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Published By: The Center for Healthy Families
500 South Front Street, Suite 930
Columbus, OH  43215
Layout and Design By: Creative Spot
September 2014

The Center for Healthy Families thanks these organizations for their special support to this study:

Academy For Urban Scholars High School, Columbus
African American Male Wellness Walk
Barack Community Recreation Center
Big Brothers Big Sisters of Central Ohio
Broad Street Presbyterian Church
Buckeye Ranch (The)
CareSource
Center for Family Safety and Healing (The), Help Me Grow
Center for Family Safety and Healing (The), Nurse Family Partnership
Central Ohio Workforce Investment Corporation, OMI, CFC
CHLOE, Inc.
City Life Center
City of Columbus (The), Infant Safe Sleep
Columbus City Schools
Columbus Early Learning Center
Columbus Metropolitan Library
Columbus Public Health, Caring For 2
Community for New Direction
Community Research Partners
Crabbe, Brown & James, LLP
CUAD Studios, LLC
Directions for Youth & Families
Far East Neighborhood Pride Center
Franklin County Children Services, Evaluation
Franklin County Department of Job and Family Services, LEAP
Huckleberry House
IMPACT Community Action
John R. Maloney South Side Health Center
Life Skills High School of Columbus Southeast
MCS-T.O.U.C.H.
Mount Carmel West, Women and Infant Services
Nationwide Children's Hospital, Teen & Pregnant Program (TAP)
Neighborhood Services, Inc.
Ohio Department of Health, Office of Health Equity
Ohio State University (The) Office of Diversity and Inclusion, ACCESS Collaborative Program
Ohio State University (The) Wexner Medical Center, High Risk Perinatal Project
Ohio State University (The) Wexner Medical Center, Moms2B
OhioHealth, Community Health and Wellness
OhioHealth, Community Partnerships
OhioHealth, Grant Medical Center, Outpatient Care, Prenatal Clinic
OhioHealth, Wellness on Wheels
Road to Success Academy (The)
Saunders Company (The)
St. Stephen’s Community House
Skreened
ThinkUp
Triumph Communications

Major funding for this study was provided by the Franklin County Board of Commissioners and administered by Franklin County Department of Job and Family Services.

The Board of Commissioners has recently funded projects that will also affect services to area pregnant and parenting teens, specifically Prenatal Care and Women’s Health (Columbus Neighborhood Health Center) and Ohio Better Birth Outcomes (Nationwide Children’s Hospital).
Dear Friends and Partners,

The Center for Healthy Families is pleased to present *Embracing Change: Franklin County Teen Pregnancy 2014*, a report on teen pregnancy and parenting in Franklin County. This report includes the thoughts and opinions of teens as well as the Resource Directory for Franklin County Pregnant and Parenting Teens, which is the first-of-its-kind.

As part of our extended outreach for this study, we conducted focus groups and interviews, reviewed case studies, analyzed existing studies and data, and collaborated with a host of organizations and service providers to compile the information contained in this report. We want to especially thank the Franklin County Board of Commissioners, who provided funding for this study, and the Franklin County Department of Job and Family Services for its partnership.

*Embracing Change: Franklin County Teen Pregnancy 2014*, illustrates our core belief that pregnant and parenting teens need advocates to help them identify resources, support, and services to transition into successful, self-sufficient adults.

Since the Center’s inception in 2007, we have made tremendous strides in supporting pregnant and parenting teens in our community. This report and directory are extensions of our efforts to raise awareness about the challenges related to teen pregnancy and to make it easier for pregnant and parenting teens to access services critical to them, their children, and the future of their families.

The Center for Healthy Families advocates on behalf of these teens and helps them continue their educational and career goals while strengthening their ability to support their children. Through our collaboration known as Healthy Families Connection (HFC), the Center brings together organizations and programs to provide services and support to pregnant and parenting teens.

The prevention of teen pregnancy and the reality of teen parenting require that teens, parents, human services and health care providers, community planners, and policy makers all embrace change—together.

This report includes the voices of teens who have given us insights into how they view the reality of our community’s understanding of their situations and their needs. Let us be inspired by them to move community dialogue into action that helps change where we are today, so that we can reduce teen pregnancy and teen parenting, as we collectively find ways for more pregnant and parenting teens to build bridges to brighter futures.

Sincerely,

Tosha Safford
President & CEO

Donna James
Founder & Chairperson
The Center for Healthy Families
Board of Trustees
Every year in Franklin County about 1,100 teens give birth, and many of them have nowhere to turn for help. At The Center for Healthy Families, our mission is to change that. We understand the reality of the challenges for pregnant and parenting teens, but we believe that together we can transform fear and despair into hope and opportunity.

**Changing the Future for Teen Families**

Pregnant and parenting teens are in urgent need of creative, sustained assistance to complete high school and avoid lives of poverty and lifelong economic disadvantages. Their children face lifelong challenges as well, including increased risk of health problems, developmental disabilities, and poor academic performance. They’re more likely to become teen parents themselves, perpetuating poverty across generations.

A small percentage of teen females do not have personal access to parenting role models and will need help to establish and maintain such a beneficial relationship. Other teen females who already have relationships with prospective parenting role models may need encouragement to benefit from those relationships.

**Transformation Through Collaboration**

The Center for Healthy Families was founded in 2007 to help pregnant and parenting teens grow into responsible parents and successful members of the community. After identifying a gap in the resources available—most programs focus only on prevention—we established the first coordinated effort to integrate services to meet the complex, diverse needs of pregnant and parenting teens.

By bringing together our community’s most trusted and effective organizations, we provide teens with a comprehensive support system with access to resources in health care, education, employment opportunities, parenting skills, child care, early childhood education, and more. Further, we work one-on-one with teens to help them navigate the process and develop a plan for social and economic self-sufficiency. Through comprehensive and coordinated assistance, we’re making accessing resources easier, less confusing, more comfortable, and above all, more likely.

**Spreading Our Wings**

The Center for Healthy Families is a powerful voice and advocate for pregnant and parenting teens. We’re improving graduation rates, reducing subsequent pregnancies, and breaking cycles of dependency. Over the past seven years, we’ve helped more than 600 teens build brighter futures for their families, and we’re continually working to better understand and address the challenges that teens face. By embracing change together, we can engage, inspire, and transform the lives of young families in our community.
Healthy Families Connection is a direct service model that brings together organizations within our community to provide comprehensive, coordinated support for pregnant and parenting teens.
Pregnancy changes everything. And for teens, it’s even more difficult and uncertain. At The Center for Healthy Families, we believe every pregnant and parenting teen should have opportunities and resources to develop healthy, stable, and productive families.
The Center for Healthy Families presents this report of experience-based opinions solicited in late summer 2014 from many individuals with personal or professional experience with teen pregnancy. In this report, we share the voices of those with personal experience—Franklin County pregnant and parenting teen females, teen fathers, parents of pregnant or parenting teens, and adult females who first became mothers during their teens. We also share the voices of those with professional experience—professionals who manage or deliver Franklin County services or who govern or administer area agencies that deliver such services to pregnant and parenting teens. In addition to the information gathered through in-depth field survey interviews, focus groups, and case study analyses, the most recently available quantitative data are presented to provide a snapshot of key facts that represent our community’s experience of teen pregnancy.

Supplementing this report is a resource guide, a first-ever directory of the Franklin County agencies and organizations that either offer services directly aimed at the needs of pregnant and parenting teens or that target pregnant and parenting teens through their outreach programs.

As the managing partner of a 12-organization service collaborative known as Healthy Families Connection (HFC) that provides health and human services to Franklin County pregnant and parenting teens, The Center for Healthy Families conducted this study not only to guide improvement and development of HFC management and services but also to stimulate community dialogue among all teens, especially those who are pregnant and parenting; their families and friends; the professionals that serve them; and the community planners, policy makers, and funders of services that think about them. Most importantly, the Center seeks to ensure that all participants in the conversation start with shared knowledge. Unquestionably, our community’s teens must be participants in the conversation. Pregnant and parenting teens are not only part of the problem; they are part of the solution, a critical resource to define goals and implement change. The full report of this study includes a first attempt to relate its findings to those of many other recent community assessments, studies, and reports that are only listed in this report.

Major funding for this study was provided by the Franklin County Board of Commissioners and administered by Franklin County Department of Job and Family Services. In addition to the nearly 180 individuals who participated in the study, more than 45 organizations provided assistance and resources to support research efforts. The study was managed by independent researcher Sharon D. Sachs, Ph.D., who worked in consultation with Community Research Partners. The Center for Healthy Families is solely responsible for the study.

The major message of all the voices heard from and of the facts reviewed is that preventing teen pregnancy and caring for teen parents and their children more effectively and efficiently requires all stakeholders to begin by embracing change.
STUDY FINDINGS

The combined voices of nearly 180 individuals who thoughtfully offered opinions and suggestions based on their personal and professional experiences with teen pregnancy in Franklin County are summarized in the following report. The major messages are themes about change, which emerged across study participants from the analysis of study findings. Changing the future is understood to be the work of individuals and families, but also of schools, human service agencies, health care organizations, service systems, community planners, and policy makers. At times, study participants made very specific recommendations. Some focused on pregnancy prevention while others focused on acceptance of teen parenting or on community aspirations. The Center for Healthy Families offers this rich resource as a place to start high-quality community dialogue and decision making that creates a better future for teens, families, and our community. See Appendix A for a detailed description of the research methods that generated the study findings.

Make pregnancy services for teens a community priority.

Goals indicated by this study as worthy of consideration include:

- Increase the number of teens who abstain from or delay sexual activity and who are protected from forced sexual encounters.
- Reduce unwanted pregnancies.
- Increase involvement of pregnant teens in first trimester prenatal care.
- Engage all pregnant teens in substance abuse treatment and mental health counseling, when needed.
- Eliminate unmet basic needs of pregnant and parenting teens.
- Improve the effectiveness of transition care services—interventions, treatments, assistance, and support that help a teen assume the adult responsibilities associated with parenthood. Expected results—improved health of the teen and babies; increased completion of education and training; and consistent progress toward entry into and retention of family sustainable employment.

Improve pregnancy prevention among teens.

Complement abstinence education with medically accurate information about highly effective forms of birth control and increased understanding of the importance of strict adherence to use instructions. Ensure sexually active teens have access to contraceptives. Consider more extensive use of reality education and training to more effectively inform teens what it really means to be a responsible parent.

Deliver reproductive health education.

Target parents of teens, in addition to their teenage children, and improve the consistent availability and reliable quality of such school-based education. Teens often lack basic knowledge about their biology and sexually transmitted diseases. Safe sex practices, and the impact of substance abuse are topics that need to be better understood in relationship to the long-term health consequences for both a teen mother and her child. Gender-related power issues between teens should be addressed to encourage mutual respect and a sense of self-worth.

Offer new relationships with supportive adults.

Parents of pregnant and parenting teens are not always able to provide safe and stable living situations or adequate encouragement and assistance to help their children develop parenting skills and reach other maturity goals. A pregnant and parenting teen has an unquestionable advantage when she or he has relationships with multiple support people, ideally including a member of her or his immediate or extended family.

Reduce infant mortality.

Plan special outreach to teen mothers and fathers and offer services that effect behavior change; surveyed teen females did not regularly practice safe sleep techniques.
Recognize importance of medical professionals.

Medical professionals are second only to family in their ability to provide information and education to teen parents or to be the source of referral information. Teen parents recognize the need to have better health and nutrition, housing assistance, relationship management, financial assistance, education and training, employment, stress management, parenting skills and involvement of supportive others, child care, and information about birth control. Medical professionals will not have the capacity to address all these needs, but they can be collaborative and refer those in need to other service providers.

Be aggressive in service outreach.

Effective outreach includes being neighborhood-based or otherwise easily accessible and providing an environment that is welcoming and comfortable for teens. While prenatal care and transition care services are required over time, the ability of service providers to maintain a relationship is limited by a teen’s priority to meet basic needs and the time they can reasonably devote to developmental tasks. The developmental stage of a teen should greatly influence service strategies. Teens can be increasingly empowered to make decisions through services that help them create and express a vision for their own lives and that of their children upon which short-term, step-by-step goals are defined and reached.

Involve a teen father in the life of his child.

The expectations of others highly influence the role a teen father will have in the life of his child, even when there is no reason to think he may be a danger to his child. Teen fathers may require encouragement and an advocate to establish parenting roles. Unmarried teen fathers and teen mothers who agree to co-parent will likely benefit from, if not require, assistance in negotiating relationships and matters of shared responsibility.

Differentiate education and training services.

The stress and challenge of balancing new parenting responsibilities and a changed life may be the primary reasons teens with education and training goals give them up. Teens that do not have educational goals prior to their pregnancies are unlikely to develop them simply in response to becoming a parent.

Transition care service strategy for each group should be responsive to these differing motivational orientations.

Share relevant and accurate data and other information to influence public opinion and shape public policy.

Teen pregnancy places additional burdens on our community’s systems, such as health care, public assistance, workforce, and education, as well as on families. Teens should be perceived as partners in this information effort. All teens could be routinely educated about the costs associated with teen pregnancy and parenting and informed of the actual role of public assistance, family support, and their own employment in meeting these costs. Service providers could regularly survey teens and add their voices to the public conversation.

The community at large and families of teens greatly influence pregnancy prevention and transition to parenthood.

It is easy to see that teen females and teen males have the primary responsibility to prevent pregnancy and to assume parenting responsibilities when they have a child. Families are not always capable or willing to provide information and access to services that teens need. Public policies that require parental approval and consent and those that set eligibility criteria determine whether or not a teen can access contraceptives, medical services, housing, and child care assistance. Emancipation laws determine what solutions are or are not possible for older teens when families are barriers to needed resources and care.

We all have a stake in Franklin County teen pregnancy.

Pregnant and parenting teens and their families, adults who became a parent during their teens, government agencies and non-profit organizations, schools and businesses, community planners and policy makers, and the community at large all share in the costs and consequences of teen pregnancy. It is possible and desirable that we all have a voice in the public conversation that contributes to improving pregnancy prevention and care services.
Prevention Recommendations

Strengthen efforts to motivate teens to avoid pregnancy. Teens could be helped to better understand the risks and consequences of teen pregnancy. Reality training could be used to introduce teens to the actual financial and opportunity costs of pregnancy and to eligibility guidelines and limits of public assistance. Teens could learn the facts associated with increased health and safety risks to children of teens, such as infant mortality, long-term health problems, and vulnerability to abuse and neglect. Teens could be introduced to public policy issues associated with teen pregnancy and the public concern for the costs associated with teen pregnancy.

Make investments in prevention services that effectively reduce the number of first and subsequent teen pregnancies.

Expect the use of evidence-based practices. Expect customized services for teen parents to help them avoid subsequent pregnancies.

Acceptance Recommendations

Adults in the lives of pregnant and parenting teens can assist them to embrace the adult experience of having a child, and to use this critical time in their life as an opportunity to move more quickly into adulthood. Having a child invites major life changes and a commitment to the well-being of a child. Supportive adults can help pregnant and parenting teens by asking them to define and meet goals, to take advantage of resources, to develop a support system, and to meet the many challenges they will face. Teens can be introduced to another adult behavior—voting—so they too can influence public policies that affect teen pregnancy. Parents of teens can learn how best to support and assist their teens in becoming responsible parents and may require help to identify and utilize useful community resources.

Offer adequate medical and human services to pregnant and parenting teens, in addition to pregnancy prevention services. While teen pregnancies can be reduced, they will likely not stop. There is no evidence that sexuality education or the availability of resources encourage teen pregnancy. Parents of pregnant and parenting teens need their community’s involvement, as they themselves often are limited in their ability to influence their behavior and to share resources.

Aspiration Recommendations

Prevention and care services and supportive assistance will never be sufficient to solve problems associated with teen pregnancy. Public and administrative policies need to change to improve outcomes, both for the teens and their children. Consider changes in policies that impact poverty rates; availability of sexuality education and birth control; and access to highly effective health care and transition care services; affordable child care; housing; and education, training, and employment opportunities that build career aspiration and a commitment to work.

Cultural differences impact teen pregnancy expectations, differences that the larger community may need to acknowledge and accept. The many and diverse needs of pregnant and parenting teens suggest that a comprehensive, coordinated service system would best serve our community, our teens, and their families. Coordinated care across services and organizations and coordinated case management should become a community standard of service for pregnant and parenting teens. The impact of trauma on the mental health of disadvantaged and sexually abused teens must be understood and considered and may require customized service strategies. A community’s concern for the economic burdens associated with teen pregnancy should not overshadow the community’s commitment to the health and well-being of babies born to teens and therefore to teen parents.
“As a teen parent, I really needed the help, especially with school, and I received lots of help over the two years I was in this program. There were times I didn’t want to go to school, and I would meet and talk with my advocate. I did drop out, but I reenrolled in high school and am well on my way to graduating within this next year! I got good info about programs that could help me, about different types of jobs, and clothes for my daughter. I have consistently used birth control to avoid any additional pregnancies. Just meeting with an adult who cares about me and knowing I had someone to talk to about anything was really good. I learned a lot about parenting. I am getting better at staying on top of things and have started to apply for jobs.”

- Teen served by Healthy Families Connection -
KEY DATA POINTS

This study of pregnant and parenting teens in Franklin County creates a snapshot in time (summer 2014) utilizing key data points: teen resident live births by age group, race, and ethnicity; teen resident live births compared to estimated teen pregnancies and other pregnancy outcomes for teens; teen resident live births compared to teen population and to all live births; and finally, teen resident live births by geographic location. The Center for Healthy Families estimates that in 2014 in Franklin County a total of about 5,200 teen females will be pregnant or parenting. This estimate projects that about 2,500 teen females will continue to parent children to whom they gave birth during the period 2009 to 2013, about 1,100 pregnant teen females will give birth in 2014, very few of whom will place their babies for adoption, about 800 teen females who will get pregnant but not give birth during 2014, and about 800 teen females will seek abortions or experience fetal deaths. While teen live births have been decreasing, any and all teen parents are of high concern. As this and other studies report, the children of teen parents and many teen parents face significant economic and health challenges that increase their vulnerability to long-term poverty and reduce their capacity to live healthy and productive lives. Infant mortality rates are unacceptable. The presented data makes it possible for our community to evaluate the current situation and set objectives for our community and for the well-being of our teen residents.

TRENDS OF TEEN RESIDENT BIRTHS BY AGE, RACE, AND ETHNICITY

Franklin County, OH, Teen Resident Live Births by Age Group, 2009 – 2013

During the five-year period of 2009 to 2013, total teen births have shown a consistent downward trend, decreasing by 37% to a low of 1,115 in 2013. Generally, about 70% of teen births are to older teens (18-19 years of age). Teen births to those under the age of 15, while small in number but of high concern, decreased by 63%. Teen births to females 15-17 decreased by 42%, followed by a 34% decrease for older teens.

Source: Ohio Department of Health. ODH specifically disclaims responsibility for any analyses, interpretations, or conclusions.
Franklin County, OH, Teen Resident Live Births by Race, 2009 – 2013

During the five-year period of 2009 to 2013, Whites and Blacks almost equally account for over 90% of teen live births. Teen live births to each racial group have shown a consistent downward trend, decreasing at a comparable rate, slightly higher than 40%.

*Unknown/Not Reported (479) or counts under 10 for either Native American or Pacific Islander/Hawaiian (21)

Source: Ohio Department of Health. ODH specifically disclaims responsibility for any analyses, interpretations, or conclusions.

Franklin County, OH, Teen Resident Live Births by Ethnicity, 2009 – 2013

During the five-year period of 2009 to 2013, Hispanic teens account for 10% of teen live births. Overall, Hispanic teens account for a relatively small number of live births and show a downward trend in the number of live births; however, the rate of decrease for Hispanics is less than that of non-Hispanics: 24% vs. 38%, respectively.

Source: Ohio Department of Health. ODH specifically disclaims responsibility for any analyses, interpretations, or conclusions.

Note: 2010 Census, U.S. Census Bureau reports 5% of Franklin County population to be Hispanic.

Franklin County, OH, Teen Pregnancy and Pregnancy Outcomes

It is estimated that out of every 10 teen pregnancies six result in a live birth, two are terminated by abortion, and two terminate due to fetal death. The rate of live births to estimated pregnancies is highest for older teens and lowest for youngest teens, 63% (18-19 years of age), 59% (15-17 years of age), and 39% (<15 years of age).

Source: Ohio Department of Health. Only fetal deaths (stillbirths) of 20+ weeks gestation are reported by ODH; total fetal losses are calculated by lead researcher of this study. ODH specifically disclaims responsibility for any analyses, interpretations, or conclusions.

To provide baseline data on pregnancy outcomes, this study selected 2010 data reports because they provided the most complete county data by age group and pregnancy outcome.
Ohio Department of Health (ODH) recently released its report, *Induced Abortions in Ohio, 2013*. Induced abortion statistics are available for Ohio dating back to 1976, however many trend comparisons in the 2013 Annual Abortion Report date back to 2001. Almost all (95%) of Ohio induced pregnancy terminations were obtained by Ohio resident females. Overall, since 2001 ODH noted a steady decline in terminations. When examined over the time period 2010 to 2013, the annual decline averaged approximately 1,150 per year.

A comparison of the number of abortions obtained by Franklin County teen residents in 2013 and 2010 shows a 33% decline. The rate of decline varies by age group. Younger teens, who overall account for fewer abortions, showed the greatest decline: 62% for teens under age 15 and 50% for teens 15–17 years of age. Older teens, who account for most abortions (60% in 2010 and 70% in 2013), showed the least decline, 22%. Race is reported by nearly 90% of area teens who obtain an abortion. Abortions obtained by Franklin County teens are only slightly more likely to be by Black than by White teens.

National trends in adoptions suggest that most live births to teens result in teen parenting. In response to an inquiry by this study, Franklin County Children Services reported that during the three years when the ages of mothers placing children for adoption were available (2008, 2011, and 2013), adoptions in Franklin County totaled 463. The ages of mothers were listed for nearly 85% of all adoptions. Mothers known to be teens accounted for 10% of adoptions for which the ages of mothers were listed and accounted for, on average, 13 adoptions per year.

### TEEN RESIDENT LIVE BIRTHS COMPARED TO TEEN POPULATION AND TO ALL LIVE BIRTHS

To provide baseline data on teen pregnancy compared to the teen female and male population and compared to all live births, this study selected 2010 data reports to provide a consistent reference period. It is important to consider teen births in the context of population. This study compares teen births to teen population and teen female population by age group. About 2% of teen females between the ages of 10 and 19 gave birth in 2010. This study compares teen births to total female population. In 2010, teen females between the ages of 10 and 19 account for 13% of the female population and were responsible for 9% of all live births.

#### Franklin County, OH Teen Population Live Births by Age Group, 2010

<table>
<thead>
<tr>
<th></th>
<th>Ages 10-14</th>
<th>Ages 15-17</th>
<th>Ages 18-19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen Population</td>
<td>73,831</td>
<td>44,736</td>
<td>36,026</td>
<td>154,593</td>
</tr>
<tr>
<td>Teen Female Population</td>
<td>36,207</td>
<td>21,897</td>
<td>17,656</td>
<td>75,760</td>
</tr>
<tr>
<td>Teen Live Births</td>
<td>18</td>
<td>467</td>
<td>1,027</td>
<td>1,512</td>
</tr>
<tr>
<td>Teen Live Births as % of Teen Female Population</td>
<td>.05%</td>
<td>2%</td>
<td>6%</td>
<td>2%</td>
</tr>
</tbody>
</table>
This study elected to compare teen births by Franklin County townships because data from the 2008-2012 American Community Survey 5-Year Estimates were both inclusive of the year 2010 and provided poverty data by geographic locations to which birth data could be aligned.

Nearly 25% of the 25 areas of Franklin County (townships, cities, and a village) referenced in the 2008-2012 American Community Survey, specifically six, comprise nearly 10% of the total population and account for nearly 65% of teen live births (970). Reported by highest to lowest number of teen births, these six townships are Franklin (265), Truro (222), Clinton (155), Mifflin (113), Prairie (110), and Sharon (105). The average percent of population below poverty-level for Franklin County areas is 18%. Only three of these six townships have higher than average rates of population below poverty-level, specifically Clinton, Franklin, and Truro. The percent of population below poverty-level in the remaining three townships ranges from 3% (Sharon) to 12% (Prairie), with Mifflin at 7%. It is important to note that 12 areas possibly share the incidence of the 233 teen births for which areas are unknown. Two are cities with a high rate of population below poverty-level, specifically Columbus city with 66% of the county population and Whitehall city with nearly 2% of the county population.
The incidences of teen pregnancy and teen parenting are often associated with the experience of poverty. Further study of county areas with high numbers of teen births and low rates of population below poverty could reveal factors beyond poverty that contribute to the possibility of teen pregnancy.

Franklin County, OH, Teen Births by Area, 2010

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>% of FC Population</th>
<th># of Population Below Poverty Level</th>
<th>% of Population Below Poverty Level</th>
<th># FC Teen Resident Live Births</th>
<th>% of Teen Resident Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County, Ohio</td>
<td>1,143,075</td>
<td>100%</td>
<td>202,812</td>
<td>17.7%</td>
<td>1512</td>
<td>100%</td>
</tr>
<tr>
<td>Bexley City, Franklin County, Ohio</td>
<td>12,016</td>
<td>1.1%</td>
<td>749</td>
<td>6.2%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Blendon Township, Franklin County, Ohio</td>
<td>9,089</td>
<td>0.8%</td>
<td>674</td>
<td>7.4%</td>
<td>53</td>
<td>3.5</td>
</tr>
<tr>
<td>Brown Township, Franklin County, Ohio</td>
<td>2,084</td>
<td>0.2%</td>
<td>78</td>
<td>3.7%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Clinton Township, Franklin County, Ohio</td>
<td>4,039</td>
<td>0.4%</td>
<td>1,300</td>
<td>32.2%</td>
<td>155</td>
<td>10.3</td>
</tr>
<tr>
<td>Columbus City, Franklin County, Ohio</td>
<td>754,832</td>
<td>66.0%</td>
<td>168,385</td>
<td>22.3%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Dublin City, Franklin County, Ohio</td>
<td>34,866</td>
<td>3.1%</td>
<td>940</td>
<td>2.7%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Franklin Township, Franklin County, Ohio</td>
<td>9,834</td>
<td>0.9%</td>
<td>1,943</td>
<td>19.8%</td>
<td>286</td>
<td>17.5</td>
</tr>
<tr>
<td>Grandview Heights City, Franklin County, Ohio</td>
<td>6,599</td>
<td>0.6%</td>
<td>432</td>
<td>6.5%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Hamilton Township, Franklin County, Ohio</td>
<td>8,218</td>
<td>0.7%</td>
<td>1,205</td>
<td>14.7%</td>
<td>35</td>
<td>2.3</td>
</tr>
<tr>
<td>Jackson Township, Franklin County, Ohio</td>
<td>40,189</td>
<td>3.5%</td>
<td>3,936</td>
<td>9.8%</td>
<td>53</td>
<td>3.5</td>
</tr>
<tr>
<td>Jefferson Township, Franklin County, Ohio</td>
<td>10,630</td>
<td>0.9%</td>
<td>426</td>
<td>4.0%</td>
<td>21</td>
<td>1.4</td>
</tr>
<tr>
<td>Madison Township, Franklin County, Ohio</td>
<td>23,230</td>
<td>2.0%</td>
<td>1,661</td>
<td>7.2%</td>
<td>83</td>
<td>5.5</td>
</tr>
<tr>
<td>Marble Cliff Village, Franklin County, Ohio</td>
<td>625</td>
<td>0.1%</td>
<td>33</td>
<td>5.3%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Mifflin Township, Franklin County, Ohio</td>
<td>35,611</td>
<td>3.1%</td>
<td>2,310</td>
<td>6.5%</td>
<td>113</td>
<td>7.5</td>
</tr>
<tr>
<td>Norwich Township, Franklin County, Ohio</td>
<td>31,889</td>
<td>2.8%</td>
<td>1,768</td>
<td>5.5%</td>
<td>36</td>
<td>2.4</td>
</tr>
<tr>
<td>Perry Township, Franklin County, Ohio</td>
<td>3,593</td>
<td>0.3%</td>
<td>50</td>
<td>1.4%</td>
<td>28</td>
<td>1.9</td>
</tr>
<tr>
<td>Plain Township, Franklin County, Ohio</td>
<td>9,709</td>
<td>0.8%</td>
<td>410</td>
<td>4.2%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Pleasant Township, Franklin County, Ohio</td>
<td>6,731</td>
<td>0.6%</td>
<td>907</td>
<td>13.5%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Prairie Township, Franklin County, Ohio</td>
<td>16,537</td>
<td>1.4%</td>
<td>1,996</td>
<td>12.1%</td>
<td>110</td>
<td>7.3</td>
</tr>
<tr>
<td>Sharon Township, Franklin County, Ohio</td>
<td>15,545</td>
<td>1.4%</td>
<td>488</td>
<td>3.1%</td>
<td>105</td>
<td>6.9</td>
</tr>
<tr>
<td>Truro Township, Franklin County, Ohio</td>
<td>26,830</td>
<td>2.3%</td>
<td>4,791</td>
<td>17.9%</td>
<td>222</td>
<td>14.7</td>
</tr>
<tr>
<td>Upper Arlington City, Franklin County, Ohio</td>
<td>33,611</td>
<td>2.9%</td>
<td>1,378</td>
<td>4.1%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Washington Township, Franklin County, Ohio</td>
<td>1,681</td>
<td>0.1%</td>
<td>55</td>
<td>3.3%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Westerville City, Franklin County, Ohio</td>
<td>26,923</td>
<td>2.4%</td>
<td>2,318</td>
<td>8.6%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Whitehall City, Franklin County, Ohio</td>
<td>18,164</td>
<td>1.6%</td>
<td>4,579</td>
<td>25.2%</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>233</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

* Indicates suppressed counts < 10.


ODH specifically disclaims responsibility for any analyses, interpretations, or conclusions.
Poverty and Teen Live Births by Township

In 2010, a comparison of number and percent of teen resident live births and number and percent of population below poverty-level by Franklin County townships reports that only six of 25 townships with 9% of the total population account for almost 65% of the total teen resident live births. However, only three of those six townships had above average rates of below poverty-level populations. While pregnancy rates and poverty rates seem highly associated, townships that are counter-trend (high number of pregnancies and low poverty rates or low number of pregnancies and higher poverty rates) should be studied further. It seems important to understand what other factors beyond socioeconomic disadvantage are highly influential in the cause of teen pregnancy.

Data Sources: 2009—2012 American Community Survey 5-Year Estimates
Ohio Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.
This study looked at teen births by zip code, an analysis that guided outreach to teen females for the purpose of engaging them in a field survey interview. Live births during 2012 and 2013 were identified by one of 47 zip codes that comprise Franklin County, OH. More than three-quarters (77%) of Franklin County teen live births were to females residing in 16 zip codes. The vast majority (87%) of survey participants were residents of these 16 zip codes. This comparison is provided as a point-in-fact and not to suggest the generalizability of the findings.

<table>
<thead>
<tr>
<th>Select and Other Zip Codes</th>
<th>Franklin County Quadrant</th>
<th>Franklin County Teen Births (2012 and 2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>43228</td>
<td>Southwest</td>
<td>188</td>
</tr>
<tr>
<td>43204</td>
<td>Southwest</td>
<td>173</td>
</tr>
<tr>
<td>43232</td>
<td>Southeast</td>
<td>173</td>
</tr>
<tr>
<td>43207</td>
<td>Southeast</td>
<td>140</td>
</tr>
<tr>
<td>43223</td>
<td>Southwest</td>
<td>135</td>
</tr>
<tr>
<td>43211</td>
<td>Northeast</td>
<td>130</td>
</tr>
<tr>
<td>43224</td>
<td>Northeast</td>
<td>124</td>
</tr>
<tr>
<td>43229</td>
<td>Northeast</td>
<td>123</td>
</tr>
<tr>
<td>43213</td>
<td>Southeast</td>
<td>105</td>
</tr>
<tr>
<td>43219</td>
<td>Northeast</td>
<td>105</td>
</tr>
<tr>
<td>43123</td>
<td>Southwest</td>
<td>85</td>
</tr>
<tr>
<td>43206</td>
<td>Central</td>
<td>84</td>
</tr>
<tr>
<td>43227</td>
<td>Southeast</td>
<td>80</td>
</tr>
<tr>
<td>43068</td>
<td>Southeast</td>
<td>72</td>
</tr>
<tr>
<td>43205</td>
<td>Central</td>
<td>56</td>
</tr>
<tr>
<td>43203</td>
<td>Central</td>
<td>53</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td><strong>1,826</strong></td>
</tr>
<tr>
<td>13 Other Zip Codes</td>
<td>Northwest</td>
<td>141</td>
</tr>
<tr>
<td>5 Other Zip Codes</td>
<td>Northeast</td>
<td>135</td>
</tr>
<tr>
<td>6 Other Zip Codes</td>
<td>Southeast</td>
<td>119</td>
</tr>
<tr>
<td>4 Other Zip Codes</td>
<td>Central</td>
<td>73</td>
</tr>
<tr>
<td>3 Other Zip Codes</td>
<td>Southwest</td>
<td>51</td>
</tr>
<tr>
<td>Unreported Zip Codes</td>
<td>Unknown</td>
<td>12</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td><strong>531</strong></td>
</tr>
<tr>
<td>47 Zip Codes</td>
<td>Total</td>
<td><strong>2,357</strong></td>
</tr>
</tbody>
</table>

**Other Zip Codes**

Northwest (13): 43202, 43210, 43214, 43220, 43221, 43234, 43235, 43002, 43016, 43017, 43026, 43065, and 43085; Northeast (5): 43230, 43231, 43004, 43054, and 43081; Southeast (6): 43209, 43217, 43110, 43125, 43136, and 43147; Central (4): 43201, 43212, 43215, and 43222; and Southwest (3): 43140, 43146, and 43119.
This study defines five areas of Franklin County and associated zip codes. All but 12 Franklin teen births in 2012 and 2013 report associated zip codes. More than 80% of Franklin County teen births are by residents of three areas: Southeast (29%), Southwest (27%), and Northeast (26%). Central Franklin County account for 11% and Northwest Franklin County for 6%.
Franklin County, OH, Teen Live Births by Census Tract (ages 12-19), 2010 – June 2014

Source: Ohio Department of Health, the Office of Health Equity.

ODH specifically disclaims responsibility for any analyses, interpretations, or conclusions.

This map highlights areas of Franklin County with a disproportionate rate of teen resident live births.
SURVEY RESULTS

A total of one hundred twenty three (123) qualified teens participated in the field survey interviews. Their experiences, opinions, and hopes are documented in this report.

Survey Participant Demographics

The demographic profile of interviewed teen females is comparable to the demographic profile of Franklin County teen births during the five-year period between 2009 and 2013 that were reported by the Ohio Department of Health. This comparison is provided as a point-in-fact and not to suggest the generalizability of the findings. Findings are unique to the experiences and opinions of the 123 participating teen females.

**Percent of Franklin County Teen Resident Live Births by Age, 2009 — 2013**

- **Franklin County Age**
  - 18-19: 70%
  - 15-17: 28%
  - <15: 1%

- **Study Participant Age**
  - 18-19: 60%
  - 15-17: 38%
  - <15: 4%

**Percent of Franklin County Teen Resident Live Births by Race, 2009 — 2013**

- **Franklin County Race**
  - Black: 45%
  - White: 46%
  - Asian: 1%
  - Native American: 2%

- **Study Participant Race**
  - Black: 60%
  - White: 15%
  - Multiracial: 13%
  - Other*: 7%
  - Asian: 3%
  - Native American: 2%

*Unknown/Not Reported (479) or counts under 10 for either Native American or Pacific Islander/Hawaiian (21)

**Percent of Franklin County Teen Resident Live Births by Ethnicity, 2009 — 2013**

- **Franklin County Ethnicity**
  - Hispanic: 10%
  - Unknown: 4%
  - Non-Hispanic: 86%

- **Study Participant Ethnicity**
  - Hispanic: 8%
  - Unknown: 4%
  - Non-Hispanic: 91%

Data Source: Ohio Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.
The vast majority (95%) of survey participants were born in the United States; 5% were immigrants. The majority (76%) of survey participants have lived in Franklin County all their lives. Of those that did not, 15% lived in Franklin County for five years or more and 10% for four years or less.

Pregnant and parenting teens were equally represented in this survey. Most pregnant teens were either in their third trimester (50%) or their second trimester (42%), and 8% were in their first trimester of pregnancy.

Fifteen interviewed teens reported multiple children (12% of all interviewed): four of whom were again currently pregnant, one of whom was possibly pregnant, and 10 of whom were definitely not pregnant. The majority of teen mothers with multiple children were Black (80%) and some were multiracial (13%) or White (7%).

A total of 89 children were reported by interviewed teen parents. Many children (63%) were under age 1; other children were equally likely to be age 2 or in the age group 3-5.

### Interviewed Pregnant Teens with Definite or Anticipated Subsequent Pregnancies (n=11)

<table>
<thead>
<tr>
<th># of Mothers</th>
<th>Current Pregnancy Status of Mother</th>
<th># Other Children Age 1 or Younger</th>
<th># Other Children Age 2</th>
<th># Other Children Age 3-5</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>May Be Pregnant</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Pregnant</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>6</td>
<td>Not Pregnant</td>
<td>7</td>
<td>4</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td><strong>16</strong></td>
<td><strong>8</strong></td>
<td><strong>12</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

The majority (75%) of interviewed teen females experienced only one pregnancy. Of the 25% who reported subsequent pregnancies, most (23) had two pregnancies, some (8) had three, and one was pregnant four times.

**Teen females report most of their pregnancies as unwanted.**

A high percentage of the 163 pregnancies that were reported by the 123 interviewed teen females were pregnancies thought to occur at the wrong time. This negative assessment varied by pregnancy from 67% at the first pregnancy to almost 40% at the second and 50% at the third. A considerable number of females were unsure how they felt about the timing of their pregnancies: 19% at both the first and second pregnancy, 13% at the third pregnancy, and 100% at the fourth pregnancy. Pregnancy occurred at the right time for only 5% (first pregnancy), 26% (second pregnancy), and 13% (third pregnancy). Overall, nearly 80% of the pregnancies experienced by interviewed teen females were self-assessed as definitely or possibly occurring at the wrong time.
Opinions of 123 Interviewed Teen Females about the Timing of Their 163 Pregnancies

<table>
<thead>
<tr>
<th>Pregnancy</th>
<th>Right Time</th>
<th>Almost Right</th>
<th>Wrong Time</th>
<th>Unsure</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Pregnancy (123)</td>
<td>6</td>
<td>12</td>
<td>82</td>
<td>23</td>
<td>123</td>
</tr>
<tr>
<td>2nd Pregnancy (31)</td>
<td>8</td>
<td>5</td>
<td>12</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>3rd Pregnancy (7)</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>4th Pregnancy (1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
<td><strong>19</strong></td>
<td><strong>98</strong></td>
<td><strong>31</strong></td>
<td><strong>163</strong></td>
</tr>
</tbody>
</table>

Some teen females are victims of illegal or coerced sex.

The profile of interviewed teen females by age group at time of a first pregnancy differed from the age of the sexual partner they know or think to be the expectant father. While the age range also differed, 12–19 for females and 12–33 for fathers, the median age was similar: age 16 for pregnant females and age 17 for expectant fathers.

Ohio law defines age-related rape as engaging in sexual conduct with another person less than 13 years of age who is not the spouse of the offender or who is the spouse of the offender but is living separate and apart from the offender. This study did not interview females who were 13 years or younger.

Even if a sexual act does not constitute an age-related offense, if sexual acts were forced or coerced or the perpetrator is in a position of power over the victim (like a teacher, coach, parent and/or guardian), they are a violation of the law.

The legal age of consent to sex in Ohio is 16. The Ohio Alliance to End Sexual Violence publishes a chart to explain age-related sex offenses based upon both the victim’s and suspect’s ages. Based upon this information, 7% (9) of interviewed females ages 14 and 15 may have been victims of illegal sex. Three teen females declined to report the age of the father of their child; five reported the age of the father of their child as 18; one reported the age of the father of their child as 21.

While the vast majority (85%) of interviewed teen females report that they were never physically forced to have sexual intercourse when they did not want to, some (13%) did report being physically forced to have sexual intercourse and a few (2%) think they may have been.

The vast majority (92%) of interviewed teen females report they were never purposefully physically hurt or threatened with physical harm by someone with whom they had or wanted to have sexual intercourse. However, some (7%) definitely were harmed or were threatened with physical harm and one (1%) thinks she may have been.

Interviewed females who reported actual or threatened physical harm were confidentially referred to The Center for Family Safety and Healing.

Number of Interviewed Expectant Parents by Age Group

<table>
<thead>
<tr>
<th>Expectant Parent</th>
<th>&lt;15</th>
<th>15-17</th>
<th>18-19</th>
<th>20+</th>
<th>N/R</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Female</td>
<td>15</td>
<td>81</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>123</td>
</tr>
<tr>
<td>Expectant Father</td>
<td>13</td>
<td>54</td>
<td>30</td>
<td>22</td>
<td>4</td>
<td>123</td>
</tr>
</tbody>
</table>
Most pregnant and parenting teen females use less effective contraceptive methods.

The Guttmacher Institute reports contraceptive effectiveness by method and by typical and perfect use. The contraceptives of focus in this study are categorized for this report based upon the proportion of females who become pregnant over one year of *typical use*, as follows.

<table>
<thead>
<tr>
<th>Highly Effective</th>
<th>Effective</th>
<th>Less Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>Injectable</td>
<td>Diaphragm</td>
</tr>
<tr>
<td>IUD</td>
<td>Pill</td>
<td>Sponge</td>
</tr>
<tr>
<td>Vaginal ring</td>
<td>Male condom</td>
<td></td>
</tr>
<tr>
<td>Patch</td>
<td>Female condom</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Withdraw</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fertility awareness methods</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spermicides</td>
<td></td>
</tr>
</tbody>
</table>

Almost all interviewed teen females (97%) reported that they or their sexual partner used some method to prevent pregnancy, a strong indication that pregnancy was not the intended result of sexual activity.

Interviewed teen females report primary use by self or sexual partner of three pregnancy prevention methods, specifically male condoms (76%), withdrawal (60%), and attempts to keep sperm out of vagina during sex play, referred to as outercourse (51%).

Some females report use of five other pregnancy prevention methods, specifically avoiding use of alcohol or drugs when engaging in sex play (44%), birth control shot (36%), avoiding any kind of sex play or abstinence (30%), birth control pill (24%), and attempting to have intercourse during a time of month when they thought they could not get pregnant (20%).

A few females report use of an intrauterine device/IUD (4%), a birth control patch (3%), and a birth control sponge (3%). Two pregnancy prevention methods were each reported as used by only one female, specifically a female condom and spermicide along without a diaphragm or cervical cap.

Four pregnancy prevention methods that were not used by any females include a birth control sponge, a birth control vaginal ring, a diaphragm, and a cervical cap.

The vast majority (89%) of interviewed females reported no problems obtaining a form of birth control that they wanted to use or to use for a longer time period; however, 11% did experience problems. Problems included the need to involve a parent or the parent’s refusal or advise (4); issues associated with the birth control shot, like bleeding, missed appointment, told to get off (4); insurance barriers (2); weight gain or loss (2); and scheduling challenges (1).

Most teen females talk about birth control before first pregnancy.

The vast majority (88%) of interviewed teen females talked to someone about birth control before their first pregnancy; however some (12%) talked to no one. Teen females are most likely to talk about birth control with their parent or guardian (58%) and a doctor or nurse (53%), and some talk to other teen females (38%), their sexual partner (34%), other family members (30%), and an adult female friend (19%). A few will talk to a school nurse (7%), some other unspecified person (7%), other teen males (4%), a teacher (3%), and an adult male friend (2%).
Almost all pregnant and parenting teen females take actions to contribute to a healthy baby.

Interviewed teen females report taking a variety of actions to help their babies be born healthy. These include avoiding alcohol and specific addictive substances (methamphetamines or amphetamines, cocaine, heroin, non-heroin opiates), reported by 99%. Teen females also were highly likely to limit sexual partners during their pregnancy to no more than three (98%), to get tested for sexually transmitted infections (96%), to continue seeing a doctor after the first visit (95%), to avoid using marijuana (95%), and to avoid using any form of tobacco (89%). The one action that many (72%) took but some (29%) did not was to see a doctor for the first time during the first three months of pregnancy. Teen females report other actions taken to help their babies be born healthy, specifically taking prenatal vitamins, eating a healthy diet, and exercising. Some also mention drinking lots of water. Individuals mention stopping particular medicines and avoiding caffeine, secondary smoke, and stress.

Teen mothers inconsistently use safe sleeping practices.

Sleeping practices that ensure the safety of the first baby of interviewed teens were not practiced as often as recommended. Many (61%) make sure the baby sleeps on her or his back, however some (29%) only sometimes do and a few (9%) seldom or never do. Less than half (49%) have the baby sleep in a crib, however some (21%) sometimes do and some (29%) seldom or never do. Less than half (48%) have their baby sleep alone, while some (29%) sometimes do and some (23%) seldom or never do.

Some pregnant and parenting teen females have no parenting role model.

The vast majority (88%) of interviewed teen females report that there are people they know and see fairly often who they think of as a good parent or a parent they would like to be like; however some (9%) report knowing no such person and a few (3%) did not report anyone. The number of such parenting role models in a teen female’s life varies greatly, from zero to 15. Most typically, a teen female will know two parenting role models.

Pregnant and parenting females live with a variety of people.

Most (70%) of interviewed teen females are living with some combination of family members, including one or more parents (63%), a brother or sister (60%), a grandparent or great grandparent (17%), a step-parent or step-brother or step-sister (14%), an aunt or uncle (9%), a cousin (5%), or other relatives (13%). Some (25%) live with a legal custodian/guardian and (22%) with a non-relative. Of the 30% of interviewed teen females who reside with only one category of persons, almost half (17) live with some relative (1+ parents, 6; other relative, 5; a grandparent, 4; an aunt or uncle, 1; or a husband, 1). Some (14) live with non-relatives, and a few (4) live with a legal custodian.

Pregnant and parenting teen females prefer parenting advice from a parent or medical professional.

Interviewed teen females report five resources as primary from which to learn more about how to protect, care for, and develop their children. The vast majority (89%) would ask a parent or guardian, a health center or pediatrician (85%), and a nurse (80%). Many would choose to learn more about parenting from a
Parenting class (64%) and from other family members (56%). Some would choose to learn more about parenting from the father of their child (49%) and from a counselor or therapist (43%). Other resources that are likely to be sought by about one-third of interviewed teen females include the library, non-family adult friends, a pre-school, a religious organization, and the Internet.

Pregnant and parenting teen females have high expectations for the father of their child.

Interviewed teen females do have expectations for how a father of their child should be involved. Almost all (92%) want the father to have direct contact with their child, however some (6%) do not and a few (4%) are uncertain. Almost all (90%) prefer that the father help raise their child, however some (6%) do not and some (7%) are uncertain. Most (82%) prefer that the father provide child care, however some (11%) do not and some (7%) are uncertain. Many (66%) prefer the father provide financial child support, however some (24%) do not and some (10%) are uncertain. Many (53%) teen females do not want the father to marry her, but some (44%) prefer that the father live with her. Teen females are more uncertain about marriage (18%) than about living together (11%). Most (85%) want direct contact with the father, however some (15%) definitely do not or are uncertain. A few teen females (5%) either definitely or maybe want the father to raise the child without her involvement.

Of the 31 interviewed teen females reporting multiple pregnancies, nine report two different males as fathers. All want the second father to have direct contact with their child and to help raise their child. They are slightly more likely to prefer that the second father provide child care (89% vs. 82%). They are equally likely to prefer that the second father provide financial child support (67%). They are slightly more likely to want the second father to marry her (56% vs. 53%) and much more likely to prefer that the second father live with her (89% vs. 44%). All want direct contact with the second father. None want the second father to raise the child without her involvement.

Pregnant and parenting teen females rely on help from family and government regarding the father of their child.

Interviewed teen females would turn to five different sources of information if they wanted help with getting a father involved or more involved in his child’s life. They would first turn to the family of the child’s father and next directly to the child’s father himself. They would also turn to government agencies (Franklin County Children Services, Child Support Enforcement, or the courts) and to their own families. A few (12) would seek a professional or a community program. Some (21) do not know where to get information and a few (8) would not seek such information.

Interviewed teen females would turn to one primary source of information if they wanted help to keep a father out of his child’s life. Many (68) would turn to government agencies or legal services (Franklin County Children Services, the courts, and a lawyer). A few (9) would turn to their own family, or the child’s father or his family (4), or a professional or program (3). Some (23) do not know where to get information and some (15) would not seek such information.

Education is important to pregnant and parenting teen females.

Almost all (98%) interviewed teen females had specific education goals before their first pregnancy, which were retained by 97% on the date they were interviewed. Finishing high school was the most frequently mentioned goal, but most (over 70%) wanted some type of job training and/or a four-year college degree and over 50% wanted to get an advanced degree. Over 50% wanted a two-year technical or associate degree.
Seventy two (72) interviewed teens reported being enrolled in high school, job training, or college when they first became pregnant. Almost 70% returned to their educational pursuits in three months or less and 26% returned but after three months. A few (4%) did not return. Lack of child care or support in general was a prohibitive factor for most.

**Teen mothers need child care and practical help to return to school.**

Interviewed teen females most frequently mentioned two resources enabling a return to school, specifically child care (often provided by family members) and other support and practical help from a family member (most often the teen’s mother). Some females mentioned their self-motivation and access to alternative education (home schooling, online schooling) or the general support of their school. A few mention friends, other community professionals, or transportation. Conversely, those few that mentioned education-stopping barriers, most frequently mentioned lack of help from others and rarely lack of their motivation.

**Pregnant and parenting teen females prefer to talk directly to school and college representatives.**

The vast majority of teen females seeking information and assistance to reach their education and training goals would seek a school or college representative. Some would talk to family members. A very few would seek information from the Internet, the library, or advertisements. About 10% of interviewed females did not know where to get information and assistance to reach education and training goals.

**Many teen mothers need part-time employment.**

Most interviewed teen females were not working before their first pregnancy (68%) or during their first pregnancy (67%); however, 52% who had given birth were working after their first pregnancy. Of those that were working, whether before, during, or after their first pregnancy, most were working regularly and part-time and a few were either working regularly and full-time or occasionally or temporarily.

**Public assistance is a household resource for many pregnant and parenting teen females.**

Almost all (95%) of interviewed teen females reside in a household that receives some form of public assistance. Of those that receive assistance, almost all (over 85%) receive Medicaid and are enrolled in the WIC Program (health and nutrition) and 80% receive food assistance. Some households receive cash assistance (30%) and child care assistance (24%). A very few individuals also mention Social Security Insurance or Survivor’s Benefits, Section 8 housing, and a subsidy for adopted children. The vast majority (87%) report that the medical expenses from their first pregnancy were paid for by Medicaid. A few individuals report that those medical expenses were paid for either by private medical insurance of a parent (7%) or by a parent in cash (3%) or that first pregnancy medical expenses remain unpaid (1%).

Interviewed teen females report that they meet expenses to care for themselves and their child or children mostly through financial support from parents (74%). About 40% receive support from the parents of the father of their child and about 40% have employment income. Only 10% report that they receive child support, although some do say the father of the child helps with expenses. While only some report independent receipt of public assistance, it is probable that support from parents includes parents who receive public assistance.
Almost 85% of interviewed teen females agreed to share their thoughts about the specific difficulties of their lives and the resources they identify to address such challenges. This level of involvement in the field survey interview was optional and was not required to receive an incentive, a child-oriented gift valued at $25.00.

Two factors were most frequently mentioned by interviewed teen females as barriers to being as healthy, happy, and hopeful as they would like to be. Specifically, they identify threats to their own health from lack of sleep, chronic stress, and poor eating; but also their living situation, ranging from no or unstable housing to problems with specific family members. Two other barriers to health, happiness, and hopefulness mentioned with some frequency were the father of the child and financial stress associated with no job or ineligibility for public assistance. Some teens also struggle with other relational problems, their own baby, lack of a social life, lack of friends and a support system, or school. Almost 20% state that they are healthy, happy, and hopeful.

Interviewed teen females are most likely to turn to their family, especially their mother, if they want help to be a healthier and happier person who is more hopeful about her future. They would next seek out a counselor, therapist, or not-for-profit organization. Some would turn to a medical professional (most often a doctor but sometimes a nurse). Fewer teens are inclined to seek help from a school professional, their child’s father, or a friend. A very few do not know from whom they would seek help to be healthier, happier, and more hopeful.

Three factors dominate as challenges to being the type of parent interviewed teen females would like to be. Most frequently they mention their lack of money, sometimes expressed as a lack of job or career. Second, they find the stress of balancing all their responsibilities (school, work, and parenting) as a barrier to being a good parent. Some readily recognize that their young age makes it difficult to be a parent. A few others mention challenges presented by the father of their child, or by their parents because of dependence on them. About 15% of interviewed teens think they are performing effectively as a parent.
Interviewed teen females are most likely to turn to their family, especially their mother or grandmother, if they want help to become a better parent. They would next seek out a parenting class or mentor. Some would turn to their child’s father or his family, or to a counselor, or to a non-profit organization. A very few would rely on themselves and possibly use the Internet or books.

**FOCUS GROUP RESULTS**

Thirty six (36) individuals with either personal or professional experience of teen pregnancy contributed their opinions about teen pregnancy by participating in one of six focus groups. Focus groups complemented information gathered from pregnant and parenting teen females through field surveys.

**Focus group participant demographics.**

Most participants (80%) were female, and nearly 20% were male, by observation.

Participants were diverse by age group, with slightly more than 55% equitably distributed in either their 30s or 40s and nearly 20% in their 20s or younger. Slightly more than 10% were in their 50s and slightly more than 5% were 60 years of age or older. Age was not reported by slightly more than 10%.

Nearly 50% were Black, slightly more than 30% were White, and slightly more than 10% were multiracial or other races. Race was not reported by nearly 10%. Nearly 85% were non-Hispanic and slightly more than 5% were Hispanic. Ethnicity was not reported by slightly more than 10%.

**Most people are unaware of the number of births to area teens.**

In 2013, Franklin County resident live births to teens totaled 1,115. Focus group participants estimated this number to be between 500 and 17,000. The median estimate of those with personal experience was similar to those with professional experience (1,000 vs. 1,500, respectively) however the top number of the range was much higher for those with personal experience than for those with professional experience (10,000 vs. 3,500, respectively). Professionals who govern or administer agencies that provide services to pregnant and parenting teens were least accurate, perhaps influenced by initial estimates by members of their focus group; their median estimate was 13,000, with a range of 10,000 to 17,000.

People agree that teens have the capacity to prevent pregnancy but differ when assigning prevention responsibility to families and the community.

A teen’s capacity to prevent pregnancy is thought of as either (a) an internal motivation based on successful experiences in academics, sports, or other activities and a vision for the future that includes further education, or (b) a personal awareness and fear of the practical and relational consequences of pregnancy. Individuals with professional experience of teen pregnancy think the community is an equal partner with teens in pregnancy prevention and that families have some but a lesser role. Individuals with personal experience of teen pregnancy think the family can contribute to teen pregnancy and is far less likely to assign responsibility to the community. Expressed opinions for teen males did not differ from teen females. Participants who were teens and parents of teens were less likely than the professionals who serve them to link public policy with a teen’s capacity to obtain meaningful health and sex education and to access birth control methods.
Pregnant teens need significant help to behave in ways that contribute to the health of their babies.

Teen females are thought to face many personal and situational challenges to adopting new behaviors in response to pregnancy, even when they have been made aware of the relationship of their own behavior to fetal health. All participants think that high or some involvement by supportive others is required for a pregnant teen female to see a doctor for the first time, especially in the first trimester but also in the second trimester and to continue seeing a doctor on a regular basis after the first visit. All think that teen females are highly or somewhat likely to require assistance to get tested for sexually transmitted infections, to avoid or stop using any form of tobacco and drinking alcohol, and to limit her sexual partners during pregnancy to no more than three. Most participants think that if a teen female is abusing drugs or alcohol, she will likely need assistance to stop doing so.

There are behavioral patterns or changes that many think a pregnant teen female can independently maintain or adopt. Specifically, participants think that if a pregnant teen understands the relationship between her behavior and fetal health, she can get herself to see a doctor for the first time in the third trimester, and if she is not abusing these substances a teen female can likely continue to avoid using marijuana, methamphetamines or amphetamines (stimulants), cocaine, heroin, and non-heroin opiates (narcotics).

Teens have considerable opportunity through community organizations to meet and establish relationships with adults who can become parental role models, if they are willing and able to do so.

Many participants think teens require a non-family adult to be a parenting role model. They think teens may hesitate to communicate either their need for mentoring or their interest and availability to talk about parenting issues, even to adults whom they know and admire. Participants are concerned that teens that are uninvolved in their community may not know or have the opportunity to interact with an adult who is an appropriate parenting mentor. Significant effort is thought to be required to ensure that every teen parent has at least one adult who is an appropriate parenting mentor. A few participants recognize that some teens have at least one parenting role model in their extended families, or that they may be able to independently learn to be effective parents, or when co-parenting, that a teen dad can learn from the teen mom.

Most think that a parenting role model need not be same-sex and that the preference of the teen to have a role model of his or her own sex is an important consideration. There is general concern that a teen father who seeks a male role model is unlikely to find many appropriate candidates in settings where teen males go or are willing to go. Many schools and social service agencies have females in the roles of teachers, social workers, and guidance counselors. A teen dad who is the primary or sole parent is highly unlikely to know a male who has experienced this situation.

Individuals with personal experience of teen pregnancy are far more likely than professionals who work with pregnant and parenting teens to have expectations for the father of a baby, prior to and after the birth.

Participants with personal experience of teen pregnancy—teen dads, parents of pregnant or parenting teen females, females in their 20s or 30s who first became mothers when in their teens—expect a teen father to give direction to his life so that he can provide for his child. They expect him to be involved with and support the teen mother during pregnancy and as a parent and to be involved with his child.

Professionals are more skeptical. They experience that involvement by a teen father is highly influenced by the type of relationship he had with the mother (casual, violent), the existence of other girlfriends and children, the expectations or lack thereof of involved
others including the birth mother and her family and of his own family. A few professionals question whether it is ultimately beneficial to the teen mom or the teen dad to have expectations of him, as a teen father is often incapable or unwilling to meet such expectations.

If teen fathers, families, and the community want teen fathers to be involved with their children, participants think teen fathers will require self-advocacy training, parenting training, and a personal or professional advocate.

People agree that teen mothers should seek out and benefit from all available help.

All participants would strongly advise teen mothers to find and use helpful individuals, public assistance programs, and agency services. All want teen mothers to continue their education (high school, college, or career-related training). Professionals additionally suggest that teen mothers develop a plan for the future, with small, achievable goals suited to each mother’s developmental level. Professionals want teen mothers to develop budgeting skills. A few participants suggest teen mothers should develop basic employability skills, get or keep a job, and explore child care resources and the quality of each resource.

Many participants are concerned that teen mothers will not pursue education and utilize available resources to develop their capabilities and increase their options. Becoming a new parent can be overwhelming and life can become unmanageable. Teen moms and teen dads may be unwilling to consider placing the baby in child care or the teen mom may be ineligible for public assistance for child care. Some teen mothers have either a mental health or a physical health crisis. A father who wants to co-parent may have different parenting priorities or preferences from the mother. Teen parents may not aspire to a future that requires additional education either because they lack exposure to their career options or they have little opportunity or support to pursue an education.

Intensive transitional support is thought to be required and may need to be available for several years for a teen parent to avoid long-term dependence and poverty. Creative and sustained outreach will likely also be required. Eligibility and availability factors can limit access to assistance and can slow down or threaten the transition process. One example is how household income as an eligibility criterion may keep a teen mother from receiving Title XX for child care. Supportive families with limited resources can become overburdened and unable to sustain their involvement or a sufficient level of financial assistance to ensure their teen’s progress toward independence.

People can readily suggest improvements to outreach and service to pregnant and parenting teens.

Those with personal experience of teen pregnancy want to improve the availability of education and other experiences that help a teen build self-confidence, self-esteem, personal power, and decision-making. They also want the availability and quality of sex education to be improved. A few people in this group suggest stronger counter-culture messaging (against the media messages of sex and drugs, for disciplined and monitored behaviors, for the idea that teen parents do go on to become successful adults). They also want leadership to improve neighborhoods—safety, quality of recreation centers, and church involvement. Additionally, they want greater job opportunities for teens and easier access to birth control.

Professionals want to improve outreach and service delivery methods, focus, and funding. Examples include service collaboration to minimize overlapping services; prevention programming; better use of incidence data to target services; funding for small organizations; more programs for teen dads; family-centered approach; specialized transitional living, including maternity homes; programming in schools; and developmentally appropriate services. Professionals caution all to remember that teens do not immediately behave as a responsible adult just because they became a parent and now have adult responsibilities. Because of this fact, a teen may not responsibly use resources that are accessible and could be helpful.
RESULTS OF CASE STUDY ANALYSES

Ten professionals who deliver services to Franklin County pregnant and parenting teens at one of 10 Franklin County organizations participated in a guided analysis of two cases involving a pregnant or parenting teen to whom they have provided services.

Client Demographics

All but one of 20 cases featured a female client. Almost all cases featured clients either in the 18-19 age group (55%) or in the 15–17 age group (35%). Two cases represented either the 13–14 age group (1) or the age group 20+ (1). Slightly more than half of the featured clients self-identified as Black (55%). Other clients identified as either White (20%) or multiracial (10%). Three clients (15%) preferred not to identify their race. The majority of clients were non-Hispanic (85%) and three (15%) were Hispanic.

There was variation in pregnancy and parenting status of featured clients at the start of service. Ten (50%) were pregnant and without other children, eight were parenting one child (40%), and two were both pregnant and parenting one child (10%). At the end of service or at the time of this analysis in cases where clients continued to receive service, 18 (90%) were parenting one child and two (10%) were parenting two children.

Determinants of the term of service were not captured and may be attributable to program design or client utilization. More than half of the clients were served for either 7–12 months (40%) or 13–18 months (20%). Three clients (15%) were served for 2–6 months and another three (15%) for 19–24 months. Two clients (10%) were served for 4-5 years.

Organizations represented youth services (3), medical and health-related services (5), employment services (1), and educational services (1). Nine of the 10 organizations were partners of the service collaborative known as Healthy Families Connection.

Demographic Distinctions

Clients thought to experience questionable or no progress have a slightly different profile by age group and race when compared to clients who experienced definite progress. Those with questionable or no progress are slightly less likely to be in the age group 15–17 and are the only clients in both the 13–14 and 20+ age groups. They comprise the majority (75%) of the small number of White clients. Due to the small sample, it is, however, unclear what effect a client’s sex, age, or race has on service impact and client progress. Studies beyond this case review would need to be reviewed and/or more research conducted to better understand possible effects.

Clients thought to experience definite progress when compared to clients thought to experience questionable or no progress are not significantly different in their pregnancy and parenting status at the start and end of service.

Service providers often deliver services near the residence of pregnant and parenting teens.

Proximity to the client definitely supports service access and neighborhood-based service locations seem important to service providers. Clients thought to experience definite progress when compared to clients thought to experience questionable or no progress are not significantly different in general location of their service site (home-based or community-based in same or different zip code from residence or campus-based).
“My girlfriend and I have a 6-month-old daughter, and we are in this program together. I do work part-time but I don’t get benefits. I needed and got help to sign up for health insurance. It felt good to get my health insurance card in the mail! I really need more people in my life who will be supportive of my goals. People who will help me see that I can.”

- Teen served by Healthy Families Connection -
Professionals are limited in their ability to maintain client relationships.

Professionals strive to address the many and diverse needs of clients, typically employing referral strategies. However, they often have limited ability to address developmental needs when basic needs are the client’s priority. Nevertheless, professionals work hard to keep a service focus on the development of parenting skills and the provision of adult and/or peer support. A coordinated or common approach to intake and assessment across organizations that serve pregnant and parenting teens may be a useful first step to achieve a collaborative service approach. Such collaborative service may assist all providers to more successfully stabilize the life situation of a client and to ensure a client’s performance of basic parenting skills and expansion of a support network. In turn, stabilization, more effective parenting, and greater support, would increase a client’s capacity to address developmental needs and to experience continuous progress.

Clients thought to experience questionable or no progress differ from clients who experience definite progress in many ways.

The focus of an agency’s services is likely determined by the agency’s mission, management priorities as expressed in allocation of resources, and by the degree to which staff is empowered to exercise flexibility. Some service strategies, such as motivational interviewing, are frequently practiced by agencies that serve pregnant and parenting teens. It is reasonable to conclude that the service focus and applied strategies in a particular case represent a professional’s decision as to how best to achieve service impact and support client progress.

Clients thought to experience questionable or no progress are the majority (75%) of the few clients with service or a service strategy that includes the following:

- **A High Focus** on managed care and/or managed referrals (they also comprise all of the few clients with Low to No Focus on managed care and/or managed referrals);
- **Some Focus** on motivational interviewing (although they are fairly equally represented among clients with High Focus on this service strategy); and
- **Low to No Focus** on the teen’s mental health and on family planning.

Clients thought to experience questionable or no progress are slightly more likely than clients with definite progress to be among clients whose service has High Focus on parenting skills development.

Clients thought to experience questionable or no progress are far less likely to be:

- Served for the period of 13–18 months (yet somewhat more likely to be served either for 2–6 months or 19-24 months);
- Among clients whose service has High Focus on mentoring/adult support for the teen and on peer support;
- Among clients whose service has Some Focus on the teen’s mental health, a safe living situation, parenting skills development, the physical health of the baby or child, the teen’s education or training, and stable housing (although fairly equally likely to be among clients whose service has High Focus on all these matters); and
- Among clients whose service has Some Focus on the teen’s physical health.
Service providers may need to expand the topics standardly addressed in their service to pregnant and parenting teens.

The majority of client services address safe sleep practices (90%) and birth control methods/pregnancy prevention (79%). It is quite likely that services address sexually transmitted diseases, testing, prevention, and/or treatment (58%). Slightly less than half (47%) of client services address substance abuse and/or treatment. It is somewhat more likely that substance abuse or treatment is addressed with clients judged to experience questionable or no progress. Teen clients and the community in general would likely benefit from a commitment to provide high-quality education and easily accessible information on the matters of safe sleep practices, birth control, sexually transmitted diseases, and substance abuse.

Service impact and client progress are influenced by professionals, individual teens, and environments in which teens live.

This study’s case analyses suggest many factors as contributors to service impact and client progress. It seems important that professionals can be flexible in their service approach. It seems essential that the client’s basic and safety needs are met, which may require tactics of control or advocacy to manage specific problematic individuals. It appears to be crucial that a client with mental health problems or substance abuse issues is in treatment to address those conditions. There is an unquestionable advantage when a teen is in relationships with multiple supportive people, ideally including a family member, whether immediate or extended. It may be that collaborative development and use of a service readiness assessment tool would be useful to guide investment in different services at different times when in a working relationship with a client and may help to optimize service impact and client progress.

Participating professionals identify nine factors that dominate as beneficial influencers of service impact and that contribute to client progress and positive outcomes, specifically:

1. A standard approach to service delivery (a service protocol),
2. Flexible approach to service delivery,
3. Involvement of some supportive person,
4. The client’s own actions,
5. Client engagement with a mentor/role model/positive influence,
6. Client’s goal-orientation,
7. Client involvement with at least one supportive family member,
8. Client enrollment school, and
9. Client access to public assistance programs.
Participating professionals do recognize that in many cases the coordination of case management across multiple services and/or organizations also positively contributed to service impact and client outcomes.

Clients thought to experience low or no progress are significantly less likely than clients who experience definite progress to be positively influenced by both flexible approaches to service delivery and by their own actions.

Clients thought to experience definite progress have significantly more positive influencers in play than do clients thought to experience low or no progress, a median of 4.5 vs. 1.0, respectively. The range of specific positive influencers was similar for both groups, 1–8 for those thought to experience definite progress and 0–7 for those thought to experience low or no progress.

Participating professionals identify six factors that dominate as negative influencers of service impact and that diminish client progress and positive outcomes, specifically:

1. Individual(s) in client’s life whose actions create significant problems for the client,
2. Client’s lack of involvement by a supportive person,
3. Client’s serious mental health problems,
4. Client’s alcohol or substance abuse, sometimes influenced by an involved partner,
5. Client’s housing instability, and
6. Client’s unsafe or chaotic living situation (for example, an environment of drugs or violence, a household with too many people).

Participating professionals also recognize that in many cases service impact and client progress are impeded by the client’s own actions or inactions and by the power of poverty to require the client prioritize purchases of competing basic needs.

There is no significant difference in the effect of problematic individuals or the lack of a supportive person for clients thought to experience low or no progress and clients thought to experience definite progress.

Clients thought to experience low or no progress have significantly more negative influencers in play than do clients thought to experience definite progress, a median of 3.5 vs. 1.0, respectively. The range of specific negative influencers also differed, 0–6 for those thought to experience low or no progress compared to 0–3 for those thought to experience definite progress.
“Yes, I am a teen mom, but as of June 2014 I am also a high school graduate! This program that I have been in for 15 months gave me ongoing encouragement and emotional support. I really benefited from hearing positive words: ‘You CAN do it; the word can’t is not in your vocabulary. Don’t let anything stop you from reaching your goals.’”
Most organizations are secular (80%), however 15% identify as faith-based and about 5% prefer not to clarify a religious affiliation.

More than half of the reporting organizations (60%) offer pregnancy-related services to teen females (10% of which offer services exclusively to teen females). Three organizations did not report this information.

Half of the reporting organizations (50%) serve expectant teen fathers (5% of which offer services exclusively to expectant teen fathers). Some limit their services to older teen males (18-19 years of age). Two organizations did not report this information.

Most of the reporting organizations (75%) offer parenting-related services to teen females (10% of which offer parenting services exclusively to teen females). A very few limit their services to older teen females (18-19 years of age). Two organizations did not report this information.

More than half of the reporting organizations (60%) offer parenting-related services to teen males (a very few of which offer parenting services exclusively to teen males). A very few limit their services to older teen males (18-19 years of age). One organization did not report this information.

Many reporting organizations offer client education (80%) and client advocacy (70%). About half of the reporting organizations offer pregnancy prevention services (50%) and intervention services (47%). Some reporting organizations offer public education (40%) and treatment services (37%). Fewer reporting organizations offer public policy advocacy (27%), professional education (20%), and research (17%). Four organizations did not report this information.

Slightly more than one-third of the reporting organizations currently deliver services to pregnant and/or parenting teens that apply one or more evidence-based programs or practices and another 10% are either planning or considering doing so. Three organizations did not report this information.

Slightly more than half of the reporting organizations (53%) have a neighborhood-based central service site. Almost 40% offer home-based services, one only in select zip codes. Slightly more than 30% offer school-based services and 25% offer clinic-based services. Slightly more than 10% offer services in government offices. Two organizations did not report this information.

Many reporting organizations (65%) offer services other than standard business hours on weekdays. Alternate times are most likely weekday evenings, however very few organizations do offer services on the weekend. Five organizations did not report this information.
Source of funds for outreach and services to area pregnant and parenting teens was reported by 31 of 34 organizations. A majority (75%) report federal funding, state funding, and/or individual donors, with state the most likely to be primary, then federal and finally individual donors. Organizational fundraising events and funds from non-corporate community grant-making organizations were a source for many reporting organizations (nearly 70%), however they were more likely to not be a primary or secondary source. Nearly 60% of reporting organizations received local public funds, more likely as a primary or secondary source. Nearly 60% of reporting organizations received funds from corporations and businesses, equally likely to be or not to be primary or secondary. About 30% of reporting organizations did receive private insurance payments, none as a primary source of funds.

INTEGRATING THIS STUDY WITH OTHER COMMUNITY STUDIES

Considerable effort was devoted to reviews of recently published community assessments, studies, and reports, and also other publications, many of which are products of collaborative efforts, in an initial attempt to relate the findings of Embracing Change: Franklin County Teen Pregnancy, 2014 to key aspects or findings of select publications.

Reviewed Publications with Local Data References

*Greater Columbus Infant Mortality Task Force: Final Report and Recommendations, The City of Columbus City Council, June 2014* (plans annual reports)

- Reports eight neighborhoods with high incidence of infant deaths; compare to areas with high incidence areas of teen births in *Embracing Change*.
- System integration and program collaboration are valued as solutions to both infant mortality and teen pregnancy.
- Identifies Lead Entity of Key Activities associated with improving reproductive health planning, improving prenatal care systems and supports for highest risk families, and promoting infant safe sleep; explore how relevant providers of services to pregnant and parenting teens can become a resource to these efforts.
- Data reports on Franklin County infant mortality do not specify age group of custodial mother, which would be useful to analyze infant mortality in relationship to teen pregnancy and to make more informed investments in relevant prevention and care services.

*2014 Franklin County Children’s Report, How Toxic Stress Threatens Success, United Way of Central Ohio*

- Some pregnant and parenting teens are both victims and perpetrators of childhood trauma and stress. Recommend more study of how multi-generational experiences of trauma and stress may have more of a causal role in multi-generational teen pregnancy than is currently understood.
Because we know that many Franklin County pregnant and parenting teens do live in poverty and some definitely have mental health problems, more attention should perhaps be given to the fact that their situation and condition immediately increase their child’s exposure to toxic stress, beginning in the womb.

The effects of a teen father’s incarceration on both the economic resources of a teen mother and on child bonding should be studied or clarified.

Some, if not many pregnant and parenting teens, have an insufficient support system and relationships to buffer the effects of the stress of their lives. The earliest intervention in the life of a pregnant and parenting teen that gives access to nurturing, sustained relationships offers hope to counteract trauma, foster resiliency, and support the whole family (the teen, the teen’s parents, the teen’s child).

Reality education in support of teen pregnancy prevention might include information in this report on the implications of educational attainment on employment, health, earnings, housing, etc.

The Median Earnings by Education Level reports gross income and after-tax earnings, a distinction that should be made when presenting information on self-sufficiency standards.

Pregnant females need to be safe, nourished and nurtured, and surrounded by loving people who support them and ease their stress. This includes pregnant teen females.

Concern for the effect of school disciplinary actions may warrant further analysis regarding teen mothers.

Asset mapping is agreeably a valuable tool.

Collective impact presented in report as a new approach may alternatively be defined as an advanced practice of collaboration. Collaboration that requires shared accountability is committed to collective impact.

Documentation regarding the Stress Profile and its count of Teen Births (309) needs to include a clarifying statement, as the count reports births only to teens ages 17 and younger.


This guide provides basic information about health care law as it relates to teens to help ensure that teens receive the medical care they need. It can assist parents, guardians, and other adults to advocate for teens.

As Ohio laws change, investments should be made in updates and redistribution.

**Benchmarking Central Ohio 2013, Community Research Partners**

This report provides a model approach that could be adapted to define and monitor standardized, measureable indicators associated with teen pregnancy, thereby empowering all stakeholders to track and assess how Franklin County is progressing in its efforts to prevent pregnancy and to provide care to pregnant and parenting teens.

While this report is based on the comparability of metropolitan areas (multi-counties, not just Franklin County), it may be possible and useful to explore approaches to teen pregnancy prevention and care services used by metro areas comparable to Columbus, with a focus on some or most of the following indicators: racial/ethnic diversity; birth rate; residential segregation; child population; households; income and wages; ration of workforce entry to exit populations; persons in poverty; households...
receiving public assistance; teen pregnancy rate; net earnings as percentage of total personal income; household income; income gap; poverty rate; low-income population; income supports; earned income tax credit; teen pregnancy; parental employment; rental housing affordability; high school attendance; higher education enrollment of 18 to 24 year olds; and infant mortality. Teen pregnancy experiences and responses in four MSAs should be investigated: Charlotte and Indianapolis, Nashville and Louisville.

The Self-Sufficiency Standard for Ohio 2013, prepared for the Ohio Association of Community Action Agencies by the University of Washington Center for Women’s Welfare

- The calculation of a self-sufficiency standard for Ohio was previously made in 2008 and 2011.
- Providers of services to pregnant and parenting teens and employers who value economic self-sufficiency for teen parents should use the county-based data to educate teens and to inform them in ways that inspire a commitment to employment as a strategy for financial independence.
- In Franklin County, the 2013 annual self-sufficiency standard for one adult, one preschooler was $39,614, which calculates as 255% of the Federal Poverty Level.

Ohio Child Fatality Review, Thirteenth Annual Report, Ohio Department of Health, September 2013

- Prematurity Deaths by Age of Mother is reported by age group where primary caregiver is identified as female biological parent, therefore some analysis can be conducted for teen parents.
- This report reminds us that while only 12% of infant deaths were deemed preventable, the detrimental effects of unhealthy lifestyles and poor prenatal care on the lives of infants are recognized.
- The perpetrator of homicide death for children less than 10 years old was more often a family member or a parent’s partner. What is the role of stress? Of lack of knowledge of basic parenting skills? Of substance abuse?
- Eighty-seven percent of child abuse and neglect deaths occurred among children younger than five years old.
- Sixty percent of reviews of child abuse and neglect deaths indicated the person causing the death as a biological parent and 21% as the parent’s partner. (It is important to note an inquiry to Franklin County Children Services by The Center for Healthy Families verified that the age of the parent/perpetrator of child abuse and/or neglect is not generally collected or reported. In 2005, records of substantiated or indicated maltreatment where the age of the parent/perpetrator was less than 18 years was less than 1% of the cases.)

Franklin County Health Map 2013, Central Ohio Hospital Council, January 2013 (plans reports every three years)

- This report provides an excellent Franklin County Community profile.
- Eight health areas are identified as being a local, priority health need, each with associated health indicators.
- Maternal Health Indicators include Infant Mortality Rate, Low Birth Weight Babies, Cigarette Use During Pregnancy, Abortion Rate, Adolescent Pregnancy, and only the latter is reported by age group. It would be useful to standardly focus on all components of teen pregnancy: pregnancy, live births, abortions, and fetal losses.
Mental & Social Health Indicators include Child Abuse, Children Hospitalized due to Abuse, Domestic Violence Incidents, Intentional Injury, Drug-Related Incidents, however none are reported by age group.

Death, Illness & Injury includes Trauma and is reported by age group.

Infectious Disease Incidence & Prevalence of AIDS/HIV is reported but not by age group.

Youth Issues include Tobacco Use, Alcohol Use, and Substance Abuse.

**Induced Abortions in Ohio, 2012, Ohio Department of Health**

- Historical county-based data are not reported by age group, reducing the capacity to analyze abortion trends for area teens (although such data were reported for 2010 and for 2012).

**Franklin County’s Children: a look at their lives in and out of the classroom, United Way of Central Ohio and Learn4Life, February 2012**

- Bold Goals are relevant to pregnant and parenting teens (graduation from high school).
- References limited availability of accredited or quality rated child care slots for children under age six and the importance of preschool programs to developing cognitive skills necessary for kindergarten and the cultivation of a child’s emotional and social skills (link to resource needs and utilization for teen parents).
- Identifies number and percentage of economically disadvantaged students by school district. Cross-reference with incidence of teen pregnancy and availability of school-based services to pregnant and parenting teens and reported in *Embracing Change* and its related resource directory.
- In addition to the 16 public school districts (with 50 high schools), reports that 73 charter school options exist, ranging from small local charter schools to statewide digital learning programs. Explore further which charter schools have enrolled teens that are pregnant or parenting.
- Presents chart of common child risks and assets that may be useful in developing a standard assessment tool for agencies serving pregnant and parenting teens.
- Reports a shared value for community partnerships that work to align and integrate effort, leverage resources, capitalize on strengths, and that identify and address barriers and gaps.

**Full Potential Community Report: Facts About Growing Up Healthy in Franklin County: 2010-2011 Collaborative Children’s Health Report, Nationwide Children’s Hospital** (begun in 2008, this is the most recent progress report)

- Monitors and reports on 10 preventable health threats that are prevalent and pressing for Franklin County children. Most recent assessment is documented.
- Teen Smoking: Improved.
- Teen Pregnancy: Birth rates unacceptably high; significant disparities in minority populations.
- Adolescent Suicide: Higher rates; inpatient psychiatric hospital beds have decreased for minors; additional and more effective safety nets for high-risk patients are needed.
- Access to Health Care: Monitor impact of mandatory coverage.
- Infant Mortality/Preterm Birth: High rates; racial and ethnic disparities.
Black Girls in Franklin County, Ohio: Progress, Power and Possibility, The Ohio State University Kirwan Institute for the Study of Race and Ethnicity, July 2011

- Expresses concern for dearth of precise data on Black girls in Franklin County.
- Reports that Black girls surpassed the overall graduation rate of Columbus City School students (2008) and also high disciplinary rates per 100 students for Black girls in the Columbus City School District (2009-2010).
- Reports number of Resident Induced Abortions by Black girls in Franklin County by age group, totaling 262 (2009).
- References the Ohio High School Youth Risk Behavior Survey (YRBS), conducted by the Ohio Department of Health from 2011 to 2013. The survey monitors six types of health-risk behaviors that contribute to the leading causes of both morbidity and mortality among the nation’s youth. The survey is an excellent source of data on teens and violence, mental health, sexual behaviors, alcohol, illegal drug use, tobacco, preventive health care, and other behaviors.
- Recognizing that neighborhood conditions are critical in promoting or impeding people, even the most motivated, it includes Opportunity Maps to illustrate the relationship of opportunity neighborhoods to other quantitative measures pertaining to Black girls. (See Appendix B for an example.)
- Reports that many service providers feel that many African American girls have lower levels of self-esteem, a lack of self-pride, few role models (that are not hyper-sexualized), and poor conflict resolution or socialization skills. Service providers also felt these girls turned toward physical violence, or engaged in unhealthy romantic relationships.
- Some service providers reported that the families of African American girls lack trust that results in reluctance to allow teens to participate in programs related to sexual reproduction or sexual health.
- Includes a literature review, which among other topics, highlights that African American female adolescents are at high risk for mental health problems and underutilization of mental health services.
- Protective factors for African American adolescents include greater levels of religiosity, maternal support, racial socialization, and strong identification with the Black community, the latter linked with less risky sexual behaviors.

Franklin County Minority Health Facts: Focus on Hispanics/Latinos, The City of Columbus, Columbus Public Health, December 2010

- (Note that The Franklin County Community Profile in another reviewed study reports that the Hispanic or Latino population is about 5%.)
- This report documents source data from 2008 and earlier.
- Illustrates critical vulnerabilities of Hispanic teens: high teen birth rate; higher risk of entering prenatal care late; higher risk of being uninsured (adults).
- Illustrates critical strengths of Hispanics/Latinos: lower risk of infant mortality and low birth weight; lower risk of smoking; less likely to be living with HIV/AIDS.
Reviewed Publications without Local Data References

*Teen Pregnancy Prevention: Statistics and Programs, Congressional Research Service, May 2014*

- Excellent resource with recent data on national and state trends, reasons for high pregnancy and birth rates among teens and for decline in pregnancy/birth rates.
- Quotes and references source for information on high economic, social, and health costs for teen parents and their families (Example: 2010 cost to U.S. taxpayers for adolescent childbearing is estimated in a 2013 study by the national Campaign to Prevent Teen Pregnancy as $9.4 billion/year: $3.1 billion in child welfare benefits, $2.1 billion in public sector health care expenses, $2.0 billion in spending on incarceration (for sons of females who had children as adolescents), and $2.2 billion in lost tax revenue because of lower earnings of children of teen mothers over their own adult lifetimes.)
- Comprehensive review of Federal Strategies and investments to reduce teen pregnancy.
- Asserts that a consensus is growing that success in teen pregnancy prevention does not have to be an either-or proposition in which abstinence-only education programs are pitted against comprehensive sex education programs.
- References list compiled by HHS of (now 35) evidence-based program models found to be effective in delaying sexual activity, increasing condom or contraception use for sexually active youth, or reducing teen pregnancy (only three of the original 31 are abstinence-only education programs). (See www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db)
- Identifies components of what many analysts and researchers agree is an effective teen pregnancy prevention program.
- Federal Teen Pregnancy Prevention Program Funding in FY2014 from largest to smallest dollar allocation: Title V Abstinence Education Block Grant, Teen Pregnancy Prevention (TPP) Program, Personal Responsibility Education Program (PREP), Adolescent Family Life (AFL) Program—Care Component, and Evaluation Funds for TPP Program. Ohio Department of Health traced grants that affected Franklin County and reports a TPP grant to OhioHealth and a PREP grant to ODH. An Abstinence Education grant was awarded to a subcontractor located outside Franklin County who reports working with two local subcontractors, Pregnancy Decision Health Centers and Healthy Relationships. ODH does not report an AFL grant anywhere in Ohio.

*The Plummeting Labor Market Fortunes of Teens and Young Adults, The Brookings Institution, March 2014*

- (Note: Ohio Bureau of Labor Market Information reported no awareness data on occupations held by teens, as BLS does not track worker demographics by occupation. The Bureau does publish Columbs MSA Occupational Employment Projections Report, 2010 – 2020, that specifies occupations by median wage and educational level requirements.)
- Columbus MSA was one of the 100 largest metropolitan areas analyzed for this report and in 2012 ranked 37th (1 indicating strong performance) for our share of non-institutionalized teens (16-19) that are employed and ranked 27th for our share of disconnected youth (16-19)—those that are not working, not in school, and have less than an associate’s degree.
- Recognizes that finding and keeping a job is a key step in a young person’s transition to adulthood and economic self-sufficiency and also provides valuable opportunities to apply academic skills and learn occupation-specific and broader employment skills such as teamwork, time management, and problem solving. Additionally, it provides work experience and contacts to help in future job searches.
Finds that education and previous work experience are most strongly associated with employment.

Claims that disconnected youth are at increased risk of long spells of unemployment, poverty, criminal behavior, substance abuse, and incarceration.

Reports on young adults aged 20-24, in addition to teens.

Recommends seven strategies for creating stronger on-ramps into the labor market for young people, based upon referenced initiatives in multiple settings across the country: integrate work-based learning into high school and college education and expand apprenticeships; link high school to post-secondary educational credentials; smooth young people’s transition into employment, especially high school graduates who do not immediately enroll in college or an apprenticeship, through increased emphases on career and technical education, career counseling, and job development/placement; provide opportunities for young people to earn a high school diploma or GED after dropping out, coupled with access to post-secondary credentials/occupational skills training and a focus on work readiness; orient career-focused education and training to the regional labor market; address weak demand for labor by creating transitional subsidized jobs programs for young people to help them support themselves, develop work experience, and gain a foothold in the labor market; and increase financial incentives for employment through an expanded EITC, specifically targeting younger workers without children.

Prevention Status Report 2013: Ohio Teen Pregnancy, Centers for Disease Control and Prevention

- Reports the status of public health policies and practices designed to prevent or reduce important health problems, describing why it is a health problem and providing an overview of solutions for preventing or reducing teen pregnancy.

- Reports an estimate by the National Campaign to Prevent Teen and Unplanned Pregnancy: Counting It Up of the annual costs of teen childbearing in Ohio (in 2008) as $392 million.

- References the Youth Risk Behavior Surveillance System, however Ohio data were inconsistently available for all years. (NOTE: 2013 Ohio Youth Risk Behavior Survey is in print. ODH is not aware of any current Franklin County surveys. The Ohio Department of Mental Health and Addiction Services is developing a statewide youth survey that will provide county-level data; collection to begin in 2015-2016 school year. ODH suggested contacting The Columbus Health Department and/or ADAMH board to learn if they have or are conducting any surveys that measure youth risk or are aware of any recent county-level reports.)

- Reports by Ohio for or through 2011 document consistent decline (since 2007) in birth rate among females 15-19 years, and 2011 YRBS reveals that 41% of Ohio female high school students who are currently sexually active do report using birth control pills, any injectable birth control, any birth control ring or implant, or intrauterine device before last sexual intercourse.

- Reports that Ohio expanded its Medicaid family planning eligibility as of August 2013 to include teens and adults with incomes up to 200% of the federal poverty level, the state’s income level for pregnancy-related Medicaid coverage (now conforms to the Healthy People 2020 target).


- Asserts that repeat teen childbearing further constrains the mother’s education and employment possibilities. Rates of preterm and low birth weight are higher in teens with a repeat birth, compared with first births.
Natality data from the National Vital Statistics System (NVSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS) from 2007–2010 were analyzed. (NOTE: Ohio PRAMS data sets can be requested from Ohio Department of Health, Family and Community Health Services, PRAMS Program, 246 N. High Street, Columbus, OH 43215; pramsoh@odh.ohio.gov)

Reports that in 2010, nationally, one in five teen births is a repeat birth (while 86% were a second child, 15% were a third to sixth child). (NOTE: In 2010, NVSS reported that Ohio was in the second tier (15-19%) of states with the highest percentages of repeat teen births for teens.)

Reports large disparities in repeat teen births and use of the most effective contraceptive methods postpartum (tubal ligation and vasectomy, implant, and IUD), reported by less than one out of four teen mothers.

Defines repeat teen birth as having two or more pregnancies resulting in a live birth before age 20.

Reports prevalence of repeat teen births varies by race/ethnicity, with the highest prevalence in 2010 among American Indian/Alaska Natives (21.6%), followed by Hispanics (20.9%), non-Hispanic Blacks (20.4%), Asian or Pacific Islanders (17.6%), and non-Hispanic Whites (14.8%).

Reports that an increasing percentage of teen mothers are actively attempting to prevent another pregnancy in the postpartum period through use of the most effective methods of contraception.

DHHS & Administration for Children and Families publishes a list of 39 home visiting programs, clarifying which models meet the DHHS criteria for an evidence-based program. Nurse Family Partnership is one that does meet their criteria and is offered through the Healthy Family Connection by The Center Family Safety and Healing. (See homvee.acf.hhs.gov/programs.aspx)

Concludes that because teens are at a high risk for inconsistent use of methods that are user-dependent (e.g., condoms and oral contraceptive pills), long-acting reversible contraception (LARC) methods might be a suitable option for teens wishing to delay or avoid future pregnancies. Also recognizes that teens face a number of barriers to LARC use, including cost, limited availability, lack of provider acceptance for this practice in teens, and teen lack of awareness of these methods. (NOTE: LARCs are gaining public attention. The Colorado Family Planning Initiative reported at a September 2014 national conference the state’s 40% decline in teen births from 2007 to 2013 as a result of various strategies including increased use of LARCs among young females. ODH, Adolescent Health would be a good contact to discuss consideration of Colorado’s strategies here in Ohio and specifically in Franklin County. Also, accessibility of LARCs by young people should be monitored in response to the implementation of the Affordable Care Act and which LARCs cost more, because inserting them involves a medical procedure and they typically last three to 10 years. The American Academy of Pediatrics suggest that in the long run LARCs are less expensive than condoms or birth control pills.)

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Reports that in 2006 Ohio Works First Learning, Earning, and Parenting Program (LEAP), which was developed to encourage parents under the age of 20 to finish high school through a system of rewards and sanctions, did improve school enrollment of young mothers at a cost of more than $2,000 per mother in administrative and support services.

References major concern for premature birth to teen mothers, quoting that teens conceiving before their 16th birthday are twice as likely as adults to have preterm births and that teens are increasingly vulnerable to preterm labor during a second birth.
Defines 10 types of problems, or costly issues, associated with teen pregnancy: poverty, health and Medicaid, premature birth to teen mothers, infant mortality, education, homelessness, domestic violence, foster care, child support, and abortion.

Makes five recommendations: open and honest communication about sexuality within the family, comprehensive sexuality education in schools, increased access to birth control, evaluation of teen pregnancy prevention programs, and change in cultural expectations of adolescence and adulthood (more emphasis on education and employment as important definers of adulthood).

Concludes that it would be beneficial for Ohio to put more effort and funding toward preventing unintended and teenage pregnancy than to pay for its consequences later.

Other Reviewed Publications That Informed the Methodology of This Study

Shelby County Teen Pregnancy and Parenting Needs Assessment, The University of Memphis, College of Arts & Sciences, Center for Research on Women, June 2012

Pregnant and Parenting Adolescents Support Services (PPASS) Program Needs Assessment, Indiana State Department of Health, Maternal and Child Health Division, February 2011


MOVING FORWARD

The report of this study offers an agenda for the community dialogue that The Center for Healthy Families will now stimulate. Our intent is to first meet with different stakeholder groups in part to build awareness of the study and develop a shared understanding of its findings, but also to discuss how the findings of the study align with the knowledge of each stakeholder group and to expand the significance and implications of this study by exploring what significance we assign and what implications we perceive.

Initially, the dialogue will be with internal stakeholders: the board of trustees of The Center for Healthy Families; the leadership team of Franklin County Job and Family Services and the Franklin County Board of Commissioners, as appropriate; the presidents, service managers, and staff of the 12-organization service collaborative Healthy Families Connection; and funders of those organizations.

The dialogue will be expanded through conversations with groups of organizations listed in the study’s resource directory; parent groups; and groups of teenagers, especially, but not only, those who are pregnant and parenting.

Concurrently, conversations will begin with representatives of other community assessments, studies, and reports that are listed in this report in an effort to integrate initiatives and actions recommended in each.

We expect that these many conversations, which will occur during the next years, will result in definite plans to improve outreach and service management, strengthened and integrated community plans, and identification of policies that deserve critical review.
Study Methods Summary

Multiple methods were employed to collect primary information on teen pregnancy and parenting in Franklin County, Ohio. These methods include field surveys, focus groups, case study analyses, data analysis, resource inventory, and mapping. Recently published community assessments, studies, and reports were reviewed to identify content and concepts that link key aspects or findings of those publications to that of this report. Some state and national publications were additionally reviewed for that same purpose. Due to the brief period during which this study was designed and implemented, methodologies were not reviewed and approved by an Institutional Review Board (IRB). Requirements typical of an IRB were reviewed and efforts taken to protect human subjects from physical or psychological harm, to promote fully informed and voluntary participation by prospective subjects capable of making such choices (or, if that is not possible, informed permission given by a suitable proxy), and to seek maximized safety of subjects. All data and recordings are securely stored in locked cabinets only accessible to the research team, and all identifying information is kept completely separated from research data.

Survey

A 22-page third-party-administered survey was developed to elicit a broad range of information from 13- to 19-year-old teens that self-identify as female, pregnant and/or parenting, and a current resident of Franklin County, Ohio. To be selected as a survey participant, qualified individuals had to sign a consent form (or if a minor, to have a parent or guardian sign a consent form) and also express a willingness to participate in a post-survey brief education intervention described in advance as a review of descriptions of various birth control methods and of sexually transmitted disease designed to add to their understanding and contribute to their health. See Appendix C for information about this brief education intervention. In addition to demographics, the survey collected required information about facts, experiences, and feelings associated with first-time pregnancy; information source and use of pregnancy prevention methods; accessibility of contraceptives; experience of actual or threatened force; behaviors to influence health of baby; accessibility to parenting role models; safe sleep practices; preferred involvement by father of child; education and training goals; employment; financial matters; and preferred source of information or assistance (to develop parenting skills, to encourage or discourage involvement of father of child, and to further education or training). The survey collected optional information about self-perceptions of mental health and parenting challenges and preferred sources of information and assistance to improve mental health and parenting skills. Survey data collection was performed in the field by a team of eight trained interviewers who conducted an in-person interview, entering reported information to an online survey. Field surveys were conducted during a five-week period in late summer 2014. Survey candidates were recruited through the public media, social media, and a network of 44 community organizations that offer services to area pregnant and parenting teens. A total of 123 surveys were completed in the field. Field locations included cooperating educational institutions and health and human service agencies, as well as arranged space at public libraries and other public community sites. Mandatory reporting requirements were respected. In addition, individuals who reported or who preferred not to answer questions related to actual or threatened force were given relevant referral information. Participants who completed both the survey and the brief education intervention (about one hour total time) received a child-oriented gift valued at $25.00 immediately upon completing the survey.

Focus Groups

Six focus groups, ranging from 2–9 participants per group were conducted during a two-week period in late summer 2014 to gather thoughts and opinions on teen pregnancy and parenting from individuals with interpersonal or professional experience of teen pregnancy. Questions were targeted to two types of participants: 1) individuals with either interpersonal or professional direct experience of teen pregnancy,
or 2) individuals with professional experience governing or administering local agencies that deliver services to pregnant and parenting teens. Separate focus groups were conducted for those with either interpersonal or professional direct experience: 1) parents of a pregnant or parenting teen, 2) teen fathers, 3) females now in their 20s or 30s who became a first-time mother during her teens, 4) professionals who manage or deliver services to area pregnant or parenting teens and whose agency is a member of a 12-organization service collaborative, and 5) professionals who manage or deliver services to area pregnant or parenting teens and whose agency is not a member of a 12-organization service collaborative. Five focus groups were asked about incidence of live births by local teens; pregnancy prevention; assistance required for a pregnant teen to behave in ways that contribute to the health of her baby; sources of parenting role models; expectations for a father of a child born to a teen girl; advice to a teen parent about education, training, employment, and child care; and recommendations for improvements to information, outreach, and service to local teens so they can understand and manage the possibility of pregnancy and, when experienced, the reality of becoming a parent. The sixth focus group was similarly asked about teen live birth incidence and for their advice to teen parents about education, training, employment, and child care. Differentially, the sixth focus group was asked to respond to select findings of studies that contrasted experiences and practices related to teen pregnancy in the United States with those of other countries or that featured class and gender differences related to contraceptive and abortion access. Additionally, the sixth focus group was asked to identify public opinion or public policy that either contributed to teen pregnancy or undermined responsible and effective parenting by teens. Participants outside the service collaborative managed by the agency conducting the study were recruited through public media, social media, and networks of community organizations known to offer services to pregnant and parenting teens. Special efforts were made to work with fatherhood groups and schools with groups of teen fathers. Individuals were further screened for their residence or agency location, required to be Franklin County. Focus groups were held at pre-announced times and at either central or known-to-be-acceptable locations. Each focus group lasted two hours. Participants reviewed and signed a consent form at the start of the session and were then asked to identify their race, ethnicity, and age group via a brief survey form that did not define the demographic information by a specific focus group. Upon completion, only participants with interpersonal experience received a child- or family-focused gift valued at $50.00. Participants with professional experience understood that the organization each represented would be recognized as a special contributor to the study in the study report.

Case Study Analyses

Ten professionals who deliver services to Franklin County pregnant or parenting teens and who represent nine agencies and 10 different programs were recruited to participate in guided interviews. The interview was telephone-based and conducted one-to-one by the Lead Researcher. The interview was designed to facilitate an analysis by each professional of key factors perceived to affect service impact and client progress. Pre-interview instructions required each professional to select two cases, each with a client who was a pregnant or parenting teen: one case thought to demonstrate definite service impact and client progress and a second case thought to demonstrate questionable or no service impact and client progress. Interviews occurred during a three-week period in late summer 2014. Professionals were recruited through member agencies of a service collaborative managed by the agency conducting the study and non-member community agencies that participated in focus groups, all of which delivered services to Franklin County pregnant and parenting teens. Seven of the 10 selected professionals had not participated in any other aspect of the study. Nine of the 10 selected professionals did represent member agencies of the service collaborative. Selected professionals represented youth services (3), medical and health-related services (5), employment-related service (1), and an educational institution (1). In addition to basic demographics and case identification as one of two types, information collected included length of service, focus of service, service site by type, concentration on particular subjects, service strategies, key factors judged to contribute to service impact and client progress (specific and open-ended), and key factors judged to detract from service impact and client progress (specific and open-ended). The average length of an interview was 40 minutes. With the exception of the agency conducting the study, each organization or program represented by a participating professional received a $50.00 stipend.
Data Analysis

Data reported by the Ohio Department of Health for Franklin County were analyzed, including resident teen live births (2009 to 2013), race/ethnicity and age groups of resident teen live births (2010), residents by age groups (2010), total resident live births (2010), estimated teen pregnancies (2010), abortions by teens (2010), and resident teen live births by zip codes (2012 and 2013). Data on Franklin County reported in the 2008-2012 American Community Survey 5-Year Estimates were analyzed, specifically township total population and population below poverty-level.

Resource Inventory

Organizations were defined as appropriate for inclusion in the resource directory if they self-identified as either (a) offering services customized to pregnant and/or parenting teens or (b) targeting pregnant and/or parenting teens for services they offer to a broader audience. A list of organizations was generated from multiple sources, including customized directories requested of HandsOn Central Ohio and online directory of area human services; site partners for project survey; recommendations from service managers of Healthy Families Connections, the service collaborative that is managed by The Center for Healthy Families; and project personnel. Detailed information was requested via an online survey instrument, initially invited by e-mail with a follow-up by telephone. Additional follow-up was also conducted. Contact information for non-responsive organizations that were defined as important resources were included. About 85 organizations are included in Resource Directory for Franklin County Pregnant and Parenting Teens, 34 with detailed information and about 50 others.

Mapping

GIS is a system for mapping, visualizing, and analyzing geographic data. Two maps were created by this project, a third was created in support of this project, and a fourth was reproduced with permission because of its relevancy to this project. One map illustrates a relationship between poverty and live births by Franklin County townships, of which there are 25. This map is based upon poverty data from the 2008-2012 American Community Survey 5-Year Estimates and Franklin County Resident Live Birth data for 2010, reported by the Ohio Department of Health. A second map illustrates the incidence of teen resident live births in 2012 and 2013 by Franklin County zip codes. A third map, produced in support of the project by the Ohio Department of Health, the Office of Health Equity, illustrates live births for 12-19 year olds from 2010 to June 2014 which is geocoded by census tract. A bivariate thematic map was created using market research demographic profiles to highlight areas of Franklin County that have a disproportionate number of teen births.

A fourth map, produced by The Ohio State University Kirwan Institute for the Study of Race and Ethnicity for its 2011 report Black Girls in Franklin County, Ohio: Progress, Power and Possibility, is reprinted with permission in Appendix B. The African American Girls in Poverty and Neighborhood Opportunity Map, Franklin County, Ohio (Map 4) represents a comprehensive index of several factors measuring neighborhood quality and opportunity with an overlay of African American girls (ages 12-17) in poverty in Franklin County. The multiple indicators of high opportunity were defined in that study by select variables, including the availability of sustainable employment, high-performing schools, safe environments, access to high-quality health care, adequate transportation, quality child care, and institutions that facilitate civic and political engagement.
Published in its 2011 report *Black Girls in Franklin County, Ohio: Progress, Power and Possibility*, The African American Girls in Poverty and Neighborhood Opportunity Map, Franklin County, Ohio (Map 4) represents a comprehensive index of several factors measuring neighborhood quality and opportunity with an overlay of African American girls (ages 12-17) in poverty in Franklin County. The multiple indicators of high opportunity were defined in that study by select variables, including the availability of sustainable employment, high-performing schools, safe environments, access to high-quality health care, adequate transportation, quality child care, and institutions that facilitate civic and political engagement.
APPENDIX C

CHF Brief Educational Intervention—A Post-Survey Experience

**Purpose:** Expand knowledge and understanding of alternative methods of birth control and of sexually transmitted diseases by interacting with pregnant or parenting teen females (ages 13-19).

**Create a Learning Environment:**

Interaction is designed to be attention-getting and to enhance the likelihood that information will be received as personally meaningful.

Interaction will most often be one-to-one (15-20 minutes) but may be in a small group of 2-8 individuals (20-30 minutes).

The parent/guardian of a minor (under age 18) has the right, but is not required, to be present. (Ask the parent/guardian what s/he prefers.) Note: If present, the parent/guardian of an 18- or 19-year old is welcome if the interviewee prefers.

**Hear and Respond to Messages**

- Show respect for lack of knowledge, the right to not know something, and dispel any feelings of “being stupid” or any need to sound knowledgeable.
- Expect poorly informed questions or misinformed statements (restate with no indication of judgment).
- Listen for vague and direct requests for information.
- Recognize and respect matters of values (morals, preferences).
- Understand concern for “being normal” (body, emotions, physical changes).
- When confronted with shocking language, reword with no indication of surprise or judgment.

**Rules for Small Group Discussion**

- Set a clear expectation: the group will not be discussing what anyone does or does not do (no personal disclosure; no talking about one’s own behaviors).
- Acknowledge that there are benefits and risks to any choice (show respect for moral, medical, emotional, legal, and interpersonal differences).

**Learning Process:** Motivational Inquiry

**Learning Materials** (to distribute):

1. ETR publication Birth Control Facts (distribute at end of birth control interaction)
2. ETR publication STD Facts (distribute at end of STD Quick Quiz)
3. CHF handout Quick Quiz with answers (distribute after verbal review of Quick Quiz answers)
4. CHF handout Find the Support You Need to Seek Health Care and Face Health Problems (distribute at end of interaction)

**Learning Materials** (to use and collect):

1. Blank 3x5 card and pen (1 per teen female, not to a parent)
2. Birth Control Methods (set of 9 individual alternatives, laminated “stick”)
3. Reference list of some STDs (laminated form)
4. Quick Quiz for Your Sexual Health (form without answers)

*Note: ETR is a California-based business offering science-based health and education products and programs, providing solutions that work for health professionals, educators, and consumers throughout the United States.*
Interaction Introductory Remarks:

The Center for Healthy Families invites you to get medically accurate information that makes it possible for you to plan a pregnancy and to avoid getting or spreading sexually transmitted diseases. Let’s have a little fun as we explore together what there is to know about alternative methods of birth control and STDs. This will take about (READ EITHER 15 minutes, if with an individual or 30 minutes, if in a small group). READ IF IN A SMALL GROUP THAT CHF FORMED: For confidentiality reasons, we are not going to share names. If after our discussion you wish to talk to someone in the group, please simply ask if you could talk to her and respect her choice.

Topic 1: Alternative Methods of Birth Control

1. Provide a pen and a blank 3x5 card to each teen.
2. Ask her (them) to write down on the blank card when she would like to give birth to her next child. Clarify that there is no assumption she wants another child and that never is one possible answer. (Note: Later in these instructions, her answer is referred to below as a goal).
3. Ask her (them) to randomly pick one birth control method from among nine that you offer (laminated “stick”).
4. Engage her (them) in a brief discussion, first having her read about the method she selected and then asking what she thinks about how likely it is that her personal goal (which remains private when in a group setting) will be supported by that birth control method. (Note: In a small group, expand discussion by asking if anyone, as they were listening to what others said, heard about a method different from the one she had chosen that she would prefer to the one she selected.) To wrap up the brief discussion, distribute the Birth Control Facts. IF THERE IS TIME refer to it to identify other birth control method(s) that might better meet her goal or confirm that the one she selected is likely to do so. (Otherwise, tell her to do this later.)
5. COLLECT (a) pen, (b) card with her goal (if she is willing to hand it in—be sure it has no name on it), and (c) laminated “sticks”—be sure you have all nine.

Topic 2: Sexually Transmitted Diseases (STDs)

1. Invite teen to review a list of some STDs (laminated). COLLECT after her review.
2. IF WITH INDIVIDUAL: Invite teen to answer questions you read to hear from a Quick Quiz and circle her answer. IF WITH SMALL GROUP: Distribute a blank Quick Quiz with a pen to each teen and ask each teen to answer by circling either true or false.
3. Review the Quick Quiz not by comparing teen(s)’ answers to the correct answer but by simply sharing the correct answer for each question and reading supplemental information that is provided. After you have completed reading, COLLECT her form (if she is willing—be sure it has no name on it), and distribute a copy of the version that provides answers and supplemental information.
4. Distribute the brochure, STD Facts, and encourage individual(s) to learn more about all STDs so that they can better protect their own health and that of children and partners.

Closing Remarks:

Thank teen(s) for participating in the discussion. Explain that we want her to have information about how to Find the Support You Need to Seek Health Care and Face Health Problems (and distribute that handout).

Invite teen to collect her gift, stating again our appreciation for her time and participation in this study.
Quick Quiz for Your Sexual Health

1. A person with a sexually transmitted infection would always have a symptom (or sign) of the disease.

   TRUE

   Many people have an STD with no symptoms. Sometimes females will notice an unusual discharge or smell from the vagina, pain in the pelvic area between the belly button and sex organs, burning or itching around the vagina, bleeding from the vagina other than during the regular period. There are other symptoms that you can read about in a brochure you will be given, but remember many times there are no symptoms. Testing is the only way to know for sure. You will also be given a handout on how to locate a local source for testing.

2. Females, Blacks, and teens are more likely than males, Whites, and other age groups to get some sexually transmitted diseases.

   TRUE

   FALSE

   Looking at Ohio from 2008 to 2012, chlamydia and gonorrhea affected 15-24 year olds at a much higher rate than all other age groups; females ages 15-24 considerably more than same-age males; and again among 15-24 year olds, Blacks far more likely than Whites.

3. A person could be cured of some sexually transmitted diseases, but not all.

   TRUE

   FALSE

   Sexually transmitted diseases that are bacterial are curable infections (chlamydia, gonorrhea, and syphilis). For many reasons, it is important to treat the infection in its early stages. STDs that are caused by a virus can be managed but are not curable infections (HIV/AIDS, genital herpes, HPV or genital warts, Hepatitis B).

4. A baby cannot be born with a sexually transmitted disease.

   TRUE

   FALSE

   Several types of STDs can be passed from mother to child: some when the baby passes through the birth canal (for example, chlamydia, gonorrhea, syphilis, genital herpes), other STDs can be passed during pregnancy (HIV/AIDS, syphilis, Hepatitis B & C), and HIV/AIDS during breastfeeding. STDs in babies can lead to premature birth, low birth weight, and serious health problems for the baby. Screening and treating pregnant females for STDs is important to prevent serious health complications to both mother and baby. Early prenatal medical care will lead to better health for mother and unborn baby.
5. A person under the age of 18 must have a parent’s/guardian’s consent to be tested for a sexually transmitted disease.

**TRUE**

In Ohio, a minor can be diagnosed and treated for an STD without consent of a parent or guardian. If the minor pays for the service through a parent’s insurance rather than directly, because of insurance rules governing Explanation of Benefits, the parent/guardian will learn that the minor has received the services. The Center for Disease Control recommends that all sexually active females ages 25 and younger be screened annually for chlamydia.

6. In addition to abstinence (not having sex), there are ways to protect one’s self from getting a sexually transmitted disease.

**TRUE**

Having sex with only one uninfected person who only has sex with you is safe. Correctly using a condom every time you have sex will protect you from STDs much of the time. Don’t have sex with someone who you think may have an STD. Remember, sexually transmitted diseases are spread during not only vaginal sex but also anal and oral. Also, you can get HIV/AIDS and Hepatitis B not only from sex partners but also by sharing a needle or from getting a tattoo.

7. A person with certain types of sexually transmitted diseases can more easily get certain other types of sexually transmitted diseases.

**TRUE**

It is easier for a person to get an HIV/AIDS infection if she has another type of sexually transmitted disease.

8. Adults are far more likely than teens to get sexually transmitted infections.

**TRUE**

Overall, STIs are highest among persons ages 15-24. Infections rates in Ohio for chlamydia and gonorrhea started to recently decline among 15-19 year olds and to increase for 20-24 year olds.