The Capstone Committee for Naiomi Jamal Certifies that this is the approved version of the following capstone:

An Evaluation Plan for a Parent Based Teen Pregnancy Prevention Program

Committee:

Cara Pennel, DrPH

Tarah Castleberry, DO, MPH

Juliet Mckee, MD

Dean, Graduate School

An Evaluation Plan for a Parent Based Teen Pregnancy Prevention Program

by

Naiomi Jamal, MBBS

Capstone

Presented to the Faculty of the Graduate School of

The University of Texas Medical Branch

in Partial Fulfillment

of the Requirements

for the Degree of

Master of Public Health

The University of Texas Medical Branch

July, 2016

Dedication

To Mama and Baba. Thank you for never giving up on your dreams and not letting me give up on mine.

Acknowledgements

I would like to begin by thanking my committee chair, Dr. Cara Pennel, for her belief, support and continuous assistance in guiding me through the work to complete this Capstone. I would also like to thank the other members of my committee, Dr. Tarah Castleberry and Dr. Juliet Mckee, for their support and guidance throughout my MPH and professional development. I would also like to thank Dr. Christine Arcari for being a staunch student advocate. I would like to acknowledge Dr. Sharon Croisant for introducing me to the Galveston Youth Risk Student Survey, Mr. John Cook at the Galveston Island Community Research Advisory Committee, Ms. Katelyn Lowery at Galveston Urban Ministries and Mrs. Janice Stanton for opening doors in the community and vouching for the project, and Mr. Jim Hilton at the Galveston County Health District for his guidance and sharing his numerous years of experience in promoting sexual health in the county. Finally, I would like to acknowledge the work of the community members I met while working on the project. Thank you so much for welcoming me in your homes, your places of worship, your offices and your neighborhoods. I am in awe of your generosity and your commitment to bettering your communities.

An Evaluation Plan for a Parent Based Teen Pregnancy Prevention Program

Publication No._____

Naiomi Jamal, MPH

The University of Texas Medical Branch, 2016

Supervisor: Cara Pennel

Almost half of all pregnancies in the United States are unintended. In 2010 alone the cost of these pregnancies was estimated to be $21 billion. The problem is further compounded when dealing with teenage pregnancy. These include a higher risk for medical complications of pregnancy, a decreased likelihood to graduate from high school and a greater likelihood of teen mothers to have daughters who become adolescent mothers and sons with increased likelihood of incarceration. Among developed countries the US continues to have one of the highest rates of teen pregnancy at 57 per 1000 for the ages of 15-19 years. Texas currently has the 5th highest rate of teen pregnancy in the US. With regards to adolescent health, sexual education programs have traditionally focused on reducing the rates of teen pregnancy and sexually transmitted infections. Research has shown, however, that best practice measures adopted the world over are ineffective. This includes traditional programs that focus on youth centres, peer to peer education and one time public meetings. Therefore, programs that concentrate on improving the parent to child communication regarding sex education are gaining in popularity. This approach could be promising in conservative states such as Texas where parental consent is often cited as an obstacle to the teaching of comprehensive sexual education.

The purpose of this capstone is to develop an evaluation plan for a parent focused sex education program in Galveston County, Texas. The short term outcomes to be examined are participant satisfaction with the program; change in knowledge, attitudes, and perceptions regarding teen pregnancy and its prevention; and improved parental involvement and/or communication regarding sex education. The ultimate long term outcome under examination will be reducing teenage pregnancy rates in Galveston County.

TABLE OF CONTENTS

List of Figures

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centers for Disease Control and Prevention
FQHCs	Federally Qualified Health Centers
HIV	Human Immunodeficiency Virus
HHS	Health and Human Services
GCHD	Galveston County Health District
GICRAC	Galveston Island Community Research Advisory Committee
GPM	General Preventive Medicine
GUM	Galveston Urban Ministries
GYRSS	Galveston Youth Risk Student Survey
PHO	Public Health Organization
RCT	Randomized Controlled Trial
STD	Sexually Transmitted Disease
TB	Tuberculosis
UNFPA	United Nations Population Fund
US	United States
UTMB	University of Texas Medical Branch

CHAPTER 1 INTRODUCTION

Teen pregnancy is deemed a grave public health concern the world over. Many view it as a violation of a child's human rights, sighting adolescent pregnancy as both a cause and consequence of rights violations.[1] Pregnancy is viewed as undermining a girl's opportunities for exercising her right to an education, health and autonomy as granted by international treaties such as the Convention on the Rights of the Child.[1] The human rights approach to teen pregnancy cannot be carried out without a multi-faceted approach that examines communities and societies as a whole in order to take advantage of local opportunities to accomplish change.

Recently, University of Texas Medical Branch (UTMB) faculty analyzed data and compiled a report for the Galveston Youth Risk Student Survey (GYRSS) of 2014. Based on the reports from the survey, which had a 78% response rate from all students attending Ball High School, (the sole public high school on the Island) we now have a glimpse of the prevailing situation with regards to risky behavior, teen pregnancy and parental involvement on the Island. According to the survey, nearly half of all 9^{th}-12^{th} grade students (44.7%) are sexually active and nearly 20% report having had sexual intercourse before the age of 13.[2] Furthermore, of those students that are sexually active, one in six report they have either been pregnant or got someone pregnant.[2] In addition, only 47% of the students were living in a two parent household, compared to a national level of 65%.[2,3] The report also shows that almost 80% of parents do not keep regular track of their children's media usage, which studies show is one of the primary sources of teen sexual health information.[4]

Studies confirm a need for coordinated, complementary programs to improve adolescent sexual health.[5] An approach that evidence-based research has shown to be effective in preventing teen pregnancy, yet has not been implemented in the community, is a program targeted towards increasing parent-child communication regarding teen sexual health. According to the National Campaign, teens report that parents most influence their decisions about sex.[6] Researchers have also found that increased parent communication with their children regarding sexuality, leads to an increased likelihood of adolescents delaying intercourse and if they do have intercourse, to use contraception and have fewer partners.[7,8,9] However, 57% parents report being uncomfortable when talking to their teen about sexual health.[10] Despite evidence of the protective role parents play in adolescent sexual health, most sex education programs have limited or no role for parents to play when it comes to the sexual education of their children.[11] Of the programs that do exist very few have been evaluated. Therefore, in the absence of comprehensive sexual education at school, a proposition was made to develop a community based Teen Pregnancy Prevention program targeted towards improving the knowledge and communication skills of parents with children between the ages of 11-16 years, using sites provided by local community centers and churches.

After partnering with the Galveston County Health District (GCHD), the need for developing a concurrent evaluation plan for this novel program with in the community was decided upon. The goal of the project is to develop a parent based teen pregnancy prevention program that increases parent-adolescent communication regarding teen sexual heath. The program will specifically be modified to meet community needs in Galveston, using evidence-based tools and resources from the US Department of Health and Human

Services, the Centers for Disease Control and Prevention, the Advocates for Youth Campaign and the National Campaign. These tools are recommended for: improving parent to child communication regarding teen sexual health, increasing the age of teen sexual initiation, decreasing teen pregnancy and its associated risks, and increasing community involvement and awareness. The ultimate goal is to decrease teen birth rates in Galveston County.

CHAPTER 2 BACKGROUND

EPIDEMIOLOGIC DESCRIPTION

Teen pregnancy poses a significant burden to parents, children and society at large. An estimated 11% of all births worldwide are borne by teenagers between the ages of 15-19 years old.[12] This has health, economic and social implications for teen mothers, their unborn child, their families and the communities in which they live. Most teenage pregnancies occur in developing countries and are largely associated with poverty, low education levels and high risk behaviours.[13]

GEOGRAPHIC DISTRIBUTION

INTERNATIONAL

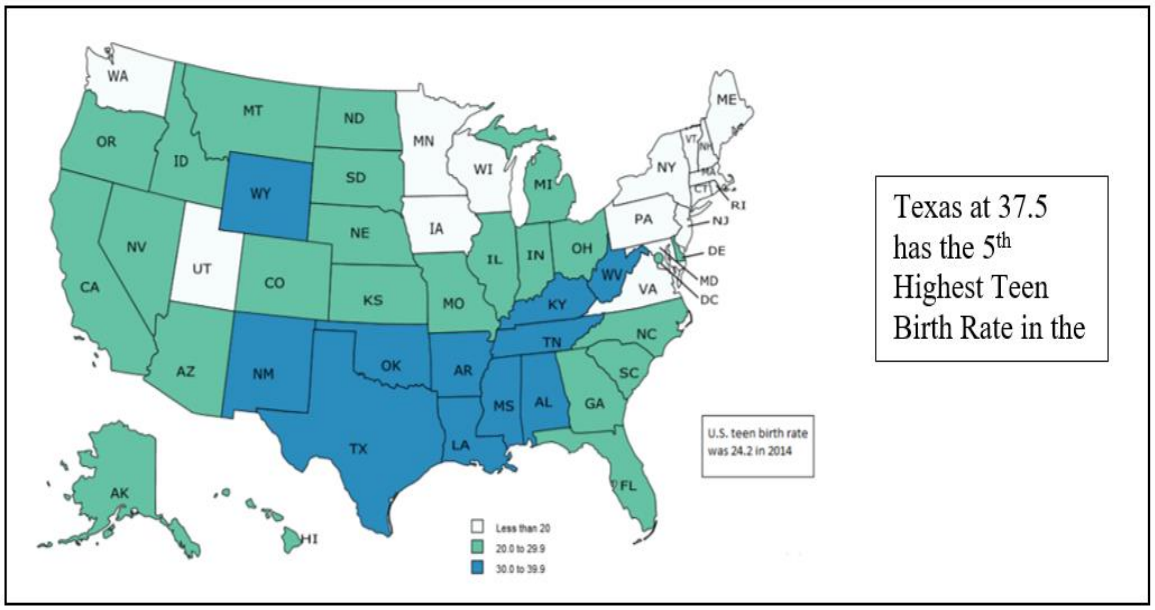
Although the rates of adolescent pregnancy are lower in high income countries, they continue to have negative outcomes for adolescents, children and communities. They also highlight disparities in various countries that are often drawn along lines of race, ethnicity, low income and low education status. Among developed countries, the US continues to have one of the highest adolescent pregnancy rates at 57 pregnancies per 1000 females for the ages of 15-19 years in 2010. England and Wales followed at 47 per 1000 females in the same age group and the lowest rates were found in Switzerland at 8 per 1000 females.[12,14] These differences were examined by Sedgh et al.[14] They noted that Switzerland has long standing sex education programs, free family planning services, wide availability of low cost emergency contraception and sexually active teens are expected to

use contraception. By contrast the US has low social acceptance of teen sexuality, inconsistent sexual education programs and wide socio economic disparities that lead to further targeting high risk groups.[14]

NATIONAL

In the US rates further differ across geographic lines (Fig 1). Globally a comparison between nations is often made by using teen pregnancy rates. This encompasses teen birth, abortion as well as miscarriage rates. Within the US however, most public health organizations including the CDC and HHS draw comparisons between states using teen birth rates. Southern states tend to have a higher teen birth rate than Northern states with the highest reported rate in Arkansas at 39.5 births per 1000 females between 15-19 years of age in 2014. The lowest rate was in Massachusetts at 10.6 per 1000 in the same year.[15]

Figure 1: Teenage Birth Rates per 1000 Females Ages 15-19 Years Old by State, 2014



Source: Martin, J. A., Hamilton, B. E., Ventura, S. J., & Osterman, M. J. K. S.C., & Mathews, T.J (2015). Births: Final data for 2014. Hyattsville, MD: National Center for Health Statistics

TEXAS

Texas has the 5th highest teen birth rate in the US.[15] The teen birth rate between the ages of 15-19 years was 37.8 births per 1000 females in 2014 compared to a national rate of 22.4 births per 1000 females in the same year (Fig 1).[16] This gap widens even further when comparing teen pregnancy rates in the 15-19 age group with rates of 73 pregnancies per 1000 females in Texas and 57 births per 1000 females nationally in 2010.[16] The increase is accentuated even further in the 18-19 age group with Texas rates at 122 per 1000 females compared to a national rate of 96 per 1000 females. The percent of repeat births for females under 20 was also higher for Texas at 21% compared to a national rate of 17% in 2013.[16]

Across Texas, according to the County health rankings 2016 report there is a wide variation between teen birth rates.[17] This variation ranges between a teen birth rate of 19 to 124 per 1000 females between the ages of 15-19 years old.

GALVESTON

The teen birth rate in Galveston County is reported at 44.9 per 1000 which is higher than the Texas rate of 37.8 per 1000 and the national US rate of 22.4 per 1000.[18]

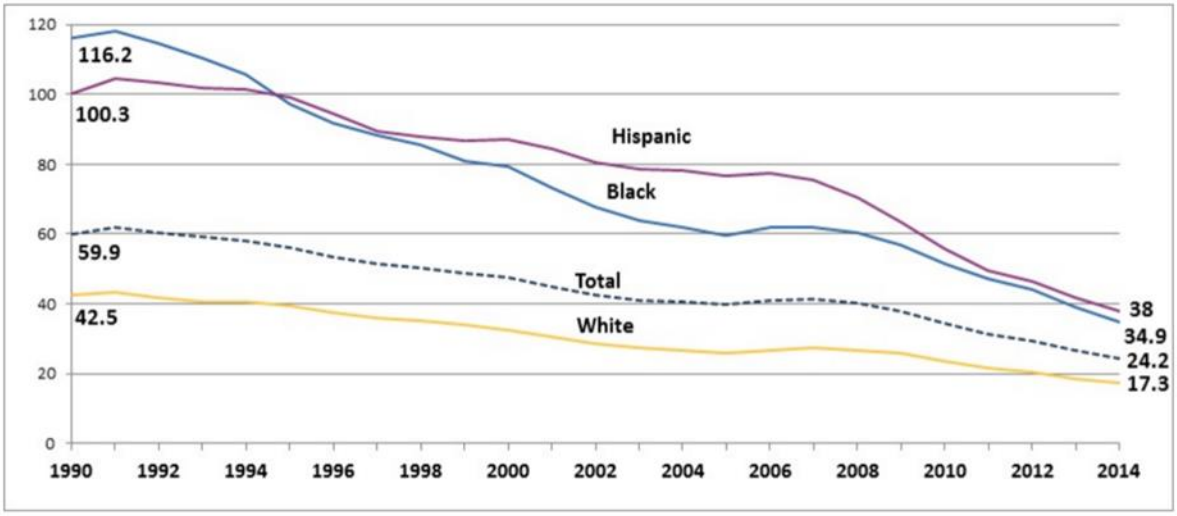
RURAL/URBAN

A further geographic divide is noted along rural and urban settings. The teen birth rate is higher in rural communities compared to urban centers regardless of race or ethnicity. In 2010, the teen birth rate was nearly a third higher in rural settings at 43 births per 1000 females between ages 15-19 years compared to an urban rate of 33 per 1000 for the same year.[19] A decreasing overall trend was noted between 1991 and 2010. However, the rate declined by 32% in rural counties compared to a 49% decline in urban centers.[19]

DISPARITIES BY RACE AND ETHNICITY

Disparities also exist along racial and ethnic lines. Since 1991, the peak year for teen birth rates, there has been a consistent decline in teen birth rates. However, the extent of the decline is not uniform across race or ethnicity. The highest rate in 2014 was among Hispanic teen girls at 38 per 1000, followed by non-Hispanic black teen girls at 34.9 per 1000.[15] That is almost twice the rate as non-Hispanic white teen girls, who have a rate of 17.3 per 1000 for the same year.[15,19] The rates for Hispanic and non-Hispanic black teens has been falling more sharply than non-Hispanic white teen girls.[15] This may be an indication of the gap narrowing.

Figure 2: Birth Rates per 1000 Females Ages 15-19, by Race/Ethnicity, 1990-2014



Source: Martin, J.A., Hamilton, B.E., & Ventura, S. J. (2015). Births: Final Data for 2014. Hyattsville, MD: National Centre for Health Statistics

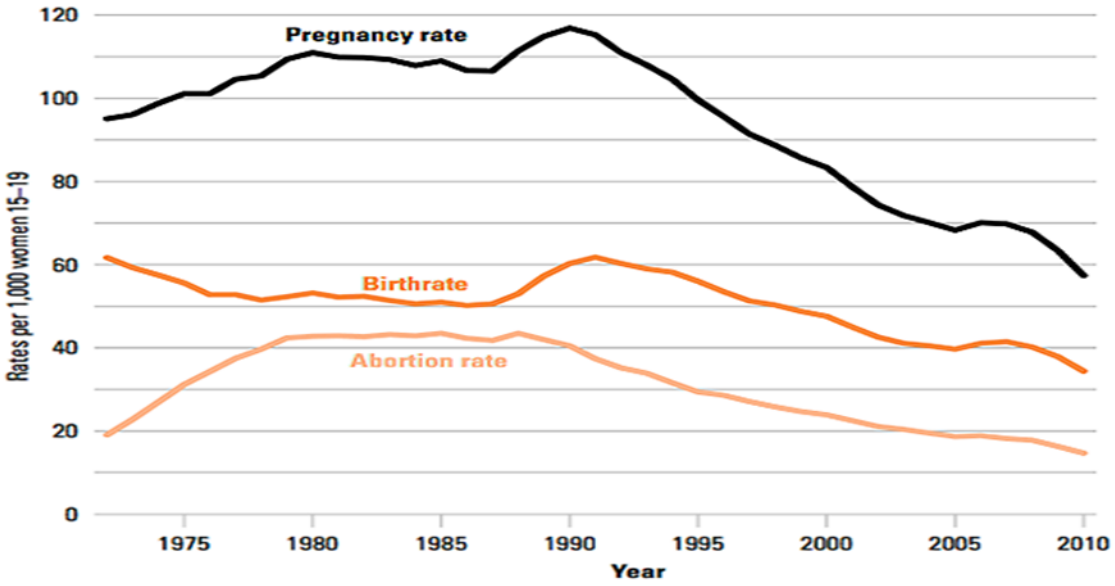
AGE DISTRIBUTION

In women under the age of 20, the teen birth rate varies by age. In 2014, 72% of teen births were in the 18-19 year age group.[15] However, there were still an estimated 66,791 births to girls age 15-17 in 2014.[15] This makes it important to continue to target age groups younger than 18 years.

TRENDS OVER TIME

Since a peak in the early nineties, despite lingering disparity, both teen pregnancy and birth rates have declined across race and ethnicity in the US. The teen pregnancy rate has decreased by 51% from a peak in 1990 to a rate of 57.4 in 2010.[20] The teen birth rate has also declined 44% from its peak rate of 61.8 births per 1000 females in 1991 to a rate of 34.4 per 1000 in 2010.[20] The abortion rate decreased by 66% from a peak rate of 43.5 in 1988 to a rate of 14.7 per 1000 in 2010.[20] However, despite these widespread downward trends, the US still continues to have one of the highest teen birth and pregnancy rates in the developed world. In addition despite a narrowing gap racial and ethnic disparities in rates continue to be a concern.

Figure 3: US Teen Pregnancy, Birth and Abortion Rates per 1000 Females Ages 15-19, 1970-2010



Source: Kost K and Henshaw S, *U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity*, New York: Guttmacher Institute, 2014

RISK/PROTECTIVE FACTORS

While examining the disparities in teen pregnancy certain socio-economic risk factors emerge. These conditions in families and the communities in which they live have been shown to contribute to high teen birth rates. These factors include low education and low income levels of the teen and/or their family, limited community opportunities for positive youth involvement, racially segregated neighborhoods, physical disorder in neighborhoods, income inequality in neighborhoods and teens in child welfare systems (e.g., young women in foster care are twice as likely to become pregnant compared to those who are not). [21,22]

Conversely, factors that protect against teen childbearing are increased parent to child communication and positive relationship, increased teen educational opportunities, and health equity.[23]

PUBLIC HEALTH SIGNIFICANCE

Family Planning is listed as one of the 10 great public health achievements of the 21st century.[24] Its improvement has led to enhanced health outcomes for women, children and families as a whole. This was mainly achieved by improved birth spacing, greater accessibility of contraceptive use, prevention and treatment of sexually transmitted infections and prevention of unintended pregnancies. In order to achieve these goals, sex education as a public health initiative has existed in some shape or form in the US since 1918 with variable success. Recently, there is an increased recognition for the need for new approaches. As a result, greater focus is now being placed on the role of parent to child communication regarding sexual education.

Of the aforementioned concerns, the issue of unintended pregnancy has proved to have far reaching consequences. Almost half of all pregnancies in the US are unintended.[25] In 2010, it was estimated that the total cost of unintended pregnancy (cumulative public costs of births, abortions and miscarriages) was $21 billion.[26] There are also a number of negative outcomes that are associated with unintended pregnancies including delayed prenatal care, reduced likelihood to breast feed, and increased risk of maternal depression and becoming victims of physical violence.[27,28,29,30]

The problem is further compounded when dealing with teenage pregnancies.[31] Teenage pregnancies are higher risk for multiple reasons. Women younger than 17 years of age are at high risk for medical complications of pregnancy, including higher pre-eclampsia rates, anemia, achieve poor maternal weight gain, have low birth weight infants, preterm delivery and receive no or delayed prenatal care.[32,33] In adolescents, the maternal mortality is also twice as high.[34] In addition, for women under the age of 19, four out of five pregnancies are unintended.[35] This predisposes teen parents and their children to even further negative outcomes, including a decreased likelihood to graduate from high school, and earning an average of $3500 less per year compared to parents who delay child bearing

till their 20s. They also receive twice as much federal aid for nearly two times longer.[36,37] Furthermore, teenage mothers are more likely to have daughters who also become adolescent mothers and sons who have a greater likelihood of being incarcerated.[36,37]

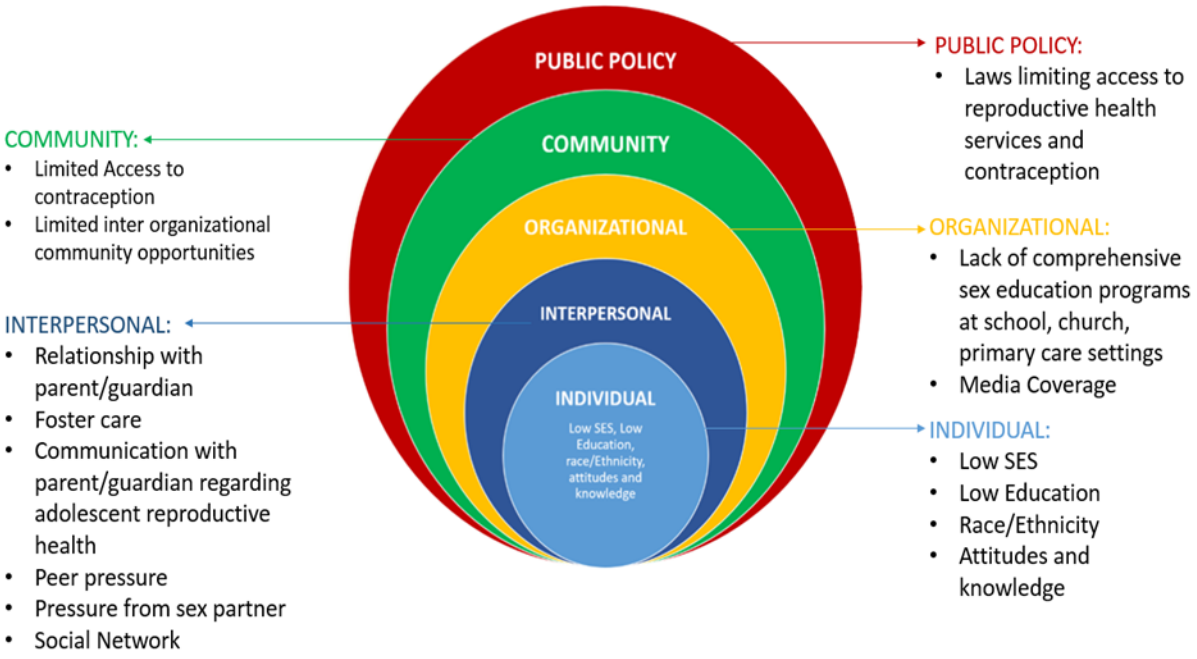
The economic perspective presents an even more compelling argument for intervention. In 2010 alone, the cost of teen childbearing to the US tax payer was estimated at $9.4 billion. Most of these costs were incurred due to public sector health care costs, child welfare costs, incarceration costs and lost revenue as a result of lower taxes paid by teen mothers over the course of their adult lives.[38,39] The total savings in 2010, due to the decline in teen pregnancy noted since 1991, was $12 billion. In the same year, the teen childbearing cost to tax payers in Texas was $1.1 billion. Teen pregnancy also seems to entrap teenage mothers, in particular, into a cycle of poverty. As the market becomes progressively competitive to secure a well paying job, it is crucial that teenagers graduate from high school and aspire to higher, specialized education. However, only 38% of teen girls who bore a child before the age of 18 had a high school diploma at age 22.[40] In addition, 30% of teen girls who dropped out of high school reported teen pregnancy or parenthood as the primary reason for doing so.[40] It is no surprise then that an estimated 67% of teen mothers who moved out of their families homes live in poverty.[40] The increased educational disparity between teen mothers and their other teen counterparts translates into fewer economic opportunities and lower earnings through the life course of teen mothers. This economic disadvantage is further perpetuated to future generations as the children of teen mothers are often born into poverty. Many would argue that teen motherhood alone cannot be blamed for the economic disparity or lack of opportunities, since poverty itself is a risk factor for teen pregnancy. Between 2009 and 2010, a reported 48% of teen mothers in the US lived below the poverty line. The rate was even higher for Hispanic and Black teen mothers, 60% and 48% of whom lived under the poverty line respectively. This was compared to 39% of White teen mothers. Recent research however

suggests that teen motherhood continues to have a detrimental effect on employment and/or future earnings, even after controlling for other factors that could affect opportunities.[41,42]

SOCIAL ECOLOGICAL MODEL

To better understand the factors that lead to teen pregnancy the socio-ecological model for teen pregnancy was formulated (Figure 4). As evidenced by the model the conditions that lead to teen pregnancy are multifaceted. An "ecological" approach to teen pregnancy examines all the multiple forces, from a national to an individual level, that drive teen pregnancy.[1] According to the United Nations Population Fund (UNFPA), approaches that have only focused on changing a girl's behavior as a means of decreasing teen pregnancy are misguided because implicit in these interventions is the assumption that if a girl becomes pregnant it is her fault.[1] To avoid this pitfall the approach has to be all encompassing taking into account the social, geographic, economic and political conditions that lead to teenage pregnancy. The model, for instance, shows that a teen pregnancy may be due to public policies that limit access to reproductive and contraceptive services, communities that lack the organizational capacity or the will to educate teens regarding sexual health, and prevailing economic and social disparities with in a country may predispose teens to becoming pregnant. The intervention was decided upon by examining the model and ascertaining which level would be best to stage an intervention that met community needs whilst still executable within the constraints of time and expense.

Figure 4: The Social Ecological Model For Teen Pregnancy



PROGRAM AIM

The aim of the project will be to form an evaluation plan for a parent education program regarding teen pregnancy and its prevention. The evaluation plan was developed concurrent with the development of the program through the public health practice experience. Several outcomes will be evaluated and examined. The most immediate outcome to consider will be increasing parent to child communication regarding adolescent reproductive health. In the model above, the corresponding level will be at the interpersonal stage. The intervention will also overlap at the organizational stage since it will be carried out in local churches and will involve community partners such as the Galveston County health district, the Galveston Island Community Research Advisory Committee (GICRAC), Galveston Urban Ministries (GUM) as well as volunteers from the University of Texas Medical Branch. GICRAC and GUM, in particular, work with vulnerable and underserved populations on Galveston Island and have close community ties with these high risk neighborhoods. Gavin et al., in a systematic review on programs that focused on

parent to child communication about reproductive health, found that such an intervention resulted in increased communication and decreased risky sexual behavior among adolescents.[43] The ultimate goal is to decrease teen pregnancy rates.

The primary community partner for the program was the Galveston County Health District. GCHD is a government organization that plays two main roles 1) the provision of local public health services, under the United Board of health that sets policy for health department services and 2) The operation of two Federally Qualified Health Centers (FQHCs) that provide primary care services, under the Coastal Health and Wellness Governing board.[44]

The public health mission of the district is "Assuring the Conditions in Which People Can be Healthy".[44] The services provided include vital statistics, food and environmental services, animal services, public health lab, STD/HIV, immunizations, TB, and public health emergency preparedness.[44] Recently, the district has updated its strategic health plan to add a wellness initiative. One of the objectives of this initiative is to promote wellness at specific worksites and in the community at large.[44] As described, teen pregnancy is a significant public health concern and the development of a teen pregnancy prevention program would be in concordance with the recently adopted community wellness initiative. It was at the request of GCHD that an evaluation plan along with the program was developed.

LITERATURE REVIEW

In a growing number of high income countries the prevention science approach is being applied to adolescent health. The Society of Prevention Research states the main goal of prevention science is ''to improve public health by identifying malleable risk and protective factors, assessing the efficacy and effectiveness of preventive interventions and identifying optimal means for dissemination and diffusion".[45] In other words simultaneous

approaches that are not focused on a single behaviour change may be needed. These would have to be a combination of those that decrease risk factors such as high risk adolescent sexual behaviours and also increase protective factors.

The school based sex education approach has been extensively adopted and examined over time. However, one argument that is consistently cited as a reason for not implementing a comprehensive sex education program in schools is parental consent or lack thereof. Around the world, more countries are now looking to improve parent to child communication to overcome this hurdle.[46] A review by Wight et al. further explored the protective effect that "parent-child connectedness" has on prevention of high risk adolescent sexual behaviour.[47] In addition most studies have found that open communication between parent and child resulted in later age at sexual initiation as well as greater contraceptive use. Certain studies, however, found no association.[47] It appears that the content of the messages communicated and the baseline parent child relationship influences the association.[47]

REVIEW OF PROGRAMS AND STRATEGIES

Several different approaches have been adopted across the country to decrease teenage pregnancy rates resulting in a downward trend for pregnancy and birth rates and increasing trends for contraceptive use. This has been achieved, in part, by improved education programs. The community preventive services task force recommends group based comprehensive risk reduction for adolescents to prevent HIV/AIDS, STDs and teen pregnancy.[48]

A review examining the accepted best practices with regards to adolescent sexual and reproductive health highlighted some of the widely accepted approaches that experience and research are now showing to be ineffective.[5] Some of these failed interventions are youth centers, peer to peer education and one time public meetings. They did not appear to improve adolescent access to sexual and reproductive health services,

change adolescent sexual behavior, or shift the social norms that often govern adolescent sexual and reproductive health.[5] The only approaches the world over that appear to work are those that take a more comprehensive approach to sex education. The success of these comprehensive programs, however, is quite frequently hampered by the lack of sustainability and commitment to delivering all the facets of the program. Looking to the future, there are as yet several uncharted frontiers that may prove even greater success.

According to the Chnadra-Mouli et al, there is a definite need for coordinated programs that complement one another to improve adolescent sexual health, and calls for an abandonment of prior approaches that have not worked.[5] *Families Talking Together* is a parent based intervention that aims to prevent or reduce high risk sexual behavior. It does so by focusing on specific objectives including 1) increasing effective communication skills; 2) building parent-adolescent relationships; 3) helping parents develop successful monitoring strategies; and 4) teaching adolescents assertiveness and refusal skills.[49] The program has several key components. These include parent discussions with a trained interventionist and a family workbook that focuses on improving communication skills, strengthen parent-adolescent relationships, improve parent monitoring skills, and empower adolescents with assertiveness and skills related to consent. The program was specifically designed to cater to the needs of high risk populations and was pilot tested on parents of African American and Latino origin who had children between the ages of 10 to 14 years old.[49]The program can be administered to participants in varying settings such as after school, medical facility or home based, through individual or group sessions.[49] Evidence showed that at nine months post intervention, compared to a control group, youth in the intervention group were significantly less likely to report ever having engaged in vaginal sexual intercourse. They also reported a significantly lower frequency of sexual intercourse over the past 30 days.[50]

Another parent based intervention is *Talking Parents, Healthy Te*ens. The program is a work site based program that consists of eight weekly sessions delivered to parents of

youth between ages 11-16 years. The aims of the program are to influence and develop parents' communication, monitoring and involvement skills; increase parent intention to communicate about sex; and challenge perceptions of "environmental barriers and facilitators" (e.g., community norms regarding such communication). The program also aims to strengthen the parent to adolescent relationship in order to further influence teen sexual behavior. The program meets these aims through videos, role playing sessions, in-session and at-home activities, and handouts.[51] In an Randomized controlled trial (RCT) Schuster et al. showed that at one week, three months and nine months after the program, parents in the intervention group reported discussing more new topics regarding teen reproductive health with their children. Adolescents of parents in the intervention group reported receiving parental instruction on how to use a condom at one week compared to baseline. This difference grew at nine months after the intervention.[52]

CHAPTER 3 METHODS

POPULATION

Galveston County lies around 30 miles south of Houston, Texas. With a population of 321,418 people, it is the 17th most populace county in the state of Texas. The County seat is Galveston city, which is an island that has a population of 50,180. Based on census data, Galveston Island has certain high risk factors that increase potential for disparities in teen pregnancy. Close to 50% of the island identifies as either black or Hispanic; the poverty rate is 23.7%; and 27.1% of the population is without health insurance. Evidence of a problem is further reinforced by the Galveston Youth Risk Survey of 2014 that shows that almost 45% of students at Ball high (the only high school on the island) are sexually active. Of those that report sexual activity, almost 1 in 6 stated that they had either been pregnant or got someone pregnant.[2] Furthermore there also seem to be gaps in protective factors such as parental monitoring, since close to 80% of students stated that their parents do not monitor their online activities.[2] The majority of students at the high school also live in single parent homes. In terms of high risk sexual behaviours, African American teens consistently have higher rates. More than 20% reported they had sexual intercourse before the age of 13, which was almost twice as high in African American male students at the high school at 40.2%.[2] Based on the above data, after consulting with local stakeholders and partners, it was decided that the target population for the program would be parents of teens between the ages of 11-16 years old, who primarily frequented community centers in underserved parts of the island, or African American Churches.

PROGRAM DESCRIPTION

The parent based teen pregnancy prevention program aims to increase parent to child communication regarding teen sexual health to ultimately reduce teen pregnancy rates on Galveston Island. It is a one year pilot program and consists of 4 weekly 60-90 minute

sessions that will be delivered at local community centers and churches to groups of about 15 parents. The program will be led by a facilitator and assistant facilitator using a standardized manual. Snacks will be provided, along with child care for the duration of the session, which will serve as incentive to participate. The program focus is to be interactive and build parent ability and confidence. Sessions and take home exercises focus on skill building and practice. The facilitator will review the prior week's session and issues that arose when practicing skills at home will be discussed in a group. Parents are provided with a folder of educational material for every session at the beginning of the program so that they have materials for future reference and missed sessions. The goals are to educate parents regarding teen pregnancy and it's negative impact, educate parent's regarding their influence and how to use it, improve parent communication skills, increase parent monitoring skills, increase parent to child communication regarding parental values, sex, contraception, consent, and setting goals for the future. The ultimate goal is to decrease teen pregnancy rates in Galveston County.

SESSION ONE:

Will focus on increasing parent knowledge regarding teen pregnancy in Texas and Galveston County and its negative impact. Parents will also hear the teens perspective and how research suggests that parents most influence teen decisions regarding sex.

SESSION TWO:

Will focus on the importance of remaining involved in their teen's life and reinforce positive parent–adolescent relationship. The session will be delivered in the form of a mini workshop that concentrates on improving parental communication skills and will highlight positive interaction, and learning to avoid roadblocks.

SESSION THREE:

This session focuses on emphasizing the importance of communicating parental values regarding sex in a clear and unambiguous manner to teens. In this session specific communication skills will be taught:

- How to start the conversation with teen regarding sexual health using the let's talk TV guide and Teachable moments.
- How to be an Askable parent
- How to deal with the concern that talking about both abstinence and contraception may be a mixed message.

This will be achieved through reviewing at home exercises, answering questions, videos, in class exercises and activities such as role playing.

SESSION FOUR:

Will focus on the importance of supervising and monitoring your children and their activities (including on line activities) and how to do so, discourage early frequent and steady dating, and helping teenagers to have options for their future by developing future goals.

The master guide for the program can be found in Appendix A for review.

PROCESS OF DETERMINING PROGRAM CONTENT

Program content was determined through stake holder involvement and community feedback. The value expectancy theory, "Health Behaviour Model" was used as a basis for driving the components chosen in the program.[53] The aim was to incorporate elements that made teen pregnancy relevant and a salient health concern, ensured that participants do perceive it as a threat, the belief that parent communication with teens regarding sexual health is a means of reducing this perceived threat at an acceptable cost, and engendering self-efficacy.[53]

EVALUATION FRAMEWORK

The evaluation framework according to the CDC is spread over several distinct steps.[54] This is to ensure that the plan serves as a roadmap through the course of the program planning, evaluation and execution. It is more than a set of indicators set to paper, but a document that is open to modification and reflective of changing program goals and focus to better serve community needs.

STEP 1: ENGAGE STAKEHOLDERS/COMMUNITY MEMBERS

In public health it is often said that everyone is your stakeholder. In order to succeed in developing a program and evaluation that meets community and consumer needs it is crucial to have their feedback and input to ensure a relevant program. For this program stakeholders and relevant community members were identified and multiple meetings were held with them to determine program components and specific objectives.

Priority stakeholders were the Galveston County Health district, GICRAC, GUM, UTMB (Department of Preventive Medicine and Community Health, Department of Family Medicine), and local church leaders. Several community members were also approached such as local teachers, health workers, physicians and parents. It was based on multiple discussions with the aforementioned groups that specific program goals, objectives and how to evaluate them was developed.

STEP 2: PROGRAM DESCRIPTION

The purpose of the program description is to ensure transparency between multiple stakeholders and to ensure that the fidelity of the program is maintained throughout the execution and evaluation process.

As a part of this step a Logic model was developed based on the components that were identified to meet community needs after input from stakeholders and other members of society. Details of this Logic model are described in Chapter 4.

STEP 3: FOCUS THE EVALUATION

Focusing the evaluation is essentially identifying evaluation questions that are checked against the logic model and are representative of identified objectives and goals. At this stage stakeholder involvement increases a sense of ownership and establishes continued stakeholder interest. A budget and funding source is also determined at this stage. An application for funding was submitted to the University of Texas Medical Branch President's Cabinet Award, which included a budget and can be found in Appendix B.

STEP 4: PLANNING FOR GATHERING CREDIBLE EVIDENCE

In this step of the evaluation, questions decided upon are then matched to specific indicators that will best answer those questions. A plan is then put in place to determine the appropriate data sources, data collection method, analysis, time frame and the person/party responsible for carrying those actions out. This is best described as a part of an evaluation matrix, details of which are described in chapter 4.

STEP 5: PLANNING FOR CONCLUSIONS

Once the program is carried out, at the midway mark of the one year execution (6 month mark---Refer to evaluation time frame Fig 10), the data is analysed and interpretations or conclusions will be drawn and shared with relevant stakeholders. After feedback from community partners conclusions will be drawn on those interpreted results. Based on these conclusions and feedback certain elements of the program may be modified.

STEP 6: PLANNING FOR DISSEMINATION AND SHARING OF LESSONS

The final step involves planning for dissemination of results and sharing lessons with stakeholders, funding sources, academics and most importantly community members. Since this is planned as a one year pilot program with potential for future expansion, the results will be shared with hosting sites, (Local churches, GCHD, GICRAC and GUM) as

well as local community members. If funding is secured then they will also be shared with the funding organization. Lessons will also be shared through presenting at local, state and national public health and teaching conferences.

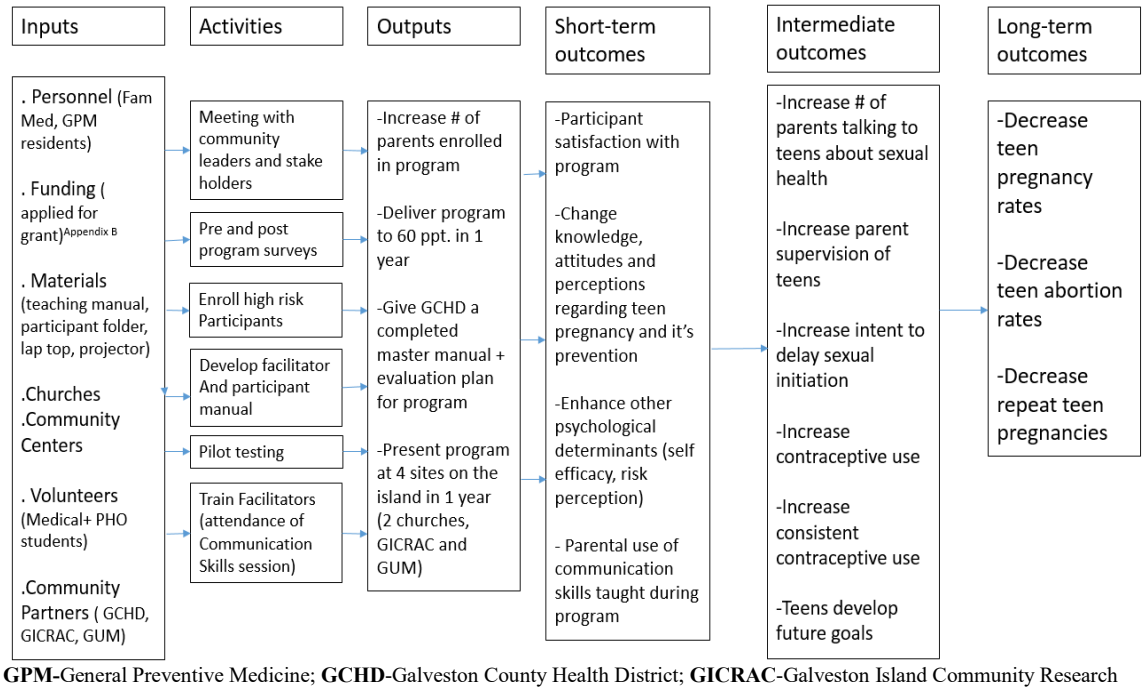
Dissemination will be done in the form of written reports, meetings and presentations. Stakeholder comments will be welcomed and incorporated in program modification and revision.

CHAPTER 4 RESULTS

The purpose of an effective program evaluation is to do more than merely collect, analyse and distribute data. It should make it possible for program stakeholders and community members to gather and use information in a meaningful way. Such that it provides a means to continually learn about the program and results in the evolution and improvement of the programs that are operated and funded.[55]

The specific aim of the program was to decrease teen pregnancy rates in Galveston County. In order to achieve this stakeholders were identified and approached in order to form a Logic Model for program development and evaluation (Fig 5).

Figure 5: Logic Model For Parent Based Teen Pregnancy Prevention



GPM-General Preventive Medicine; **GCHD**-Galveston County Health District; **GICRAC**-Galveston Island Community Research Advisory Committee; **GUM**-Galveston Urban Ministries; **PHO**-Public Health Organization; **PPT**-Participants

Based on the logic model specific, smart objectives were formulated and evaluation questions were generated. These questions were then paired with indicators and the data source, collection method, time frame and person/group responsible for maintaining credibility were ascertained. The process along with specific goals and objectives are highlighted in the evaluation matrix. The matrix was formed for the process objectives-(outputs-Figure 6) and for short term, intermediate and long term outcome objectives (outcome objectives-Figure 7, 8, 9).

Figure 6: Process Objectives Evaluation Matrix

Process Objectives:

1. In 1 year enroll 60 parents with children between the age of 11-16 years, in Galveston Island, in the program.
2. In 1 year, ensure the content of the program was delivered as planned.
3. In 1 year ensure that the program was delivered at 4 sites (2 churches, 1 GICRAC site and 1 GUM site), in Galveston Island.

Evaluation Question	Indicators	Data Sources	Data Collection	Time Frame	Person/Organization Responsible
1.How many participants were enrolled in the program?	Number of participants enrolled	Registration log	Review of Registration log	Data will be collected and analysed pre and post program. Tables and graphs will be presented post program (end of year 1)	Program manager and facilitator
2.Was the program content delivered as planned?	Number of content topics addressed during each session	Observation: Checklist to be completed by co-facilitator to record deliverance of each topic	Review of checklist	Checklist reviewed after each session	Program Manager
3.Was program conducted at selected sites?	Number and location of sites	Registration log	Review of registration log	To be reviewed pre program, at 6 months and post program	Program manager/Stake holders

Figure 7: Short Term Outcomes Evaluation Matrix

Short Term Outcome Objectives:

1. In 1 year, the parents in Galveston Island who participated in the program, will demonstrate, using a pre and post program questionnaire, an increase in their knowledge regarding teen pregnancy and its prevention.
2. In 1 year, the parents in Galveston Island who participated in the program will demonstrate, through a pre and post program questionnaire, an increase in their confidence while talking to teens about sexual health.
3. In 1 year, the parents in Galveston Island who participated in the program will demonstrate through a pre and post program questionnaire, satisfaction with the program.
4. In 1 year, the parents in Galveston Island who participated in the program will demonstrate, use of communication skills taught during program when talking to their teens about sexual health.

Evaluation Questions	**Indicators**	**Data Sources**	**Data collection**	**Time Frame**	**Person/Organization Responsible**
1.Did parents who participated in the program increase their knowledge of teen pregnancy and its prevention?	% of participants who can correctly identify risks and impact of teen pregnancy and it's prevention	Survey(self administered pre and post program) to be completed by participant	Differences in response of pre and post program survey will be analysed	Before and after each session All data analysis, will be done by the end of the program (year 1)	Program manager will work closely with facilitators.
2.Did parents who participated in the program increase their confidence level when talking to teens about sexual health?	% of participants who reported an increase in confidence when talking to their teens post program	Individuals who participated to fill out pre and post program survey	Differences in response of pre and post program survey will be analysed	Baseline and After each session All data analysis, will be done by the end of the program (year 1)	Program manager will work closely with facilitators.
3.Were parents satisfied with the program?	# of parents who expressed satisfaction with program	Post test session and post program survey filled out by participants	Review of post session and post program survey	Done before and after each session and end of program	Program manager will work closely with facilitator
4.Did parents who participated in the program use the communication skills taught during the program?	# of parents who used skills	Exercise and homework sheets filled out by participants	Review of at home exercise and homework sheets	Done before and after each session	Program facilitator

Figure 8: Intermediate Term Outcomes

Intermediate Term Outcome Objectives:

1. In 1 year, the parents who participated in the program will demonstrate through pre and post program surveys, talking to their teens regarding sexual health (communicate parental values, contraception).
2. In 1 year, the parents in Galveston Island who participated in the program will demonstrate through a pre and post program survey an increase in supervising their teens.
3. In 3-5 years, teenagers in Galveston Island whose parents participated in the program, will indicate through surveys, an increased intention to delay sexual initiation.
4. In 3-5 years, teenagers in Galveston Island whose parents participated in the program will demonstrate through surveys, an increase in contraceptive use and consistency.
5. In 3-5 years teenagers in Galveston Island will indicate through surveys, an increase in developing goals for the future.

Evaluation Questions	**Indicators**	**Data Sources**	**Data Collection**	**Time Frame**	**Person/Organization Responsible**
1.Did parents who participated in the program increase talking to their teens regarding sexual health?	% increase in participants that reported talking to their teens about sexual health	Pre and post program survey	Review and analysis of pre and post program survey	Data to be reviewed and analysed pre and post program	Program manager will work closely with facilitator
2.Did parents who participated in program report an increase in supervising their teens?	% increase in parent supervision of teens	Pre and post program survey filed out by participants	Review and analysis of data from Pre and post program survey	Data to be reviewed and analysed pre and post program	Program manager will work closely with facilitator
3.Did Teenagers whose parents participated in the program, increase intention to delay sexual activity?	% increase in teenagers who reported intention to delay sexual initiation	Teens of parents who attended program	For baseline values a preprogram and post program questionnaire will be distributed to teens of participating parents after parental consent. Follow up survey administered at later date. Comparison to other teens made through GYRSS	Data to be reviewed and analysed pre and post program	Program manager will work closely with facilitator
4.Did teenagers whose parents participated in	% increase in teenagers who reported contraceptive	Teens of parents who attended the program	For baseline values a preprogram and post program questionnaire will be distributed to	Data to be reviewed and analysed	Program manager will work closely with facilitator

the program increase contraceptive use and consistency?	use and consistency		teens of participating parents after parental consent. Follow up survey administered at later date. Comparison to other teens made through GYRSS	pre and post program	
5.Did teenagers whose parents participated in the program show an increase in developing goals for the future?	% increase in teenagers who report developing goals for the future	Teens of parents who attended the program	For baseline values a preprogram and post program questionnaire will be distributed to teens of participating parents after parental consent. Follow up survey administered at later date. Comparison to other teens made through GYRSS	Data to be reviewed and analysed pre and post program	Program manager will work closely with facilitator

GYRSS: Galveston Youth Risk Student Survey

The intermediate outcome objectives in Figure 9, were based on the logic model and represent behaviour change. In order to ascertain this change parents will be asked questions in a pre and post program survey and follow up done at a later stage for certain outcomes. After gaining parental and teen consent, evidence of teen behaviour change will be collected in the form of pre and post program surveys and follow up done at a later state for longer term outcomes. The program is only a one year pilot program, and follow up of these outcomes will most likely take place in the context of program expansion. Comparisons can be made with baseline Island teen rates for contraceptive use, consistency, and future goal development by reviewing GYRSS data.

Figure 9: Long Term Outcomes Evaluation Matrix

Long term Outcome Objectives:

1. In 10 years, decrease teen birth rates in Galveston County.
2. In 10 years, decrease teen abortion rates in Galveston County.
3. In 10 years, decrease repeat teen pregnancy rates in Galveston County

Evaluation Question	**Indicators**	**Data Sources**	**Data Collection**	**Time Frame**	**Person/Organization responsible**
1.Did teen birth rates decrease in	Teen pregnancy rates in	CDC database and census data	Review of CDC database and Census data	Pre and post program. Following program expansion	Program manager and stake holders

Galveston County?	Galveston County			annual rates to be compared	
2.Have you ever been pregnant or got someone pregnant?	Teen pregnancy rates Ball high school	GYRSS	Review and analyse data from GYRSS that specifically asks this question	GYRSS review pre and post program. Following program expansion annual review	Program manager and stakeholders
3.Did teen abortion rates decrease in Galveston County?	Teen abortion rates in Galveston County	CDC database and census data	Review of CDC database and Census data	Pre and post program. Following program expansion annual rates to be compared	Program manager and stake holders
4.Did repeat teen birth rates decrease in Galveston County?	Repeat teen birth rates in Galveston County	CDC database and census data	Review of CDC database and Census data	Pre and post program. Following program expansion annual rates to be compared	Program manager and stake holders

Long term objectives were based on the long term outcomes identified in the logic model that were agreed upon by stakeholder and community partner involvement. These long term outcomes cannot be evaluated during the span of the one year pilot, however post expansion of the program, the overall decreasing trend can be determined through review of CDC, census and GYRSS data. GYRSS data is particularly useful since Galveston Island only has a single high school. The recent GYRSS had a 78 % response rate and was fairly representative of the teen population on the Island.

The data will be reviewed by the program manager, and feedback will be gained from stakeholders and community partners at every stage. At present the primary community partners are GCHD, GICRAC and GUM.

Figure 10 shows the timeline for carrying out the evaluation plan.

Figure 10: Projected Timeline For Evaluation Plan

Evaluation Activities	Months								
	1	2	3	4	5	6	7	8-11	12
Plan evaluation with stake holders									

Develop evaluation data collection instruments									
Monitor attendance and participation levels of workshop participants									
Educate parents through sessions and collect pre and post program survey from them									
Collect post program performance exercises from parents									
Analyse evaluation data									
Report findings--- (to funding agency/community partners)									
Revise program/modify if needed									

ANTICIPATED RESULTS

Based on the literature review, programs that focus on improving parent to child communication regarding sexual health had varying outcomes. These included delaying sexual initiation to varying degrees, reducing sexual frequency, increasing condom use, and reducing teen pregnancies and birth.[56] Studies also show that parents who feel more confident in their ability to communicate with adolescents are more likely to initiate conversations with their children about sex.[57]

CHAPTER 5 DISCUSSION

Studies have shown that programs that focus on parent to youth communication regarding sexual health increase parent confidence and result in delayed teen sexual initiation, increase contraceptive use, decrease in number of sexual partners and reduction in teen pregnancy and birth rates.[58] Furthermore, a positive adolescent connection with parents makes teens less likely to initiate sex at a younger age or have frequent intercourse, and more likely to use contraception.[29,59,60]

If targeted towards high risk groups, these programs have significant public health impacts that lead to reduction of teen pregnancy, particularly in vulnerable populations. According to the CDC, the elimination of disparities and addressing the social determinants that cause teen pregnancy accomplishes: "Helping achieve health equity, improving the life opportunities and health outcomes of young people, and reducing the economic costs of teen child bearing."[19]

In order to meet these goals however, individual level programs would have to be partnered with community and national level approaches. Studies have attempted to understand what particular factor has the most impact on teen pregnancy reduction. This was done by attempting to determine the cause for declining teen pregnancy and birth rates since the 1990's in the US and the geographic, racial and economic disparities that still persist. Two elements have emerged: a delay in sexual initiation and increase contraceptive use; however, the analysis shows that they alone do not account for the drastic reduction seen in teen birth rates since 1991. Expanded Medicaid family planning services and reduction of social welfare only accounted for 12 percent of the reduction in teen pregnancy rates between 1991 and 2008 (the issue of reduced social welfare itself is questioned, since European countries that have more social welfare have lower teen pregnancy and birth rates than the US).[61]

To understand the reason for continued geographic and racial disparities in the US the ecological multifaceted approach takes on even greater significance. Studies suggest that youth risk surveys seem to indicate that contraception access is not cited as the primary reason for not using it. A possible explanation could be ambivalence that many have linked to "hopelessness" and "marginalization". Teenagers who feel they have opportunities and educational goals, regardless of their socio-economic background, are more likely to prevent a birth during their teenage years.[62]

Approaches, such as sex education, abstinence counselling, increased contraceptive access, are unlikely to cause drastic reductions in teen pregnancy rates in disadvantaged populations unless they are partnered with broad based social and cultural changes. Levin et al. concluded that two such cost effective interventions would be early childhood education and college scholarships in these populations.[63] An even more ambitious approach would be to uplift neighbourhoods economically, provide greater educational opportunities and change national attitudes towards teen sexuality.[62]

A starting point could perhaps be launching community wide mobilization that focuses on teen pregnancy prevention. A footprint for this step wise approach is provided by the CDC and Advocates For Youth through a Let's Talk Month Guide.[64,65] Highlighted in both strategies is community involvement, community wide events to raise awareness, partnering with stakeholders and involvement of media. These programs may facilitate change in perceptions and attitudes, but for that to translate into decreased disparity in teen pregnancy rates, social, health and economic disparities will have to be addressed. In addition, to replicate evaluation plans for individual level programs, future research will have to be dedicated towards policy, national and social level interventions as well.

Teen pregnancy, for the aforementioned reasons, is considered a "marker of a social problem rather than the underlying problem itself."[62] This makes evaluating intermediate and long term outcomes particularly difficult when dealing with individual level strategies such as the parent based teen pregnancy prevention program. Long term outcomes, such as

reduction in teen pregnancy rates, will be effected by several individual, family, community, policy and national level strategies and approaches. Most indicators will reflect changes that occur on these multiple levels and not just a single strategy or intervention.

The process of developing a parent based teen pregnancy prevention program, along with an evaluation plan, was an act of balancing program fidelity, community involvement and adaptations. The program itself was developed after multiple meetings with stake holders, a thorough literature review, and community input and feedback. This was to ensure that the program gained acceptance and the core components reflected CDC, HHS recommendations as well community needs.

Appendix A Parent Based Teen Pregnancy Prevention Master Guide

PARENT BASED TEEN PREGNANCY PREVENTION PROGRAM

Materials in the program have been used with permission from Advocates for Youth, The National Campaign, Planned Parenthood and the Centers for Disease Control and Prevention.[66,67,68,69]

Session 1: Why Teen Pregnancy Prevention Matters (60 minutes)

- Participant introduction and establishment of ground rules (10-15 min)
- Power point presentation about teen pregnancy in Galveston (20 min)
- Videos. (10 min)
- Reflections/ Question and Answer session (10-15 min)

Introduction:

- Facilitator to welcome participants and introduce his/herself along with other volunteers. Allow participants to introduce themselves to the Group.
- Go over ground rules and importance of the group being a safe place to share ideas and concerns.

Ground Rules: (Used with permission from Advocates for Youth.)[67]

- Each participant has the right to pass.
- Each participant agrees to respect the confidentiality of other participants.
- Each participant agrees to listen with respect and without interruption.
- Participants agree to use "I" statements.
- Participants agree that everyone has a right to his/her opinions and feelings.
- Participants agree to hear and respect all questions.
- Participants agree to respect differences.
- Participants agree that parenting values may differ.

- Ensure that the participants have the materials for session one in their folders.

Participant materials for session one include:

- Copy of Power Point presentation.
- Advice for parents from the national campaign
- Copy of links to videos for later viewing.
- Note pad and pen to write experiences and Questions.

Videos :

https://www.youtube.com/watch?v=Lf4LTb4uVOs

https://thenationalcampaign.org/resource/how-parents-can-help-prevent-teen-pregnancy#

Reflections:

Group Question and Answer session generated around power point presentation and videos.

At home exercise:

-view the advice for parents sheet. Use at least one tip and share the experience (can either journal or share with class).

Session 2: Parent to child communication seminar (75 minutes).

(Used with permission from Advocates for Youth).[67]

Review facilitator's manual and slides.

Participant materials for session 2 should include:

- Bookmark/ badges/ cards for seminar
- Evaluation for seminar
- Homework: how well do you know your parent/Teen

Parent-Child Communication Basics: An Education Program to Enhance Parent-Child Communication.[67]

(Used with permission from Advocates for Youth) [67]

This 75-minute workplace seminar for parents will introduce them to some basic concepts of effective communication. Participants should be encouraged to utilize the library, the Internet, their local PTA and educational associations, and family and child welfare social services agencies for longer and more in-depth courses in communication. One seminar can accomplish little more than imparting knowledge, opening doors to understanding some of the basics about communication, and encouraging parents to attend other seminars in this series.

The facilitator needs to be comfortable and skilled in human relations, family life, or parenting education.

The seminar is divided into nine sections:

1. Introduction and Review of Agenda, Goal, and Ground Rules
2. Getting Acquainted Communication Exercise
3. What Makes a Family Healthy, Strong, and Successful?
4. Why Is Effective Communication Important?
5. Developmental Tasks of Children and Adolescents
6. Road Blocks and Building Blocks to Effective Communication Exercise
7. Steps of Active Listening
8. Reflecting about Communication With My Children
9. Closing
   a) Summary of Key Elements of Effective Communication
   b) Evaluation.

Forms, transparencies, handouts, and take-home activity sheets for use in the seminar are included in a later section of this notebook. Transparencies, handouts, and take-home activity sheets may be copied and distributed to the participants. (See Suggested Participant's Packets and section on Forms and Transparencies.)

Materials Checklist

The following checklist will help the facilitator prepare for the seminar. It's a good idea to review this checklist before each seminar and make sure everything needed is on hand.

- Overhead Projector and Screen—plus an extra bulb

- Extension Cord—for the overhead projector
- Magic Markers—of the type that can be used on newsprint (not dry erase which has a strong odor and can cause unpleasant side effects)
- Newsprint (Flip Chart), Stand (Easel), and Tape or Push Pins
- 3x5 Cards and Pencils or Pens
- Sign-In Sheets—for participants
- Forms and Transparencies—in order
- Refreshments
- Evaluation Form
- Participant's Packet —one for each participant, plus extras for last minute registrations.

Guide to Setting the Stage

In planning prior to the day of the seminar, consider the following:

- Determine group size. Discussion is more difficult if the group is large. An ideal group is between seven and 15 participants. (This may not be possible due to factors beyond the facilitator's control.)
- Confirm group size through pre-registration to ensure sufficient seating for everyone and plenty of handouts.
- Check out seminar site. All participants should be able to see the facilitator and the overhead projector. The room should be large enough so that all participants can be comfortably seated.
- Put chairs in a circle or semicircle to encourage group discussion. Avoid, if possible, placing chairs in rows.
- Make charts or use transparencies. (See section on Forms and Transparencies.)
- Write the goal of the seminar on a chart. Display the goal prominently throughout the entire seminar. (See section on Forms and Transparencies.)
- Copy transparencies, handouts, and take-home activity sheets. Make sure you have more copies than you have registrants. People who didn't pre-register may show up for the seminar. (SeeSuggested Participant's Packet and section on Forms and Transparencies.)
- Determine whether translators, signers, or other special assistance will be needed.
- Review curriculum and supplemental materials.

- Determine whether and what refreshments will be available.
- If using an external trainer or facilitator, call three days before and confirm.
- Prepare name tags.

75-minute Seminar Curriculum

Prior to Registration (30 minutes before scheduled start time)
Facilitator's responsibilities:

- Set up a registration table with sign-in sheets and name tags
- Place chairs in a circle or semicircle to permit maximum participation and ease of conversation
- Organize handouts that will be distributed to participants (See Suggested Participant's Packet.)
- Display chart on easel or wall with the goal of the seminar
- Display charts on easels or walls or set up transparencies to offer the following information: (See section on Forms and Transparencies.)

    1. Agenda
    2. Goal
    3. Ground Rules
    4. What Makes A Family Healthy, Strong, and Successful?
    5. Why Is Effective Communication Important?
    6. Developmental Tasks of Children and Adolescents
    7. 10 Road Blocks to Effective Communication
    8. Definitions of Road Blocks to Effective Communication
    9. 10 Building Blocks to Effective Communication
    10. Definitions of Building Blocks to Effective Communication
    11. Steps of Active Listening
    12. Reflecting about Communication With My Children.

Registration (15 minutes before scheduled start time)
Facilitator's responsibilities:

- Greet participants
- Ask participants to sign in
- Hand out name tags
- Hand out index cards.

INTRODUCTION AND REVIEW OF AGENDA, GOAL, AND GROUND RULES

10 minutes

Introduction

- Welcome participants, briefly introduce yourself, and describe your previous experience in leading this seminar or seminars of this kind.
- Personalize your introduction with information about your children or children that are important in your life. You want the group to feel that you care about this issue. If you have a communication learning experience, you might share it with the group.
- Share with the group that participants are not necessarily all parents. Some participants may be surrogate parents, family members, or professional caregivers. Use inclusive language, such as partner and/or significant other (rather than husband and wife).
- Ask participants to complete the evaluation forms (in theparticipant's packets) and leave them in a designated place after the seminar.
- Discuss length of seminar (75 minutes) and say that you will start and stop on time.
- Discuss housekeeping—restrooms and refreshments.

Tell participants that you will give them handouts and take-home activity sheets as well as supplemental materials to share with their families, friends, and co-workers. Inform participants that the handouts, take-home activity sheets, and supplemental materials will help them continue to build a lifelong dialogue with their children. You can hand out participants' packets at this time or inform participants that you will do so at the end of the seminar. Packets should include copies of the following:

- Evaluation Form and Transparencies
- Handouts and Take-Home Activity Sheet.

Also inform participants about the availability of supplementary resources, if any, for seminar participants.

Review agenda using transparency or chart

1. Introduction and Review of Agenda, Goal, and Ground Rules
2. Getting Acquainted Communication Exercise
3. What Makes a Family Healthy, Strong, and Successful?
4. Why Is Effective Communication Important?

5. Developmental Tasks of Children and Adolescents
6. Road Blocks and Building Blocks to Effective Communication Exercise
7. Steps of Active Listening
8. Reflecting about Communication With My Children
9. Closing.

Review goal using transparency or chart

- To explore basic concepts of effective communication which enhance relationships between parents and their children.

If you use a transparency to display the goal, you should also display the goal of the seminar on an easel or a wall. Keep the chart prominently displayed throughout the seminar.

Be clear that the seminar is an *introduction* to effective parent-child communication and cannot resolve the concerns or issues of individual participants.

Review ground rules using transparency or chart

Briefly discuss the ground rules. Do not read the transparency or chart, but rather *highlight* the important concepts. Explain that the following ground rules facilitate a comfortable and respectful environment in which all participants may be active and involved.

If you use a transparency to display the ground rules, you should also display the ground rules of the seminar on an easel or a wall. Keep the chart prominently displayed throughout the seminar.

- Each participant has the right to pass.
- Each participant agrees to respect the confidentiality of the other participants. This means that any personal stories shared in the meeting should stay within the room.
- Each participant agrees to listen with respect and without interruption.
- Participants agree to use "I" statements ("I believe …," "I feel …," and "In my opinion …") when offering thoughts or opinions. This reinforces that people hold a variety of values and that each is offering his/her own opinion.
- Participants agree that everyone has a right to his/her feelings and opinions. Other participants may disagree, and that is *their* right.
- Participants agree to hear and respect all questions.

- Participants agree to respect differences, including race, religion, color, national origin, gender, sexual orientation, political affiliation, and age among others.
- Participants agree that parenting values may differ.

These ground rules include some of the most basic and important communication skills, both verbal and nonverbal, that make individuals feel valued and respected. Ask participants to really focus on using these ground rules here in the seminar and in their relationships with their families, friends, and coworkers in the future.

GETTING ACQUAINTED COMMUNICATION EXERCISE

10 Minutes

Goal:
To introduce participants and help them feel comfortable with each other and the facilitator

Materials:
3x5 cards with one stem sentence written or printed on each card (Stem sentences are included here as well as on cards in the Forms and Transparencies section.)

Procedure:
The purpose of this exercise is to introduce everyone and to learn something about each other.

Put the cards into a deck with the stem sentences face down. Explain that each person will tell the group his/her name, give the ages of any children (his/her own children or children for whom the participant is attending the seminar) and read the sentence aloud, completing the sentence quickly and honestly. Tell the group that there are no right or wrong answers, just their first thoughts and feelings. Each individual may pass the deck or go to the next card if he/she doesn't want to complete that sentence. Ask the group to try to associate each person's name with the sentence completed.

The facilitator should go first to model how participants will complete the exercise. Then, hand the deck to one participant with the stem sentences down. Ask him/her to introduce himself/herself by name, tell the ages of his/her children, if any, and read the sentence aloud, completing the sentence quickly and honestly. Tell him/her to put the card on the bottom of the deck and pass the deck to someone else. Each person follows the same procedure until everyone has had the opportunity to complete a sentence.

Thank each participant as he/she completes the stem sentence.

If there are more than 10 participants, have them get into groups of three to four. Ask them to go around the small group, giving their names and ages of their children. Choose three or four stem sentences and read one aloud to each group. Each person in the small group responds to the same question just to their small group.

Thank participants for sharing in the small groups.

Stem Sentences:

Hi! My name is … and my children are ages …

Read and complete the stem sentence on the card.

One thing I love about being a parent is …
In my family, I …
I hope my children …
My father would describe my parenting as …
One thing that frustrates me about being a parent is …
One of my favorite books about parenting is …
I'd like to learn …
When I disagree with my children, I …
When my children get really angry, I …
One of my most important rules about parenting is …
My mother would describe my parenting as …
As a parent, I'm learning to …
One word that describes my family is …
One way I've tried to parent differently than my parents is …
Being a parent is …
One thing we do in my family to communicate better is …
My children would describe me as …
A "teachable" moment is …
One thing I really liked that my parents did …
When I feel sad, I …
I'm proud of my children when …
I feel really close to my children when …
Parents should always …
Parents should never …

Participants' responses to the Getting Acquainted Communication Exercise may indicate that they are aware of some key qualities of healthy, strong, and successful families.

WHAT MAKES A FAMILY HEALTHY, STRONG, AND SUCCESSFUL?

5 minutes

Ask participants to brainstorm functions of healthy, strong, and successful families. What do healthy, strong, and successful families do? What is important to healthy, strong, and successful families? List participants' responses on a transparency or chart.

Relate participants' responses to those they shared during the Getting Acquainted Communication Exercise.

Use the following transparency or chart to review the highlights if participants have not offered the responses. These functions are the "actions" that individuals take in the family—all of which rely on positive communication to ensure that each family member feels capable, loved, and valued.

What Makes A Family Healthy, Strong, and Successful?

- Commitment—Family comes first
- Safety—Families meet the needs of each member; trust and security
- Appreciation—Family members express love often—verbally and nonverbally
- Time together—Quantity and quality are present
- Spiritual wellness—Parents model character and values; actions reflect values
- Coping skills—Parents use and model positive strategies to handle day-to-day pressures
- Communication—Family members express who they are and what they need.

Note for the Facilitator
See the *Strengthening Family Relationships* handout in the Suggested Participant's Packet section for a more in-depth discussion of what makes a family healthy, strong, and successful.

WHY IS EFFECTIVE COMMUNICATION IMPORTANT?

5 minutes

Encourage participants to offer their ideas about why effective communication is important. List participants' responses on a transparency or chart. Use the following five reasons to stimulate the discussion. Acknowledge that other reasons exist and that *all* the reasons are important.

Why Is Effective Communication Important?

- Because we love our children and want them to grow up happy, healthy, and responsible
- Because our children love us and want our guidance, approval, and support
- Because how, what, and when we communicate helps determine how our children will communicate with others
- Because children learn values from our words, our tones, our postures—they all send messages to our children about our beliefs and values
- Because our children will often need good communication skills to address problems or situations in a positive, healthy and affirming manner.

DEVELOPMENTAL TASKS OF CHILDREN AND ADOLESCENTS

Briefly review the four major tasks of children and adolescents using the transparency or chart.

Tell the participants that, as their children move from childhood through adolescence to adulthood, the tasks are clarified and addressed in many ways. Parents play a critical role helping their children make this journey successfully.

Developmental Tasks of Children and Adolescents

To Answer These Questions about Themselves

- Am I Competent?—"What do I do well?"
  Developing skills, abilities, and strengths to prepare for independent lives as adults
- Am I Normal?—"Am I like everyone else?"
  Learning to feel comfortable and at ease with his/her body, thoughts, and feelings while changing from child to adult
- Am I Loving?—"Am I capable of loving others?"
  Learning to contribute to family and society; developing values such as responsibility, respect, and honesty; developing skills of intimacy for healthy relationships
- Am I Lovable?—"Am I loved by others?"
  Learning to be trustworthy and to trust; learning to communicate and listen when others communicate needs, feelings, and desires appropriately.

Communication skills and how they are modeled in a family affects all of these tasks.

Let's look at how we can learn more about effective communication.

ROAD BLOCKS AND BUILDING BLOCKS TO EFFECTIVE COMMUNICATION EXERCISE

Explain that you will be asking them to participate in a discussion of some common ways that our words, the tone of our voice, and the way we approach someone physically can shut or close the door to communication (Road Blocks) or strengthen and build healthy, respectful communication (Building Blocks). Verbal communication is the words we use; nonverbal communication is how we say the words (our tone, emotions, and body language).

In the tables below are some situations that illustrate Road Blocks and Building Blocks to effective communication. Situations or statements from a child are on the left. Possible adult responses are on the right. Included in the manual are two sets of index cards with adult responses on them. The white index cards are the Road Blocks responses and the blue index cards are the Building Blocks responses. The index cards are numbered to correspond to the situations or statements in the tables below. The facilitator will read the situations or statements and the participants will contribute the responses from the index cards.

Road Blocks to Effective Communication

10 minutes

Pass out one white Road Blocks index card to each participant. If you don't have 10 participants, ask some participants to take two index cards. If you have more than 10 participants, some will not receive a Road Blocks card. Make sure that those who do not receive a card, receive a Building Blocks card.

Display the definitions of Road Blocks transparency or chart. Beginning with the Road Blocks, you should read a situation or statement from the left side of the table below and ask the participant who has the corresponding, numbered response to read it with energy, as a parent or adult who might say it in this situation. Briefly demonstrate how you want the participants to complete this exercise.

Referring to the definitions transparency or chart, explain very briefly what this Road Block is called and what it means. If time permits, you may choose to role play some of the situations. Tell participants that you will give them a handout with all the situations or statements and responses to take home. Road Blocks usually start with judging, critical, or demanding words such as "you should …," "you'd better …," and "you're stupid."

You may close the exercise by asking the group to brainstorm feelings they had as the adult's response was read (i.e., hurt, angry, left out, demeaned, and unheard, among other feelings). Or, you may ask participants to share examples of when they have experienced these Road Blocks.

10 Road Blocks to Effective Communication

Situations	Adult Responses (on white index cards)
S-1. Mom, I'm not sure what to do about my class schedule this year. It's really tough with all the extras I've got to do.	R-1. You should take every math and science course offered. You ought to see how important that is.
S-2. Dad, that boy just took my truck.	R-2. It's your problem. You solve it.
S-3. Mom, the jar of glue just fell over on the floor.	R-3. Look what you did! The carpet is ruined! It's all your fault!
S-4. Your 8-year-old got dressed for school—orange and blue shirt, green and yellow striped pants, red socks, sandals, and a baseball hat.	R-4. Only a clown would dress like that for school!
S-5. Dad, it's not my fault my math teacher hates me.	R-5. Let me tell you about my boss. You think you've got trouble!
S-6. I think I'll go to the movies tonight Mom.	R-6. You will not. You're going to stay home and

	study. You're going to bring your grades up.
S-7. But Dad, it's the last night for "Star Wars," and I haven't seen it.	R-7. If you don't study, there will be no car this weekend.
S-8. Mom, I really need to know if I can go to the concert on Saturday night.	R-8. We'll see—I'll think about it.
S-9. I'll pick up the puzzle later Dad.	R-9. I'm not going to tell you again. I've told you ten times to pick it up. Now!
S-10. Your child comes home from school, slams the door shut, drops his/her clothes on the floor, kicks the cabinet, and turns on the TV.	R-10. You frown, cross your arms, tap your foot, and stand in front of your child.

Definitions of Building Blocks to Effective Communication

Verbal		Examples
S-1. Judging	Making a judgment	You should … You ought to …
S-2. Rejecting	Giving no support	It's your problem, not mine.
S-3. Blaming/Criticizing	Placing fault on the other person	It's your fault.

S-4. Labeling	Calling names or words that are negative	Only a dummy would do it that way.
S-5. Transferring	Not listening and jumping in with one's own problems	Let me tell you what happened to me.
S-6. Ordering	Giving solutions with no choices	You must do this now.
S-7. Threatening/Bribing	Using threats or bribes to try to make someone do something	If you don't do what I want … If you do what I want, I'll do this for you.
S-8. Waffling	Not being clear and consistent in setting limits	Well, maybe … We'll see … I'll think about it …
S-9. Nagging	Persistently repeating orders or requests	I've told you a thousand times … How many time do I have to ask you to …
Nonverbal		Examples

S-10. Acting	Using body language that sends negative messages or that rebuffs; being physically abusive	Crossing arms; not looking at speaker; walking away; tapping feet; shaking finger in face; hitting; kicking

Building Blocks to Effective Communication

10 minutes

Pass out one blue Building Blocks index card to each participant. Follow the same procedure with the Building Blocks exercise. Remember to display the definitions of Building Blocks transparency or chart.

10 Building Blocks to Effective Communication

Situations	Adult Responses (on blue index cards)
S-1. Dad, it's been a terrible day. Absolutely horrible—I really messed up!	R-1. Would you like to tell me about it? I'll just listen.
S-2. Look at what I made with my blocks and trucks and sticks!	R-2. You worked a long time to build your city and look at how you used every block.
S-3. I hate you!	R-3. I love you and feel very sad when you say that.
S-4. Mom, I don't know what to do. He says he will break up with me if I don't go all the way.	R-4. What can I do to help you with this tough decision?
S-5. I can't believe that my teacher is giving me a "C" on my paper. I worked	R-5. You sound very frustrated and disappointed? Is that right? Would you like to talk about it?

really hard and did everything he told me to do.	
S-6. She is a good driver. She is careful and makes everyone wear a seatbelt. Can I ride to the lake with her?	R-6. I know I can trust you and you have good judgment.
S-7. Dad, look at me, look at me! I swam to the other side of the pool.	R-7. You are such a good swimmer and know how to be safe in the water.
S-8. You won't believe what she said and did to me. I'll never be her friend again!	R-8. You sound very angry with her. Is that right? Would you like to talk about it?
S-9. I hate him. He's such a dumb-dumb. I don't care if I ever play with him again.	R-9. Can you tell me more about what happened with him?
S-10. Your child comes home from school, slams the door shut, drops his/her clothes on the floor, kicks the cabinet, and turns on the TV.	R-10. You sit next to your child, hold his/her hand, look him/her in the eye, and then tell him/her that you would like to know why he/she is so angry.

Definitions of Building Blocks to Effective Communication

Verbal		Examples
S-1. Listening	Focusing on the present; not bringing up past problems or mistakes; creatingsafety to express anything	I feel that right now you need me to just listen to you.
S-2. Praising	Giving earned rewards frequently; recognizing effortsrather than products or end results	You worked so long and so hard on the project.

S-3. Feeling	Sharing feelings such as anger, joy, and frustration; using "I" statements	I feel … I'm so angry when you … I love you.
S-4. Respecting	Letting others make decisions; avoiding judging and advising; trying to help him/her make his/her own decisions	It's your choice. What can I do to help you?
S-5. Listening	Identifying the feeling as well as the content and asking the person to confirm it	It sounds like you were very frustratedby the class change. Is that right?
S-6. Trusting	Being consistent; asking for input and understanding that children need to learn in their own way even if they make mistakes	I know you will be thoughtful and responsible.
S-7. Affirming	Finding the positiveto express	You are so competent. You make me happy when you …
S-8. Reflective Listening	Reflecting what another says; paraphrasing a person's words so he/she know he/she has been heard	You sound angry about your friend's response. Is that so?
S-9. Clarifying	Asking for more information when unsure	Could you tell me more about your fight with your friend?

Nonverbal		Examples
S-10. Acting	Finding physical ways to show care, concern, and attention	Making eye contact; touching when appropriate; hugging; staying near the person

Close the Building Blocks exercise with discussion as you did for the Road Blocks exercise. Ask the group to brainstorm feelings they had as the adult's response was read. Offer that Building Blocks help people feel valued, listened to, understood, respected, and/or loved. Stress that listening, especially reflective listening, is emphasized as a Building Block because it is the cornerstone of effective communication.

Review the Road Blocks situations by displaying the 10 Road Blocks to Effective Communication.

Ask participants to construct Building Blocks responses to the Road Blocks situations. You may ask participants to pair up or ask for role play volunteers. Have one participant read the situation and the other participant give a Building Block response. You may also ask individual participants to read the situations and ask anyone in the group to offer a Building Block response.

Distribute copies of the Road Blocks and Building Blocks transparencies—both the definitions and the situation/adult responses—(or refer participants to their packets) and summarize this discussion with the following key points.

- Effective, healthy communication skills can be learned.
- Children deserve to learn communication skills from adults who are honest, respectful, and caring.
- Nobody is perfect. We all sometimes lose our patience and say and do things that we regret. But, we can say we're sorry—and use the Building Blocks to strengthen our relationships.

Collect the index cards and return them to the notebook.

STEPS OF ACTIVE LISTENING

10 minutes

Discuss the steps of active listening using the following situation: a 16-year-old teen asks his/her mom, "Can I go to the prom?" Encourage participants to use these active listening steps with their families, friends, and coworkers in the future.

Steps of Active Listening

Steps	Responses
Encouraging Sound open and positive beforeyou make a decision.	"Tell me more about the prom …" "It's wonderful that you want to go …"
Fact Finding Get information to make a decision or state your ideas. Who, what, where, when, why, how?	"I need more information …" "Tell me more …"
Restating Understand the facts; be clearabout what the other person is asking.	"What you're asking me is can you go to the prom and stay out all night?"
Reflecting Identify your feelings and the feelings of the other person.	"I know you're excited about the prom and you will probably be disappointed that you cannot stay out all night. I am glad that you get to go."
Summarizing Clearly state the decision or agreement.	"This is my decision … you can go to the prom, go to the party afterwards, and be home by 2 am." OR "This is what we agreed upon … you can go to the prom, go to the party afterwards, and be home by 2 am. Is that right?"

REFLECTING ABOUT COMMUNICATION WITH MY CHILDREN

5 minutes

Ask participants to pair up with someone else and take turns completing each of the following stem sentences with their partners.

Or, you may distribute blank index cards and ask participants to write their responses to each of the following stem sentences on the card. You may ask each participant to read his/her response. Alternatively, you may collect and shuffle the cards and redistribute them so no one has his/her own card. Say that if someone gets his/her card, it's okay. No one else will know. Ask a few of the participants to share the card's message on reflecting on communication.

Reflecting about Communication With My Children

- Today I learned …
- One thing I am going to do differently than my parents is …
- One thing I am really proud of is …

CLOSING

5 minutes

- Use the Agenda transparency or chart to summarize key elements of effective communication.
- Thank participants for taking time to participate in the seminar.
- Request participants to complete the evaluation form and leave it on the registration table.
- Review handouts and take-home activity sheets with the participants.
- Thank the sponsor, if any, of the seminar.
- Request that participants recommend the program to their PTA, church, mosque, synagogue, or neighbourhood group.
- Remind participants that you are available to answer questions.
- Collect the stem sentence cards and replace them in the envelope in the notebook. Return all transparencies to the notebook.

Transparencies:

1.Agenda:

1. Introduction and Review of Agenda, Goal, and Ground Rules
2. Getting Acquainted Communication Exercise
3. What Makes a Family Healthy, Strong, and Successful?
4. Why Is Effective Communication Important?
5. Developmental Tasks of Children and Adolescents
6. Road Blocks and Building Blocks to Effective Communication Exercise
7. Steps of Active Listening
8. Reflecting about Communication With My Children
9. Closing

2.Goals:

To explore basic concepts of effective communication which enhance relationships between parents and their children.

3.Ground Rules:

Each participant has the right to pass.
Each participant agrees to respect the confidentiality of other participants.
Each participant agrees to listen with respect and without interruption.
Participants agree to use "I" statements.
Participants agree that everyone has a right to his/her opinions and feelings.
Participants agree to hear and respect all questions.
Participants agree to respect differences.
Participants agree that parenting values may differ.

4.What makes a family Healthy, Strong and Successful:

Commitment—Family comes first
Safety—Families meet the needs of each member; trust and security
Appreciation—Family members express love often—verbally and nonverbally
Time Together—Quantity and quality are present
Spiritual Wellness—Parents model character and values; actions reflect values
Coping Skills—Parents use and model positive strategies to handle pressures
Communication—Family members express who they are and what they need.

5.Why is effective communication important?

Because we love our children and want them to grow up happy, healthy, and responsible
Because our children love us and want our guidance, approval, and support

Because how, what, and when we communicate helps determine how our children will communicate with others
Because children learn values from our words, our tones, our postures—they all send messages to our children about our beliefs and values
Because our children will often need good communication skills to address problems or situations in a positive, healthy, and affirming manner.

6.Developmental Tasks of Children and Adolescents:

To Answer These Questions about Themselves

Am I Competent?—"What do I do well?"
Am I Normal?—"Am I like everyone else?"
Am I Loving?—"Am I capable of loving others?"
Am I Lovable?—"Am I loved by others?"

7. 10 Road Blocks to Effective Communication:

SITUATIONS	ADULT RESPONSES (ON WHITE INDEX CARDS)
S-1. Mom, I'm not sure what to do about my class schedule this year. It's really tough with all the extras I've got to do.	R-1. You should take every math and science course offered. You ought to see how important that is.
S-2. Dad, that boy just took my truck.	R-2. It's your problem. You solve it.
S-3. Mom, the jar of glue just fell over on the floor.	R-3. Look what you did! The carpet is ruined! It's all your fault!
S-4. Your 8-year-old got dressed for school—orange and blue shirt, green and yellow striped pants, red socks, sandals, and a baseball hat.	R-4. Only a clown would dress like that for school!
S-5. Dad, it's not my fault my math teacher hates me.	R-5. Let me tell you about my boss. You think you've got trouble!

S-6. I think I'll go to the movies tonight Mom.	R-6. You will not. You're going to stay home and study. You're going to bring your grades up.
S-7. But Dad, it's the last night for "Star Wars," and I haven't seen it.	R-7. If you don't study, there will be no car this weekend.
S-8. Mom, I really need to know if I can go to the concert on Saturday night.	R-8. We'll see—I'll think about it.
S-9. I'll pick up the puzzle later Dad.	R-9. I'm not going to tell you again. I've told you ten times to pick it up. Now!
S-10. Your child comes home from school, slams the door shut, drops his/her clothes on the floor, kicks the cabinet, and turns on the TV.	R-10. You frown, cross your arms, tap your foot, and stand in front of your child.

8. Definitions of Road Blocks to Effective Communication

VERBAL		EXAMPLES
S-1. Judging	Making a judgment	You should … You ought to …
S-2. Rejecting	Giving no support	It's your problem, not mine.
S-3. Blaming/Criticizing	Placing fault on the other person	It's your fault.
S-4. Labeling	Calling names or words that are negative	Only a dummy would do it that way.

S-5. Transferring	Not listening and jumping in with one's own problems	Let me tell you what happened to me.
S-6. Ordering	Giving solutions with no choices	You must do this now.
S-7. Threatening/Bribing	Using threats or bribes to try to make someone do something	If you don't do what I want … If you do what I want, I'll do this for you.
S-8. Waffling	Not being clear and consistent in setting limits	Well, maybe … We'll see … I'll think about it …
S-9. Nagging	Persistently repeating orders or requests	I've told you a thousand times … How many time do I have to ask you to …
NONVERBAL		EXAMPLES
S-10. Acting	Using body language that sends negative messages or that rebuffs; being physically abusive	Crossing arms; not looking at speaker; walking away; tapping feet; shaking finger in face; hitting; kicking

9.10 Building blocks to effective ways of communication:

SITUATIONS	ADULT RESPONSES (ON BLUE INDEX CARDS)

S-1. Dad, it's been a terrible day. Absolutely horrible—I really messed up!	R-1. Would you like to tell me about it? I'll just listen.
S-2. Look at what I made with my blocks and trucks and sticks!	R-2. You worked a long time to build your city and look at how you used every block.
S-3. I hate you!	R-3. I love you and feel very sad when you say that.
S-4. Mom, I don't know what to do. He says he will break up with me if I don't go all the way.	R-4. What can I do to help you with this tough decision?
S-5. I can't believe that my teacher is giving me a "C" on my paper. I worked really hard and did everything he told me to do.	R-5. You sound very frustrated and disappointed? Is that right? Would you like to talk about it?
S-6. She is a good driver. She is careful and makes everyone wear a seatbelt. Can I ride to the lake with her?	R-6. I know I can trust you and you have good judgment.
S-7. Dad, look at me, look at me! I swam to the other side of the pool.	R-7. You are such a good swimmer and know how to be safe in the water.
S-8. You won't believe what she said and did to me. I'll never be her friend again!	R-8. You sound very angry with her. Is that right? Would you like to talk about it?

S-9. I hate him. He's such a dumb-dumb. I don't care if I ever play with him again.	R-9. Can you tell me more about what happened with him?
S-10. Your child comes home from school, slams the door shut, drops his/her clothes on the floor, kicks the cabinet, and turns on the TV.	R-10. You sit next to your child, hold his/her hand, look him/her in the eye, and then tell him/her that you would like to know why he/she is so angry.

10. Definition of building blocks of communication:

VERBAL		EXAMPLES
S-1. Listening	Focusing on the present; not bringing up past problems or mistakes; creatingsafety to express anything	I feel that right now you need me to just listen to you.
S-2. Praising	Giving earned rewards frequently; recognizing effortsrather than products or end results	You worked so long and so hard on the project.
S-3. Feeling	Sharing feelings such as anger, joy, and frustration; using "I" statements	I feel … I'm so angry when you … I love you.
S-4. Respecting	Letting others make decisions; avoiding judging and advising; trying to help him/her make his/her own decisions	It's your choice. What can I do to help you?
S-5. Listening	Identifying the feeling as well as the content and	It sounds like you were

	asking the person to confirm it	very frustratedby the class change. Is that right?
S-6. Trusting	Being consistent; asking for input and understanding that children need to learn in their own way even if they make mistakes	I know you will be thoughtful and responsible.
S-7. Affirming	Finding the positiveto express	You are so competent. You make me happy when you …
S-8. Reflective Listening	Reflecting what another says; paraphrasing a person's words so he/she know he/she has been heard	You sound angry about your friend's response. Is that so?
S-9. Clarifying	Asking for more information when unsure	Could you tell me more about your fight with your friend?
NONVERBAL		EXAMPLES
S-10. Acting	Finding physical ways to show care, concern, and attention	Making eye contact; touching when appropriate; hugging; staying near the person

11.Steps of Active listening:

STEPS	RESPONSES
Encouraging Sound open and positive beforeyou make a decision.	"Tell me more about the prom …" "It's wonderful that you want to go …"

Fact Finding Get information to make a decision or state your ideas. Who, what, where, when, why, how?	"I need more information …" "Tell me more …"
Restating Understand the facts; be clearabout what the other person is asking.	"What you're asking me is can you go to the prom and stay out all night?"
Reflecting Identify your feelings and the feelings of the other person.	"I know you're excited about the prom and you will probably be disappointed that you cannot stay out all night. I am glad that you get to go."
Summarizing Clearly state the decision or agreement.	"This is my decision … you can go to the prom, go to the party afterwards, and be home by 2 am." OR "This is what we agreed upon … you can go to the prom, go to the party afterwards, and be home by 2 am. Is that right?"

12.Reflecting about communicating with my child:

- Today I learned …
- One thing I am going to do differently than my parents is …
- One thing I am really proud of is …

Distribute session 2 Homework.
-How well do you know your parent/teen.

Session 3: Tips for parents part 1 (60 min)

(Tip 1-10 are based on the National Campaign Ten Tips for Parents. The materials have been used with permission from the National Campaign).[68]

-Weekly check in /discussion about homework (10 min)

-Go over tips 1-3: (45 min)

Participants Material for session 3 should include:

- 10 tips for parents book (The National Campaign)
- TV talk show guide.
- Let's talk guide.
- Copy of CDC Frequently Asked Questions regarding contraception
- Copy of CDC contraception effectiveness slide.

Tip 1:

Be clear about your own sexual values and attitudes

- IN CLASS EXERCISE: Ask parents to spend 5 minutes answering the following questions:

.What do you really think about school-aged teenagers being sexually active — perhaps even becoming parents?

.Who is responsible for setting limits in a relationship and how is that done, realistically?

. Were you sexually active as a teenager and how do you feel about that now? Were you sexually active before you were married? What do such reflections lead you to say to your own children about these issues?

. Is abstinence best for teens? What do think about teens using contraception?

Tip 2:

Talk to your kids early and often about sex and be specific

-Examples of two situations where you can start the conversation:

1. Let's Talk TV Guide (How to use the TV)

https://www.youtube.com/watch?v=lyeR7_mfdQ4 (using the TV)

Remind participants that they can refer to the TV guide in their folder for reference when using technique at home.

2. Teachable Moment:

https://www.youtube.com/watch?v=c7V08Q02ucg (teachable moment)

-Be an Askable parent:

(Used with permission from planned parenthood).[69]

Types of Questions that teenagers ask include:

How do you know when puberty is over?

A. It can be hard to tell. Some people don't experience all the changes that happen during puberty until they're 20 years old. But it can end earlier than that. Do you have other questions about puberty?

Q. How big will my breasts get?

A. It depends. Breasts come in all sizes, shapes, and colors. And when they're developing, they change all the time. Breasts can range from small to enormous. Whether yours are lemons or grapefruits, they're normal.

Q. Is it true that a girl can't get pregnant the first time she has sex?

A. No, that's not true. If you're having vaginal intercourse and not using condoms or other birth control, you can get pregnant — whether it's the first time or the one hundred and first time. That's why most people use birth control the first time they have sex.

Q. What's the best birth control method?

A. Different methods of birth control are best for different people. That's why it's important to learn about each method of birth control so you can choose the one that best for you. (Teens who are thinking about birth control might find it helpful to use My Birth Control.)

Q. Should people have sex if they're in love?

A. Not necessarily. Sex is just one part of a whole relationship. It's just one way to express love. Choosing to be in a sexual relationship is a big decision. There's a lot to think about. And two people can love each other very much without having sex. Do you think you're in love?

Q. Does it hurt to lose your virginity?

A. Some women experience pain the first time they have vaginal intercourse. That's because they may have a hymen in the opening of their vaginas that gets stretched open during first intercourse and may cause pain and bleeding. Guys do not have hymens, so this is not an issue for them. Do you have other questions about virginity?

Tip 3:

Used with permission from Advocates for Youth.[67]

How to deal with the concern that talking about both abstinence and contraception may a mixed message

Even if you as the parent do not talk about both messages with your children, in today's media dominated world they are being bombarded by multiple messages

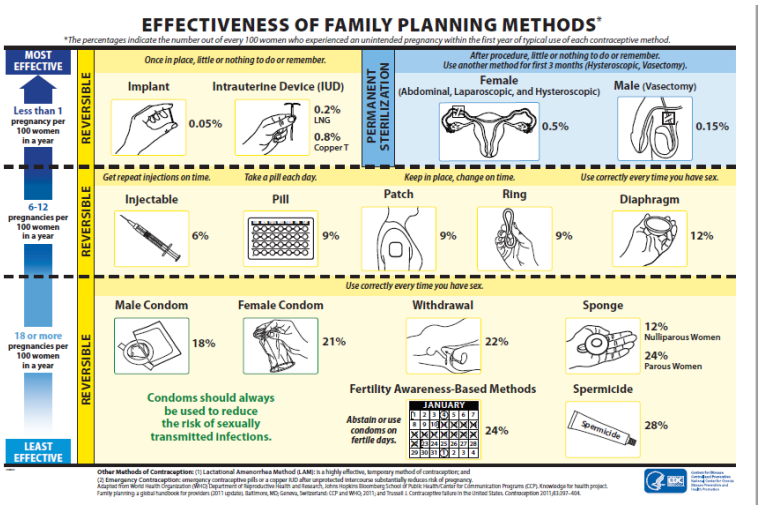
To deal with this you must send a clear message

I feel very strongly that ***not*** having sexual intercourse while you are a teenager is your best option. It is also important for you to receive information about birth control or protection, so that someday, when you are ready to have intercourse, you will be better prepared to prevent an unplanned pregnancy or disease.

In Class Exercise:

Role playing session on how to deliver that message.

-Share information with parents regarding contraception (power point/ answer any questions they may have).


EFFECTIVENESS OF FAMILY PLANNING METHODS*
*The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.
MOST EFFECTIVE
Less than 1 pregnancy per 100 women in a year
6-12 pregnancies per 100 women in a year
18 or more pregnancies per 100 women in a year
LEAST EFFECTIVE
REVERSIBLE
Once in place, little or nothing to do or remember.
Implant
0.05%
Intrauterine Device (IUD)
0.2% LNG
0.8% Copper T
PERMANENT STERILIZATION
After procedure, little or nothing to do or remember.
Use another method for first 3 months (Hysteroscopic, Vasectomy).
Female (Abdominal, Laparoscopic, and Hysteroscopic)
0.5%
Male (Vasectomy)
0.15%
REVERSIBLE
Get repeat injections on time.
Take a pill each day.
Keep in place, change on time.
Use correctly every time you have sex.
Injectable
6%
Pill
9%
Patch
9%
Ring
9%
Diaphragm
12%
REVERSIBLE
Use correctly every time you have sex.
Male Condom
18%
Female Condom
21%
Withdrawal
22%
Sponge
12% Nulliparous Women
24% Parous Women
Condoms should always be used to reduce the risk of sexually transmitted infections.
Fertility Awareness-Based Methods
Abstain or use condoms on fertile days.
JANUARY
24%
Spermicide
28%
Other Methods of Contraception: (1) Lactational Amenorrhea Method (LAM): is a highly effective, temporary method of contraception; and (2) Emergency Contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.
Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011, and Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397-404.

Session 4: Setting Boundaries Tip 4-10 (60 min)

(Tips 1-10 are based on The National Campaign Ten Tips for Parents. Material has been used with permission from the National Campaign).[68]

-Weekly check in (10 min)
-Tips 4-10 (45 min)

Participant material for session 4 should include:

-10 tips for parents (The National Campaign)

- List of resources for families.

Tip 4: Supervise and monitor your children and adolescents:

As much as possible, try to have an adult at home when teens are there. This could be a parent, a neighbor, or another family member. Teens are more likely to take part in risky behavior when they have friends over with no adult around. And when it's not possible for an adult to around, we can make sure we touch base with our teens frequently while they are alone by phone or text.

Encourage teens to get involved in activities where an adult will be around — like afterschool clubs or sports.

When teens go to parties, make sure there will be an adult there. We can call the parents of the teen who is having the party. We might even offer to help supervise the party.

If hosting a party, keep alcohol, drugs, and tobacco out. If we choose to let our teens have parties, it's important that we stay home during it and make sure only invited guests are allowed in. We can also ask guests to leave bags and jackets in a safe place when entering the party to help prevent guests from bringing in alcohol and other drugs.

Tip 5: Discourage early, frequent and steady dating:

Discourage younger teens from hanging out with older teens. Older teens are more likely to take risks, so this can lead to trouble.

Do not encourage teens to date. A romantic partner can have a big influence on teens, and this influence may not always be good. Teens who date early are more likely to engage in risky behaviors. This is even more likely when teens date people much older. This does not mean that we should forbid our teens from dating. But there's no need for us to encourage it. Keep in mind that for many teens dating a specific person lasts for a short period of time, but dating is closely connected to the likelihood of being sexually active. If our teens are dating, we can try to help them from keeping things from getting "too serious" too quickly.

-Show video on consent: *https://www.youtube.com/watch?v=fGoWLWS4-kU*

Tip 6:Know your Children's friends and their families

Support teens spending time with friends who are good influences. Encourage them to have a number of friends.

Know our teens' friends. We can take the time to talk with our teens and their friends about what makes a good relationship.

Talk with other parents. We can get to know the parents of our teens' friends and stay in touch with them.

Tip 7: Know what your kids are watching reading and listening to:

Keep track of your teens online. It's important to set clear expectations about Internet and cell phone use and online communication, and to talk with our teens about how they spend time online.

Here are some tips :

Protect your privacy. There's no such thing as sharing information only with a select group of friends online. Anyone can forward the information to others outside the group. It's also easy to track down people through screen names, e-mail addresses, and other online profile information. And because it's so easy for people to disguise who they are on social networking sites and on e-mail, you don't always know who you're interacting with. So never post or send anything you wouldn't want the whole world to see.

• **Be careful with humor**. Even if you think it's obvious that you're just kidding, not everyone will get the joke. If you want to post or send something that's meant to be playful — especially something sexy — make that clear in your message.

• **Be yourself**. Your best friend thinks it would be fun to post naked pictures of yourselves? Your boyfriend wants you to "sext" him? If you don't feel comfortable with it, don't do it. Also be aware that in many places, it's illegal to send nude or semi-nude pictures of minors — even if you are a minor, so sexting can have very serious consequences.

• **It's permanent and easily shared**. You had second thoughts about that sexy photo you posted, so you deleted it. But someone else already copied it and posted it to another site. And someone else downloaded it and texted it to a friend. And somehow, it landed in your teacher's inbox.

Tip 8: Help your teenager to have options for the future that are more attractive than early pregnancy and parenthood:

If their future appears bright your teenager is more likely to delay having sex, pregnancy and parenthood. Help them set meaningful goals for the future, talk to them about what it means to help future goals come true, and helping them reach those goals. Helping them use their spare time in useful community service that will teach job skills and help them come in contact with an array of committed and caring adults.

Let you kids know you value education highly. Limit number of hours spent at work to less then 20 hours per week

Tip 9: Be available.

It's important that we make sure our teen knows how to contact us at any time.

Tip 10: Continue to work on developing and maintaining a strong lose relationship with your children.

-Refer to skills used in session 2.

Appendix B Grant Submitted to President's Cabinet Award

PARENT BASED TEEN PREGNANCY PREVENTION PROGRAM

II. PROPOSAL

A. Project Description

Introduction:

Teen pregnancy has health, economic and social implications for teen mothers, their unborn child, their families and the community in which they live. As a part of Dr. Jamal's Masters of Public Health practice and capstone projects with the department of Preventive Medicine and Community Health (PMCH), we reached out to several community stakeholders and leaders to share local youth risk behaviour data on teen sexual behaviour, teen pregnancy and its associated risks in Galveston County. Based on the feedback generated from these community meetings, it was decided that a parent-based teen pregnancy prevention program, which targets parent-adolescent communication regarding teen sexual health, would best suit our community needs. The program will be run in collaboration with the Department of Preventive Medicine and Community Health (PMCH), the Department of Family Medicine, and Galveston County Health District.

Problem Statement:

In the United States, the highest teen birth rates are found in southern states. The state of Texas has the 5th highest reported teen birth rate in the country.[1] Teenage pregnancy rates are higher in Texas for multiple reasons, including inconsistent sex education programs, lack of access to family planning services and high rates of unintended pregnancy. These higher rates come with medical, public health, and societal implications. Teen mothers have an increased predisposition to medical complications of pregnancy, including higher pre-eclampsia rates, pre-term deliveries, increased maternal mortality and operative vaginal deliveries.[2] In addition, for women under the age of 19, four out of five pregnancies are unintended.[3] This predisposes teen parents and their children to even further negative outcomes, including a decreased likelihood to graduate from high school, and earning an average of $3,500 less per year compared to parents who delay child bearing till their 20s. They also receive twice as much federal aid for nearly two times as long. Texas tax payers in 2010 alone spent $1.1 billion on teen pregnancy.[4] Furthermore, teenage mothers are more likely to have daughters who also become adolescent mothers and sons who have a greater likelihood of being incarcerated.[2]

Recently, the Galveston Youth Risk Student Survey of 2014 was analysed and the report was compiled. Based on the reports from the survey, which had a 78% response rate from all students attending Ball High School, we now have a glimpse of the prevailing situation with regards to teen pregnancy and parental involvement on the Island. According to the survey, nearly half of all 9th-12th grade students (44.7%) are sexually active and nearly 20% report having had sexual intercourse before the age of 13.[5] Furthermore, of those students that are sexually active, one in six report they have either been pregnant or got someone pregnant.[5] These rates are higher than both state and national levels. In addition, only 47% of the

students were living in a two parent household, compared to a national level of 65%.[6] The report also shows that almost 80% of parents do not keep regular track of their children's media usage, which studies show is one of the primary sources of teen sexual health information.[7]

Studies confirm a need for coordinated, complementary programs to improve adolescent sexual health.[8] An approach that evidence-based research has shown to be effective in preventing teen pregnancy, yet has not been implemented in our community, is a program targeted towards increasing parent-child communication regarding teen sexual health. According to the National Campaign, teens report that parents most influence their decisions about sex.[9] However, 57% parents report being uncomfortable when talking to their teen about sexual health.[10] In the absence of comprehensive sexual education at school, we propose developing and implementing a community based Teen Pregnancy Prevention program targeted towards improving the knowledge and communication skills of parents with children between the ages of 11-16 years, using sites provided by local community centers and churches.

Goal:

The goal of our project is to develop and implement a parent based teen pregnancy prevention program that increases parent-adolescent communication regarding teen sexual heath. The program will specifically be modified to our community needs in Galveston, using evidence-based tools and resources from the US department of Health and Human Services, the Centers for Disease Control and Prevention, the Advocates for Youth Campaign and the National Campaign. These tools are recommended for: improving parent to child communication regarding teen sexual health, increasing the age of teen sexual initiation, decreasing teen pregnancy and its associated risks, and increasing community involvement and awareness.

Objectives:

Short-term:

1. Increase parent knowledge regarding teen pregnancy and its associated risks in Galveston.
2. Increase parent to child communication regarding teen sexual health with a focus on preventing teen pregnancy.
3. Provide parents with resources and reliable tools to communicate with their child regarding teen sexual health.

Long-term:

1. Decrease teen pregnancy rates in Galveston, Texas.
2. Increase knowledge of teenagers regarding teen sexual health.
3. Increase community awareness regarding the deleterious effects of teen pregnancy in Galveston.

Strategies:

We have already met with various community leaders and stakeholders including the Galveston County Health District, Galveston Island Community Research Advisory Committee, Galveston Urban Ministries, and several faith based organizations on the Island. These conversations informed community members about local youth risk behavioral data, provided insight into the appropriate types of programs, program components, and community settings for program implementation, and helped establish buy-in. We have also met with clinicians, researchers and social workers at the teen health clinic in Ball High School and UTMB, who have extensive experience with preventing teen pregnancy and providing adolescent health care on the Island. Based on these community meetings, decisions were made about the core components and program structure. In addition, several churches and community organizations and centres have agreed to host sessions at their premises and recruit members and clients for the parent based teen pregnancy prevention program.

The program will include a series of 4-6 educational and skill-building sessions with minor modifications to better meet the each center's participant needs. Each session will be 60-75 minutes long, and will have no more than 20 parents who have children between the ages of 11-16 years of age. The sessions will cover topics pertaining to improving parent to child communication on teen sexual health, teen pregnancy and its associated risks, and relevant issues such as communicating the concept of consent, parental values, and teen support. These tools will be provided and skills will be taught to parents through group discussions, presentations, videos, role playing, and take-home exercises.

The sessions will be facilitated by UTMB General Preventive Medicine and Family Medicine Residents, which will be a requirement of their community medicine rotation, and other student organizations, including the Public health Organization (PHO). Each facilitator will attend a two hour session run by us in conjunction with the Family Medicine fellows and Behavioural Medicine Faculty to ensure uniformity and quality teaching. We will provide participants with healthy snacks, a participant folder that will include materials for the course, and on-site child care for the duration of the sessions. The program and evaluation will be shared by presenting at national public health meetings such as the American College of Preventive Medicine and Texas Public Health Association.

Timeline:

If successful in obtaining funding through this award, the program will be implemented at the first center in November 2016. This will allow us time to make the necessary purchases and print educational materials. After the completion of the 4-session course at the first center, the program will then roll out to three other hosting centres on the Island through the course of the fiscal year. The sessions will be held on a weekly or fortnightly basis (based on each center's preference). We will be accompanied by General Preventive Medicine and Family Medicine residents who will assist in facilitating sessions as a requirement for their community medicine rotation. We are requesting funding for one year.

Definition of need:

Teenagers at our local high school are at risk of unsafe sexual behaviour and teen pregnancy. In the absence of a comprehensive, uniform sexual health curriculum in the high

school, we will fill a community need by educating parents about the need to increase communication with their children regarding teen sexual health and imparting effective tools and resources they can employ to increase their knowledge and skills.

The Project is an interdepartmental effort between the Department of Preventive Medicine and Community Health and the Department of Family Medicine. Residents from both departments along with medical and public health students will be involved in the execution and implementation of the program.

This project will recognize the shared interests of the university and its surrounding community in promoting a safe, healthy, supportive and collaborative environment by allowing Fellows, residents and students across several different departments to become community teachers and work with various community organizations, towards the ultimate goal of decreasing teen pregnancy and its associated risks in Galveston, County. In addition, engagement of UTMB faculty, fellows, residents, students and the broader community, working toward a common goal, can build individual, interprofessional, organizational, and community capacity.

Ongoing Activity After President's Cabinet Award:

Once the President's Cabinet Award is depleted, we plan to continue our outreach efforts into the community. Involvement of churches, community-based organizations, other community members, Family Medicine Residents, and other student organizations will help facilitate sustainability of the program. After a one year pilot of the program and completion of the short-term evaluation, we anticipate that we will be able to continue running the program through community partnership and relationships we have built. We also plan to research other funding opportunities from both within the university and outside sources for expansion into more centres in Galveston County.

B. Project Budget:

Amount Requested: $7,950 over one year

	Year 1/overall
	Requested
Supplies and Educational Materials: Facilitators guide for 4 providers $240, brochures/posters $100, shipping and handling $150, Participant folders for 60 participants $3500.	$3,990
Healthy Snacks	$950
Books for participating centers/church leaders ("Countering the silence: a faith leaders tool kit for preventing teen pregnancy" $10 dollars each with shipping and handling)	$100
Childcare	$910

Laptop + mobile projector (for projecting videos and slides during the sessions-one time purchase)	$1000
Travel expense to present findings at national public health meeting	$1000
Award Request Total	$7,950

Impact Statement:

These funds will allow us to implement and evaluate a Teen Pregnancy Prevention Program that will be developed by July 2016 tailored along with an evaluation plan specifically for Galveston County. Based on 2014 survey data, some students at Ball High School are at risk for unsafe sexual behaviours and teen pregnancy. Adopting an approach that is supported by literature and informed by the community, we will be able to empower parents to step up and become the primary teachers with regards to their child's sexual health. In fact, "seven in ten teens agree it would be much easier for them to postpone sexual activity and avoid teen pregnancy if they were able to have more open, honest conversations about these topics with their parents".[11] This collaborative effort between the university and various community partners will serve as a protective factor against teen pregnancy.

C. Project Evaluation and Stewardship:

An evaluation plan for the program will be designed as a part of Dr. Jamal's public health capstone project and Practice experience. In addition, inputs, activities, outputs and outcomes (short, medium and long-term) will be established, based on community feedback and needs, and placed in a logic model format. An evaluation matrix to evaluate each outcome will be designed. Evaluation activities will include a pretest knowledge survey's before each session and a posttest survey at the completion of the entire 4-session program. In addition, we will review at-home exercises, request participant feedback about the program, and consider feedback generated from group discussions to make any modifications that may be needed. We will also periodically observe facilitators for consistent implementation of the program components and request feedback from the program facilitators about what works and what could be improved. We will make adjustments to improve the program quality where necessary. While long-term outcomes cannot be evaluated as part of the one-year program, we will track these outcomes as the program expands in the future. We will provide status reports at six months and one year as required.

References:

1. The National Campaign to prevent teen and unplanned pregnancy. Teen Birth Rate comparison,2014. https://thenationalcampaign.org/data/compare/1701
2. Centers for Disease Control and Prevention. Reproductive Health: Teen Pregnancy. http://www.cdc.gov/teenpregnancy/about/
3. Finer L, Zolna M. Unintended pregnancy in the United States: Incidence and Disparities, 2006. *Contraception*. 2011 Nov; 84(5): 478–485.

4. The National Campaign. Counting it up. The public costs of Teen Childbearing in Texas in 2010.
5. Croisant S.A, Wallace B, Anthony A. The Galveston Youth Risk Student Survey, 2014.
6. Data for 2008-2015: Child Trends calculation of US Census Bureau, Current Population Survey, Annual Social and Economic Supplement.
7. Strasburger, V. C. American Academy of Pediatrics. Policy statement--sexuality, contraception, and the media. *Pediatrics.* Sep 2010, 126 (3) 405-407; DOI: 10.1542/peds.2010-1463.
8. Venkatraman Chandra-Mouli,,Catherine Lane,,Sylvia Wong. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. Global Health: Science and Practice 2015 (3) 333-340.
9. The National Campaign to prevent teen and unplanned pregnancy. With One Voice 2012: Highlights from a Survey of Teen and Adults about Teen Pregnancy and Related Issues.
10. New Poll: Parents are Talking With Their Kids About Sex but Often Not Talking Harder Issues"; Kantor and Guilamos-Ramos, "New 'Let's Talk Month' Poll Remind Us That Sex Ed Begins with Parents.
11. The National Campaign to prevent teen and unplanned pregnancy. Ten Tips for Parents to help their children avoid teen pregnancy.

III. LETTERS OF SUPPORT:

A. Kathy Barroso, CPA, Chief Executive Officer, Galveston County Health District.
B. Victor S. Sierpina, MD, Professor, Family Medicine Director Medical Student Education.

References

1. UNFPA. Motherhood in childhood: Facing the challenge of adolescent pregnancy. State of World population 2013.
2. Croisant S.A, Wallace B, Anthony A. The Galveston Youth Risk Student Survey, 2014.
3. Data for 2008-2015: Child Trends calculation of US Census Bureau, Current Population Survey, Annual Social and Economic Supplement.
4. Strasburger, V. C. American Academy of Pediatrics. Policy statement--sexuality, contraception, and the media. Pediatrics. 2010; 126 (3): 405-407. doi: 10.1542/peds.2010-1463.
5. Chandra-Mouli V, Lane C, Wong S. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. *Global Health: Science and Practice*. 2015; 3: 333-340.
6. The National Campaign to prevent teen and unplanned pregnancy. With One Voice 2012: Highlights from a Survey of Teen and Adults about Teen Pregnancy and Related Issues.
7. Hutchinson MK, Jemmott JB 3rd, Jemmott LS, Braverman P, Fong GT. The role of mother–daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: a prospective study. *J Adolesc Health.* 2003;33(2):98-107.
8. Karofsky PS, Zeng L, Kosorok MR. Relationship between adolescent-parental communication and initiation of first intercourse by adolescents. *J Adolesc Health.* 2000;28(1):41-5.
9. DiClemente RJ, Wingood GM, Crosby R, Cobb BK, Harrington K, Davies SL. Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *J Pediatr.* 2001;139(3):407-12.
10. New Poll: Parents are Talking With Their Kids About Sex but Often Not Talking Harder Issues"; Kantor and Guilamos-Ramos, "New 'Let's Talk Month' Poll Remind Us That Sex Ed Begins with Parents.
11. Kirby D. Emerging Answers: research findings on programs to reduce teen pregnancy. Washington (DC): National Campaign to Prevent Teen Pregnancy; 2001. Available from: http://www.teenpregnancy.org/resources/data/report_summaries/ emerging_answers/
12. Teen Pregnancy Rates Declined in Many Countries Between the Mid 1990s And 2011. Guttmacher institute website. Published January 23, 2015. Accessed March 3, 2016.
13. World Health Organization. Maternal, newborn, child, and adolescent health. At http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy /en
14. Gilda Sedgh, Sc.D. , Lawrence B. Finer, Ph.D., Akinrinola Bankole, Ph.D., Michelle A. Eilers, and Susheela Singh, Ph.D. Adolescent Pregnancy, Birth, and Abortion

Rates Across Countries: Levels and Recent Trends. *Journal of Adolescent Health.* 2015;56: 223-230.
15. The National Campaign to Prevent Teen and Unplanned Pregnancy. Fast Facts. Teen Childbearing in the United States, 2014 Birth Data. Published January 2016. Accessed April 16th , 2016.
16. U.S Department of Health and Human Services. Office of Adolescent Health. Reproductive Health. Texas Adolescent Reproductive Health Facts. At http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/fact-sheets/state.html?s=texas
17. County Health Rankings Texas.2016.
18. Community Health Status Indicators. Centers for Disease Control and Prevention web site. http://wwwn.cdc.gov/CommunityHealth/info/AboutProject/TX/Galveston/. Accessed May 13th, 2016.
19. . Social Determinants and Eliminating Disparities in Teen Pregnancy. Centers of Disease Control and Prevention web site. At http://www.cdc.gov/teenpregnancy/prevent-teen-pregnancy/social-determinants-disparities-teen-pregnancy.htm. Accessed April 20th , 2016.
20. K Kost, S Henshaw. U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity. May 2014.
21. Penman-Aguilar A, Carter M, Snead MC, Kourtis AP. Socioeconomic disadvantage as a social determinant of teen childbearing in the U.S. *Public Health Rep*. 2013;128(suppl 1):5-22.
22. Boonstra HD. Teen pregnancy among women in foster care: a primer. Guttmacher Policy Review. 2011;14(2).
23. Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, et al. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA* 1997;278(10):823-32.
24. Centers for Disease Control and Prevention. Achievements in public health, 1900–1999: Family planning. *MMWR Weekly*. 1999 Dec 3;48(47):1073-80. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847a1.htm
25. Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, New England Journal of Medicine, 2016, 374(9):843-852. doi: http://nejm.org/doi/full/10.1056/NEJMsa1506575
26. Sonfield A, Kost K. Public costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care National and State Estimates for 2010. New York, NY: Gutt-macher Institute;2015. Available from: http://www.guttmacher.org/pubs/public-costs-of-UP-2010.pdf
27. Logan C, Holcombe E, Manlove J, et al. The consequences of unintended childbearing: A white paper. Washington: Child Trends, Inc.; 2007 May. Available from: http://thenationalcampaign.org/sites/default/files/resource-primary-download/consequences.pdf

28. Cheng D, Schwarz E, Douglas E, et al. Unintended pregnancy and associated maternal preconception, prenatal and postpartum behaviors. *Contraception*. 2009 Mar;79(3):194-8.
29. Kost K, Landry D, Darroch J. Predicting maternal behaviors during pregnancy: Does intention status matter? *Fam Plann Perspect*. 1998; 30(2):79-88.
30. D'Angelo D, Gilbert BC, Rochat R, et al. Differences between mistimed and unwanted pregnancies among women who have live births. *Perspect Sex Reprod Health.* 2004;36(5):192-7.
31. Family Planning. Healthy People 2020 website. Accessed April 20th, 2016.
32. Scholl TO, Hediger ML, Belsky DH. Prenatal care and maternal health during adolescent pregnancy - A review and meta-analysis. *J Adolesc Health*. 1994;15:444-456.
33. Chandra PC, Schiavello HJ, Ravi B, Weinstein AG, Hook FB. Pregnancy outcomes in urban teenagers. *Int J Gynaecol Obstet*. 2002;79:117-122.
34. Coughlin L. Practice Guideline Briefs AAP report on Pregnancy in Adolescents. *Am Fam Physician*. 2005 Oct 1;72(7):1398-1400.
35. Finer L, Zolna M. Unintended pregnancy in the United States: Incidence and Disparities, 2006. *Contraception.* 2011 Nov; 84(5): 478–485.
36. Hoffman S, Maynard R, eds. Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy, 2nd ed. Washington: Urban Institute Press; 2008.
37. Hoffman S. By the Numbers: The Public Costs of Teen Childbearing. Washington: National Campaign to Prevent Teen Pregnancy; 2006. Available from: https://thenationalcampaign.org/resource/numbers
38. The public costs of teen child bearing: key data. Counting it up. The national campaign , December 2013
39. What policy makers can do. Counting it up. The National Campaign website. Accessed May 12th , 2016.
40. Why it matters. Teen childbearing, education and economic well being. The National Campaign website. Accessed May 12th , 2016.
41. Lee, D. The early socioeconomic effects of teenage childbearing: A propensity score matching approach. Demographic Research. 2010; 23: 697-736.
42. Fletcher, J.M., & Wolfe, B.L. Education and labor market consequences of teenage childbearing: Evidence using the timing of pregnancy outcomes and community fixed effects (Working Paper No. 13847). Cambridge, MA: National Bureau of Economic Research.2008.
43. Gavin LE, Williams JR, Rivera MI. Programs to Strengthen Parent-Adolescent Communication About Reproductive Health: A Systematic Review. *Am J Prev Med*. 2015;49(2 Suppl 1):S65-72. doi: 10.1016/j.amepre.2015.03.022
44. Galveston county health district. http://www.gchd.org/admin/welcome.htm
45. Prevention Action ,Dartington : The Social Research Unit; c2007-2015 updated 2012 Jul 9; cited 2015 Aug 4. Prevention science – all is revealed; Available from: http://www.preventionaction.org/preventionnews/prevention-science-all-revealed/5842

46. Camper L, Walker D, Atienzo EE, Guteirrez JP. " A quasi-experimental evaluation of parents as sexual Health educators resulting in delayed sexual initiation and increased access to health condoms". *Journal of Adolescence*. 2011;34:215–223.
47. Wight D, Fullerton D. "A review of interventions with Parents to Promote the Sexual Health of Their Children". *Journal of Adolescent Health*.2013; 52:4–27.
48. The Guide to Community Preventive Services. Preventing HIV/AIDS, Other STIs, and Teen Pregnancy: Group-Based Comprehensive Risk Reduction Interventions for Adolescents At http://www.thecommunityguide.org/hiv/riskreduction.html
49. Teen Pregnancy Prevention Evidence Review. The Department of Human Health and Services website. http://tppevidencereview.aspe.hhs.gov/document.aspx?rid=3&sid=53&mid=2
50. Guilamo-Ramos, V., Bouris, A., Jaccard, J., Gonzalez, B., McCoy, W., & Aranda, D. A parent-based intervention to reduce sexual risk behavior in early adolescence: Building alliances between physicians, social workers, and parents. *Journal of Adolescent Health.* 2011;48(2) :159–163.
51. Eastman KL, Corona R, Schuster MA. Talking Parents, Healthy Teens: a worksite-based program for parents to promote adolescent sexual health. *Prev Chronic Dis.*2006:3(4). Available from: http://www.cdc.gov/pcd/issues/2006/oct/06_0012.htm
52. Schuster MA, Corona R, Elliott MN, et al. Evaluation of Talking Parents, Healthy Teens, a new worksite based parenting programme to promote parent-adolescent communication about sexual health: randomised controlled trial. *BMJ.* 2008;337:a308. http://dx.doi.org/10.1136/bmj.39609.657581.25
53. Theories and Models Commonly Used for Health Promotion Interventions. In: Mckenzie J, ed. Planning, Implementing and evaluating health promotion programs a primer. 6th ed. Pearson; 2014. 173-175.
54. Developing an Effective Evaluation Plan. Atlanta, Georgia: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; Division of Nutrition, Physical Activity, and Obesity, 2011.
55. W.K Kellog Foundation, Logic Model Development Guide. Updated January 2004.
56. Manlove J, Fish H, Moore K A. Programs to improve adolescent sexual health and reproductive health in the US: a review of the evidence. *Adolescent Health, Medicine and Therapeutics.* 2015;6:47–79.
57. Raffaelli M, Bogenschneider K, Flood MF. Parent-teen communication about sexual topics. *J Fam Issues*. 1998;19:315-33.
58. Jaccard J, Dittus PJ, Gordon VV. Parent-teen communication about premarital sex: factors associatedwith the extent of communication. *J Adolesc Res*. 2000;15:187-208.
59. Jaccard J, Dittus PJ, Gordon VV. Maternal correlates of adolescent sexual and contraceptive behavior. *Fam Plann Perspect*. 1996;28(4):159-65, 85.
60. Crosby RA, Miller KS. Family influences on adolescent females' sexual health. In: Wingood GM, DiClemente RJ, eds. Handbook of women's sexual and reproductive health. New York (NY): Kluwer Academic/Plenum Publishers; 2002.

61. Kearney MS, Levine PB. Explaining Recent Trends in the U.S. Teen Birth Rate.2012. NBER Working Paper 17964.
62. Kearney MS, Levine PB. Why is the Teen Birth Rate in the United States So High and Why Does It Matter? *Journal of Economic Perspectives* 2012;26(2):141-166.
63. Levine PB, Zimmerman DJ. eds. 2010. Targeting Investments in Children: Fighting Poverty when Resources are Limited. University of Chicago Press.
64. Huberman B. Let's talk month planning guidebook. Advocates for youth 2012.
65. Strategies guided by best practice for community mobilization. Advocates for youth website. Accessed May 12th , 2016.
66. Centers for Disease Control and Prevention Website. http://www.cdc.gov/
67. Advocates for Youth Website. http://www.advocatesforyouth.org/
68. The National Campaign to Prevent Teen and Unplanned Pregnancy Website. http://thenationalcampaign.org/
69. Planned Parenthood. Care. No matter what. Website. https://www.plannedparenthood.org/

Vita

Naiomi Jamal was born on April 1, 1983 in Peshawar, Pakistan to Syed Ghazi Gulab Jamal and Lubna Hassan.

Naiomi Jamal attended the Aga Khan University in Karachi, Pakistan where she obtained a Bachelors in Medicine and Bachelors in Surgery Degree (MBBS) in 2007. Naiomi Jamal then worked in a refugee camp and a government hospital, The Hayatabad Medical Complex at the Department of Obstetrics and Gynecology in Peshawar, Pakistan where she taught midwives and did residency training. In 2012 she joined the University of Texas Medical Branch (UTMB) Family Medicine Department as a resident. After graduating in 2015, she joined the Department of Preventive Medicine and Community Health to further specialize as a resident. In 2015 she enrolled in the Master of Public Health Graduate Program.

Education

MBBS ,2007, Aga Khan University, Karachi, Pakistan.

Publications

Jamal N, Elliott T. "MY APPROACH to treating Menopause". *Primary Care*. March 1, 2016

Elsaid S, **Jamal N** et al. "What is the best initial treatment for plantar warts in children?". *Evidence Based Practice.* 2016 Mar;18(12):E3-E4.

Westriech D, **Jamal N,** Smith J, Scholze D et al, "Injectable and oral contraception in the incidence and progression of cervical disease in HIV infected women in South Africa". *Contraception.* 2014 Apr;89(4):286-91.

Permanent address: 1055 FM 646 Rd West, Apt 1431, Dickinson, TX 77539.

This Capstone was typed by Naiomi Jamal.