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The Perfect Storm: Perceptions of Influencing Adults Regarding Latino Teen Pregnancy in Rural Communities

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Abstract

Introduction—Recognition of the importance of adolescents' environments in influencing their sexual and reproductive health (SRH) decision-making necessitates a deeper understanding of the role that community stakeholders play in shaping Adolescent and Young Adults (AYA) access to SRH education and care. We describe community stakeholders' knowledge, beliefs, and attitudes about AYA's SRH needs in three rural Latino communities in Kansas.

Methods—Key stakeholders completed a written survey incorporating the theory of Planned Behavior to assess attitudes, norms, and intentions to support AYA's SRH education and access to care.

Results—Across three rural immigrant community settings, respondents (N = 55) included 8 community health workers, 9 health care providers, 7 public health officials, 19 school health officials, and 12 community members. More than half self-identified as Latino (55%). Six (11%)

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Code Availability Not applicable.

Ethical Approval Research reviewed and approved by the Institutional Review Board of the University of Kansas.

Consent to Participate Participants were verbally consented to participate in this study.

Consent for Publication Consent was obtained to publish de-identified data.

participants, half of whom were in the health sector, thought SRH education would increase the likelihood that teens would engage in sexual activities. In contrast, other stakeholders thought that providing condoms (17, 30.9%), contraception other than condoms (14, 25.5%), and providing HPV immunization (5, 9.6%) would increase the likelihood of engaging in sexual activity. Ambivalence regarding support for SRH education and service provision prevailed across sectors, reflected even in the endorsement of the distribution of less effective contraceptive methods. Obstacles to care include immigration status, discrimination, lack of confidential services, and transportation.

Conclusion—Key stakeholders living in rural communities revealed misconceptions, negative attitudes, and ambivalent beliefs related to the delivery of SRH education and services, potentially creating barriers to AYA's successful access to care.

Keywords

Community Stakeholders; Latinx; Rural; Adolescents; Reproductive health

Introduction

Adolescents and young adults (AYA), aged 15–19, living in rural areas of the United States have higher teen pregnancy rates than their urban counterparts (Ng & Kaye, 2015). Their unmet sexual and reproductive health (SRH) needs are in part explained by multiple obstacles to accessing health care in rural communities, including high rates of poverty, (Ng & Kaye, 2015) the overall shortage of health care providers, (Devoe, 2009) and geographical isolation (Ng & Kaye, 2015). Access to rural SRH care presents even more obstacles, especially for AYAs, who describe the lack of anonymity and confidentiality as key obstacles to care-seeking in rural settings (Garside et al., 2002). One of the few studies that have focused on SRH barriers for AYAs living in rural areas determined that youth recognized their need for such services and knew where to access services yet avoided seeking services due to embarrassment and fear of stigma (Elliott & Larson, 2004).

AYAs may also experience attitudinal barriers from parents, teachers, and health care providers (HCP) when seeking contraceptive information and care World Health Organization, 2004). Young women may feel an even stronger influence (Caal et al., 2013). HCPs' unfavorable attitudes toward a comprehensive range of reproductive health options because of "conscientious objection," misinformation that drives their beliefs, and knowledge deficits about SRH can limit access to accurate, comprehensive health information and negatively influence contraceptive counseling for AYAs (Guttmacher Institute, 2007; Curlin, 2007. Furthermore, immigrants living in rural areas may also face unique challenges in accessing SRH care services as compared to their non-immigrant counterparts. These include lower levels of education and health literacy, higher rates of poverty, lower rates of insurance coverage, language, and communication difficulties, legal concerns, discrimination, and lack of transportation (Cristancho et al., 2008).

A factor that has been understudied in Latino rural communities is the powerful influence that key community members surrounding AYAs may play, given their strong opinions regarding cultural norms within their ethnic community along with the broader community's

beliefs and stigmas regarding sexuality, that can further isolate AYAs from pertinent health information and care. Apart from individual-level factors, external factors, including social and environmental factors, have also been shown to have a great effect on adolescent sexual risk behaviors (Rotheram-Borus, 2000).

Little is known about the specific knowledge, beliefs, and attitudes held by key stakeholders (more specifically community health workers (CHWs), HCPs, public health officials, school health officials, and community members living in rural immigrant Latino communities regarding their level of support for AYA's reproductive health needs. The objective of this descriptive study was to document community stakeholders' knowledge, beliefs, and attitudes about rural AYAs' SRH needs in 3 rural counties with a proportionately large immigrant Latino population. We used the theory of planned behavior (TPB, shown in Fig. 1) as a framework to understand stakeholders' beliefs, attitudes, and intentions based on the idea that, *"The more favorable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person's intention to perform the behavior in question."* (Ajzen, 1991).

The TPB and its constructs have been used to explain both the intention and prediction of HCP's clinical behavior (Godin et al., 2008). Understanding key stakeholders' nuanced intentions and potential ambivalent views in their roles in supporting AYA's SRH in rural Latino communities may help inform programming to mitigate unsupportive perspectives, as well as respond more effectively to the high teen pregnancy rates in their communities.

Methods

Study Design and Sample Selection

From July 2014 to May 2016, we conducted a survey regarding AYA's access to SRH as envisioned by key stakeholders living in 3 rural Kansas counties with relatively large percentages of Latinos. In 2014, while 11% of the Kansas population was Hispanic, they represented 48% in the county of Finney, 53% in Ford, and 59% in Seward (Pew Research Center, 2014). In 2016, teen birth rates in these counties were higher than state rates: 73, 72, and 88 per 1000 15–19-year-old female adolescents, respectively (38 for the state of Kansas) (Foundation, 2020).

Research was conducted in accordance with prevailing ethical principles, and reviewed and approved by the University of Kansas's Institutional Review Board. A trained bilingual community liaison recruited key stakeholders from 5 different groups: CHWs, HCPs, public health officials, school health officials, and community members. Interested participants were eligible if they represented any of these groups and spoke either English or Spanish. Participants were enrolled in the study in different work settings, for example, health care waiting rooms and community agencies; those interested were verbally consented and completed a written survey. All participants received a $50 gift card for their time and were offered light refreshments during the time they completed the survey privately.

Procedures

Research staff distributed a 41-item, paper-based, approximately 20-min, anonymous survey to participants in their preferred language (English or Spanish), and in their chosen location (community center or work). The community liaison handed each participant their survey and waited for its completion, sitting a short distance away to provide privacy.

Survey data were manually entered by research staff into Research Electronic Data Capture (REDCap).

Survey Measures

The survey measures assessed: (1) demographics, (2) acculturation level of Latino respondents, (3) attitudes, norms, and intentions to support AYA's SRH education and access to SRH care, and (4) knowledge regarding whether AYAs sought SRH health care.

(1) Demographic Questions—Included job description, age, gender, level of education, religion, race, and ethnicity, and nationality.

(2) Assessment of Acculturation—The Short Acculturation Scale for Hispanics (SASH) (Marín et al., 1987) was used to calculate acculturation; responses to all 4 items are given on a 5-point Likert scale, 1 is "Only Spanish" and 5 is "Only English," with a midpoint (3) of "Both equally." The total score reflects the average rating across all answered items. An average of 2.99 is the recommended cut point; scores above indicate higher levels of acculturation, and scores below indicate lower levels of acculturation (Lindberg & Maddow-Zimet, 2012).

(3) Assessment of Beliefs/Attitudes, Subjective Norms (TPB)—The TPB was used to guide dependent variable measures with 3 main constructs as predictors of a behavior: (1) behavioral beliefs (which produce a favorable or unfavorable attitude toward the behavior), (2) normative beliefs (which result in perceived social pressure or subjective norm) and (3) intention to support SRH education and access to care (Ajzen, 1991).

The team developed and piloted tested items based on a combination of a review of the published literature and best practices for TPB survey development (Song et al., 2019). Five initial respondents from the target participant group pretested it, and minor modifications were made to increase clarity. All TPB variables were measured in relation to supporting AYA's access to SRH education and services. Constructs assessed and specific items are described in Table 1.

(4) Contraceptive Knowledge—Participants' knowledge of contraceptive methods was assessed by asking if they had heard of each method (as above) and if they understood how each method is used. Respondents who identified as HCPs were also specifically asked which methods of contraception they regularly recommended or provided to patients, including counseling about abstinence, condoms, natural family planning, hormonal methods, long-acting reversible contraception [LARC], emergency contraception [EC], and sterilization.

Data Analysis

Descriptive statistics were reported for each survey item. Differences in responses to construct assessment between the five categories of stakeholders (CHWs, HCPs, public health officials, school health officials, and community members) were analyzed using chi-square and Fisher's exact tests. SAS version 9.4 (SAS Institute Inc., Cary, NC) was used for all analyses.

Results

Sample Description

Fifty-five participants completed the survey (Table 2), including providing information on their roles in the community. The mean age of participants was 44 years (SD = 15.18). Most were female (46, 83%) and had attained at least some college education (42, 76%). Most participants were Christian/Catholic (39, 71%). Half of the respondents were themselves Hispanic/Latino (29, 55%). More than half of the participants (32, 60%) were born in the U.S. Among the 29 participants who identified as Hispanic or Latino, 9 (31%) were born in the US, 19 (66%) in Mexico and one was born elsewhere (3%). Based on the results of the SASH, participants had a low level of acculturation, with only 40% scoring in the high acculturation group (> 2.99).

Behavioral Beliefs and Attitudes Towards the Provision/Support of SRH Services Access

Six (11%) participants, half of whom were in the health sector, thought SRH education and the provision of services would increase the likelihood that teens would engage in sexual activities. When asked about specific contraceptive methods and services, substantial numbers of participants thought they would increase the likelihood of engaging in sexual activity: condoms (17, 30.9%), contraception other than condoms (14, 25.5%), and providing HPV immunization (5, 9.6%).

When asked about the acceptability of a man and a woman having sex before marriage, nineteen (35%) thought it was always or almost always wrong, 26 (47%) thought it was wrong sometimes or not at all, and 10 (18%) did not know or declined to answer. When asked this same question, but pertaining to those under 18 years old, 36 (65%) thought it was always or almost always wrong, 13 (24%) thought it was wrong sometimes or not at all, and 6 (11%) didn't know or declined to answer. There were no significant differences in these responses based on job group nor gender or acculturation status.

Normative Beliefs (Subjective Norms) Regarding Access to Contraceptive Methods

Though respondents expressed hesitation regarding the provision of SRH education and services, most respondents (45, 81.8%) still expressed that either they agreed or strongly agreed that birth control methods should be available to teenagers under 18 years old, even if parents do not approve. Of note, 1 of the 9 HCP replied "don't know" to this question, 1 of the 7 public health department staff members declined to answer, and 2 of the CHWs disagreed/strongly disagreed with this statement. There were no statistical differences based on job group, gender, or acculturation level for this question.

Perceived Obstacles for AYA to Access Healthcare

Perceived obstacles for AYAs to access health care included immigration status (23, 51.1%), fear of non-confidential services (19, 42.2%), lack of transportation (13, 28.9%), distrust of the health care system (7, 15.6%), previous bad experience (7, 15.6%), fear of discrimination (5, 11.1%), and other (15, 33.3%). When analyzing differences based on job group, gender, or acculturation level, we found a higher proportion of females compared to males identifying lack of legal papers or documentation as an obstacle for AYAs' access to care (52.2% vs. 11.1%, Fisher's exact test, P=0.03); a higher proportion of less acculturated participants identified "fear of non-confidential services" as an obstacle for AYAs seeking care (51.6% vs. 14.3%, $\chi^2 = 7.52$, $P = 0.006$).

We also found a significant difference among different job groups in the proportion that believed fear of discrimination was an obstacle to health care access: 33% of HCPs, 17% of community members, but none of the CHWs, public health staff, and school officials (Fisher's exact test, $P = 0.02$) indicated that this was an issue.

When asked: "How easy is it to obtain professional information on sexual and reproductive health where you live?", 55% (30) of the participants thought it was very/somewhat easy, and 45% (24) thought it was somewhat/very difficult.

Assessment of Intention to Provide Support to AYAs' in Their Efforts to Access Reproductive Health Education and Care

While most participants (n = 52, 94.5%) supported sexuality education in public schools, we only asked about some topics usually included in this type of education. However, within the topics asked, overall, participants' support for SRH was higher for sexually transmitted infections (STI) screening and provision of SRH care information than for abstinence education, provision of contraception, and HPV immunization (Table 3). However, we did not explore other education topics, such as LGBTQ or how to access confidential clinical services, or what the best teaching methods entail (role plays, site visits to clinics, or visits to pharmacies to see whether condoms are readily available).

Analyses of support for the provision of reproductive health information by type of stakeholder showed that only half (n = 4, 50%) of the CHWs supported it, whereas over 90% of each of the other job groups supported such provision ($P = 0.01$). Additionally, not all CHWs and public health department staff agreed with providing birth control to teens (that is, did not respond "agree a lot" or "extremely agree"). Support for HPV immunization differed, though differences were not statistically significant (Fisher's exact test, $P = 0.06$) among stakeholder groups: 42.9% (n = 3) of CHWs supported immunization, compared with 80% (n = 8) of community members, 89.9% (n = 8) of HCPs, 89% (n = 17) of school officials, and 100% (n = 7) of public health department staff. Support for other services (STI screening, abstinence education, and provision of contraception), did not differ significantly based on stakeholder group, gender, or acculturation status.

Healthcare Providers' Recommendations on Contraception

Highly effective contraceptive methods, such as injections and LARCs, were recommended by 71% of providers. Condoms were recommended by 83% of providers and EC by only 57% of providers. A high proportion of HCPs (71%) recommended less effective methods for adolescents (abstinence, pills, patch, and ring), as well as female sterilization, which is not indicated for adolescents.

HCPs also recommended highly ineffective contraceptive methods, especially for adolescents: withdrawal was recommended by 3 of 9 (43%) of providers, and lactation and sponge by 2 of 9 (28.6%). Rhythm method and natural family planning methods were recommended by 4 of 9 (57.1%) providers, the same percentage as vasectomy or male sterilization, again, not relevant for AYAs.

Other participants' recommendations on birth control options were not statistically significantly different from those of HCPs. Of note, LARCs were recommended by 25% (n = 2) of CHWs and 43% (n = 3) of public health staff, and EC was recommended by 37.5 and 28.6-respectively (n = 3 and 2) of respondents in these two groups.

Discussion

This is one of the first studies to examine a variety of key community stakeholders' attitudes, beliefs, and intentions to support Latinx AYA's access to SRH education and care in three rural communities in Kansas, as well as their potential roles in increasing barriers to such services. Our findings are framed within the Theory of Planned Behavior and highlight the extent to which many stakeholders experience wide-ranging ambivalence regarding AYA's sexual behavior. This ambivalence is further reinforced by strongly held misconceptions across different participant groups linking the provision of SRH education and contraceptive care with increased sexual risk behaviors, despite extensive research refuting that association (Santelli et al., 2017).

This study further differentiates the wide range of existing beliefs and misconceptions held by influential stakeholders in the lives of AYAs, including CHWs, HCPs, schools, and public health staff that can also shape the environment in which AYAs are able to make their SRH-related decisions. Although most participants supported the provision of SRH education, contraception, STI screening services, and HPV vaccination overall, support was not consistent across all professions.

Sexual and Reproductive Health Education

Aligned with findings from other studies that have reviewed parental support of sex education (Akers et al., 2010), most of the stakeholders in our study supported the provision of SRH education in schools, including abstinence education, acknowledging an important knowledge gap. However, given the misconceptions held by key participants regarding the availability of contraceptives contributing to a higher risk for sexual behavior, it is unclear whether they would fully support comprehensive sex education. Comprehensive sexual education in middle and high schools has been replaced by "abstinence-only-until-marriage" programs in politically conservative communities such as the ones reflected in these

findings, resulting in marked disparities in access to medically accurate, comprehensive sex education between school districts and states (Kelly et al., 2008). These patterns mirror the ambivalence among survey respondents.

Sexual and Reproductive Health Services

Ambivalence was noted even among health professionals, such as HCPs, CHWs, and public health department staff, who showed inconsistent support for providing birth control services and contraceptive methods to AYAs. These findings point to the importance of community values and beliefs that either support or obstruct access to care. Indeed, previous studies have documented negative beliefs about contraception that exist within the healthcare community and how these can negatively influence contraceptive counseling and prescribing practices, in turn, shaping AYAs contraceptive uptake (Emergency Contraception, 2012; Society for Adolescent Health & Medicine, 2016).

Furthermore, only about half of the HCPs endorsed the use of ECs, an important tool in preventing unintended pregnancy and abortion (Committee on Health Care for Underserved Women, 2012; Samson et al., 2013). In contrast, the use of ECs has been widely supported by the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Society for Adolescent Health and Medicine (Committee on Health Care for Underserved Women, 2012; Miller et al., 2011; Samson et al., 2013). In light of the limited availability of over-the-counter ECs in rural areas (Gavin et al., 2014), the role of providers becomes crucial for AYA's access. Lack of support for EC education and EC provision as a potential influence on the timely availability, provision, or prescription by rural providers has been examined previously (Gavin et al., 2014) and the results also reflect these findings. Lack of support may reflect not only knowledge deficits but may be highly driven by individual personal beliefs and attitudes (Ford, 2010).

Confidential Sexual and Reproductive Health Services

The provision of contraception to minors without parental consent was also not consistently supported by our participants, particularly about whether younger teens should have such access. A recent study examining parental and teens' stand on confidentiality in the U.S. showed that although parents value clinical preventive services, they do not always support confidentiality for these services (Akers et al., 2010). The lack of confidential services is an established barrier to comprehensive teen health care (American Medical Association, 2013). Additionally, cultural factors may also interfere with the provision of confidential care, including time alone with a provider in which the AYAs can share confidential information (Ford et al., 2004). Consequently, major professional societies, including the American Academy of Pediatrics, the American Medical Association, the American College of Obstetricians and Gynecologists, and the Society for Adolescent Health and Medicine have all issued statements asserting that confidential reproductive health services benefit youth and should be made available to them (American Academy of Family Physicians, 2014; Jones et al., 2005; Lawrence et al., 2009). Confidential services increase access for AYAs, particularly for reproductive health, mental health, and substance use concerns (Reddy et al., 2002). Mandatory parental involvement, on the other hand, discourages the use of prescription contraception, shifting adolescents' use to more cumbersome and

less effective methods, potentially resulting in AYAs engaging in unprotected intercourse. (Bonville et al., 2017; Patel & Berenson, 2013) Obstacles to confidential contraceptive counseling and services for AYAs may also decrease access to other important health services, such as risk-reduction counseling, screening, and treatment for STIs (Vaccination Coverage Trend & Report, 2008).

Human Papilloma Virus Vaccine (HPV)

The relationship between contraceptive access and increased sexual risk was also noted among CHWs and HCPs regarding the receipt of HPV immunization as a factor in increased sexual behavior. In fact, less than half of the surveyed CHWs supported HPV immunization provision, and not all HCPs and school officials supported it either.

Parental concerns regarding the potential for HPV vaccination to increase sexual activity (Vaccination Coverage Trend & Report, 2008) and providers' related hesitance to vaccinate (Chuang et al., 2012) have been previously noted, although the perceptions of CHWs on this matter have not been previously described. The role of the CHW is particularly noteworthy as they often provide vaccine education and crucial outreach for immunization in rural areas. Their ambivalent or negative influence can potentially have deleterious impacts on immunization rates, especially in a state like Kansas that had the lowest coverage in the nation for the HPV vaccine in 2018 (Kate, 2002).

Perceived Obstacles to Health Care for AYAs

Finally, our stakeholder respondents describe multiple perceived obstacles to AYA's access to health care including lack of confidential services and transportation challenges, both previously reported in rural areas (Bartolo & Marina, 2019; Brindis et al., 2020; Bronstein & Morrisey, 1990). Participants noted the additional multiplier effects of legal documentation issues and discrimination faced by many Latino immigrant communities (Cristancho et al., 2008).

These perspectives reflect in part the highly charged, political atmosphere with stringent immigration and deportation policies. As a result, immigrants are increasingly hesitant to interact with public health or service agencies to access care ("the chilling effect" of federal public charge policies) (Tebb & Brindis, 2022). It is therefore expected that SRH care would continue to be inaccessible for this rural immigrant population, even when such policies no longer remain in place.

Overall, the study identifies the role of stakeholder ambivalence and its influence on the lack of consistent support for the types of SRH education and services that Latino AYAs living in rural communities receive (Bronstein & Morrisey, 1990). Given pervasive adult ambivalence about facilitating the provision of SRH education and care to AYAs, including CHWs who are crucial for communities that traditionally are underserved, high teen pregnancy rates in the surveyed community are not surprising. Our findings suggest that these obstacles, fueled by the levels of misinformation and resistance among some of their most trusted members of the community, as well as the pragmatic realities of more limited services, potentially contribute to documented higher risk for unintended pregnancy and STDs among Latinx immigrant communities. They also imply that unless we address external environmental

factors, including attitudes and perceptions of influencing surrounding adults, we will continue to place youth at the center of the perfect storm, perpetuating disparities in teen pregnancy rates in communities that continue to be marginalized in the United States.

Limitations

We acknowledge that teen pregnancy is a complex issue and stakeholder ambivalence and its influence in the lack of consistent support for SRH education and services, are just one part of this complexity (Brindis et al., 2020; Tebb & Brindis, 2022). Study limitations include a cross-sectional design with small sample size and few participants in each job-role group. We also do not have available information on those who might have declined participation, and therefore our sample might not be fully representative and generalizable. The use of self-reports in the design may have resulted in recall bias regarding the length of training and familiarity with contraceptive methods, as well as social desirability bias in responses. There is limited generalizability due to sampling being restricted to a specific geographic area and community. However, as a step in better understanding how the environmental cues provided by influential stakeholders could shape adolescents' access to sexual and reproductive health care and education, as well as their inconsistent responses within and across groups, offer perspectives that may be important to respond to in future development of community-focused interventions.

Our participants responded to some questions regarding SRH education and access for AYA in their communities, but future studies should also include even more controversial topics, such as the needs of LGBTQ AYAs and specific role plays and community-based homework assignments (e.g., visiting a clinic or seeing how difficult it is to pick up condoms in a drugstore). Future studies will also need to build more ethnic/racial comparisons for groups living in rural communities, especially in light of different levels of acculturation and a changing immigration policy environment.

Conclusion

Our study examines key community stakeholders' attitudes, norms, and intentions to support AYA's SRH care education and access and identifies barriers that must be overcome in midwestern rural Latino communities. Understanding community key stakeholders' perceptions can be revealing of community expectations and interest in SRH that is central to informing additional community engagement efforts in the development of SRH programs and access to care. This contextual understanding is necessary to better address the unique social, economic, and structural determinants of health for vulnerable teens living in Latino immigrant rural communities.

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Conflict of interest

Dr. Trent receives research grant funding/supplies from Hologic, Inc. and SpeeDx, LLC to Johns Hopkins University. She also serves on the Trojan Sexual Health Advisory Council sponsored by Church and Dwight, Inc.

Data Availability

Deidentified survey data collected is available in Research Electronic Data Capture (REDCap).

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Significance

Little is known about the knowledge, beliefs and attitudes held by key stakeholders in rural immigrant Latino communities regarding their level of support for AYA's SRH needs. Key stakeholders may harbor influential and ambivalent opinions regarding AYA's sexuality considering existing cultural norms, therefore, stigmatizing access to SRH education and care. We examined key community stakeholders' attitudes and norms as measures of intentions to support AYA's SRH education and care. We identify actionable steps needed to eliminate existing barriers to AYA's access to SRH education and care among at-risk immigrant Latino communities in the rural Midwest.

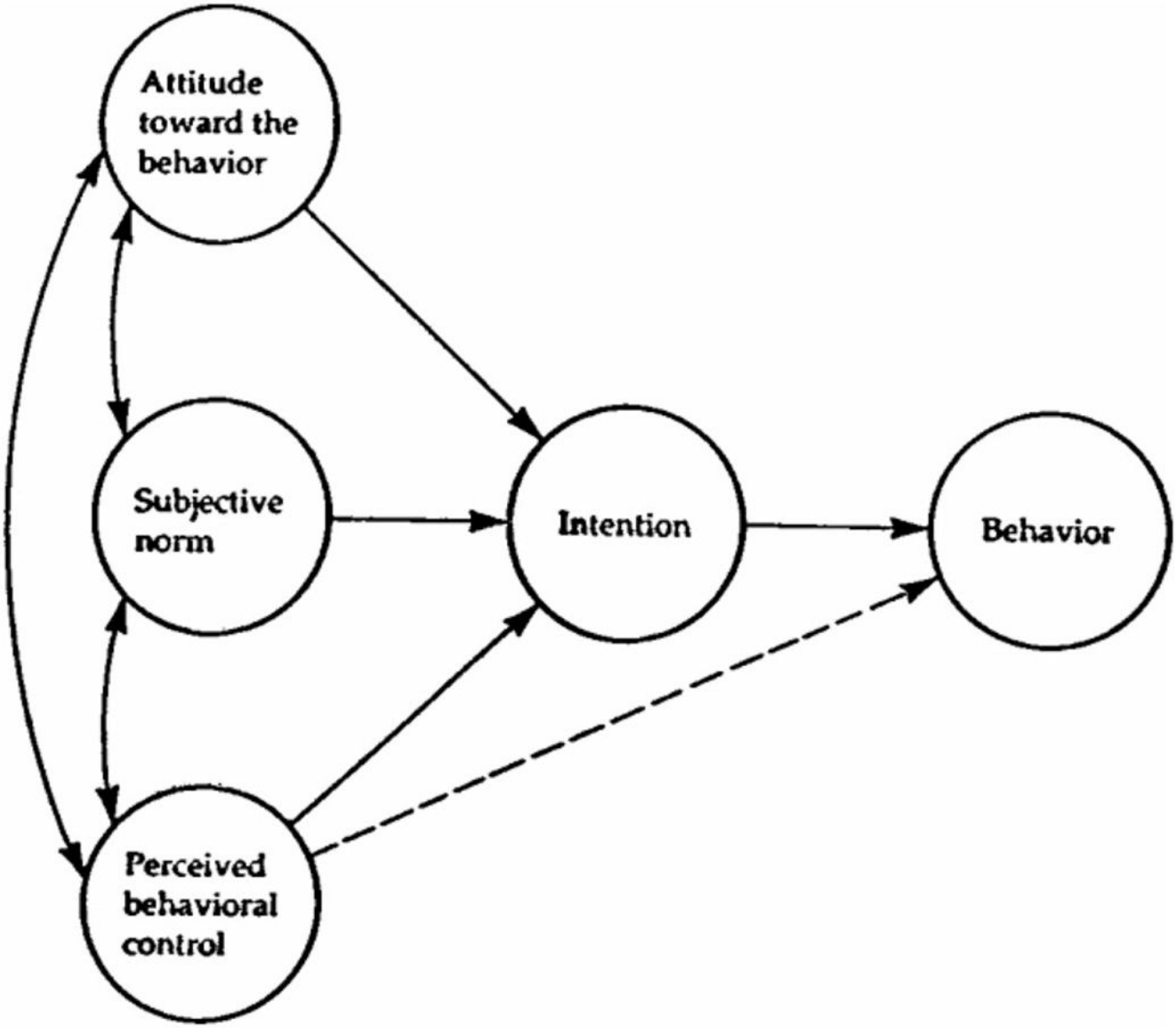

Fig. 1.
Theory of Planned behavior (Ajzen, 1991)

Table 1

Theory of planned behavior: domains, definitions, and survey items measuring support for adolescent and Young Adult's (AYA's) sexual and reproductive health education (SRH) and access to care

Domains and definitions of dependent variables	Survey questions
Behavioral beliefs and attitudes (This construct refers to the outcomes of performing the behavior)	• "Do you think reproductive health education would increase the likelihood that teens will engage in sexual activities?"
Values that influence beliefs and attitudes	• "Do you think providing contraception would increase the likelihood that teens will engage in sexual activities?" • "Do you think providing condoms would increase the likelihood that teens will engage in sexual activities?" • "Do you think providing human papilloma virus (HPV) vaccination would increase the likelihood that teens will engage in sexual activities?" Responses were recorded on 4-point scales from "strongly agree" (1) to "strongly disagree" (4), with "Don't know" and "Decline to answer" options • "There has been a lot of discussion about the way morals and attitudes about sex are changing in this country. If a man and a woman have sex before marriage, do you think it is always wrong, almost always wrong, wrong only sometimes, or not wrong at all?" • "What if they are under 18 years old? In that case, do you think sex before marriage is…?" Answers to these last 2 questions were measured with 4-point (1–4) scales using "Always wrong" (1) to "not wrong at all" (4) endpoints, with "Don't know" and "Decline to answer" options
Subjective norms (This construct refers to the belief about whether most people approve or disapprove of the behavior. It relates to a person's beliefs about whether peers and people of importance to the person think he or she should engage in the behavior)	• "Should birth control methods be available to teens under 18 if their parents do not approve?" Responses were recorded on 4-point scales from "strongly agree" (1) to "strongly disagree" (4), with "Don't know" and "Decline to answer" options • "How easy is it to obtain professional information on sexual and reproductive health where you live?" Responses to all items were scored on 4-point Likert scales, ranging from "very easy" (1) to "very difficult" (4) "What are the obstacles that people aged 15–24 face when trying to access health care?" Answer options included lack of transportation, fear of lack of confidential services, documentation issues, distrust of the health care system, fear of discrimination, previous bad experience, and other
Intention to support SRH education and access to care	• "Do you support sexuality education in public schools?" Answers to these questions were yes/no • "To what extent do you agree with the following reproductive health services for teens?" Answer options included offering counseling about abstinence, provision of reproductive health information, provision of birth control, provision of STD screening, and provision of HPV immunization. Responses were scored on 5-point Likert scales ranging from "not at all" (1) to "extremely" (5)

Table 2

Selected participants demographics

(n = 55)	n (%)
Mean Age, years (SD)	44 (15)
Female	46 (83)
Role in community	9 (16)
• Health care provider (2 physicians, 1 nurse practitioner, 4 nurses and 2 CNAs)	7 (13)
• Public Health Department staff (Administrators, community program leaders)	8 (15)
• Community health worker (Teen parent educators, pregnancy care center staff, community health coalition staff)	12 (22)
• Community member (1 waiter, 1 janitor, 1 housewife, 5 community leaders, 2 public officials including the county commissioner, 2 college students)	19 (35)
• School staff (4 counselors, 6 teachers, 1 college advisor, 4 administrative assistants, 2 federal program staff, 2 parent coordinators/advisor)	
Religion	39 (71)
Catholic/Christian	8 (16)
Protestant	2 (4)
Other	
Education	13 (24)
HS or less	14 (25)
Some college	10 (18)
Bachelor’s degree	18 (33)
Advanced degree	
Hispanic/Latino	29 (55)
Born	32 (60)
In the US	19 (36)
In Mexico	
High Acculturation (Average SASH scores > 2.99)	21 (40)

Table 3

Support for Adolescents and Young Adults' (AYAs) access to different reproductive health education and services by type of stakeholder group

		Stakeholder group					
		% Agreed a lot/extremely					
Reproductive Health Services	**Community Health Worker n = 8**	**Community Member n = 11**	**Health Care Provider n = 9**	**Public Health Staff n = 7**	**School Official n = 20**	**Total n = 55**	**p-value***
	n (%)	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	
Abstinence education	4 (57.1)	7 (70)	6 (66.7)	5 (71.4)	11 (61.1)	33 (64.7)	0.97
Provision of reproductive health information	4 (50)	11 (100)	9 (100)	7 (100)	17 (89.5)	48 (88.9)	0.01
Provision of birth control	6 (75)	8 (72.7)	9 (100)	5 (71.4)	17 (89.5)	45 (83.3)	0.30
Provision of STD screening	7 (87.5)	10 (90.9)	9 (100)	7 (100)	17 (89.5)	50 (92.6)	0.95
Provision of HPV immunization	3 (42.9)	8 (80)	8 (88.9)	7 (100)	17 (89.5)	43 (82.7)	0.06

*Fisher's exact test