications for both mother and fetus and increase the risk of adverse health effects (Gipson, et al., 2008). Studies have reported associations between unintended pregnancies and physical neonatal or maternal health outcomes. Retrospective and prospective studies found unwanted pregnancies in the United States have an increased risk of premature delivery, low birth weight, congenital anomalies, and spontaneous abortion (Orr, Miller, James, & Babones, 2000; Sable and Wilkinson 2000). Additionally, induced abortion to terminate unintended pregnancies is not an option available to all women in the United States due to age, state, or financial restrictions (Guttmacher Institute, 2020; Yazdkhasti, et al. 2015). Women who are forced to seek alternative abortion practices outside of a clinical setting are at greater risk of short term and longer-term morbidity, and death

(Gipson, Koeing, & Hindin, 2008; Yazdkhasti, et al., 2015). Even when women have access to safe abortion practices and facilities, women may wish to avoid a medical event and possible health complications not of their choosing (Gipson, et al., 2008; Yazdkhasti, et al., 2015).

Unintended pregnancy costs

Assessments from 2010 estimate that the US government spends roughly $21billion on unintended pregnancies, abortions, and miscarriages from unintended pregnancies in the US (CDC, 2015). In addition to direct cost, indirect cost can bear an even greater toll on society. Population health is affected by its age structure, population growth, unemployment, and health characteristics of its population. Just over half (50.8%) of the US population is female, and roughly one quarter (24%) are of childbearing age (Monte & Ellis, 2014). Unintended pregnancies can lead to higher levels of school dropout rates, lower levels of education, lower levels of income, and decreased professional advancement (Yazdkhasti, et al., 2015; Monea & Thomas, 2011). Lower levels of educational attainment and reduced career opportunities decrease a woman and her family's financial stability (Yazdkhasti, et al., 2015), and also deprives the US economy of contributions from a significant portion of its population.

Unintended pregnancy trends

Unintended pregnancies in the US rose from 48% to 51% between 2001 and 2008 but began to decline in 2011. The most recent estimate from 2011 indicates that roughly 45% of all pregnancies in the United States are unintended (Finer & Zolna 2016). Although rates of unintended pregnancy have declined, the US unintended pregnancy rate remains higher than other developed regions in the same time frame, such as Western and Northern Europe (28% and 27%) (Bearak, et al., 2018). Despite narrowing slightly, disparities amongst different racial and

ethnic groups, and income brackets have continued. As of 2011unintended pregnancy rates for women below 200% of the federal poverty level (FDL) were three times higher (six for those below 100% of the FDL) than women above 200% FDL. Rates among Black non-Hispanic and Hispanics remained higher than White-non-Hispanics in the US, even when controlling for income. Correlations between lower education levels and higher unintended pregnancy rates have also continued. While Finer and Zolna did not directly analyze factors that may have contributed to the decline in unintended pregnancy rates in 2011, they did note that more women in all demographic groups reported using highly effective long-acting methods of birth control between 2007 and 2012 which may have had an effect (Finer & Zolna 2016).

Teen Pregnancy and Sexual and Reproductive Health Outcomes

Teen pregnancy remains high in the United States (Wall-Wieler, Roos, & Nickel, 2016). Teen pregnancies in adolescents are largely reported as unintended pregnancies (Potter, Trussell, & Moreau, 2009; Finer & Henshaw, 2006). Negative health consequences exist for both mother and baby. Infants born to adolescent mothers are more likely to be born premature, have lower birth rates, and higher chances of neonatal mortality (Chen, Wen, Felming, Demissie, Rhoads, & Walker, 2007; Wall-Wieler, et al, 2016; Satin, Leveno, Sherman, Reedy, Lowe, & MicIntire, 1994). Teenage mothers who carry to term may be at greater risk of maternal mortality and delivery complications compared to women who deliver between the ages of 20-30 (Nove, Matthews, Neal, & Cambacho, 2014). Teen pregnancy can also have detrimental financial and social impact on the mother and child (Nove, et al., 2014; CDC, 2019a). Teen mothers are less likely to finish high school and more likely to experience economic hardship (Wall-Wieler, Roos, &Nickel, 2016; Hoffman & Marynard, 2008) compared to women who deliver at a later

age. Teenage girls who do not experience a pregnancy or birth are 90% likely to receive a high school diploma by age 22, compared to just under 50% of teen mothers (Perper, Peterson, & Manlove, 2010; CDC, 2019a). Lower education and economic insecurity can have lasting impacts on the adolescent and child (Hoffman & Maynard, 2008). Economic insecurity can cause a great disturbance to the future of both the individual and society and is an area of concern as the US teen birth rates remain high. The 2018 US teen (15-19 years old) birthrate was the lowest on record at 17.4 births per 1,000 (CDCb, 2019), but remains higher than the UK, Western Europe, Canada, and other developed nations (Kawakita, et al., 2017). Reducing teen pregnancy is a major US priority (Kost & Henneshaw, 2012) and continues to be an area in need of response.

Factors that influence adolescent SRH outcomes

Contraception

Contraceptive use, access to SRH care, sensitive counseling, and sexual education influence adolescent SRH knowledge and outcomes (UNFPA, 2014). Non-use and misuse of contraception is a major contributing factor to teen pregnancy (Bell, Gifford, Rashid, McDuffie, & Knight, 2020; Potter, et al., 2009, Manlove et al, 2004). Within their first year of use, 85% of sexually active females of reproductive age who use no method of birth control are likely to experience an unintended pregnancy, compared to 6-9% of those using a form of birth control (pill, patch, shot, or NuvaRing), 0.2-0.8% using an intrauterine contraceptive (IUD), or 0.05% using an implant (Trussell, 2011). In 2017, under half of sexually active female adolescents used oral contraception, and even fewer used a shot, patch, IUD, or implant. A 2017 study examined adolescent (aged 15-19 yeas) sexual activity and pregnancy prevention methods using national

survey data from 2011-2015. Of the female respondents, 42.4% having had sexual intercourse (Abma & Martinez, 2017). Female adolescents who had sexual intercourse were asked about the types of pregnancy prevention methods they had ever used. In the 2011-2015 time-period, 97% of female adolescents had used condoms, 56% had used an oral contraceptive, 5.8% had used long acting contraceptives (LARC) (Abma & Martinez, 2017).While contraception has slightly increased in more recent years (2011-2015) (Abma & Martinez, 2017), improvements in contraception use and availability are needed.

Access to and use of SRH services for adolescents

Lack of access to contraceptive care and SRH services can cause disruption or non-utilization of care and can thus negatively impact SRH outcomes among adolescents (Hock-Long, Herceg-Baron, Cassidy, & Whittaker, 2003). US adolescents are more likely than other industrialized regions such as western Europe, Canada, and the United Kingdom to experience barriers to SRH services (Hock-Long, et al., 2003).

Financial issues exist such as health insurance coverage and ability to pay (adolescent's or family's) for services and prescriptions. Structural issues, such as level of confidentiality adolescents have with their providers (Fuentes, Ingerick, Jones, & Lindbergh, 2018) and youth friendly access and awareness of SRH services (Fuentes, et al., 2018; Hock-Long, et al., 2003) remain barriers to adolescents in the US as well. A 2018 study, which examined U.S. adolescents' SRH confidentiality concerns using national survey data from 2013-2015, found 18.9% of female adolescent (15-17 years) respondents would forgo SRH services for fear of a parent finding out. Concerns were more common for younger adolescents of both sexes (Fuentes, et al., 2018). However, Fuentes, et al. found that female adolescents who had discussed more

SRH topics with their parents were "more likely to have had time alone with their health care-care provider at their last visit" (2018).

Sex education

Sexual education classes in classrooms and community centers have been shown to improve adolescents' receipt of sexual health information (Lindberg, Ku, & Sonenstein, 2000); however differences in content and delivery methods leads to varied results (Hall, Sales, Komro, Santelli, 2016). Comprehensive sexual education is effective at increasing adolescent's receipt of sexual information and increasing contraception and condom use (Chin, Sipe, Elder, et al, 2012; Linderbergh & Maddow, 2012) while abstinence only until marriage (AOUM) has been shown to be less effective at reducing sexual activity and risky behaviors (Boonstra, 2008; Hall, et al., 2016; Santelli, Ott, Lyon, Rogers, Summers, & Schleifer, 2006). Despite the lack of evidence of the efficaciousness of AOUM education, deep seated religious and cultural norms affect state and national policies and funding surrounding content and delivery methods of sexual education in schools (Shalet, Satnelli, Russel, et al., 2014; Hall, et al., 2016). Until 2009, federal funding was almost exclusively given to AOUM , despite strong evidence that sexual education emphasizing a rights-based approach that engage adolescents being proven most effective (Strasbuger & Brown, 2014; Shalet, et al., 2014; SEICUS, 2015). While federal funding has changed since 2010, funding for AOUM programs persist and allows for AOUM continuance in schools today (Shalet, et al., 2014). While declines in teen pregnancy occurred in the 2006-2013 time period and contraception use increased during the 2007-2014 time period, sexual education programs declined, suggesting adolescents receive SRH and contraception information elsewhere, including peers and family (Santelli, Lindberg, Finer, & Singh, 2007).

Parent-adolescent communication

The adolescent period (10 to 19 years of age) is a crucial developmental time for an individual, especially when learning to form romantic relationships and establishing sexual identities and behaviors (Widman, Choukas-Bradley, Noar, Nesi, & Garrett, 2016). In developmental and health behavior theory, it is widely acknowledged that both parents play an influential role in child and adolescent development and can impact adolescent behavior. (Widman, et al., 2016; Flores & Barroso, 2017). According to The National Campaign to Prevent Teen and Unplanned Pregnancy's national survey, parents (41%) hold the greatest influence over a female adolescent's sexual and reproductive health decisions, more than friends (20%) or the media (9%) (Albert, 2012). Furthermore, studies show that parent-adolescent relationships play a significant role in unintended pregnancy outcomes, particularly among adolescent and young adult unintended pregnancies (Albert, 2012; Widman, et al., 2016; Flores & Barroso, 2016).

Notably, teens prefer parents for sexual education (Somers & Surmann, 2004) and teens themselves believe in the importance of parent-adolescent communication surrounding sexual and reproductive health. One study found that nine out of ten teens reported that open communication with their parents would help them avoid teen pregnancy (Albert, 2012). Parent-adolescent discussions regarding sexual and reproductive health (which will be defined for this paper as discussions between an adolescent and their guardian related to contraception, sexual behavior, and STI and pregnancy prevention) have been shown to reduce teen's risky sexual behavior and engage in healthy sex practices that prevent STI and pregnancy (Lantos, et al., 2019; Widman, et al., 2016). Furthermore, teens who have described having a high level of communication with their parents also report protective behaviors such as condom use at first

and most recent sexual intercourse encounters, and discussing STI prevention with their sexual partners (Lantos, et al., 2019; Widman, et al., 2016; Flores & Barroso, 2017). Female adolescents, in particular, who discuss sex with their parents, are more likely to use condoms when engaging in sexual activity, and to also delay their sexual debut (Lantos, et al., 2019).

A mixed methods study conducted by Bell, Gifford, Rashid, McDuffie, and Knight (2020) explored mother-daughter SRH contraceptive discussions and adolescent contraceptive service use. They found young woman's contraceptive beliefs and practices were influenced by SRH discussions and interactions with their mothers. For example, they found mothers played a large role in their daughter's access to contraception, including picking up their daughters' oral contraceptives from the pharmacy, reminding their daughters to pick up their prescriptions, or to schedule a contraceptive service visit (Bell, et al., 2020). Bell, et al. (2020) found that young women were more likely to have used a contraception method (pill, injectable, or LARC) if older women in their household had also used the same method. This indicated that mothers play an influential role in not only the initiation of contraceptive SRH services, but also in the type of contraception their daughters use. Additionally, of the mother/daughters who both used oral contraception, 33% shared the same prescribing physician (Bell, et al., 2020), signifying daughters may also be more likely to utilize their mother's physicians. Analysis also found that of young woman participants who used oral contraception, those aged 15-17 years old were significantly more likely to share the same contraceptive form as the older women in their household than those over the age of 18 (Bell, et al., 2020).

Although parent-adolescent discussions regarding SRH have also been shown to reduce negative sexual health outcomes, disparities in the frequency and content of SRH discussions among racial/ethnic groups and gender exist (Hall, Moreau, & Trussell, 2012a; Meneses, Orrell-

Valente, Guendelman, Oman, & Irwin, 2006). Meneses et al. suggest disparities in parent-adolescent SRH discussions among racial/ethnic groups may contribute to the disparities in sexual health outcomes amongst different adolescent racial/ethnic groups in the US (Meneses, Orrell-Valente, Guendelman, Oman, & Irwin, 2006). Overall, white teens have reported having more SRH conversations with their parents than black and Hispanic teens (Meneses, Orrell-Valente, Guendelman, Oman, & Irwin, 2006). Mothers who identified as Hispanic reported fewer SRH discussions with their teen children as compared to white and black mothers. Hispanic mothers from the same study, however, more accurately reported if their teenagers were sexually active. Meneses et al. theorized that Hispanic mothers may have been communicating in indirect ways with their teens about sexual behavior. Differences among parent-adolescent SRH discussions also vary by gender. Female adolescents are more likely to receive information regarding the negative consequences of sexual activity, while male adolescents are more likely to receive information regarding pregnancy and STI prevention (Lantos, et al., 2019; Widman, et al. 2016). Mothers tend to be the primary SRH communicator with their teen (Lantos, et al., 2019), and female adolescents' SRH discussions with mothers were shown to have a larger protective impact on sexual behavior than SRH discussions with fathers (Widman, et al., 2016).

Adolescent SRH service use and health implications

In 2002 to 2006, unintended pregnancy (Finer & Zolna, 2016), teen pregnancy and STI rates increased in the United States (Potter, Trussell, & Moreau, 2009). During this same timeframe, utilization of SRH services decreased among young women (Hall, Moreau, & Trussell, 2011). From2008 to2011, teen pregnancy rates greatly declined (Finer & Zolna, 2016).

Using data from the National Survey for Family Growth, Hall, et al. (2012b) found that all SRH service use increased from 50% in the 2006-2007 survey year to 57% in 2008-2010 among all young women aged 15-24. Among sexually active young women, contraceptive service use increased from 61% in the 2006-2007 survey year to 67% in 2007-2010, general SRH service use increased from 74% in 2006-2007 to 78% in 2007-2010, and STI service use increased from 22% in 2006-2007 to 33% in 2008-2009 (but decreased to 28% in the 2009-2010 time period) (Hall, et al, 2012b). The correlation between increased SRH service use and lower STI and pregnancy rates also exists in previous years. From1995-2002 SRH service use, such as STI and contraception counseling increased, while at the same time, STI and adolescent pregnancy rates decreased (Hall, et al., 2012b; Mosher, Martinez, Chandra, Abma, & Wilson, 2004). In the 2002-2008 time period, however, STI and unintended pregnancy rates rose, while SRH service use declined (Hall, Moreau, & Trussell, 2012d).

Early and consistent SRH visits are important in lowering adverse reproductive health outcomes in adolescents and young women, such as sexually transmitted diseases and unintended pregnancies (Ralph & Brindis, 2010). The American College of Obstetricians and Gynecologists (ACOG) recommends adolescents have their first reproductive health visit between the ages of 13 and 15 years of age (Ralph, 2010). Utilization of SRH services from Hall, Moreau, and Trusell's 2012(b) study, however, differed by participant's sociodemographic background (education level, income, employment, residence, insurance coverage, parent education and income level, two-parent household). Ethnic/racial minorities and socially and economically disadvantaged women had lower contraceptive service use compared to their counterparts (Hall, Moreau, & Trussell, 2012b). Hall et al. theorized that the disparities in SRH care among ethnic/racial minorities and economically disadvantaged women "may help to

explain the disproportionately negative reproductive health sequelae occurring across demographic and socioeconomic groups throughout these years" (Hall, Moreau, & Trussell, 2012b).

Parent influence on adolescent SRH use

There is limited literature exploring parent influence on adolescent SRH use. However Hall, Moreau, Trussell (2012a) conducted a study analyzing data from a national survey that captured the young women's (15-19 years old) SRH service use and the types of SRH discussions between parent and adolescent (Hall, et al., 2012a). The study defined service use as receipt of contraceptive care, such as counseling, evaluation, or provisions, and STI testing and gynecological care. SRH topics were classified as contraception, condom use, STIs, and abstinence or how to say no to sexual intercourse. Their findings reported 43% of participants utilized SRH services within the last year at the time of the 2012 survey. Three-fourths (75%) of participants had had a SRH related discussion with a parent. Participants that discussed approximately all forms of SRH communication topics (contraception, condom use, STIs, and abstinence) with their parents were more likely to receive SRH services. Conversely, parent-adolescent abstinence-only SRH communication was associated with lower SRH service use (Hall, Moreau, & Trussell, 2012a).

Parent-adolescent communication styles have also been shown to impact the way in which information is absorbed and acted upon by teens. Parents who engage in SRH conversations with perceived openness, share life experiences, and take turns speaking with their adolescent are more likely to have adolescents report a feeling of open communication and understanding (McCallister, et al., 2019; Edwards & Reis, 2014). When parents engage this way,

adolescents are more likely to talk to their parents about SRH related topics and respond better to parental guidance (Baumrind, Lerner, Petersen, & Brooks-Gunn, 1991; Kochanska, 1997). Conversely, parents who adopt a more authoritarian communication style have been shown to narrow the channel of open SRH communication with their children (Heller and Johnson, 2010). This emphasizes the importance of messaging, as well as the importance of parent's perceived level of openness and comfort discussing SRH with their adolescents (Fasula & Miller, 2006).

SRH, religion, and legislation in the South

SRH in the South

Southern states (categorized in the figure 1 below) have higher unintended pregnancy, teenage pregnancy (depicted in figure 2 below), and STI rates than other regions in the continental United States. The South also has higher poverty rates and population growth, as well as lower educational attainment than other regions (Djamba, Davidson, & Aga, 2012). The culmination of factors associated with lower SRH service use, such as lower SES and education and higher religiosity, combined with negative sexual and reproductive health outcomes such as high unintended pregnancy, teen pregnancy, and STI rates in this region of the United States makes the South an area in need of further SRH related studies and improvement.

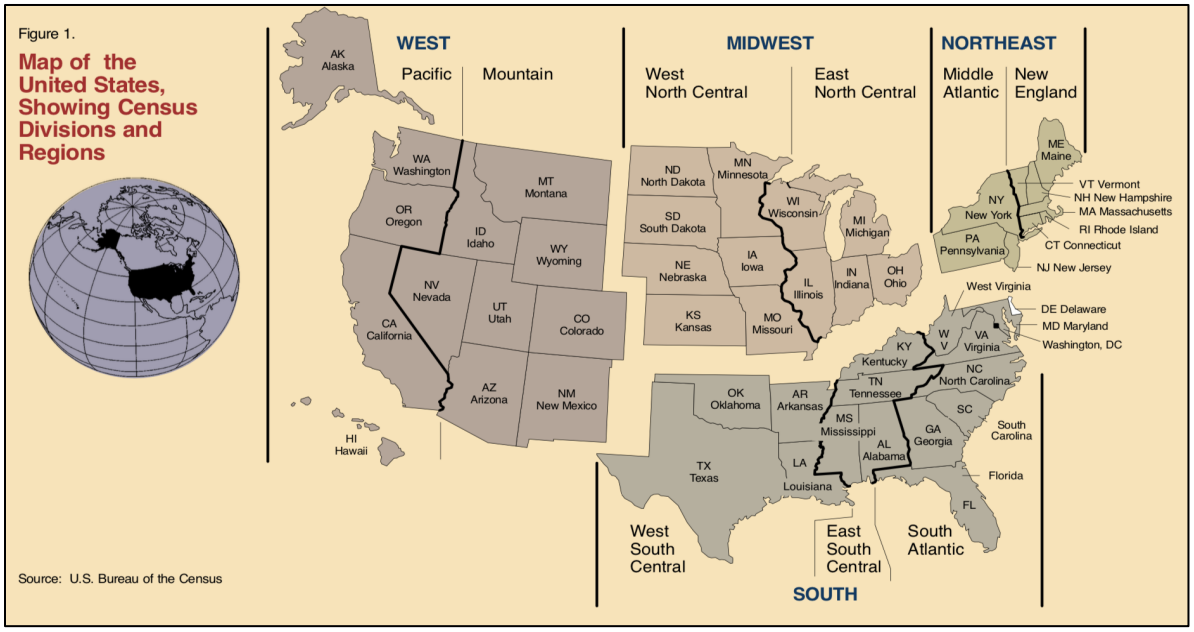

Figure 1: Map of the United States by region in 1995, adapted from the U.S. Bureau of the Census (U.S. Census Bureau, 1995).

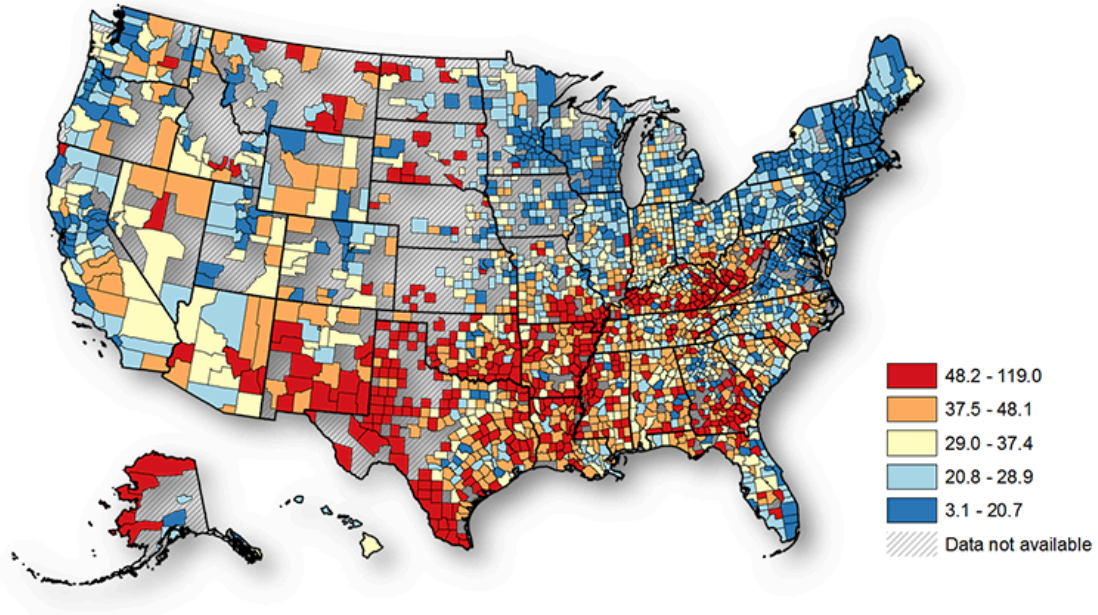

Figure 2: Adolescent (15-19 years old) birth rate per county by quintile in 2016, adapted from the Center for Disease Control and Prevention (CDC Reproductive Health: Teen Pregnancy, 2016).

Religiosity and SRH

The "Bible Belt" (depicted in Figure 3) consists primarily of Southeastern states (including Georgia) and reflect states with higher religiosity and conservative values than other parts of the country (Abadi & Gal, 2018). In turn, highly religious states have been shown to have higher rates of teenage pregnancy and more negative sexual and reproductive health outcomes (Strayhorn & Strayhorn, 2009). The South is 76% Christian. Of the 76% Christians, 34% are Evangelical Protestant, 14% are Mainline Protestant, 11% are Historically Black Protestant, and 15% are Catholic (Pew Research Center, 2019). Christianity, and Evangelical Protestants in particular, have historically held conservative viewpoints on sexuality. Abstinence until marriage is still a mainstream message of Christianity, as well as discouraging abortions (Shorto, 2006).

In Southern states, and more specifically those in the "Bible Belt", it can be more difficult to obtain contraception and access SRH services (Castle, 2011). White supremacists, Christian fundamentalist, and Evangelist have frequently mobilized privately held religious beliefs into political campaigns, organized funding, and public policy (Goodwin, 2020; Brostoff, 2019; Castle, 2011). This is particularly true for issues surrounding SRH, as family structure and sexual purity remain a major component of the Religious Right's (in the Conservative Party) political platform (Hedges, 2004) and abortion access inspired by eugenic ideology are a major interest of white supremacists (Brostoff, 2020). White supremacist influence on US policies can be seen in the late 19th century when lobbyist groups, such as the American Medical Association, argued that abortion and contraception would ultimately lead to a "genocide" of the White race (Brostoff, 2019). Their lobbying was ultimately successful in the South and much of the US

(Brostoff, 2019). White conservative Christian influence is reflected in Southern laws surrounding sexual education in public schools and access to SRH services, particularly abortion. Restrictive laws, such as limits to the number of abortions a physician can perform, mandatory (24 hour) delays, "gag" rules are more common in these states (NARAL, 2020; Goodwin, 2020).

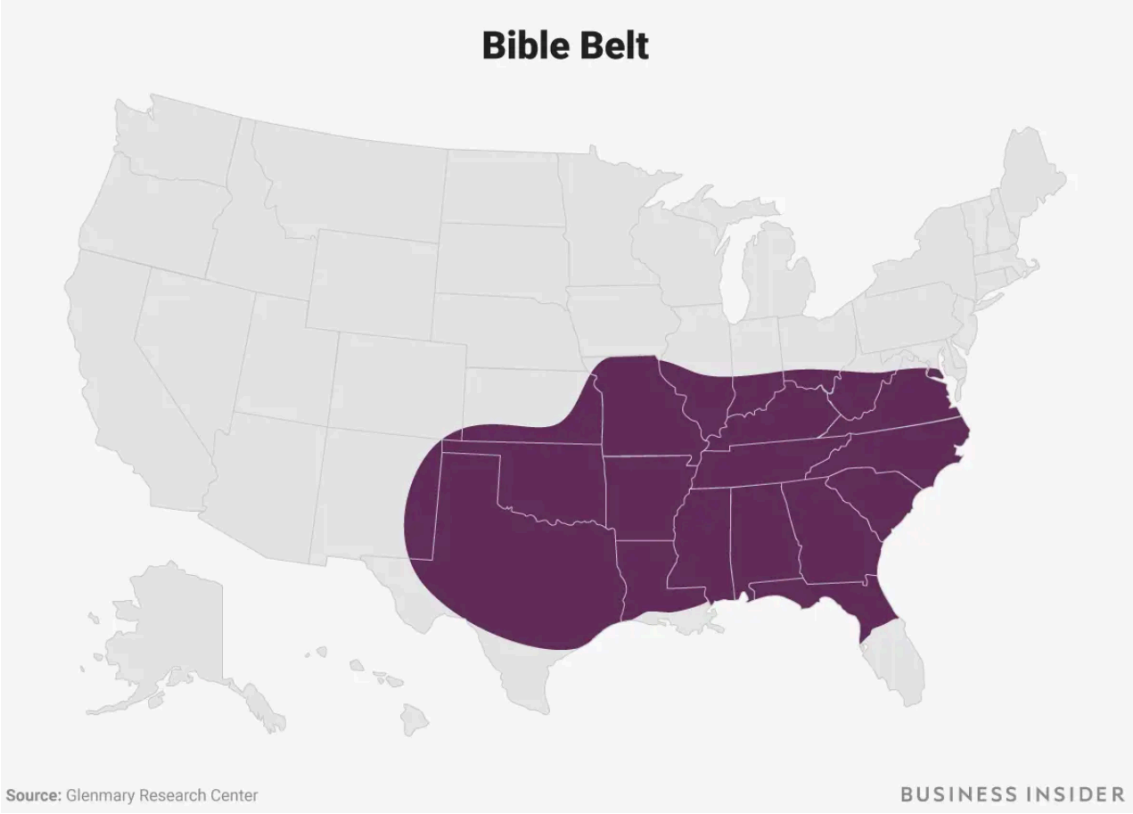

Figure 3: "Bible Belt" regional area in the United States, per Business Insider (Abadi & Gal, 2018).

SRH legislation in Georgia

Georgia also has restrictive policies that reflects its conservative landscape. The state of Georgia prohibits public employees of the state from receiving abortion coverage in their state health-insurance plans, prohibits abortion coverage in the state health-insurance exchange, and also prohibits low-income women eligible for state medical assistance from abortion coverage (except in cases of incest, rape, or life-endangerment) (NARAL, 2020). Parent consent for

abortions being performed on a minor is not legally required, however parental notification is, even when the minor is a victim of rape, incest, or child abuse (NARAL, 2020).

Georgia law requires that prescription medication is given equal coverage under health insurance plans. Contraception falls under this coverage, thus is accessible to women in Georgia with health insurance plans that provide outpatient medication coverage issued or renewed after July 1, 1999 (including Medicaid) (NARAL, 2020). Minors are allowed to consent to contraceptive services without their parent's permission (Guttmacher, 2020). Additionally, medical staff and pharmacists are legally allowed to refuse family planning services, such as contraception counseling and care, to any individual under Georgia law (NARAL, 2020).

Another example of religious and conservative value interplay impacting public policy in the South, is the prevalence of Crisis pregnancy centers (CPCs). CPCs, also classified as pregnancy resource centers, are religious affiliated non-profit organizations (NGOs) who aim to persuade pregnant women to carry to term (Swartzendruber, Newton-Levinson, Feuchs, Phillips, Hickey, & Steiner, 2018). They can provide pregnancy tests and counseling, but information is typically presented in a skewed and biased manner intended to persuade women to carry their pregnancy to term (Uffalussy, 2016). A 2018 study conducted by Swartendruber, et al., reviewed information displayed on CPCs websites in Georgia, and found that 53% "included false or misleading statements regarding the need to make a decision about abortion or links between abortion and mental health problems or breast cancer" (Swartzendruber, et al., 2018). This is a major problem as a recent law passed in 2016 provides state funding for CPCs, allowing for further reach of these clinics (Uffalussy, 2016). A main issue of CPCs is they can tout their services as comprehensive and medically accurate, without the culpability of requiring them to be either (Uffalussy, 2016). As Swartzendruber et al. (2018) found, CPCs in Georgia have false

information presented on their websites claiming links between abortion and mental health issues and breast cancer, as well as misinformation regarding condom effectiveness. State funding for services that misrepresent SRH information makes scientifically backed, medically accurate SRH education to women and young girls an even more pertinent issue in Georgia. SRH education in Georgia, however, also fails to fill the desideratum (Yowell, 2019), which may make parent-adolescent discussions even more important to improving adolescent's SRH outcomes.

Sex education policies

Deep rooted religious and cultural norms of The South are reflected in the sexual education and policies in the region. Currently, 39 states in the US require abstinence only information be given in sexual education (Guttmacher, 2020). All 21 Southern states (in addition to the District of Colombia) are required by law to either cover or stress AOUM in sexual education (Guttmacher, 2020). In the state of Georgia, sexual education is mandated, but is not required to be medically accurate, age or culturally appropriate, and is allowed to promote religious values. AOUM in particular is stressed, the importance of sex within the confines of marriage is promoted, and contraception does not need to be covered (Guttmacher, 2020). States that promote AOUM and do not provide information regarding contraception options or services tend to have higher STI and teen birth rates (Yowell, 2019). Adolescents who receive AOUM curricula do not exhibit lower sexually risky behavior, nor do they prolong their sexual debut (Downey, 2015). This is reflected in Georgia's STD rates among female adolescents. In 2018 Georgia ranked 8th in Chlamydia, 13th in Primary and Secondary Syphilis, and 16th in Gonorrhea rates among young women (15-24 years) in the US and territories (CDC, 2018). Additionally, in 2017 Georgia tied

with Nevada and Louisiana as the states with the 16th highest teen pregnancy rates (21.9) in the US (HHS, 2017). Sexual education that lacks relevant SRH information, such as condom use and its protective benefits, family planning location and services, and contraception availability can produce negative SRH consequences among adolescents (Downey, 2015).

Parent-adolescent SRH discussions and religiosity

Abstinence only messaging is highly linked with religiosity (Lantos, et al., 2019) and has been associated with delayed sexual debut, however it is also highly associated with lower contraceptive use when adolescents start to engage in sexual activity (Manlove, Logan, Moore, Ikramullah, & Pathways, 2008). Additionally, higher religious services attendance is associated with lower SRH service use among adolescents, (Hall, Moreau, & Trussell, 2012c). In the Southern US, this poses a unique challenge, as conservative religious and political views are more common than in other parts of the continental US (Shorto, 2006).

Several studies conclude that religiosity influences how conversations are formed surrounding SRH messaging to adolescents (Afifi, Joseph, & Aldeis, 2008; Flores & Barroso, 2016). Southern parents are particularly responsive to faith-based SRH discussions, and therefore may express more religious viewpoints in parent-adolescent SRH conversations (Afifi, Joseph, & Aldeis, 2008). Parental religiosity is also linked to parent discomfort speaking about SRH with adolescents, and also may be linked to fewer parent-adolescent SRH discussions and initiated at later times in the adolescent's life (Baier & Wampler, 2008; Flores & Barroso, 2016). Adolescents who receive delayed or abstinence-only SRH discussions from parents are at a higher risk for negative sexual health outcomes (Downey, 2015).

Abstinence is highly linked with religiosity (Lantos, et al., 2019) and has been associated with delayed sexual debut, however it is also highly associated with lower contraceptive use when adolescents start to engage in sexual activity (Manlove, Logan, Moore, Ikramullah, & Pathways, 2008). Research such as this has depicted the large role parents play in their children's SRH decision making process (Albert, 2012; Somers & Surmann, 2004; Widman, et al., 2016; Flores & Barroso, 2017; Lantos, et al., 2019). Given the need to improve adolescent SRH outcomes in Georgia, and acknowledging the impact of parent-adolescent discussions on adolescent SRH decision making, exploring parent-adolescent discussions and its possible associations on female adolescent's SRH contraception and service use in Georgia could be an important area of study to improve SRH outcomes in this population.

Justification for Research

Female adolescent utilization of SRH service use has been associated with lower unintended pregnancies and negative SRH health outcomes (Ralph & Brindis, 2010). Parent-adolescent communication has been shown to influence adolescent SRH behavior and service use. While studies have explored the connection between parent-female adolescent SRH discussions and SRH service use, further questions remain regarding the content and influence of these SRH discussions. Moreover, most research exploring parent-adolescent SRH discussions and service use are based on quantitative data sources, based primarily on surveys (Hall, Moreau, and Trussell, 2012a). Survey's do not capture the nuances of SRH communication, which can play a key role in understanding parent-adolescent SRH discussions and its effects on adolescent service use (Hall, Moreau, & Trussell, 2012a; Widman, et al, 2019).

Select studies have explored the types of communication styles parents employ when speaking to their children about SRH, however fewer have explored the content of SRH discussions, and little research has been conducted in terms of the association between the content of parental SRH discussions with female adolescent SRH service use (McCallister, Akers, Worlds, & Morrison, 2019; Hall, Moreau, & Trussell, 2012a). The South is an important region to study parent-adolescent SRH discussions and first-time service use given the religious and political relationship the Southern United States has with sex (Shorto, 2006) and its evident impact on parent-adolescent SRH discussions (Widman et al, 2016). Exploring the relationship between parent-adolescent discussions and first-time SRH service use using in-depth interviews can help to illuminate some of the more nuanced communication taking place, give better insight as to the types of messaging being formed around this topic, and the discussions impact on their first SRH service use experience. This study will assess the association between the content of parent-female adolescent SRH discussions and female adolescent's first sexual and reproductive healthcare seeking experience amongst low income women in suburban areas outside of Atlanta, Georgia.

Chapter 3: Project Content

Methods

Contributions:

This study uses secondary data from a larger study "*Exploring Multiple Influence on Equity: A Mixed Methods Study of Low-income Women's Access to Family Planning Services in the South."* Dr. Anna Newton-Levinson, the study's lead researcher, devised the original study, coordinated participant recruiting, created the interview guide, surveys, and the deductive codes and inductive codes relevant to the original study's research questions. She conducted all interviews, coded all transcripts, and supervised all research assistants that assisted in transcript coding. Dr. Newton-Levinson was heavily involved in the editing and guidance of this research project.

The student assisted in data collection of 1 transcript, contributed to and served as primary coder for 13 codes in analysis of all 25 transcripts of the original study. The student created the research question for this study, developed and refined additional codes relevant to this study's research questions, conducted a review of literature, and is the primary author of this study.

Setting and population

The study was conducted in suburban areas surrounding Atlanta, Georgia mapped out in figure 4 below. Barriers to family planning services are more common for women in areas outside the metro Atlanta area where transportation can be more difficult and public funding for family planning clinics is fewer. Women were selected if they met the following criteria: low-income (below 250% FPL) women of reproductive age (18-34) who were sexually active, were biologically female with no history of sterilization or hysterectomy, did not want to become

pregnant in the upcoming year, and spoke English (indicated in figure 5). The study population included women who sought care from a variety of healthcare settings, women who were non-care seeking, and an effort was made to recruit women who identified as Hispanic, Black, and White.

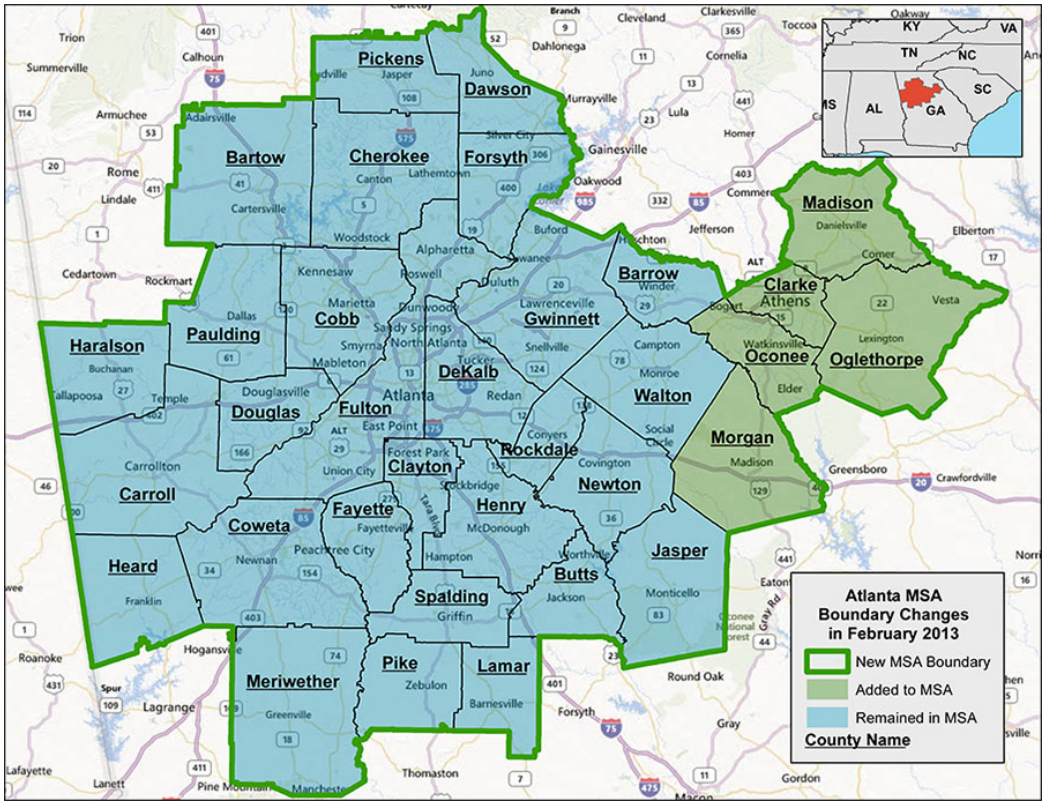

Figure 4: Recruitment counties (Newton-Levinson, 2019).

Demographic/ Question	Eligible	Not Eligible
Age	• Age 18-34	Under 18 Over 34
Sex	• Biologically female ○ Any gender identity	• Sex: Male or Intersex + currently identifies as male or trans woman
Race	• Identifies as black or white	• Does not identify as black or white
Sexual Activity	• Sexually active (in past 6 months)	• Not sexually active • Refuse to answer
Pregnancy Status & Intention	• Not currently pregnant or seeking abortion services • Do not wish to become pregnant in the next year	• Currently pregnant • Trying to get pregnant in next year, wouldn't mind being pregnant in next year
Able to become pregnant	• No history of hysterectomy or sterilization	• Has had a hysterectomy, oophorectomy, sterilization, etc.
Residence	• Lived in Georgia for at least 1 year	• Does not live in GA • Has only lived in GA for under a year
Household Income	• At or below 250% of FPL	• Above 250% of FPL
Service seeking area	• Live in **OR** have sought FP services in one of the following counties: ○ Douglas, Clayton, Rockdale, Bartow, Cobb, Henry, Gwinnett, Hall, Paulding, Coweta, Cherokee, Forsyth	**Does NOT live in counties in study area AND has not gotten services in study counties in past 3 years**

Figure 5: Eligibility criteria (Newton-Levinson, 2019).

Study procedures

Data collection

Recruitment of women and data collection took place between January 2019 to February 2020. Women were recruited at healthcare settings, community settings, as through social media advertisement. Screening surveys were administered to determine if women met the study's eligibility criteria by the study team. Interviews were 60-90 minutes and took place in a private room in a public setting such as a public library or coffee shop. All interviews took place in

person and conducted by the study's lead researcher, Dr. Anna Newton-Levinson, who has extensive qualitative interviewing experience. Interviews consisted a life history interview (LHI) and a survey. 25 women completed the study

Instruments

LHIs are semi-structured, individual interviews that allow for participants to drive the direction of the interview by following their life stories and allowing for topics to be discussed that are most relevant or important to them (Goldman et al., 2003). Participants were also asked to draw timelines to demonstrate their SRH history and to foster memory recall to more fully answer questions during their interviews (Kolar et al., 2015). Interviews were then structured around the participant's timeline, and the study's lead researcher probed participants' SRH experiences. This study focused on the participants descriptions of their SRH discussions with their parents and their first SRH care seeking experience specifically. Participants were directly asked about their first care seeking experience and where they first learned about birth control, but volunteered information regarding their SRH discussions with their parents.

Ethical considerations

Prior to recruitment and data collection, this study received exception from Emory University's Institutional Review Board (IRB #00106658). Participants gave consent before being administered the survey and in-depth interview. Women informed of what the study would entail, such as the study's research aim, any discomfort that may arise from the interview, and confidentiality information. Each participant received a $40 gift card as compensations for their time.

Data analysis

An audio recorder was used to record the interviews. Each LHI was then transcribed. Research assistants also took notes during each LHI for clarification. MAXQDA 2020 was used for qualitative analysis of the transcribed interviews. MAXQDA is a qualitative and mixed methods software program (MAXQDA, 2020) that allows you to code parts of interviews that are coordinated with specific codes or themes of a study. The study's lead investigator and a team of research assistants coded all 25 interviews for the larger study. All transcripts were deidentified. All study participants were given the option to choose a pseudonym. Participants that did not have a name preference were later assigned one.

Thematic analysis was used to analyze this study. First, deductive themes were coded. Deductive themes were assigned by the study's lead researcher (ANL) and came from the interview guide and a framework by Levesque et al that explores the dimensions of patient-centered access to care, such as approachability, acceptability, availability/accommodation, affordability, appropriateness as well as the individual's capability to interact with those domains through their ability to perceive, seek, reach, pay, and to engage with care (2013). Inductive codes were parsed out from the larger deductive codes of "Family" and "Care Seeking Process". For example, inductive themes related to parent-adolescent SRH discussions, such as "Initiation" and "Content", were created under the deductive code "Family". Sub-codes were created for closer examination. "Protection", "Contraception", and "Sexual and Reproductive Healthcare Services" for example were created to more closely analyze the "Content" of SRH discussions. These themes were central to assessing the association between the content of parent-female

adolescent sexual and reproductive health discussions and female adolescents' first SRH care seeking experience. Codes were re-defined and refined as needed.

Themes were mapped out and reconfigured to answer the central research question. In the results, themes were organized in relation to the process of parent-adolescent SRH discussions and its impact on their first care seeking experience. The first phase explored themes related to the initiation of SRH discussions to assess which emerged as a driver of parent-adolescent conversations. The second phase explored themes related to the content of the SRH discussions, and the last phase assessed themes related to the impact of the SRH discussions on the participants' first care seeking process.

Results

Overall this study found that parent-adolescent SRH discussion influenced adolescents' first care seeking experience. Results are organized into three sections: 1) initiation of SRH discussions; 2) content of discussions; and 3) influence of discussions on participant's care seeking experience. Most initiation of SRH discussions were prompted by a parent's desire to prevent their child from experiencing negative SRH outcomes, the participant moving away from home, or when the participant may become sexually active. The content of these discussions were usually centered around contraception, SRH services, and protection of the adolescent's physical health and future. Discussions influenced SRH care, and often impacted which providers participants sought out, the type of contraceptive method they received, and in some cases when they started use. Participants were also more likely to let their parents know when they were ready for SRH services if they had already received conversations regarding SRH care or contraceptive use.

I. Initiation of SRH discussions

Initiation of sexual and reproductive health (SRH) discussions between the participants and their parents were described by seventeen women when discussing their SRH knowledge and experience.

Parent vs Adolescent. Eighteen participants discussed having SRH conversations with their parents during their interviews. Four did not discuss having SRH related conversations and three discussed receiving abstinence only messaging. Initiation of SRH discussions were relatively split between adolescents and their parents. Of participants who discussed having sexual and reproductive conversations with their parents, 7 of the conversations were described as initiated by the participants and 11 conversations were described as parent initiated. The majority of the parent-adolescent SRH conversations discussed were between the participants and their mother. Participants who reported having SRH conversations with their father indicated conversations were initiated by the father rather than the participant. In most instances these conversations were instigated by finances, usually regarding financial assistance for SRH medical bills or contraceptive costs, or disapproval of contraceptive services due to the father's discomfort with their daughter's sexual activity and its association with contraception.

Reasons for Initiation

Common themes that prompted SRH discussions between parents and adolescents were prevention, sexual activity, and family events.

***Prevention*.** Seven participants described their parents desire to 'prevent' the participant from experiencing negative SRH outcomes as motivation of some parent-adolescent discussions. Prevention, such as safe sex practices, and STI and pregnancy prevention sparked parent-adolescent discussions described by seven participants who noted having SRH conversations with their parents. Parents predominately instigated these discussions and they were framed

around their desire to protect their daughter's future and physical health. For some participants, family events or traumas, such as a sibling becoming pregnant, sexually active at a young age influenced the initiation of parent led SRH prevention conversations. One participant, Von, 31, Black, described her sister prostituting at a young age and the influence it had on her SRH discussion with her mother:

Von: And my family members, my aunts, and I believe my grandmother, had found her, and she was prostituting… And that was the first conversation that I had ever heard or experienced about sex… But yeah, I was – I was terrified. I – more so for her as well, too. It was a very intense conversation.

Interviewer: Yeah. And did they tell you all about sex, or was it just like a little bit, or –

Von: Um, the main things about diseases… and, um, you know, being taken advantage of.

A few conversations regarding pregnancy prevention specifically were started by the parent's desire to protect their daughter's educational attainment and to avoid financial hardship. Few conversations described were initiated by a parent's desire to protect their adolescent's mental health, however a few participants did describe SRH conversations where a parent discussed sexual partner selection and being taken advantage of.

Independence. A second theme involved conversations that were centered around independence. Participants described life events in which they garnered more independence, such as moving out of their family home or going off to college, as a catalyst for contraception conversations with their parents. These cases were primarily initiated by the parent and propelled by the parent's desire to prepare their daughters with contraception for when they no longer were

under adult supervision and direct guidance. This type of initiation was predominately instigated by the participant's parents.

"I waited until I was going to college, you know, because then my mom can't hover over me, see... what's going on. It was more like I'd rather you just have it, you know how to use it, it's already, you know, you're good into, uh oh, hey, mom, I'm pregnant my first semester of college. So, I'm sure, you know, the timing for her was like all right, you know, you're smart, you're responsible, you know. Just do that." -Laila, 28, Black

Sexual activity. A third theme included conversations regarding the participant's sexual activity and sexual debut. This instigated SRH discussions amongst adolescents and parents, especially as it related to contraception. Both participants and their parents initiated these conversations. Participants that initiated contraception or first-time service use SRH conversations with their parents were prompted to do so when they were ready to become sexually active or were already engaging in sexual activity, as described by Goldie, 25, Black:

"*On my 18th birthday I told my mom that I wanted to have sex. And she told me, 'Okay, let's go to--' I know it was Planned Parenthood we went to, but I don't know which. And we went there and got an appointment. I was able to get my… Implanon in my arm, the one that lasts for five years."*

Likewise, parent initiated contraceptive SRH conversations aimed to discuss the importance of contraception, but expressly in the hopes that it was before their daughter became sexually active. Contraception and sexual activity were closely linked by both participants and parents of participants who described the initiation of these discussions. Those that voiced hesitation initiating contraception-basedSRH discussions with their parents expressed concern that their

parents would assume they were having sex (whether they were or were not). In some cases, participants described reluctance to speak to either of their parents if they suspected that one parent would assume that they were sexually active and disapprove. In some cases, this also led participants who wanted contraceptive services to delay services until a later time. For some participants, this led to usage of alternative contraceptive methods such as condoms, spermicide, or the pullout method, as described by Shay, 22, Black:

"*I think, around that time – here I said I decided against birth control. Now, this is the thing, because with me being in high school… I didn't have access to my own avenues to health care... So, if I went to the doctor, it was either I went with my parents up until that point, or they knew about it. I didn't have my car at that point… Then, of course, I heard all the horror stories about the implant and different things. So, I just decided that this wasn't it. But I did look into other ways. Then, I guess that's how I found [out] about spermicide."*

II. Content of Discussions

Participants also described the types of topics they covered in discussions with their parents. Common content themes among participants who described having SRH discussions with their parents related to positive and negative experiences, SRH service information, contraception, and protection.

Positive and negative experiences. Of participants who discussed having SRH discussions with their parents, most described their interactions as either positive or neutral, such as the neutral conversation described by Kiara, 22, Black:

"She didn't really have any negative opinions about it. She didn't think anything. She was fine with me getting it. And yeah. It was an open conversation. [Laughs]"

Participants were more likely to describe the exchange as positive if information or resources were given. SRH service use and contraceptive conversations were described as the most helpful or positive by participants. Conversely, parent-initiated conversations that focused primarily on abstinence or the participant not becoming pregnant, without providing information, were more likely to be described as a negative exchange, as were discussions participants felt were initiated too late and after they were already sexually active for several years. Women were also more likely to describe a negative exchange if they felt judgment or disapproval from their parents due to the participants sexual activity or SRH care needs. As one woman described a negative experience with her mother:

"I became sexually active at 13. Soon after my parents found out that I wasn't a virgin … I just have this long rap sheet and this plethora of unhelpful sex talks from my mom. Because like I said, she's very religious. It's always abstinence only. Sex is only for married people. Two people shouldn't even be sleeping in the same bed. She's just very traditional. So, I literally have – mind you, she's an R.N. But I have no information from her." –Shay, 22, Black

Sexual and Reproductive Healthcare Services. Discussions regarding SRH services were described by fifteen participants and included logistical information, preparation, and facilitation. Fourteen participants disclosed receiving "logistical discussions" in their interviews, which included parents describing what services may be offered, the types of providers to utilize, which providers were covered under their family's insurance (or which providers would offer free care if the family did not have insurance). Three participants discussed "preparational discussions" helping participants to prepare for their first SRH service visit typically focused on financial issues, such as potential contraceptive costs or visit fees that may incur. In some cases, participants' mothers prepared them by providing questions they should ask their provider regarding contraception. Laila, 28, Black described how her mother told her to inquire about

generic birth control pills to lower the costs of her contraception if her provider did not initially offer them to her:

"Just having an older sister, ... and parents who were like, no, you go in there and you ask for the generic version…When I went, I think my first time was at 17. I went on birth control, and they didn't offer me the generic version. [They said] 'This is what our clinic offers, and this is all we have' ... then I had to ask, and it was like, oh, okay, well, if that's what you want, then we'll have to write you, like, a prescription ..from a different place."

Lastly, ten participants described how their parents assisted them by facilitating their first SRH service visit. Some of these "facilitation discussions" went beyond conversations and included parents offering financial assistance, scheduling appointments, picking up their daughter's birth control prescriptions, and providing transportation.

Contraception. Thirteen participants described having discussions specifically about contraception with their parents. Most discussions were positive or neutral, however a few negative experiences were described. Some participants described wanting their parent's opinion regarding birth control types or for assistance with procurement. A few women described how their mother's own experiences obtaining birth control shaped their contraception discussions, such as Dilly, 19, Black-Hispanic:

"My mom told me when she first got [birth control], they used to tell her [at] the doctor's office, 'Your da-da-da is going to cover this and it's going to be this.' But, I didn't find out until I got to the pharmacy."

Of these participants, some described conversations in which their mothers discussed what types of birth control worked for them, and others described what types of contraception were available.

Negative experiences were typically due to parent disapproval or a lack of contraceptive information provided by the parent. Some participants described their parent's qualms about birth control. In some cases, it was due to health concerns, such as side effects of contraception or concerns regarding its effect on the participant's body due to their age. In one case a mother's apprehension towards birth control was due to the mother's own negative experience with contraception, as Nina, 26, White, described:

"My mom had – she wasn't – we weren't religious, so she wasn't very anti-sex. She had told me before that she had been open with sex. But she was very against birth control 'cause when she took it back in the 70s – I don't know – she said it made her heart race, which was a thing back then I guess."

Protection. "Protection discussions" involved parents focusing on how women could protect themselves against STIs and pregnancy. Of participants that discussed having protection based SRH discussions, conversations were focused on their physical health, while a few were centered on their mental wellbeing. Jasmin, 24, Black, for example, described how her mother warned her that not everyone deserves sex:

" […]my mom did sit down and talk to us about it, of course, and just kind of put us on game, I guess you could say, about like, hey, not everybody deserves it (sex). Not everyone deserves it, but that would be your decision to make."

A few protection conversations also centered around how to "say no to sex" and "abstinence only" messaging. Most participants found these protective discussions to be unhelpful, especially if parents discussed pregnancy or STIs without providing information on how to prevent these outcomes, as described by Sadiyah, 33, Black:

"Because a lot of parents don't talk about it. They say, "Don't do it or don't get pregnant." "Well, how do we not get pregnant?"

Three women described discussions that focused solely on abstinence and discussed how abstinence was pushed by their parent to protect the participant from pregnancy or expressed it was "the right thing to do" until marriage. Most of these conversations were religious based or discussed by participants' parents who were described as holding conservative values. These conversations were usually described as unhelpful as Amy, 28, White discussed:

"They don't even go to church, but they have weird super conservative ideas about most things that you don't necessarily know until the topic comes up and then they feel really strongly out of nowhere about it. And it's really confusing when it happens. Why do you care? But yeah, they would be definitely opposed [to sex]… My family always says stuff like when you get pregnant it should be the right way… what is the wrong way?"

III. Impact of parent-adolescent discussions on first time SRH care seeking experience

Whether or not participants received SRH related discussions from their parents, parents influenced their care-seeking in several ways. This section describes the experiences of those that received SRH discussions compared to those that lacked SRH discussions or received discussions focused on abstinence.

Care-seeking implications for those who received SRH discussions.

Reception of sexual and reproductive health services discussions. Largely, participants wanted to feel ready for their first SRH visits and to receive guidance, even if it was an uncomfortable conversation. Some participants alluded to the awkwardness that ensued during some parent-adolescent SRH discussions. However, as one participant described, she was grateful to have received the information from a reliable source, instead of a source which may provide inaccurate information.

"*It was a little awkward. I was like, mom, can you just not? Because she was a little abrasive with it, but I do appreciate all the information, because otherwise, I would have learned it from school probably the wrong way [such as] not knowing how to use a condom, getting all the wrong facts about birth control, like they're trying to kill you, don't take it." –Charlie, 25, Black*

Impact of sexual and reproductive services discussions. In most cases, participants who received contraception sought care due to sexual activity. In select cases, participants' first care seeking experience was due to menstruation or a hormonal imbalance. Participants who discussed receiving "logistical discussions" with their parents were more likely to describe setting up their first care seeking visit as manageable, and also more likely to have their first visit before age 18. Participants were also more likely to describe having their first visit by 18 if they discussed receiving "facilitation discussions" with their parents as well.

Of the participants who received "logistical discussions", eleven were able to obtain contraception by the age of 18. Conversely only two of the eleven participants who did not receive "logistical discussions" obtained contraception by age 18. Some participants who discussed "logistical discussions" with their parents expressed the conversation helped determine which provider they went to, and in some cases, participants used the same provider or contraceptive methods as their mothers.

Participants felt that "preparation discussions" regarding financial expectations during their first visit allowed them to navigate issues related to affordability of services such as anticipating possible costs and allowing them to ask questions regarding cheaper options. Some participants also felt prepared to ask more contraception questions with their provider. "Facilitation discussions" were largely described as useful by participants who described received them. These discussions include financial assistance, help scheduling their appointment,

picking up their birth control prescriptions, and providing transportation. For many women this was a new section of the healthcare system to navigate, and parental assistance allowed them to transition more smoothly. Most participants who discussed receiving help from a parent in setting up their appointments described the appointment process as "easy" or manageable. Some participants also discussed their parents picking up their prescription from the pharmacy. Of those who received this help, most described it as a helpful facilitator.

Impact of contraception-specific discussions. Parental contraceptive discussions and opinions influenced some participants' first care seeking experiences. Participants were more likely to describe "contraception discussions" as helpful if they included information on types of contraception or where to obtain it. Of women who described contraceptive-friendly discussions, most who expressed they were ready for sex or contraception to their mother received help setting up their appointments or guidance on where to obtain services. Women were also more likely to approach their mother when they were ready for contraception if they also described having contraception positive discussions previously?. Speaking to mothers who spoke positively about contraception and who provided avenues to care were also described as a helpful facilitator by some women who had internalized social stigma regarding contraception.

Parent contraception discussions and guidance were seemingly more impactful for participants whose first care seeking experience was at a younger age (before 16). In these cases, their mothers were usually in the room with them at the time of their appointment or were involved with their healthcare discussions with their providers, and were usually for more so for health reasons, such as hormonal imbalances, than pregnancy prevention. Of these participants, some also described how their mother's approval and opinion of contraception influenced whether they started use.

Parent presence. Parental presence or absence influenced some participants care seeking experiences. Some participants described how parents would physically accompany them to their first visit. Of these participants, a few described feelings of discomfort or embarrassment when their mother was in the exam room during their first visit. Some women described that their mother spoke for them or over them. In one case, a participant described embarrassment when her mother too abrasively stated the participant was sexually active to her provider. Some participants, especially if their first visit was at a younger age (12-18), expressed sex was a sensitive and awkward topic to discuss with their provider. Conversely, those who discussed starting contraception for menstruation needs other than sexual activity, were less likely to describe the experience as uncomfortable.

Although most participants preferred to be alone in the exam room, select participants described comfort that their mom in the waiting area, which as one participant described, allowed her to more forcefully ask for cheaper contraception.

"I go in there, and like I said, they're like, oh, we have this $75 one, and this is the best brand, whatever brand it was. And I'm like, no, I do remember my mom saying ask for the generic version, and if you don't believe me, she's sitting in the waiting room. So, they're like, oh, well, we'll – and I think she ended up offering me something that was much, much cheaper." – Laila, 28, Black

Implications of lack of SRH discussions.

Six participants stated they either had no SRH discussions with their parents or did not discuss having SRH discussions in their interviews. Two additional participants discussed having abstinence only SRH conversations with their parents which lacked SRH information.

Lack of information and lack of comfort. Of the eight participants who described abstinence only-or no SRH conversations with their parents in their interviews, five expressed a desire to obtain more information. Lack of discussions impacted some participants' SRH care seeking experiences. Lack of discussions were associated with a lack of comfort surrounding contraception and also a lack of confidence seeking contraceptive care. Women who did not describe receiving SRH discussions, or women who described receiving discussions, but described not receiving useable information in their discussions, such as where to obtain services, what kind of services were offered, or how to prevent STI or pregnancy, were more likely to describe weariness starting birth control during their first care seeking experience or cease use shortly after starting it.

"My mom has never told me to use any birth control, she just never did. I talk to my best friend from school. She lives in [Southern City] … She's been on Depo forever and it works for her, and it works for my sister now. But I just worry about the side effects. Maybe they have done long term studies where they have looked at what happens. But maybe someday in the future if I want a child there would be an unexpected side effect. It's just weird to me to not have a period, even though I don't want one. Its enticing but I don't know." –Shirley, Black, 30

Lack of SRH discussion in some cases led to unplanned pregnancies before evening seeking services, and for three participants the first time they spoke to their parents about SRH was after they had an unplanned pregnancy. Most participants indicated that they wanted to receive contraceptive and SRH care information from their parents, and some women expressed how open communication with parents would be an important facilitator for easier navigation of SRH care.

"Because I just know that when I needed birth control, [family and school] would've been two things to make it easier for me… No family members. I guess it's hard if you don't have … I

didn't have anyone to tell me about birth control. So not having that guidance you know it makes it harder." –Alexandria, 32, White

Trauma and shame. Lack of communication also exacerbated feelings of shame in some cases. Some participants discussed a lingering stigma or shame surrounding SRH health care that made them uncomfortable seeking care.

"Information wasn't provided to me in school or by any of my relatives or family members, so I had to go and look for it myself… The things that are harder is just not knowing, so you don't want to look stupid when you go, just having a fear or any stigmas along with it, or any shame" –Carol, 23, Hispanic

Participants who discussed a sense of shame or stigma relating to sex and SRH also discussed their parents' negative attitudes towards sex. In many cases this was attributed to religious reasons. Three participants also discussed how regionally, there is a conservative culture concerning sex in the South. Life experiences, such as personal trauma also impacted their shame regarding SRH. Ruby, 23, White, described her the circumstances surrounding her first care seeking experience:

"I lost my virginity when I was, I think, 13. It's kind of hard to remember. And then because of the unfortunate situation that I was in, I think that that started a lifetime thing of anxiety. So, I told my mother that I had this weird stomach pain going on. And I think, really looking back on it, that it was my anxiety about getting pregnant. Because at the time, everything was secretive, hidden from the family, hidden from the school."

Ruby's trauma and secrecy surrounding this first time in her life needing birth control impacted her relationship with SRH, as she described a negative experience she encountered later in life and the shame she felt at times:

Ruby: So [the negative experience] just [brought] back bad feelings of shame that had hovered around my getting into acquiring birth control. That had been abated for a few years from good experiences. And then just a really negative experience

Interviewer: Can you tell me a little bit about what those feelings of shame were about when you first got into it?

Ruby: I guess not only shame about even just needing this healthcare because – it's a difficult thing to articulate. I think women's health is very stigmatized and often made into a joke. It's something that it's difficult to even just talk openly about because it has to be something that we're secretive about… So, there was that kind of shame, just of needing women's health. And also, just shame about my own body.

Another participant, Daniela, 32, Hispanic, disclosed that the only SRH discussion she had with her mother was when her mother found out she was pregnant at a young age and provided her with an abortion pill that her mother had found online. The participant also discussed how her personal trauma and the impact of her mother's reaction when she found out the participant was "playing house" with a boy in her youth. Her mother hit her and told her it was wrong. The participant then associated sexual contact as a negative interaction and was unable to tell her mother of her sexual abuse later on in life for fear that she would be punished. Daniela disclosed this lingering trauma and lack of SRH discussions at home impacted her relationship with SRH services.

"[…] I guess … all the decisions that you make sexually are … based on your traumas and self-esteems. So… when abuse happens, sexually, it distorts everything… [And] when you don't have any type of therapy, I think you make the wrong decisions after another, another, based on your traumas… Because when my mom did that to me, I think that's what really messed me up. Because when the time came that I was being molested… 'cause my mom just hit me and grounded me, but she never came back and told me anything… And then… when I got my period, no one explained to me what it was or what it meant. And I'm glad… that's when [my mom] went to get us, because I started having my period before I turned 10... And if my mom wouldn't [have] come and got us, I don't know what could have happened, 'cause I had already my period. So, if the molestation kept going, I could have gotten pregnant… So, that's the reason why I influence all the decisions that I made and maybe not seeking out like, not wanting to learn more. It wasn't a conversation at home."

Chapter 4: Discussion, Conclusion, and Recommendations

Discussion

The goal of this research thesis was to assess the association between parent-adolescent sexual and reproductive health discussions and adolescents' first care seeking experiences amongst low-income women in Georgia. Research has shown parent-adolescent communication can influence adolescent SRH behavior and decision making. While select studies have explored the association between parent-adolescent communication and SRH service use, most were limited to quantitative data which narrowed the scope of the study. This study found that parent-adolescent SRH discussions often impacted which providers participants sought out, the type of contraceptive method they received, and in some cases when they started use.

SRH Discussions

Previous studies found adolescents registered their parents as one of the more trusted and preferred sources for SRH and contraceptive information (Somers & Surmann, 2004; Albert, 2012). This study established similar findings. In interviews several participants discussed that school, friends, and internet sources were not always accurate or trustworthy, or do not provide enough information related to SRH. Few participants discussed any notion of mistrusting the information their parents gave them regarding contraception or care. This reinforces other study findings that parents play an integral role in providing adolescent SRH knowledge and are considered a trusted source (Albert, 2012; Widman, et al., 2016; Flores & Barroso, 2017). Additionally, several participants discussed wanting to know more information about the process of seeking care or contraceptive methods before their first visit. This again speaks to other findings that adolescents want SRH and contraceptive specific information to make informed decisions regarding their sexual health (Albert, 2012).

Received SRH discussions

Participants who described receiving "logistical discussions" from their parents and assistance setting up their first care seeking appointment were more likely to describe the appointment process as manageable and more likely to have received care by age 18. Likewise, participants who described "facilitation discussions" with their parents related to finding a provider, whether it was in their insurance network, a place to obtain free contraception, or in some cases recommending the mother's own provider, also more frequently reported having received care by age 18. This speaks to other research that concludes parents can influence adolescent's contraceptive behaviors. It adds to the current literature as studies have found early and consistent SRH visits are important in lowering negative SRH outcomes in adolescents and young women (Ralph & Brindis, 2010). It also adds to literature that daughters may also be more likely to utilize their mother's physicians or use the same contraceptive method (Bell et al., 2002), especially if they had a contraceptive specific discussion.

In some cases, studies have shown establishing a provider can be a barrier to women's access to SRH care (Bertrand, Hardee, Magnani, and Angle, 1995). This barrier could be compounded by an adolescent's lacking experience or knowledge in their first time using this SRH care in the healthcare system. Parental guidance during this part of the care seeking process may be important to facilitating access. In this study, while assistance setting up their first appointment was described as one of the more helpful facilitators in accessing care, if it was not also coupled with SRH discussions regarding care or other SRH information, it was less likely to be described as a positive experience. These results thus indicate that setting up appointments may not be enough to reduce anxiety surrounding first time service use. Thorough discussions on

the process of receiving SRH care and what to expect at first visit may be helpful facilitators in alleviating stressors or discomfort surrounding first time service use.

Participants who had conversations with their parents that contained positive contraception messages more often described feeling comfortable seeking care or discussing their need for contraception with their parents when they were ready for services. This builds on existing literature that found adolescents may be more receptive to contraceptive communication if the adolescents have positive feelings about their relationship with their parent (Widman et al, 2016).

Additionally, while most participants who discussed parents driving them to their first appointment described it as a helpful or positive experience, most participants preferred to be alone with the provider in the exam room. While this notes the important faciliatory role parents can play in adolescents' access to SRH care, this complements existing literature which describes adolescents' desires for privacy with their provider when discussing care (Fuentes, et al., 2018).

Did not receive SRH discussions or received AOUM discussions

In this study, abstinence only messaging and stigmatizing discussions regarding sexuality or SRH care, however, were almost always described as a negative experience by participants or listed as a barrier that can make care seeking more difficult. In some cases this led women who desired contraceptive services to wait until a later time. In most cases it was due to fear of a negative conversation or opinion from a parent. This led to participants waiting to seek care or using alternative contraceptive methods such as condoms, spermicide, or the pullout method. In other cases due to fear of their parents finding out they used contraceptive services, participants circumnavigated their parents' health insurance utilizing other avenues of care such as Planned Parenthood or health centers, thus restricting their choice of providers and demonstrating the

importance of confidential, accessible care for teens. This complements existing literature that parent's attitudes and discussions regarding SRH can impact adolescents' SRH perspectives (Widman, et al., 2016) and may be associated with greater use of the SRH services (Hall, et al., 2012a). Lastly, three of the four participants that described stopping contraceptive methods (usually birth control pills) shortly after beginning use did not receive, or did not state that they received, SRH discussions from their parental support or information allows participants to more successfully continue a method. Further research is needed to identify whether stopping methods is associated with experiences of side effects or due to difficulties in access.

Recommendations for public health

This study has public health implications and recommendations for future research. In an effort to help increase adolescent's use of SRH services, the author of this study has the following recommendations for parents and schools:

Parents

Parental assistance scheduling first appointment. Parental assistance setting up an adolescent's first SRH visit may be a helpful facilitator in providing access to this sector of the healthcare system.

First time contraceptive visits can be fear inducing. In this study, this seemed to be compounded when women did not know what to expect during their visit. Women who discussed feeling nervous about their initial visits also discussed how new the process was, indicating that some of the fear women encounter during their first visit may be due to unfamiliarity. While a few participants discussed preparational conversations in their interviews,

most of these conversations were focused around questions to ask the doctor or financial costs that may incur. Assistance setting up their first appointment and having parents that discussed contraception positively were large facilitators for participants who received care at a younger age.

As other studies found early and consistent SRH visits are important in lowering negative SRH outcomes in adolescents and young women (Ralph & Brindis, 2010). As noted previously, studies have shown establishing a provider can be a barrier for women's access to SRH care (Bertand, Hardee, Magnani, and Angle, 1995), and could be exasperated by an adolescent's lacking experience or knowledge in their first time using the SRH branch of the healthcare system. Parental guidance setting up their first appointment in this new sector of the healthcare system may be important facilitating access. However, as other research has also concluded, participants preferred to be alone in the exam room when receiving contraceptive services their provider (Fuentes, et al., 2018).

Information regarding contraceptive service process. Providing adolescents with information regarding their first time SRH visit may help prepare them and reduce anxiety or discomfort that may arise from unfamiliarity with the process.

Several participants discussed discomfort or nervousness during their first time seeking services. Many participants expressed a desire to know more about the process of seeking care itself. This was usually due to unfamiliarity of the SRH process. Some participants expressed the fear of not wanting to look like they were unintelligent or uninformed during their visit. This indicates a gap in knowledge may exist for adolescents utilizing contraceptive services for the first time. Given that previous studies concluded parents are a trusted and important resource for adolescent SRH knowledge (Albert, 2012; Widman, et al., 2016; Flores & Barroso, 2017),

parents could play a crucial role in mitigating these fears through SRH discussions with their adolescents.

Current SRH guidelines for adolescents primarily concentrate on information regarding an adolescent's sexuality and the types of contraceptive methods available to use. Few guidelines exist for parents to help navigate adolescents' first SRH visit, and those that do primarily focus on provider-patient interaction or are tailored towards adolescents making their first appointment (Advocates for Youth, 2020; Planned Parenthood, 2010; Planned Parenthood 2020, Society for Adolescent Health and Medicine, 2020). While this is an important part of comprehensive SRH discussions, this study has found that parent discussions regarding SRH services was associated with earlier SRH service use. This is important because, as noted previously, early and consistent SRH visits are associated with lowering negative SRH outcomes in adolescents (Ralph & Brindis, 2010). Developing parent-adolescent discussion guidelines regarding adolescent's first-time service use may helpful. Programs looking to increase positive SRH outcomes in adolescents could consider providing parents with relevant information to discuss with their adolescents to prepare them for their first time and developing discussion guidelines focus on the what to expect logistically, financially, and emotionally may help alleviate some of the unfamiliarity and anxiety associated with first time use.

Schools

Comprehensive Sexual Education. While not the focus of this study, we found the majority of participants who discussed receiving sexual education in school described negative experiences which focused primarily on abstinence only messaging, such as how to say no to sex, focused on STI information, or generally lacked comprehensive SRH information. Some

participants noted wanting to receive more comprehensive sexual education information such as sexual autonomy, sexual efficacy, and the mental implications of sex. This agrees with existing literature that found female adolescents desired more holistic SRH information such as socio-emotional skills (Adams & Williams, 2011). Teaching comprehensive sexual education in schools could both meet the SRH educational needs of the students and improve their sexual and reproductive health outcomes (Chin, Sipe, Elder, et al, 2012; Linderbergh & Maddow, 2012).

Future Research

Parent-adolescent SRH discussions and SRH service use. More research is needed to explore the relationship between parent-adolescent discussions and its impact on adolescents' SRH service use. While this study explored initial concepts, more qualitative studies would add to the limited existing literature and could expand on the parent-adolescent SRH discussions and its impact on adolescent SRH service use.

Repetition of SRH information. Some discussions by participants in these interviews suggest adolescents may need repetition of SRH information to normalize the content to better act on the information provided. Even when participants discussed receiving contraceptive information or directions on condom use, some participants reported discomfort asking their sexual partner to wear a condom or telling their parents when they were ready for contraceptive services even if they had a contraception discussion with their parents before their sexual debut. One discussion may not be enough for adolescents to feel they can act on what they have learned. Current literature does not adequately address repetition or behavior establishment and its impact on adolescents SRH routine, especially concerning contraceptive use.

Destigmatizing contraception and SRH service use. Efforts have been made to destigmatize adolescents' sexuality, however, less has been done to destigmatize their use of contraception and SRH services (Loi, et al., 2019). Internalized stigma and shame regarding contraception and service use was discussed by several participants. Lack of discussions, religion, and region were discussed by some participants as the drivers behind their internalized contraceptive stigma. Future research could explore ways to reduce contraception stigma and its impact on adolescents' SRH service use.

Limitations

This study used secondary data from a larger study which explored equity and access to family planning services in the south amongst low-income women. Parent-adolescent discussions and its impact on participants' first care seeking experience was not the original research question, thus interview questions were not tailored to this specific area of interest and may not have fully investigated this subject in depth. While not an initial question of this research study, participants' SRH discussions with their parents were discussed by all but one participant of the study. More tailored questions could have produced more detailed descriptions of parent-adolescent discussions and their impact on the participants' care seeking experiences. Additionally, participants were asked to remember their experiences from a younger age. Participants' ages ranged from 19 to 33. For some participants their first care seeking experience was more recent and may have been easier to recall. For older participants, recalling their first care seeking experience may have been more difficult, and details may have been missed.

Although participants were not directly asked about their SRH discussion with their parents, this in turn also speaks to the strength of this study's research question, as parental

influence on adolescents' first SRH experience emerged an important influence and was described by participants without specific prompting. Due to the structure of LHIs, participants were able to guide the interview and speak about what was important to them as an individual. This allowed for a more holistic view of their experiences, including their SRH discussions with their parents and its impact on their first care seeking experience, which produced a more thorough examination of their experiences.

Conclusion

Parents can be a strong facilitator in providing SRH knowledge to adolescents and access to services, and while current literature states parents have an influence over adolescents' SRH outcomes, few focus on service use. This study assessed the association between parent-adolescent sexual and reproductive health discussions and adolescents' first care seeking experiences amongst low-income women in Georgia and found parents influence adolescent's SRH service use. The type of parent-adolescent SRH conversations received impacted participants' care seeking in different ways.

"Logistical discussions" included what services were offered, the type of providers available, and where the participants insurance would be accepted. These discussions were associated with earlier SRH service use, with most participants who received this type of discussion receiving care by age 18. "Facilitation discussions" were largely conversations focused on adolescents' access to SRH services, such as assistance setting up their appointment, prescription pick up, and providing transportation. These discussions were also associated with earlier SRH service use. "Contraception discussions" that were informative were described as positive or neutral conversations by participants. Participants were more likely to approach their parents when they were ready for contraception if they had previously had a positive

contraception discussion with their parent. Most participants expressed a desire to know more SRH contraceptive and service use information.

Abstinence only messaging had a negative protective effect. Of the three participants that discussed abstinence only messaging, none had received contraceptive services. Two participants described not wanting services and a wariness of contraceptive methods' effects on the body. The other participant expressed an interest in services, but ultimately never sought care. Two of the three participants experienced an unintended pregnancy. Lastly, lack of SRH discussions or negative SRH discussions exacerbated feelings of shame regarding contraceptive care amongst select participants and was associated with lack of comfort surrounding contraception and also a lack of confidence seeking contraceptive care.

Appendix

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