



ALTURA CENTERS FOR HEALTH

**REPRODUCTIVE HEALTH
NEEDS ASSESSMENT**

Focusing on Selected Areas of Tulare County



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INTRODUCTION

Family planning constitutes a critical part of reproductive health and the general health care system. Family planning has been called one of the 10 great public health achievements of the 20th century¹ because the availability of these services allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, women, and families.² It is also important because, for many people, a family planning clinic may be the entry point into the health care system and, for women, one they consider their usual source of care.³

In California, federal Title X funds along with the state Medi-Cal and Family PACT (Planning, Access, Care and Treatment) Programs are the main source of support for providing high quality, culturally sensitive education and clinical family planning services for low-income, under-insured and uninsured individuals. Uniquely, Title X funds critical infrastructure needs not paid for under Medi-Cal and private insurance, such as staff salaries, patient education, and community education about family planning and sexual health issues.⁴ These public funds help avert unintended pregnancies, reducing the need for abortion services.

Nationally, about two-thirds of women at risk for unintended pregnancy are estimated to use contraceptives consistently and correctly throughout the course of any given year; these women account for only 5% of all unintended pregnancies. By contrast, the 18% of women at risk who use contraceptives inconsistently or incorrectly account for 41% of all unintended pregnancies. The 14% of women at risk who do not practice contraception at all or who have gaps of a month or more during the year account for 54% of all unintended pregnancies.⁵

In California in 2010, the federal and state governments spent \$1.8 billion on unintended pregnancies; of this, \$1,062 million was paid by the federal government and \$689.3 million was paid by the state.⁶

In addition to the economic costs, research has shown that unintended pregnancy has been associated with maternal depression, increased risk of physical violence during pregnancy, and children who experience poor mental and physical health during childhood, and have lower educational attainment and more behavioral issues in their teen years.⁷ Adolescent pregnancy

¹ Centers for Disease Control and Prevention. Achievements in public health, 1900–1999: Family planning. *MMWR Weekly*. 1999 Dec 3;48(47):1073-80.

² <https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning#one>

³ Frost J. US women’s reliance on publicly funded family planning clinics as their usual source of medical care. Paper presented at National Survey of Family Growth Research Conference; 2008 Oct; Hyattsville, MD.

⁴ By law, Title X funds are not the sole source of income for providers. Rather, Title X funding is leveraged throughout the health centers in its network.

⁵ Sonfield A, Hasstedt K, Gold RB, *Moving Forward: Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014.

⁶ 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: Guttmacher Institute, 2015.

⁷ Research compilation cited at <https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning#seven>

has long been a concern because the negative consequences associated with unintended pregnancies are even greater for teen parents and their children. Despite overall declines in teenage pregnancies and births over the past 20 years, the California rate, and particularly the Tulare County rate described later in this report, remains significantly higher by comparison.

In addition to disparities by age group, reproductive health disparities exist by ethnic group that have applicability for Title X services in Tulare County given its large proportion of Hispanic/Latino population. For example, unmarried Latina women 20-29 years old have an unintended pregnancy rate of more than double that of non-Latina unmarried white women of the same age,⁸ and between young adult Latina and white women about 30% of Latinas will give birth by age 20, compared with 14% of non-Latina white women.⁹ These disparities have far-reaching economic and societal consequences including the ability to advance education and career goals.

Purpose and Scope of this Report

This report focuses on the estimated need for Title X reproductive health services in selected communities in Tulare County—principally, the cities of Tulare and Woodville and surrounding rural communities that comprise the service areas of Altura Centers for Health. The purpose of the study, conducted for Altura Centers for Health, was to examine relevant community health, demographic and socioeconomic indicators and other community characteristics, and engage in a community input process to identify the highest unmet needs for family planning services. The assessment meets the Title X requirement for community needs assessments and can guide partner organizations and other stakeholders in improving access to services.

Acknowledgements

We wish to thank the many individuals who took the time and interest to participate in the interviews and small-group discussions, sharing their experiences and perspectives about family planning and making suggestions for expanding access and improving services. We are also very appreciative of the various organizations that hosted and facilitated the focus groups, in some cases providing interpreter services.

Barbara Aved Associates (BAA), which provides strategic planning and program evaluation for health and human service organizations, was engaged to conduct this needs assessment. Barbara Aved, RN, PhD, MBA, who has served a number of organizations in Tulare County, designed and conducted the needs assessment; Larry Meyers, PhD, and Michael Funakoshi of BAA contributed to the statistical analysis. Dr. Aved is a former Chief of the Office of Family Planning in the California Department of Health Services.

⁸ Zolna MR, Lindberg LD. (2012). Unintended pregnancy: Incidence and outcomes among young adult unmarried women in the United States, 2001 and 2008. New York: Guttmacher Institute, in Caal S et al. Reproductive Health Care through the Eyes of Latina Women: Insights for Providers. *Child Trends*. August 2012.

⁹ Martinez G, Daniel K, Chandra A. (2012). Fertility of men and women aged 15-44 years in the United States: National Survey of Family Growth, 2006-2010. Hyattsville, MD: National Center for Health Statistics, in Caal S et al. Reproductive Health Care through the Eyes of Latina Women: Insights for Providers. *Child Trends*. August 2012.

METHODS

DATA COLLECTION

Community needs assessments, including those specific to reproductive health, involve gathering, analyzing and *applying* both quantitative and qualitative data and other information for strategic purposes. These methods provide the necessary input to inform planners, providers and other decision makers about the challenges they face in improving health status as well as programs and services, and the priority areas where support is most needed.

SECONDARY DATA: PUBLICLY-AVAILABLE STATISTICS

Data to create a Community Profile were collected from all applicable existing public data sources and included demographic, economic and health status indicators, including service availability. Some recently available data collected for other sources, e.g., *2016 Tulare County Community Health Needs Assessment*,¹⁰ were shared for inclusion in this report.

PRIMARY DATA: COMMUNITY INPUT

To gain a better understanding of how consumer perspectives and family planning programs and services could be improved, input from selected Tulare County communities was solicited through focus groups, key informant interviews and a Community Survey. While some of the study population samples are small, they are suitable for this qualitative community research.

Community Focus Groups

Four community focus groups encompassing the cities of Tulare and Woodville and hosted by local non-profit organizations were conducted. Although the participants constituted a convenience sample, in the aggregate the groups were relatively diverse and included the populations of highest interest for Title X.¹¹ A common set of structured questions was used for all groups, with appropriate follow-on questions asked to capture fuller information. The questions were generally open-ended to encourage discussion; prompting with information or data was limited to reduce the potential for bias or leading participants to conclusions. For consistency, the study author (Dr. Aved) conducted all of the groups, which lasted about 45-50 minutes. Appropriate bilingual interpreters were available for Spanish-speaking participants. Refreshments were provided at most of the groups, and in some cases a drawing for a \$50 VISA gift card was provided. The organizations that sponsored the community meetings helped to publicize the sessions and promote attendance. The focus group input was recorded by the facilitator during the meetings then transferred to written summary formats where the notes were reviewed, summarized and coded for analysis based on thematic topics.

¹⁰ Draft report provided by Tulare County Public Health Department, October 2016.

¹¹ Two additional focus groups of high school students were planned and scheduled; ultimately, however, the school was not able to generate interest among the students and parents (who had been asked to explicitly approve students' participation).

Key Informant Interviews

Telephone interviews using a structured set of questions with additional, customized questions to obtain more in-depth information were conducted with 13 individuals who agreed to participate in an interview (a list of names is included in Attachment 1). The interviews provided an informed perspective from those who work directly with the public and/or determine some of the policies that affect reproductive health and family planning services in Tulare County. These individuals were able to offer information about local resources and gaps in services, high-priority needs, and suggestions for positive change. The interview data were handled similar to the input from the community focus groups described above.

Community Survey

A survey for the community was developed in English and Spanish that solicited residents' opinions about most-important reproductive health needs, use of services, barriers to access, and suggestions for community health improvements (Attachment 2). Certain questions that serve as markers for access to services were also included. The survey was made available in hard copy in selected communities served by Altura, and distributed in locations where the groups of interest would best be reached such as at family resource centers, WIC, migrant housing, Head Start and schools. The survey data were cleaned, coded, and entered into an Excel where they were analyzed.

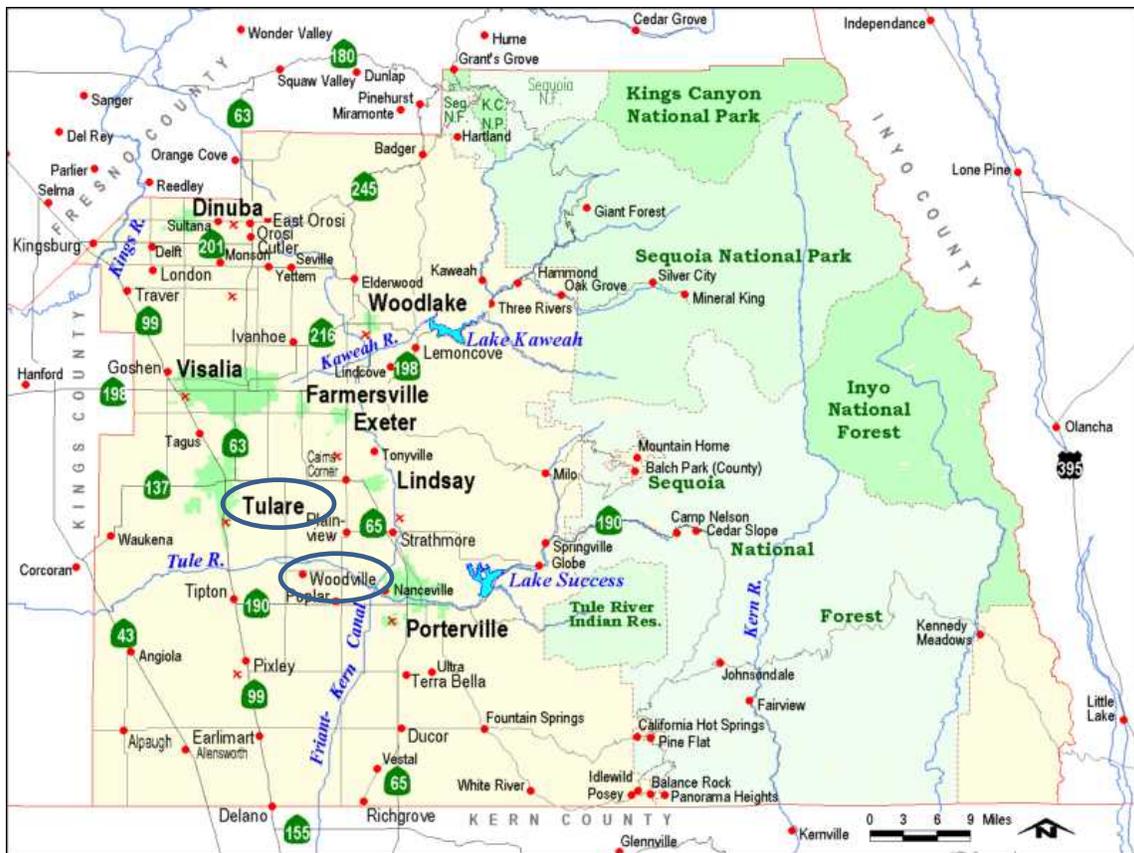
FINDINGS

This section of the needs assessment is organized into two parts. Part I provides a profile of selected Tulare County community indicators relevant to Title X and a summary of access to reproductive health services. Part II presents the results of the community input process.

Part I. Tulare County Overview

Centrally located in the Central Valley of California, Tulare County is composed of 8 incorporated cities and 71 unincorporated communities. In 2015, the county was home to a population of 466,339, about 57% (or 266,720) of whom were ages 18-64. With a median age of 28.5 years, Tulare County residents are one of the youngest regional populations in California.¹² The map below indicates with circles the primary communities served by Altura Centers for Health.

Map 1. Tulare County with Main Cities



¹² <http://www.census.gov/quickfacts/map/PST045214/06107,06>

Map 2. Tulare County, California



Despite its agricultural prominence and the benefits of living in close supportive communities, disparities exist for many Tulare County residents who struggle with economic and health-related challenges. These include low educational attainment, living in poverty, limited access to affordable services, and poorer-than-average rates for community indicators such as substance abuse and teen pregnancy. For instance, according to the 2016 County Health Rankings, Tulare ranks the highest in the state in the rate of births to 15-19 year-olds (59 per 1,000 female population), a rate described more fully below.¹³

Community Profile

Demographic and Socioeconomic Indicators

While overall city population changes vary from year to year, Tulare County city/county population estimates with annual percent change between January 1, 2015 and January 1, 2016 show slight growth for the county overall (Table 1).

Population Characteristics

Table 1. Population Estimates of Tulare County Cities

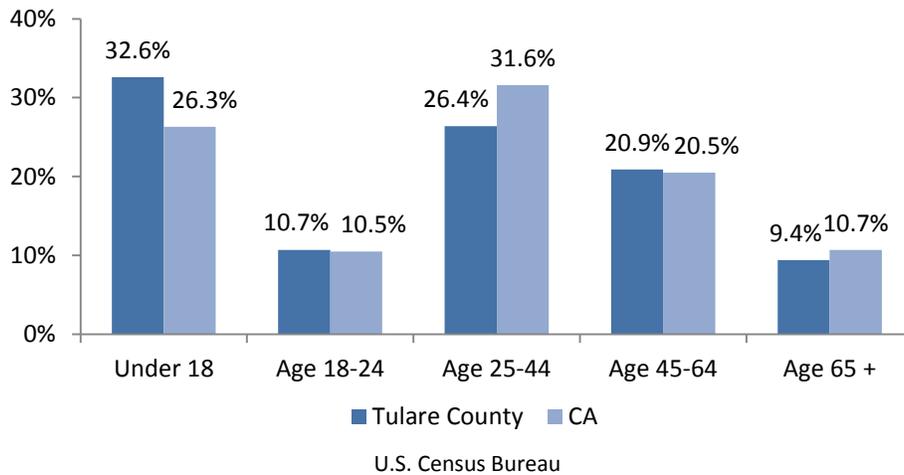
County/City	Total Population		Percent Change
	1/1/2015	1/1/2016	
Tulare County	461,589	466,339	1.0
Dinuba	24,288	24,657	1.5
Exeter	10,963	11,047	0.8
Farmersville	11,084	11,161	0.7
Lindsay	12,789	12,960	1.3
Porterville	57,039	60,070	5.3
Tulare	62,726	63,515	1.3
Visalia	128,447	130,231	1.4
Woodlake	7,602	7,648	0.6
Balance of County	146,651	145,050	-1.1

Source: California Department of Finance.

¹³ <http://www.countyhealthrankings.org/app/california/2016/rankings/tulare/county/outcomes/overall/snapshot>

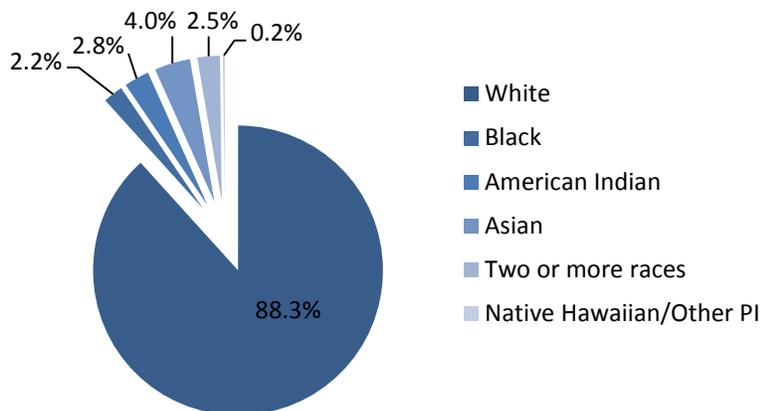
Tulare County’s population is relatively young compared to the statewide average. Its median age, 28.5 is lower than California’s at 33.3.¹⁴ This is especially evident in the age group 0-17, as shown in Figure 1.

Figure 1. Population by Age Group, 2010.



The majority (88.3%) of the population in Tulare County is white. While Hispanics may be of any race, and so are included in the applicable race categories shown in Figure 2 below, July 2015 estimates from the American Community Survey show that 63.6% of the county’s population is of Hispanic or Latino origin.

Figure 2. Racial Origin, Tulare County



Source: American Community Survey, Population Estimates

¹⁴ U.S. Census Bureau, 2010. Population Estimates Program (PEP). <http://www.census.gov/popest/>.

Data on language show that in 2011-2015 in Tulare County, 50.9% of persons age 5 years and older spoke a language other than English at home (vs. 43.9% statewide).¹⁵ This information is important to understand how well people in each community speak English to ensure that information about public health, laws, and so forth is communicated in languages that community members understand. As an example, of Tulare City School District’s total 2015-16 K-12 enrollment of 9,583, 27.2% of the students were English-Learners compared to 22.1% statewide.¹⁶

Poverty

Studies have confirmed the relationship between income and education and health outcomes.¹⁷ Some of the ways in which poverty contributes to poor health are immediately obvious: deprivation leading to poor nutrition may lead to susceptibility to chronic disease; higher incidences of teen pregnancy are associated with poverty along with a myriad of other adverse health outcomes. Poverty is a pressing issue for Tulare County as in 2013 39.9% of children ages 0-18 were living below the federal poverty level, nearly twice the proportion of the statewide average (Figure 3).

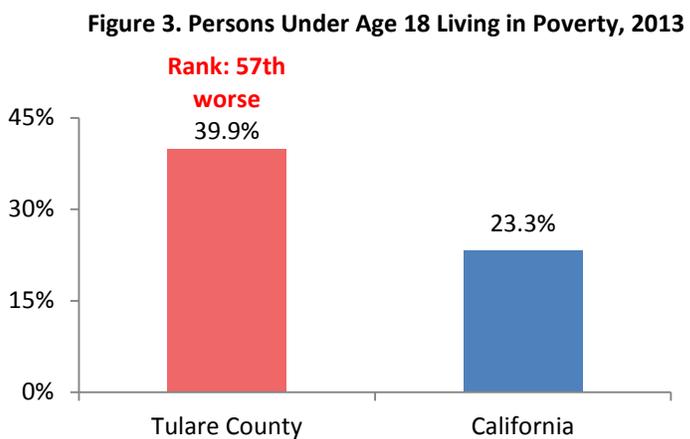


Table 2 reports the estimated percentage of Tulare County households receiving the Supplemental Nutrition Assistance Program (SNAP) benefits. This indicator is relevant because it assesses vulnerable populations that are more likely to have multiple health access, health status, and social support needs.

¹⁵ U. S. Census Bureau, American Community Survey, 5-Year Estimates.

¹⁶ California Department of Education, 2015-16. <http://www.cde.ca.gov/ds/>

¹⁷ Wilkinson RG, Marmot MG (eds.). Social Determinants of Health: The Solid Facts, 2nd Edition. International Center for Health and Society. World Health Organization, 2003.

Table 2. Households Receiving SNAP Benefits

Report Area	Total Population	Non-Hispanic White	Black	Asian	American Indian / Alaska Native	Other Race	Multiple Race	Hispanic or Latino
Tulare County	19.24%	5.40%	25.53%	15.49%	20.68%	25.96%	18.51%	28.02%
California	7.21%	2.79%	14.52%	3.97%	13.85%	13.84%	9.97%	13.42%

Source: US Census Bureau, American Community Survey: 2008-2012.

Unemployment

Although it is difficult to quantify the impact of work alone on personal identity, self-esteem and social contact and recognition, the ability to have employment can have a significant impact on an individual's well-being. According to September 2015 labor market data, 89.2% of Tulare County's labor force was employed. The proportion ranged within the county, in the communities that primarily comprise Altura's service area, from 8.2% in Woodville to 19.0% in East Porterville (Table 3 below).

Table 3. Percent of the Population Unemployed

Area Name	Unemployment Rate
Tulare County	10.8%
Ducor CDP*	12.4%
Earlimart CDP	16.5%
East Porterville CDP	19.0%
Lindsay city	15.0%
Pixley CDP	14.8%
Porterville city	11.2%
Strathmore CDP	14.6%
Terra Bella CDP	16.2%
Tipton CDP	8.9%
Tulare city	9.1%
Woodville CDP	8.2%

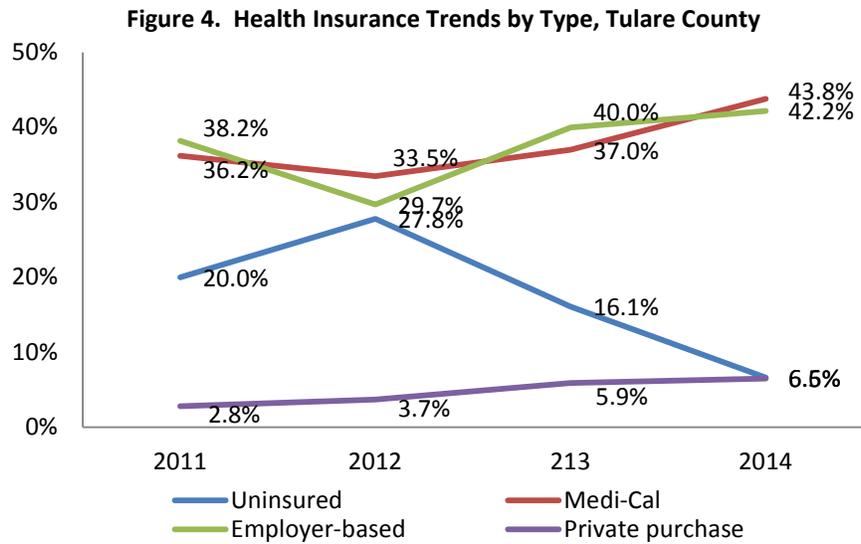
Source: US Census Bureau, American Community Survey: 2009-2013

*CDP is "Census Designated Place" - a recognized community that was unincorporated at the time of the 2009-2013 5-Year American Community Survey.

Health Insurance

Data regarding health insurance coverage in Tulare County show a decreasing trend in the percentage of uninsured residents from a high of over 25% in 2012 to a low of 6.5% in 2014 (Figure 4 below), in part reflecting access to insurance through the Affordable Care Act. *Having* insurance coverage does not necessarily translate to adequate *access* to health care services, however, as some residents have reported difficulty finding doctors that accept particular plans.¹⁸

¹⁸ Focus group findings reported in *2016 Tulare County Community Health Assessment*.

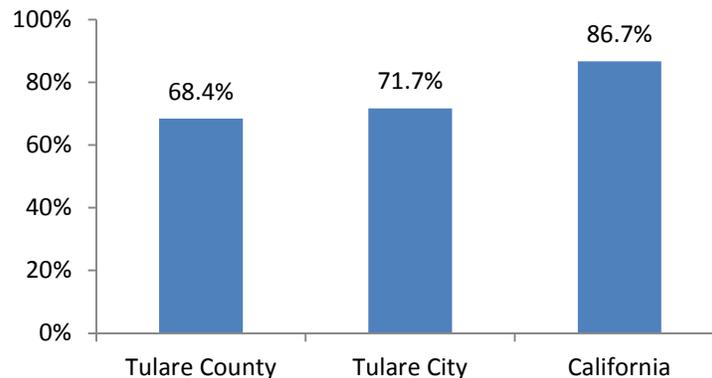


Educational Attainment

In general, higher levels of education equate to the ability to earn higher wages, experience less unemployment and enjoy increased family stability. The indicator typically used to measure educational attainment is “persons aged 25 and older with less than a high school education.”

In the 2011-2015 5-year estimate for Tulare County, 68.4% of residents aged 25+ had a high school diploma or higher (Figure 5). The proportion among residents in the City of Tulare was slightly higher (71.1%), but both areas were less favorable than statewide (Figure 5).¹⁹ The high school cohort dropout rate for 2014-15 was slightly lower in Tulare County than statewide: 10.2% versus 10.7%,²⁰ a favorable finding.

Figure 5. Percent of Residents Age 25+ With a High School Education or Higher



¹⁹ U. S. Census Bureau, American Community Survey, 5-Year Estimates. <http://factfinder2.census.gov>

²⁰ California Department of Education. DataQuest. <http://dq.cde.ca.gov/dataquest/dataquest.asp>

Research shows low educational attainment—particularly dropping out of school—increases the risk of school-age pregnancy. High levels of school engagement have been found to be associated with postponing pregnancy.²¹ In 2012, 31.0% of Tulare County births were to mothers with no high school degree, compared to 20.3% statewide.²²

Health-Related Indicators

Births

In 2013, there were 7,651 live births reported for women in Tulare County. The county’s birth rate is about 25% higher than the average for the state (Table 4).

Table 4. Birth Rate, 2013*

Tulare County	California
16.8	12.9

Source: California Department of Public Health, Vital Statistics Query System

*Rate per 1,000.

While about half (48.6%) of the births in California were to women of Hispanic origin, in Tulare County close to three-quarters (72.6%) of births were to this group (Table 5). Births to Mexico-born mothers represented about 31% of the county’s births vs. 19% in the rest of the state.²³

Table 5. Births by Race/Ethnicity, 2013

	Tulare County	California
Hispanic	72.6%	48.6%
White	20.4%	27.2%
Black	1.0%	5.3%
Asian/Pacific Islander	3.0%	14.0%
Other	3.0%	4.9%

Source: California. 1991-2012 Birth Cohort and Birth Statistical Master Files

Births to Teen Mothers

The negative consequences associated with unintended pregnancies are greater for teen parents and their children. A meta-analysis of the literature on unintended childbearing among young women and adolescents found evidence of a significant association with reduced likelihood of breastfeeding, poorer mental and physical health during childhood, poorer outcomes of the

²¹ The influence of high school dropout and school disengagement on the risk of school-age pregnancy. *Journal of Research on Adolescence* 8(2):187-220, 1998.

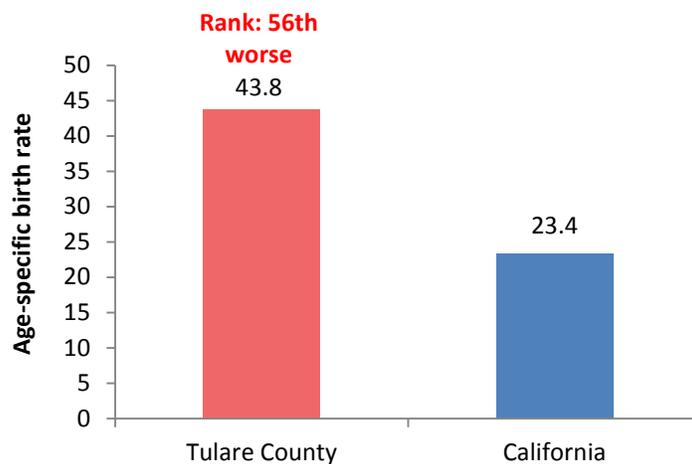
²² Improved Perinatal Outcome Data Reports Tulare County Profile, 2012. State of California. 1991-2012 Birth Cohort and Birth Statistical Master Files.

²³ Ibid.

child, poorer maternal mental health, and an increased risk of the mother experiencing physical violence during pregnancy.²⁴ Because most (an estimated 82%) pregnancies to mothers ages 15 to 19 are unintended²⁵ it may be safe to assume that is also the case or close to it in Tulare County.

Although adolescent birth rates have declined in recent years, data show that in 2015 teen birth rates were highest in small towns and rural communities.²⁶ Tulare County is no exception, and the Central San Joaquin Valley continues to have some of the highest rates in the state.²⁷ Tulare County's three-year average adolescent birth rate (per 1,000 female population), was 43.8 in 2012-2014, nearly twice the statewide rate of 23.4, ranking the County near the bottom of California's 58 counties (Figure 6).

Figure 6. Births to Mothers Aged 15-19, 2012-2014 (Average)



Source: California Department of Public Health

The extent of difference between the county and statewide adolescent birth rates has not significantly changed in the last decade (Figure 7 on the next page).²⁸

²⁴ Logan C et al. The Negative Consequences of Unintended Childbearing: A White Paper. *Child Trends*. May 2007.

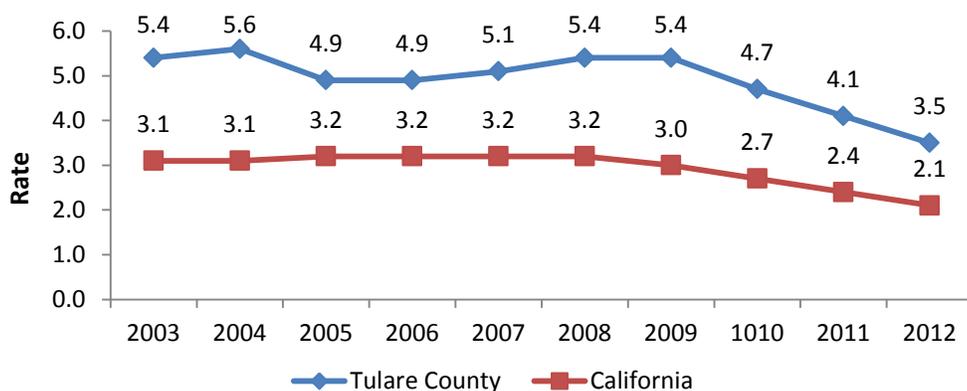
²⁵ Finer L, Henshaw S. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspect Sex Reprod Health*. 2006 Jun;38(2):90-6.

²⁶ Teen Birth Rates for Urban and Rural Areas in the United States, 2007–2015. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/products/databriefs/db264.htm>

²⁷ Adolescent Births in California 2000-2014. California Department of Public Health. August 2016 <http://www.cdph.ca.gov/data/statistics/Documents/2014ABRFinalPressReleaseSlides.pdf>

²⁸ Health Status Profiles, California Counties. California Department of Public Health.

Figure 7. Births to Mothers Under Age 18, 2003-2012

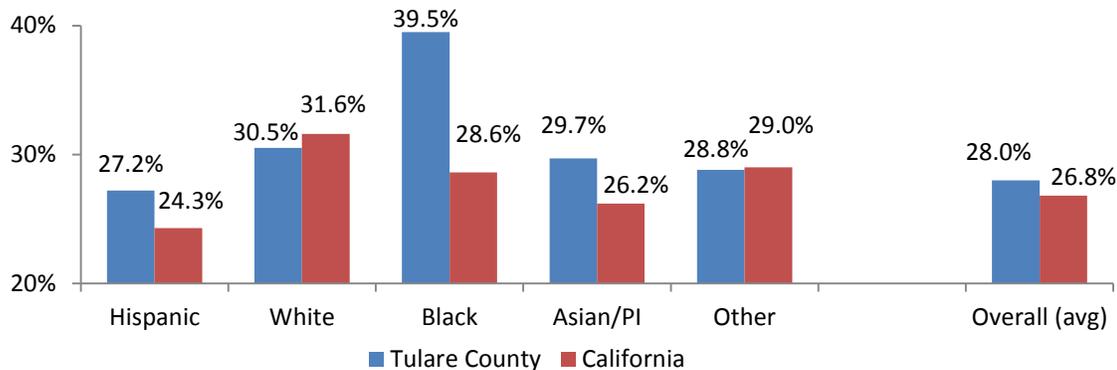


Source: California. 1991-2012 Birth Cohort and Birth Statistical Master Files

Also of significance, Tulare County’s *repeat* teen birth rate—calculated as the percentage of all births to mothers aged 15-19 with one or more previous live births—of 21.3 exceeds the statewide average of 17.0.²⁹ The national figure for repeat births is 18.3%.³⁰ Repeat teen births pose greater challenges because additional births can further constrain the mother’s ability to attend school and obtain job experience.

Closely spaced births are an important issue because short birth intervals can have health consequences for both the mother and infant.³¹ (An inter-pregnancy interval is considered short if it is less than 18 months.) Among all women giving birth in Tulare County in 2012, 28% vs. 26.8% statewide experienced a short birth interval.³² As Figure 8 shows, white and black mothers had slightly shorter birth intervals than the county average.

Figure 8. Mothers with Inter-Pregnancy Intervals Less than 18 Months, 2012



Source: California. 1991-2012 Birth Cohort and Birth Statistical Master Files

²⁹ Ibid.

³⁰ Vital Signs: Repeat Births Among Teens — United States, 2007–2010. *MMWR*. April 5, 2013;62(13):249-255

³¹ Klerman LV. Another chance: preventing additional births to teen mothers. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy; 2004.

³² Improved Perinatal Outcome Data Reports Tulare County Profile, 2012. State of California. 1991-2012 Birth Cohort and Birth Statistical Master Files.

The 2010-2013 teen birth rates from Tulare and Alpaugh zip codes where Altura targeted its Teen Pregnancy Prevention Grant in 2010-2015 are shown in Table 6 from highest to lowest rates.

Table 6. Number of Births and Birth Rate, by Selected Tulare County Zip Codes, Age 15-19

Year	Zip Code	Births	Rate ¹
2010	93201	10	---
2011	93201	4	---
2012	93201	9	---
2013	93201	3	---
2010	93274	185	65.8
2011	93274	173	61.5
2012	93274	146	51.9
2013	93274	134	47.7
2010	93201+93274	195	68.4
2011	93201+93274	177	62.1
2012	93201+93274	155	54.4
2013	93201+93274	137	48.1

Source: Tulare County Health and Human Service Agency, Public Health, September 2016.

¹Birth rates are live births per 1,000 females aged 15-19.

Births by Intendedness

Applying national statistics to local populations provides a potential picture about the proportion of births to women in Tulare County that were intended (though it would vary by race/ethnic and age groups). According to the 2006–2010 National Survey of Family Growth (NSFG), one of the largest national databases for examining community health indicators, 62.9% of births among U.S. women are estimated to be intended; the remainder, 37.1%, are estimated to be unwanted or mistimed.³³ These proportions suggest that relative to the 7,651 live births in Tulare County in 2013, 2,838 could be the result of unintended, unwanted or mistimed births.

Intendedness and reasons for not using contraception at the time of conception varies by Hispanic/non-Hispanic origin, which has relevance for Tulare County as 72.6% of the county’s births in 2013 were to women of Hispanic origin. Among all women in the NSFG survey who had an unintended birth in the prior 3-year period, the number one reason for not using contraception at the time of conception was “Did not think I could get pregnant.” While 35.2% of non-Hispanic or Latina women gave this reason, half (49.4%) of the Hispanic or Latina respondents did so, indicating a greater lack of knowledge about pregnancy among this group.

Access to family planning education and clinical services is the key. Nationally, improvements in contraceptive use have been largely responsible for leading to the drop in the risk of unintended

³³ <https://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf>

pregnancy for all women, but particularly among younger women aged 15–19.³⁴ Some research in fact suggests that improved contraceptive use accounted for the entire 28% decline in teen pregnancy risk between 2007 and 2012 while teen sexual activity remained steady during that same period.³⁵

Prenatal Care

While the percentage of women receiving prenatal care in the first trimester and the proportion of low birth weight babies are slightly lower in the county than in the state, the rate of infant deaths matches the statewide average rate (Table 7).

Table 7. Prenatal Care and Birth Outcomes in Tulare County and California, 2012-2014 (average)

Measure	Tulare County			California	
	Rank Order	Rate	Percent	Rate	Percent
First trimester prenatal care	22		80.8		83.5%
Low birth weight infants	32		6.4%		6.7%
Birth cohort infant death rate (all races)	28	4.7		4.7	

Source: California Department of Public Health, Health Status Profile for 2016.

Medi-Cal as Payer

In 2012 (the latest year for which these data are available) in Tulare County, more than two-thirds (70.2%) of births were paid with Medi-Cal as the primary payer compared to fewer than half statewide (46.4%). The County’s proportion of births paid for by Medi-Cal—and its difference from the California average—has remained relatively unchanged since 2005.³⁶

Sexually Transmitted Diseases³⁷

Sexually transmitted diseases are largely preventable when individuals have adequate knowledge and access to reproductive health services. The human papillomavirus (HPV) is the most common sexually transmitted infection. Nearly all sexually active men and women will get HPV infection at some point during their lives. HPV-associated cancers accounted for 3.2% of all cancers diagnosed in females and 1.9% of all new cancers diagnosed in males California in 2010.³⁸ Two HPV vaccines are currently available to protect both males and females against

³⁴ Declines in Teen Pregnancy Risk Entirely Driven by Improved Contraceptive Use. Levels of Teen Sexual Activity Essentially Unchanged Between 2007–2012. Guttmacher Institute. August 2016.

³⁵ Lindberg L et al. Understanding the Decline in Adolescent Fertility in the United States, 2007–2012. *J Adolesc Health*. November 2016;59(5):577-583.

³⁶ Improved Perinatal Outcome Data Reports Tulare County Profile, 2012. State of California. 1991-2012 Birth Cohort and Birth Statistical Master Files.

³⁷ For consistency with the Title X grant from Essential Access Health and the Centers for Disease Control, “sexually transmitted diseases” is used throughout this report. However, it should be noted that this term is used interchangeably in public health and similar work with “sexually transmitted infections” which is becoming more preferred.

³⁸ Cook SN et al. Human Papillomavirus (HPV)-Associated Cancers and HPV Vaccination Coverage in California. Sacramento, CA: California Department of Public Health, Chronic Disease Surveillance and Research Branch, June 2014.

infection. Teen and adult respondents—the 2 groups combined—to the 2007 CHIS (the last time HPV information was available) who said they “had heard of the HPV vaccine or shot to prevent cervical cancer” were asked if they had even received this vaccine or shots; 6.7% in Tulare County compared to 16.6% statewide answered affirmatively. The county data are considered unreliable, however, due to the small sample size.

Table 8 below displays the incidence or cases of the STDs commonly and regularly reported as morbidity indicators by the California Department of Public Health. The case rates shown in the table are per 100,000 population.

Table 8. Tulare County Morbidity by Cause, 3-Year Average

Indicator	2012-2014				Healthy People 2020 Target
	County Rank Order	Cases (Avg) Tulare County	Crude Case Rate		
			Tulare County	CA	
AIDS Incidence (age 13+)	40	14.3	4.1*	7.3	^a
Chlamydia incidence	49	2,252.3	493.9	447.0	^b
Gonorrhea incidence females ^c	38	120.7	127.3	172.1	251.9
Gonorrhea incidence males ^c	37	142.0	143.1	255.6	194.8

Source: County Health Status Profiles 2016. California Department of Public Health

^a Objective has not been established.

^b Prevalence data were not available in all California counties to evaluate Healthy People 2020 Objective

^c Age 15-44

Although chlamydia is only one of many STDs, it is the most common bacterial STD in the U.S. and one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain.³⁹ Like other STDs, it is associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death.^{40,41} Chlamydia often has no symptoms, and people who are infected may unknowingly pass the disease to sexual partners. The 3-year (2012-2014) case rate of chlamydia for Tulare County was slightly higher than the statewide rate, 493.9 vs. 447.0. Figure 9 below shows Tulare County’s 6-year trend for chlamydia. Although the overall number of cases for gonorrhea and syphilis in the county are lower than that of chlamydia, the 6-year trend for each of those STDs is on the rise as illustrated in Figures 10 and 11 on the next page.⁴²

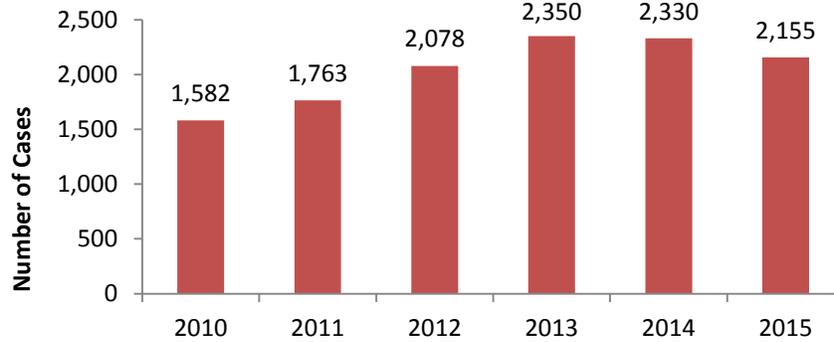
³⁹ Genuis SJ, Genuis SK. Managing the sexually transmitted disease pandemic: A time for reevaluation. *Am J Obstet Gynecol.* 2004;191:1103-1112.

⁴⁰ Meade CS, Ickovics JR. Systematic review of sexual risk among pregnant and mothering teens in the USA: Pregnancy as an opportunity for integrated prevention of STD and repeat pregnancy. *Soc Sci Med.* 2005;60:661-678.

⁴¹ Haggerty CL, et al. Risk of sequelae after Chlamydia trachomatis, genital infection in women. *J Infect Dis* 2010;201:134-155.

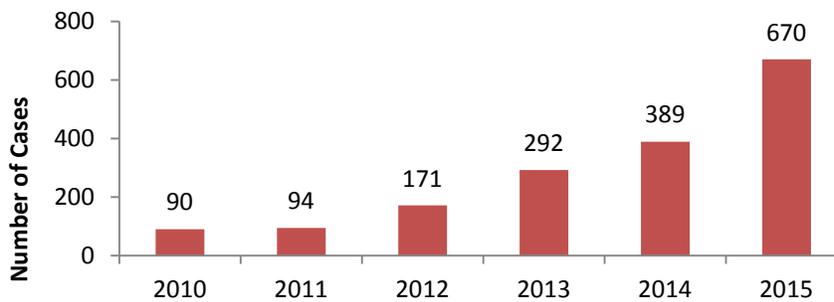
⁴² Figures 9 – 11 are reproduced from 2016 Tulare County Community Health Assessment.

Figure 9. Chlamydia Cases 6-Year Trend, Tulare County



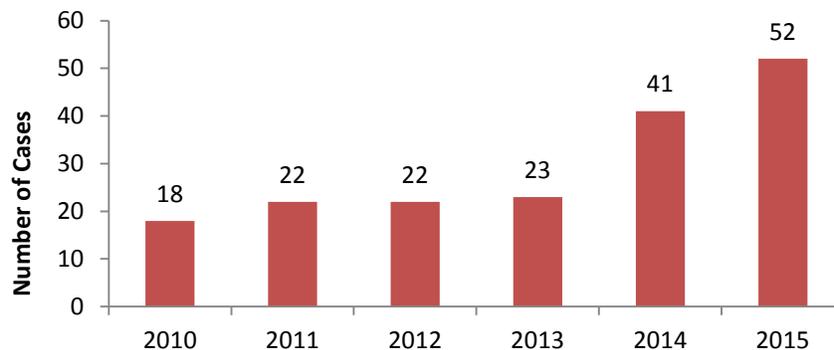
Source: California Department of Public Health, electronic reporting system, 2015

Figure 10. Gonorrhea Cases 6-Year Trend, Tulare County



Source: California Department of Public Health, electronic reporting system, 2015

Figure 11. Early Syphilis Cases 6-Year Trend, Tulare County



Source: California Department of Public Health, electronic reporting system, 2015

Clients who seek HIV counseling and testing services and clients who seek family planning services are often the same people. According to the Centers for Disease Control and Prevention, young people are the most likely to be unaware of their infection.⁴³ At the end of 2014, 35 people in Tulare County were newly diagnosed with HIV infection and 333 adults and adolescents

⁴³ HIV in the United States: At A Glance. <https://www.cdc.gov/hiv/statistics/overview/ataglance.html>

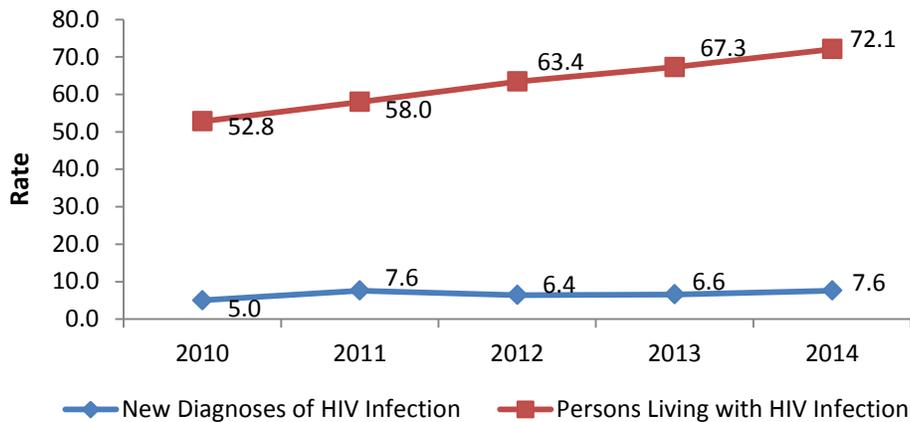
were living with diagnosed HIV infection (Table 9).⁴⁴ While the number of deaths of persons with HIV remained relatively stable in recent years, the rate of new cases and the rate of persons living with HIV infection has increased (Figure 12).

Table 9. Persons with Diagnosed HIV Infection, Tulare County, 2010-2014

	2010		2011		2012		2013		2014	
	No.	%								
New Diagnosis	22	0.4%	34	0.7%	29	0.6%	30	0.6%	35	0.7%
Persons living with HIV	234	0.2%	260	0.2%	287	0.2%	307	0.2%	333	0.3%
Deaths from HIV	6	0.4%	7	0.4%	6	0.4%	7	0.5%	6	0.4%

Source: California Department of Public Health

Figure 12. Rates of HIV Diagnosis and Persons Living with HIV, Tulare County, 2010-2014



Source: California Department of Public Health
Rates are per 100,000 population.

Cervical Cancer

Related preventive health services include services that are considered to be beneficial to reproductive health, are closely linked to family planning services, and are appropriate to deliver in the context of a family planning visit such as breast and cervical cancer screening which saves lives. In California in 2007, 1,465 women were diagnosed with cervical cancer, and 400 women were estimated to have died from this disease needlessly.⁴⁵ The cervical cancer incidence and deaths rates are higher in Tulare County than in California as Table 10 on the next page shows.

⁴⁴ California HIV Surveillance Report—2014. California Department of Public Health, Center for Infectious Disease, Office of AIDS, October 25, 2016.

⁴⁵ California Department of Public Health. <http://www.cdph.ca.gov/HealthInfo/discond/Pages/CervicalCancerStatistics.aspx>

Table 10. Age-Adjusted Rates of Cervical Cancer, 2010-2014, Tulare County

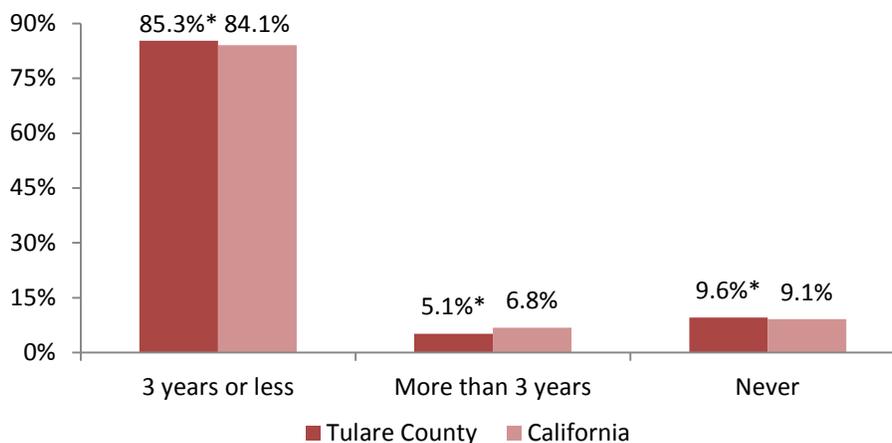
	Tulare County		California
	No. of Cases	Rate	Rate
Incidence rate	95	9.66	7.31
Death rate	36	3.69	2.24

Source: California Department of Public Health, Cancer Registry.

Unlike many cancers, cervical cancer can be prevented⁴⁶ and the incidence reduced through public health interventions such as education on risk factors, especially HPV infection. Mortality could be reduced and virtually eliminated through regular screening and early detection of the disease through a Pap smear—one of the important preventive services covered by Title X.

The California Health Information Survey (CHIS),⁴⁷ the largest state health survey in the nation, is a rich data source for community health needs assessments and provides useful information for health planners. The last time CHIS asked about Pap test history was in 2007, so more recent data were not available for this report. In 2007, 85.3% of women in Tulare County reported having a Pap screening within the last 3 years, 5.1% reported it had been more than 3 years since their last test, and 9.6% reported never having had the test—proportions that are similar to statewide screening results (Figure 13).

Figure 13. Pap Test History, Tulare County and California



Source: California Health Interview Survey, 2007

*Statistically unstable due to small sample size.

Asked of women 18 years or older who have never had a hysterectomy

Breast Cancer

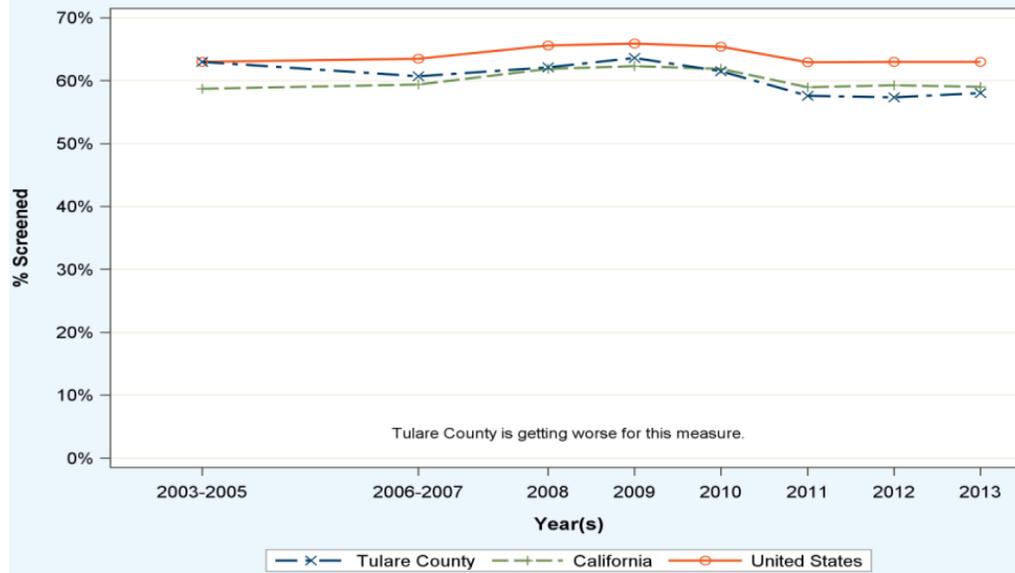
Breast cancer is the second most common type of cancer among women in the United States. The county’s age-adjusted rate of death from female breast cancer of 20.6 in 2012-2014 was only

⁴⁶ Kinde I et al. Evaluation of DNA from the Papanicolaou test to detect ovarian and endometrial cancers. *Sci Transl Med* 2013 January 9;5(167):167.

⁴⁷ UCLA Center for Health Policy Research. <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

slightly higher than the statewide rate of 20.3.⁴⁸ Evidence suggests that mammography screening reduces breast cancer mortality.⁴⁹ The percent of women ages 40-69 receiving a mammogram is a widely endorsed quality of care measure. Like cervical cancer screening, family planning clinics provide access to referrals for mammograms. Ten-year screening data from RWJ *County Health Rankings*⁵⁰ indicate that Tulare County is slightly worsening for this measure compared to state and national trends (Figure 14).

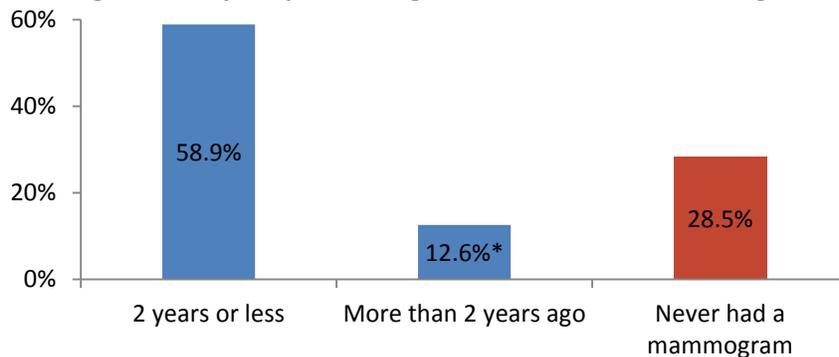
Figure 14. Mammography Screening in Tulare County, County, State and National Trends, 2013



Source: RWJ County Health Rankings, 2016

The percentage of women, 58.9%, who reported a recent mammogram to CHIS⁵¹ (Figure 15) is consistent with the Health Rankings data above.

Figure 15. Mammogram History, Respondents age 30+ who ever had a mammogram, Tulare County



Source: California Health Interview Survey, 2014

*Statistically unstable due to small sample size.

⁴⁸ County Health Status Profile, California Department of Public Health, 2016.

⁴⁹ Elmore JG, Armstrong K, Lehman CD, Fletcher SW. Screening for breast cancer. *JAMA*. 2005;293(10):1245-1256.

⁵⁰ RWJ County Health Rankings.

<http://www.countyhealthrankings.org/app/california/2016/rankings/tulare/county/outcomes/overall/snapshot>

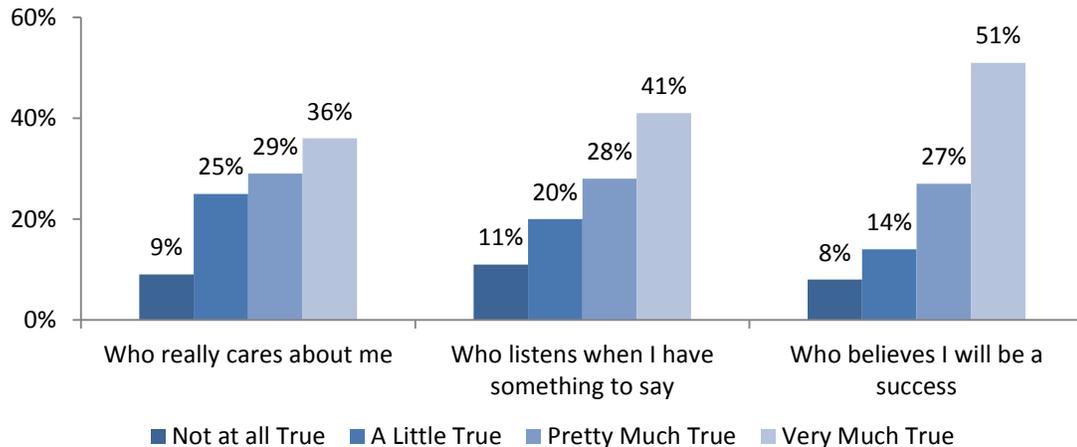
⁵¹ UCLA Center for Health Policy Research, California Health Interview Survey, 2014.

Other Key Indicators: Youth Attitudes and Experience

California Healthy Kids Survey

Youth's feelings about school connectedness—an academic environment in which students believe that adults in the school care about their learning and about them as individuals—are an important indicator because students are more likely to succeed and less likely to engage in high-risk behaviors or drop out when they feel connected to school. The California Healthy Kids Survey (CHKS),⁵² which is used for guiding school improvement efforts, shows that while the majority of 7th graders in the Tulare City School District reported positive feelings about these measures, between one-quarter and one-third did not agree or agreed very little that they were listened to, cared about or thought of as becoming a success (Figure 16).

Figure 16. School Connectedness Measures Reported by Tulare City School District 7th Graders, 2013-14 (n=697)



Source: 2013-14 California Healthy Kids Survey.

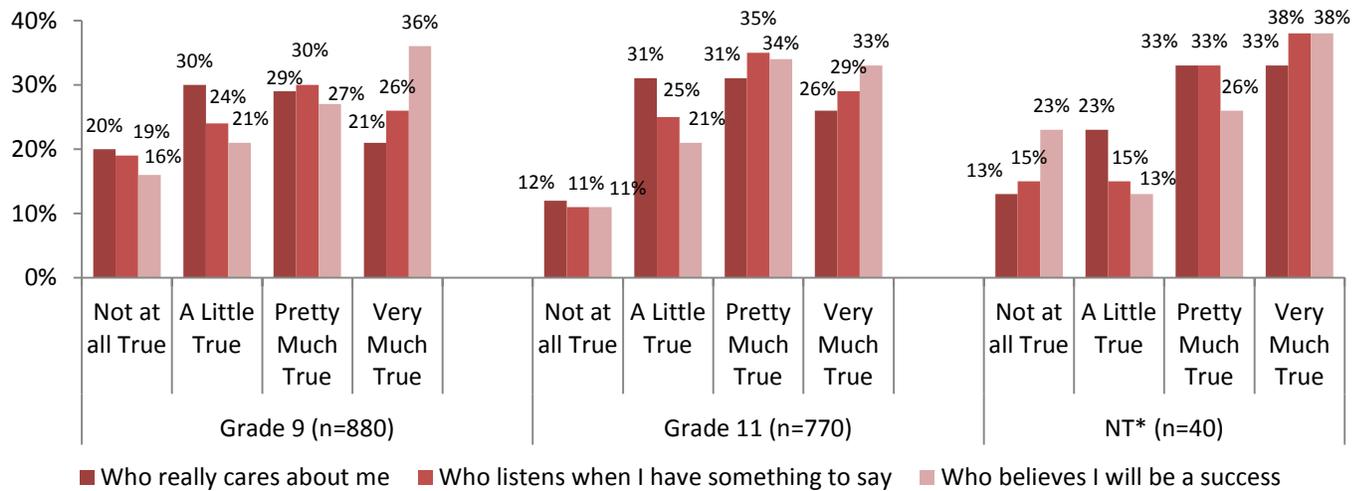
The question asked was: "At my school there is a teacher or some other adult who...."

Similar 2013-14 CHKS school connectedness data for Tulare Joint Union High School⁵³ District are less positive; 16%-20% of 9th graders, 11%-12% of 11th graders and 13%-25% of alternative school students disagreed that they were cared about, listened to or thought of as becoming a success (Figure 17 on the next page).

⁵² Tulare City School District. *California Healthy Kids Survey, 2013-14: Main Report*. San Francisco: WestEd Health & Human Development Program for the California Department of Education. Note that while the CHKS includes a Sexual Behavior Module, this module was not administered.

⁵³ Tulare Joint Union High School District. *California Healthy Kids Survey, 2013-14: Main Report*. San Francisco: WestEd Health & Human Development Program for the California Department of Education. Note that while the CHKS includes a Sexual Behavior Module, this module was not administered.

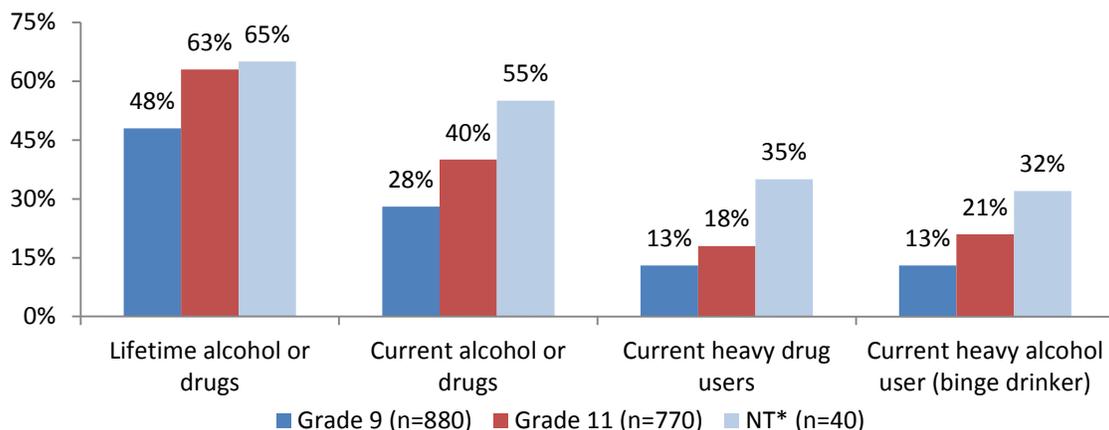
Figure 17. School Connectedness Measures Reported by Tulare Joint Union High School, 2013-14



Source: 2013-14 California Healthy Kids Survey.
 The question asked was: "At my school there is a teacher or some other adult who...."
 *Note: NT includes continuation, community day, and other alternative school types.

Similar to measures of school connectedness, alcohol and other drug (AOD) use is another marker for sexual behavior that needs assessments examine. Despite inconsistencies in the manner in which substance use and risk are sometimes measured, research suggests that the use of alcohol or drugs is related to sexual behavior that is high-risk for HIV/STDs. Additionally, risk-takers may be more likely to use alcohol or drugs on any given occasion and more likely to engage in unprotected intercourse.⁵⁴ As Figure 18 shows, Tulare Joint Union High School students self-reported relatively high rates of current AOD use in the 2013-14 California Healthy Kids Survey.

Figure 18. Summary Measures of Level of AOD Use, Tulare Joint Union High School, 2013-14



Source: 2013-14 California Healthy Kids Survey.
 Note: "Current" experience is past 30 days.
 *NT includes continuation, community day, and other alternative school types.

⁵⁴ Leigh BC, Stall R. Substance use and risky sexual behavior for exposure to HIV: Issues in methodology, interpretation, and prevention. *Am Psychol* (1993);48(10):1035-1045.

Risk Reduction Program

Unintended pregnancy and STDs, including HIV, can be addressed effectively if young people reduce their sexual risk behaviors. In 2013-14, 1,206 students in the mainstream high schools in the Tulare Joint Union High School District (Tulare Union, Western and Mission Oak High Schools) participated in a *Reducing the Risk* curriculum as part of an Altura Teen Pregnancy Prevention grant. The 9th grade students took a pre-test (before the first lesson), a post-test (after the last lesson) and then one year later took a follow up test as 10th graders. Evaluation results from an average response rate of 92% of the students at post-test, and 55.5% of them one year later, provide useful information for better understanding students' knowledge gain and risk behaviors.⁵⁵

As Table 11 shows, the students demonstrated knowledge gain on a variety of questions related to STDs/HIV and condom use, including understanding that parent permission was not required to seek services. A greater proportion of them also reported currently discussing sexual activity, risk factors and prevention with their parents after taking the course. There was some slight loss on all of these measures at the time of the 1-year follow-up, most noticeably with the proportion of students at Mission Oaks currently discussing STDs/HIV with their parents.

Table 11. Percentage of Students Answering Risk Reduction Curriculum Questions Correctly

Topic	Mission Oaks HS ¹			Tulare Western HS ²			Tulare Union HS ³		
	Pre	Post	1-Yr	Pre	Post	1-Yr	Pre	Post	1-Yr
STD/HIV									
Transmission even if healthy	80.8	89.1	88.4	80.6	88.6	84.3	84.7	87.4	-
Incidence	56.8	89.5	-	53.3	86.4	-	52.6	91.1	-
Needle sharing	78.0	94.7	92.5	79.9	93.2	91.3	75.6	94.2	-
Risk for HIV	69.0	85.9	-	66.5	81.4	-	67.9	79.8	66.0
Transmission during pregnancy	68.1	85.3	-	73.0	88.2	-	75.3	82.2	-
Relation to blood donation	37.3	69.2	-	32.0	58.6	-	40.6	64.4	-
No parent permission required	20.6	86.1	57.7	21.6	87.5	-	13.2	77.9	-
CONDOM USE									
Correct placement	30.7	85.3	71.8	35.7	84.3	66.1	29.7	83.7	68.0
Correct process for use	-	-	-	24.8	53.2	49.6	20.6	52.8	43.5
Risk with multiple use	54.7	88.3	-	60.5	84.3	-	58.8	88.7	-
PARENT INVOLVEMENT									
Currently talk about sex	37.3	53.0	42.3	36.4	47.1	43.9	30.0	47.2	-
Currently discuss birth control	22.0	35.3	-	20.7	33.9	-	22.1	38.0	-
Currently discuss STIs/HIV	43.8	51.1	25.3	40.4	48.9	-	-	-	-

Source: Central Valley Health Policy Institute.

(-) Same-question data not available.

¹Pre n=287; post n=266; 1-yr n=241.

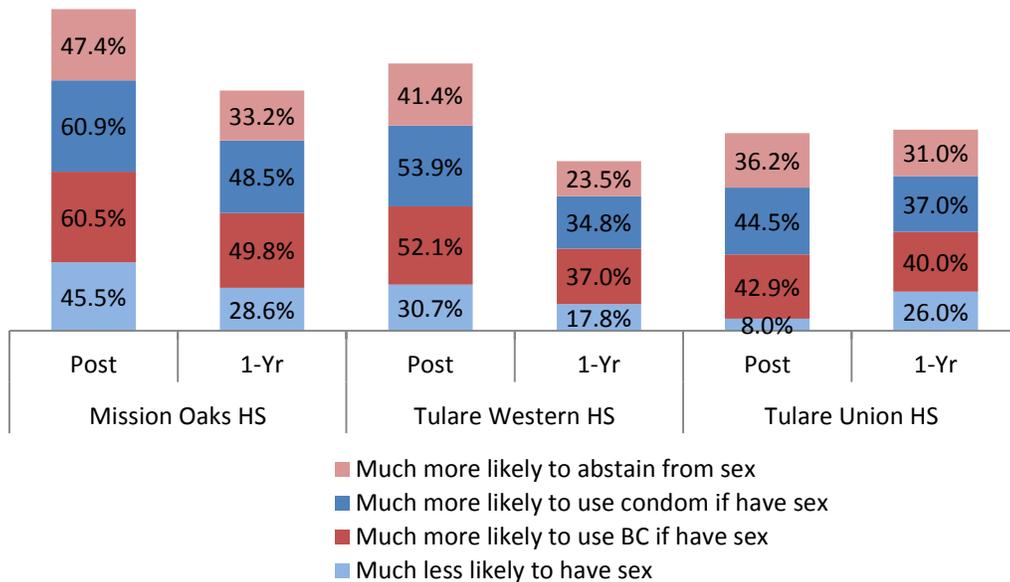
²Pre n=319; post n=280; 1-yr n=230.

³Pre n=340; post n=325; 1-yr n=198.

⁵⁵ The evaluation of this program and all summary data reported here were prepared by Marlene Bengiamin, PhD, Central Valley Health Policy Institute. The same pre/post data were not available for all of the evaluation questions or for all of the schools.

The high school students were also asked several “impact” questions about safe sex practices at the end of the program and 1-year later. Students from Mission Oaks and Tulare Western High Schools reported less likelihood of abstaining from sex and of using birth control including condoms if they were having sex at the follow-up period (Figure 19), indicating riskier behavior, while students at Tulare Union High School reported greater likelihood of using birth control and of using condoms. A greater proportion of the Tulare Union students than at the other 2 high schools indicated at follow-up they were more likely to abstain from having sex than they had a year earlier.

Figure 19. Students’ Self-Reported Likelihood of Using Safe Sex Practices Within the Next Year



Source: Central Valley Health Policy Institute.
The questions were preceded by “In the next year...”

Access to Reproductive Health Services

Individuals in the cities of Tulare and Woodville (as well as the rest of the county) have access to family planning and other reproductive health services through the following organizations.

Altura Centers for Health*

Altura Centers for Health (formerly Tulare Community Health Clinic) is a nonprofit community-based organization that operates 8 federally qualified health centers (FQHC) in Tulare County that provides comprehensive medical, dental, mental health and ancillary healthcare services. Clinic services are provided in Tulare, Tipton, Woodville (MSSA 230 service area) and surrounding rural communities and include 2 school-based mobile clinics. Family PACT services are currently provided at 5 sites. Approximately three-quarters (73.7%) of the patients are residents in the

* Organizations with an asterisk are Family PACT providers and receive Title X funds.

93274 zip code (the city of Tulare). The agency provided services, including family planning and reproductive health services, to 27,020 patients in 2015, 97.2% of whom were living at 200% or less of the federal poverty level. Half (50.2%) of the patient visits were related to women's health (women aged 15-44) with 71.5% reported as receiving cervical cancer screening; 542 of the organization's prenatal patients delivered in 2015.⁵⁶

Family Health Care Network (FHCN)*

Family HealthCare Network is a nonprofit community-based organization that operates 18 federally qualified health centers (FQHC) throughout Tulare and Kings Counties that provide comprehensive medical, dental, mental health and ancillary healthcare services. Tulare County sites include Cutler-Orosi, Farmersville, Goshen, Ivanhoe, Pixley, Porterville, Springville, Terra Bella, Three Rivers, Traver, Tulare Woodlake, and Visalia. Traver is a school-based site—offering full clinic services, including family planning—and Pixley is a satellite of the Traver clinic. The agency provided services, including family planning and reproductive health services, to 131,142 patients in 2015, 97.6% of whom were living at 200% or less of the federal poverty level. About half (48.8%) of the patient visits were related to women's health (women aged 15-44) with 50.3% reported as receiving cervical cancer screening; 2,887 of the agency's prenatal patients delivered in 2015.⁵⁷

Planned Parenthood*

The Planned Parenthood site in Tulare County is located in Visalia and is open 3 full days/week (Tuesday-Thursday) during daytime hours. The clinic provides family planning education; the full range of birth control methods including the morning-after pill; pregnancy testing, counseling and referrals; STI testing, treatment and vaccine; and HIV testing and counseling. Currently, the clinic does not provide physical exams, pelvic exams or Pap smears. This health center does not provide abortion services; it provides counseling and referrals (including to the Planned Parenthood site in Fresno) for women who choose that option.

College of the Sequoias (COS), Tulare Campus

Family planning services on this campus are limited to pregnancy testing with counseling and referral; condom giveaways (provided free to the campus by Planned Parenthood) and HIV/STD education. Planned Parenthood used to offer direct family planning services on the COS campus (limited morning hours, 2 days a week) but does not do so anymore because it reports it needed to build up its current site in Visalia. COS hopes to bring back direct services when the student health center Coordinator completes her nurse practitioner program and could provide the services on the campus.

⁵⁶ <http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=095340&state=CA&year=2015>

* Organizations with an asterisk are Family PACT providers and receive Title X funds.

⁵⁷ <http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=093640&state=CA&year=2015>

Hillman Healthcare Center

Hillman Healthcare Center is a division of Tulare Regional Medical Center and offers the full range of family planning services through 2 outpatient clinics: Tulare Woman’s Pavilion and Hillman Health Care Clinic, both located in the city of Tulare. Reproductive health services (Family PACT, pregnancy testing, counseling and referral out, and prenatal care) are offered daily Monday – Friday 8 a.m. – 5:00 p.m. A sliding fee schedule is available for individuals who do not qualify or have any form of health coverage.

Private Medical Providers Who Accept Medi-Cal

Tulare County residents covered by Medi-Cal receive health services through enrollment in a Medi-Cal managed health plan; the plans contract with private providers, including community health centers, which deliver direct services, including family planning. The state’s Medi-Cal website⁵⁸ shows the following as current Medi-Cal providers in the greater Altura service area:

Table 12. Private Providers Who Accept Medi-Cal (Limited to Altura Service Areas)

Provider	Office Name	Address	City	Zip Code
Geiling, Michael D DO, Inc	Porterville Womens Med Assoc	254 N Kessing St	Porterville	93257
J. Myron Lord, M.D. Inc	J. Myron Lord, M.D. Inc	229 W Cherry Ave	Porterville	93257
Salas, Jose R. MD Inc	Salas, Jose R. MD Inc	575 W Putnam Ave	Porterville	93257
Betre, Abraham DO	Betre, Abraham DO	939 N. Gem Street	Tulare	93274
Gupta, Parul MD	Gupta, Parul MD	979 Gem Street	Tulare	93274
Istvan Potorke, M.D.	Istvan Potorke, M.D.	925 E Merritt Ave	Tulare	93274
Valdivia, Leopoldo E. D.O.	South Valley Women’s Health	1068 N Cherry St	Tulare	93274

Source: California Department of Health Care Services, Medi-Cal Providers by County. December 2016.

*In alphabetical order by city.

It should be noted that these private physicians who accept Medi-Cal in the city of Tulare are OB-GYNs. It should also be noted that it is a 45-minute drive from Tulare to Porterville.

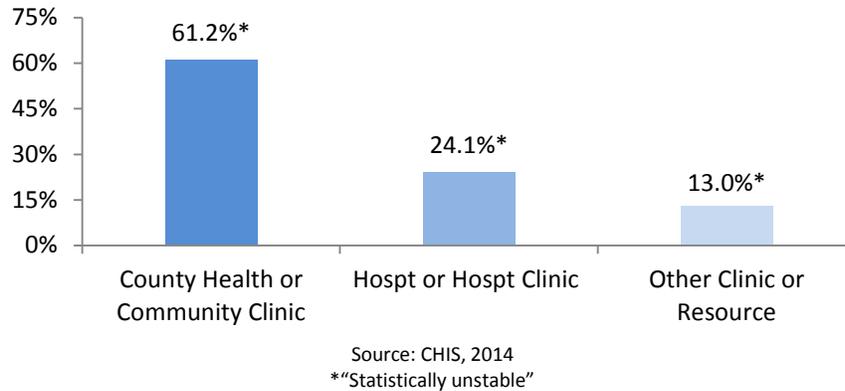
Utilization of Family Planning Services

Despite the availability of reproductive health services, some low-income individuals face barriers when trying to access these services. Notable barriers to accessing clinical family planning services include financial constraints, transportation difficulties, hours of operation, and lack of family planning service providers in rural areas. Adolescents, particularly, face barriers including cost, limited availability, lack of provider acceptance for contraceptive services for teens, and teen lack of awareness of birth control methods. Although the Tulare County data for some of the California Health Information Survey (CHIS) measures are considered “statistically unstable” due to small sample size, they offer an additional picture about utilization of family planning services in the county.

⁵⁸ http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Presumptive_Eligibility/PE%20Qualified%20Providers/54_Tulare_County.pdf

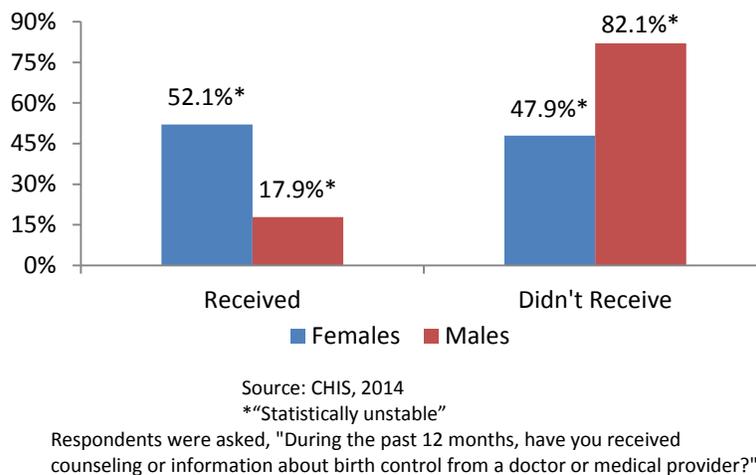
As Figure 20 shows, the majority (61.2%) of adults in Tulare County report receiving family planning services from a community or county health department clinic. Because the survey response choice “Planned Parenthood” had too few respondents to report, it is likely the “Other Clinic or Resource,” which was reported by 13.0% of the respondents, included the Planned Parenthood services which at that time (2014) were offered in the City of Tulare at the College of Sequoias health center.

Figure 20. Main Place Where Adults Ages 18-44 in Tulare County Received Birth Control Services



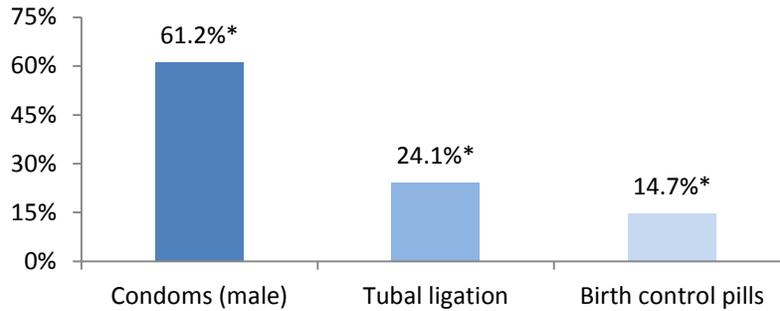
Just over half (52.1%) of adult women responding to the CHIS survey in 2014 said they had received birth control information or counseling from their doctor (Figure 21), while fewer than 1 in 5 men reported receiving information from a medical provider.

Figure 21. Percentage of Adults Ages 18-44 in Tulare County Who Received Birth Control Counseling or Information



The main birth control method or prescription adult women reported using in the CHIS survey was condoms (61.2%) followed by tubal ligation (24.1%) and birth control pills (14.7%) (Figure 22).

Figure 22. Main Birth Control Method or Prescription Women Ages 18-44 in Tulare County Received



Source: CHIS, 2014
**"Statistically unstable"

Note: IUD and "Other" figures too small to calculate.
Asked of females 18-44 years who received a birth control method/prescription from doctor or medical in past year. Excludes women who reported receiving a hysterectomy.

Part 2. Community Input

One of the most important aspects of a needs assessment is obtaining information and views from community members themselves. This involves surveying a representative sample of the community to inquire about needs, use of services and service gaps, barriers and suggestions for improvement. It also explores the factors that affect the design of programs and services to address effectively the identified issues. This report draws on and was enriched by findings from a community input process that included focus groups, interviews and a community survey.

Community Survey

Description of Respondents

Altura staff distributed the *Community Survey* developed for this needs assessment at various community sites in the cities of Tulare and Woodville in an attempt to reach a wide sample of residents in its service areas. A total of 367 surveys were returned, 62.7% completed in English and 37.3% in Spanish (Figure 23).⁵⁹ In 6.6% of the Spanish-language version of the survey the respondent reported not being of Hispanic or Latino(a) origin.

Figure 23. Community Surveys Received by Survey Language Type (n= 367)

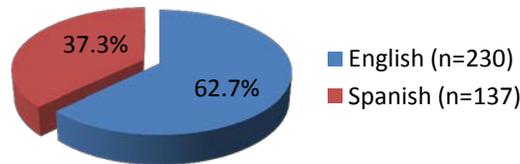


Table 12 on the next page displays selected characteristics of the survey respondents. It should be noted that the respondents represent a convenience sample and so may not be representative of the entire target population of Tulare County or possibly even in the communities in which the surveys were distributed. Nonetheless, the survey results provide the information that was sought from the small subset of the larger population and help illuminate the challenges and opportunities for Altura Centers for Health and other local family planning advocates.

The respondents were most likely to report their age group as 25-44 (68.7%) followed by ages 18-24 (17.2%). Females completed the greatest majority of the surveys, 84.3%. Of the individuals who answered the question about ethnicity, 82.9% identified as Hispanic or Latino(a). Residents of Tulare completed about two-thirds (66.4%) of the surveys and the remainder came

⁵⁹ Although 1,000+ surveys were printed, it wasn't possible to calculate a response rate as some surveys may not actually have been distributed at the sites where they were left.

primarily from the Woodville community; residents of Porterville and Lindsay made up the majority of the “Other” category. The majority (69.1%) of the survey respondents depended on Medi-Cal for their insurance coverage; only 6.4% reported being uninsured.

Table 12. Characteristics of the Community Survey Respondents

Characteristic	Respondents	
	Number	Percent
Age (n=361)		
17 and under	27	7.5%
18-24	62	17.2%
25-44	248	68.7%
45 and older	24	6.6%
Gender (n=362)		
Female	305	84.3%
Male	57	15.7%
Hispanic/Latino origin (n=363)		
Yes	301	82.9%
No	62	17.1%
City or community (n=360)		
Tulare City	239	66.4%
Woodville	92	25.6%
Other	29	8.1%
Type of health insurance (n=359)¹		
Medi-Cal	248	69.1%
Private	62	17.3%
Uninsured/self-pay	22	6.4%
Other	16	4.5%

¹Percentages do not total 100% because 3.1% of respondents chose more than 1 response.

Source of Information About Health

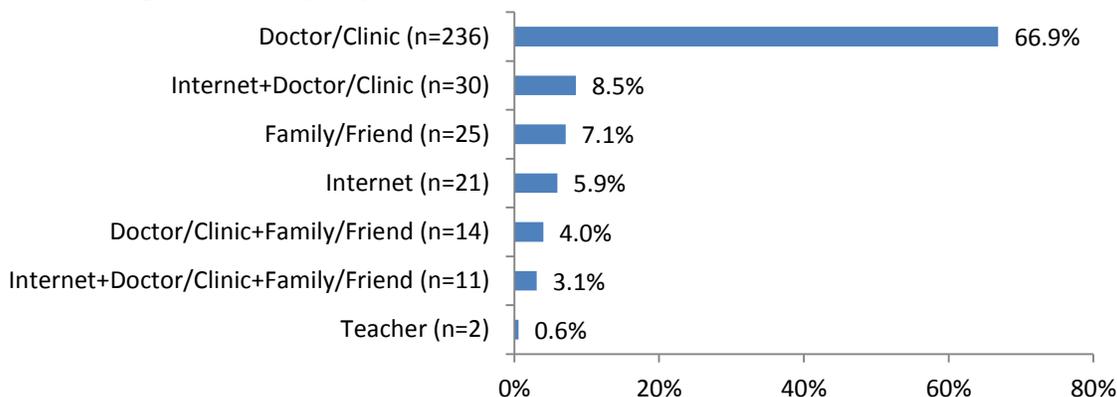
Two-thirds (66.9%) of the survey respondents reported turning to a doctor or clinic when they wanted to get information about their own or their family’s health (Figure 24 on the next page). Only 5.9% said their main source for health information was the Internet, though some respondents checked online use along with other information sources. About 7.1% stated they sought advice or answers from friends and family (“*I trust my mom; she raised a lot of kids*”).

The relatively low use overall of the Internet for health questions is atypical; 72% of adults in the U.S. report depending on the Internet and looking online for health information in the past year.⁶⁰ Dependence on online sources was not age-related; for example, only 25% of the age group 17 and under reported using the Internet to get health information. That so many

⁶⁰Health Online 2013 (January 15, 2013): Pew Survey of Americans' Online Health Habits. <http://www.chcf.org/publications/2013/01/pew-survey-online-health>

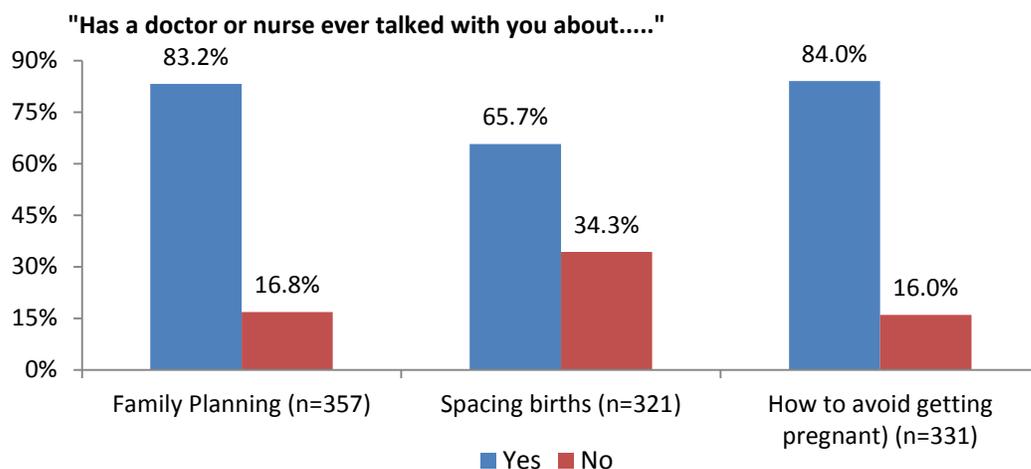
respondents turned to their doctors and clinics indicates the value residents place on these professionals as a trusted source of information and suggests where there might be new opportunities to enhance family planning education.

Figure 24. Survey Respondents' Usual Source of Information About Health Issues



While over 80% of the survey respondents recalled at least one conversation they had had with a doctor or nurse about family planning and avoiding pregnancy, two-thirds (65.7%) indicated the discussion had not included information about spacing births (Figure 25). There were no differences between respondent surveys completed in English or Spanish. Not including the issue of birth spacing in conversations about family planning is a missed opportunity to set reproductive health in the context of good maternal health. Pregnancies that start less than 18 months after birth are associated with adverse maternal and child health outcomes,⁶¹ and, as noted above, inter-pregnancy intervals are shorter for Tulare County women than for women statewide.

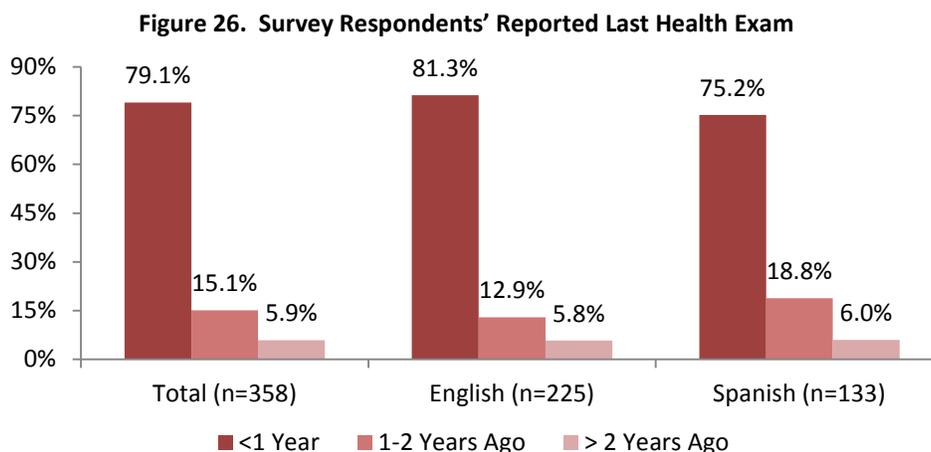
Figure 25. History of Receiving Family Planning-Related Information



⁶¹ DeFranco EA, Seske LM, Greenberg JM, Muglia LJ. Influence of interpregnancy interval on neonatal morbidity. *Am J Obstet Gynecol.* 2015 Mar;212(3):386.e1-9.

Use of Health Services and Source of Care

While most (79.1%) respondents overall reported having a general health check-up within the last year, a slightly higher portion of those who completed the survey in English than in Spanish had had a recent visit, about an 8% difference (Figure 26).

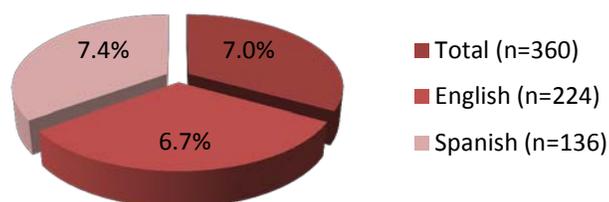


Eighty-nine percent (88.8%) of respondents identified a source for their last health check-up. Where the source they wrote in was legible and specific (vs. generic such as “the clinic”) and legible, Altura was cited in 42.5% of the English-completed forms and 52% of the Spanish-completed forms. Family Healthcare Network was cited in 26% and 48% of the forms, respectively. An additional 24.7% of English-language respondents reported a private physician for their source of care (none of the Spanish-language forms had this response). The remainder included Women’s Community Clinic, Tulare Community Clinic, Hillman, Veteran’s, National Guard, and Mexico.

Awareness of Available Family Planning Services.

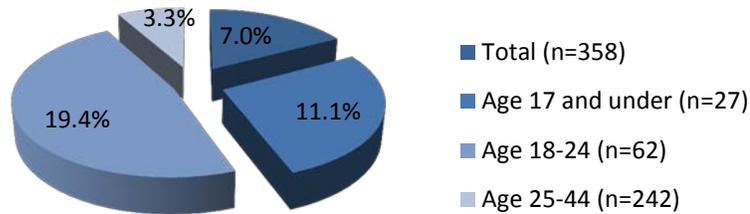
Respondents were also asked if they knew where they could get family planning services in their area (family planning was defined as *birth control, pelvic exams and Pap smears, testing or treatment for sexually-transmitted diseases*). Overall, 93% of the survey respondents replied they were aware of locally available family planning services. While the differences were small, a slightly higher proportion of the responses by those who completed the form in Spanish reported being unaware than in English, 7.4% vs. 6.7% (Figure 27).

Figure 27. Percentage Unaware of Available Family Planning Services, by Survey Language Type



The differences in awareness of available family planning services by age group were notable. The *least* aware group was individuals age 18-24 where 1 out of 5 respondents (19.4%) reported *not* knowing where they could find family planning services in their area (Figure 28). This finding is important as birth rates are highest for women in their 20s⁶² (whether the pregnancies were intended or unintended). The age group with the most awareness was individuals 25-44.

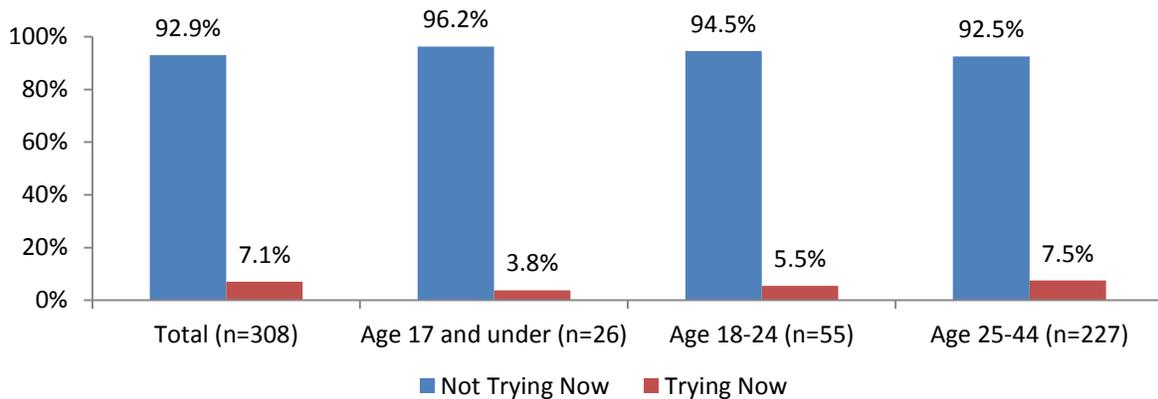
Figure 28. Percentage Unaware of Available Family Planning Services, by Age Group



Pregnancy Goals

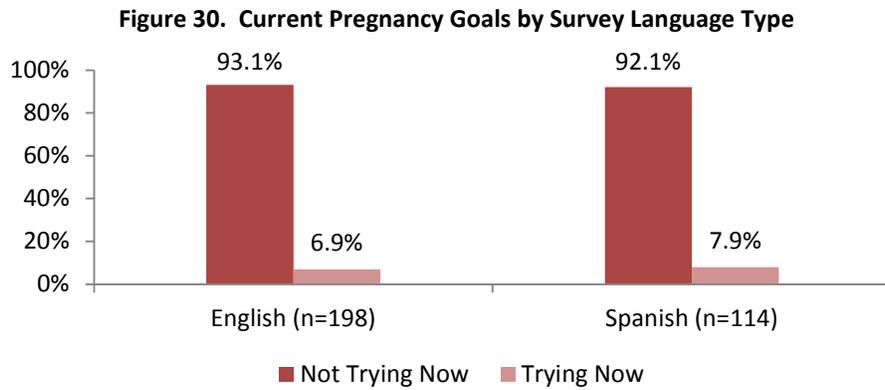
Close to 93% of respondents reported they were currently not trying to get pregnant; 95.7% of the males who answered the question (46 of the 57 male respondents) also reported their pregnancy goal was “not get pregnant now.” The differences by age group were small (Figure 29), with a slightly higher percentage of adolescents age 17 and younger stating this was also their goal.

Figure 29. Current Pregnancy Goals, by Age Group



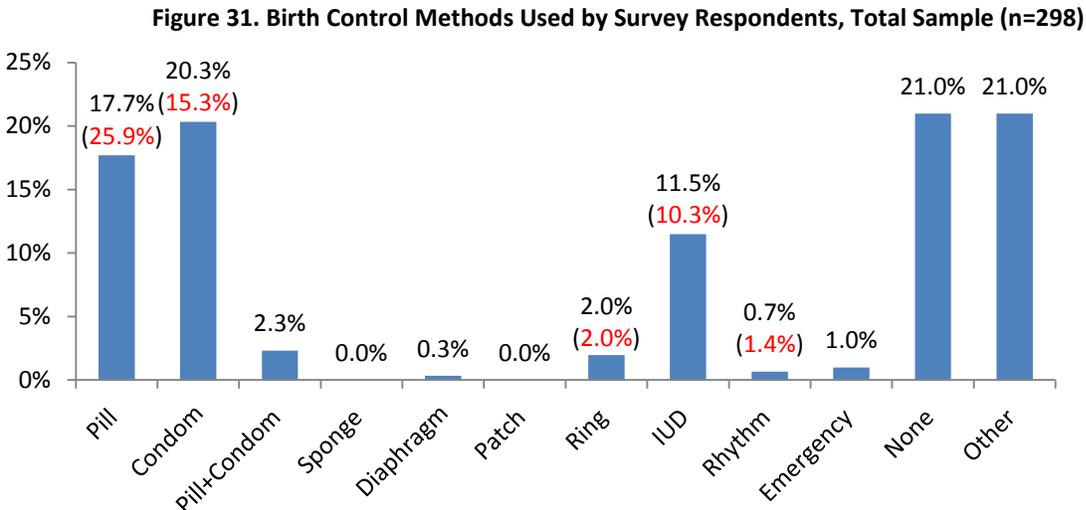
Respondents’ pregnancy goals were very similar whether they completed the survey in English or Spanish, 93.1% and 92.1%, respectively (Figure 30 on the next page).

⁶² Age-Specific Birth Rates, California, 2011, California Department of Finance population estimates.



Method of Birth Control

Respondents who answered “not get pregnant now” as their current pregnancy goal were asked what method of birth control they were using. Contrary to national data, in which the pill was the most common contraceptive method used by women of childbearing age in 2012, the most common method used by Tulare County survey respondents was the IUD, reported by 20.3% of the total sample (Figure 31).⁶³ The difference may be due to the relatively small number of adolescents in the local survey sample. The Tulare County figures for the other methods are similar to the national figures.

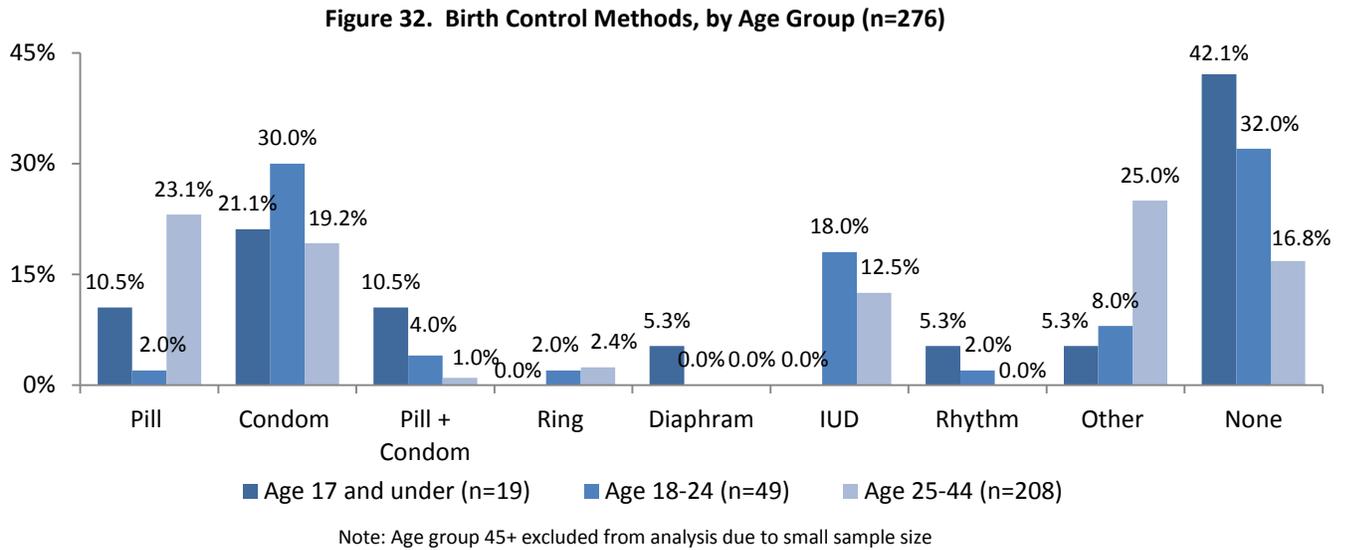


Note: Figures in parenthesis in red are national birth control method-use statistics. Citation is footnote 62.

When the birth control method choices were examined by age group (Figure 32 on the next page), the age group 17 and under reported condoms as the most commonly used method—a less reliable contraceptive method although a good “safe sex” choice. Their proportion of use of

⁶³ Contraceptive Use in the United States. Fact Sheet. September 2016. Guttmacher Institute. <https://www.guttmacher.org/factsheet/contraceptive-use-united-states>

the pill and pill+condoms was the same for both, 10.5%. An unexpected finding for the age group 18-24 was use of the pill—reported by only 2% of respondents; similar to the youngest age group, this young adult group also most commonly depended on condoms (30%) as their main contraceptive method; use of the IUD (18%) followed.



The most commonly used birth control method reported by individuals who completed the survey in Spanish was condoms, reported by about one-quarter (24.2%) of the sample, compared to 19.8% of those responding on the English form (Figure 33). Respondents reported use of the pill second, 21.1% and 17.0% by Spanish- and English-language respondents, respectively. Both language groups reported the same percentage of use of the IUD, 12.6%

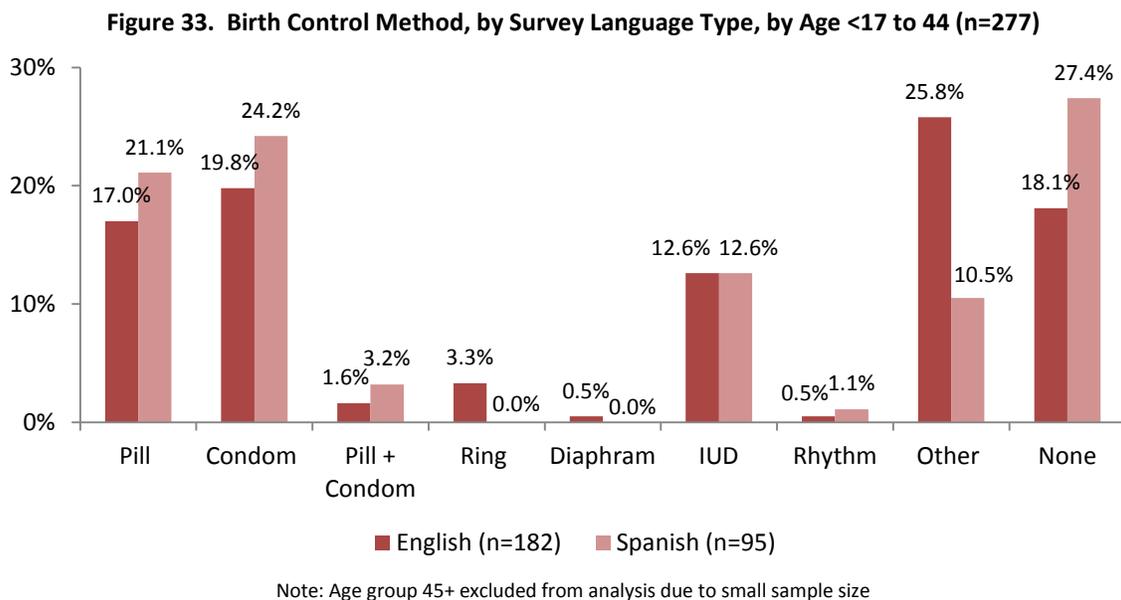


Table 13 describes the “Other” birth control methods the survey respondents reported.

Table 13. “Other” Birth Control Methods Reported by Survey Respondents, Total Sample (n=51)

	<18 (n=1)	18-24 (n=4)	25-44 (n=42)	>45 (n=4)
	<i>n</i>	<i>n</i>	<i>n</i>	<i>n</i>
Male/female sterilization	1 (100%)	0	28 (66.7%)	3 (75%)
Implant	0	3 (75%)	10 (23.8%)	0
Abstinence	0	1 (25%)	1 (2.4%)	0
Injection	0	0	3 (7.1%)	0
Menopause/”old age”	0	0	0	1 (25%)

The findings concerning the group “No birth control method” could be important when looking alongside their self-reported goal of “not get pregnant now” *if the respondents were sexually active*.^{*} Nearly 17% (45 of 268) of respondents claimed to want to avoid pregnancy yet reported not using a birth control method (shown in the red-shaded row in Table 14). These respondents’ self-reported ratings of not wanting to get pregnant while reporting no contraceptive use could imply a case of wanting one thing while practicing another (assuming they are sexually active), or these respondents perhaps not having the knowledge or the resources to act in accordance with their stated pregnancy goals.

Table 14. “Not Using Birth Control” and Pregnancy Goals Reported by Survey Respondents, Total Sample (n=62)

	<18 (n=8)	18-24 (n=16)	25-44 (n=34)	>45 (n=4)
Pregnancy Goals	<i>n</i>	<i>n</i>	<i>n</i>	<i>n</i>
Not get pregnant now	8 (100%)	11 (68.7%)	26 (76.5%)	0
Trying to get pregnant now	0	1 (6.3%)	5 (14.7%)	0
Currently pregnant*	0	4 (25.0%)	3 (8.8%)	0
Menopause/”old age”	0	0	0	4 (100%)

*Note: information not requested on survey but volunteered by some respondents.

Shaded row implies at-risk group.

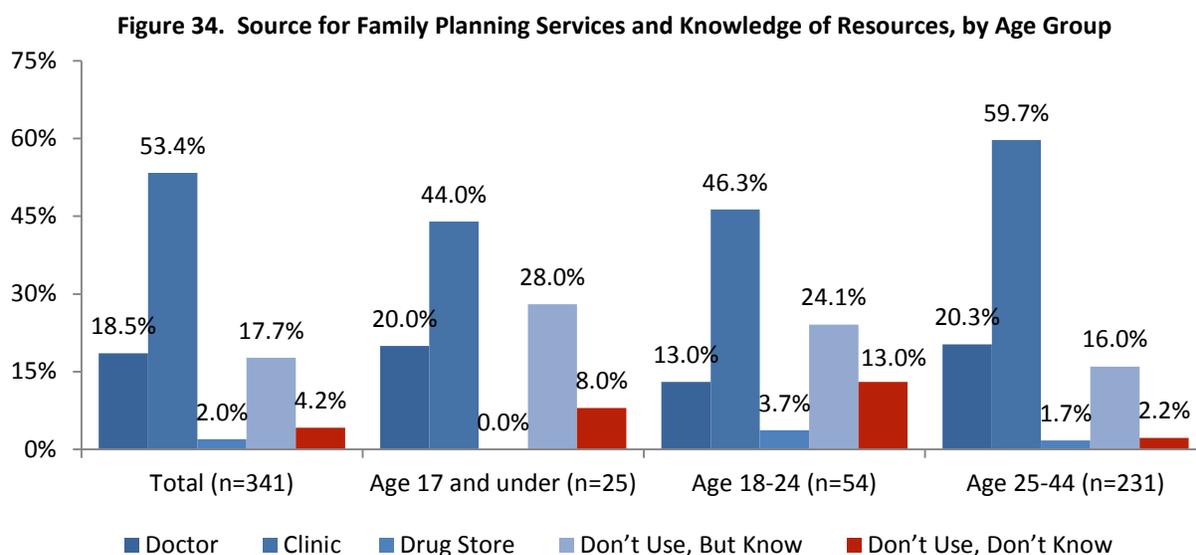
Source for Family Planning Method

Family planning services were most commonly reported to be accessed through one of the area community clinics, used by 53.4% of survey respondents overall, 44%-46% by those age 24 and younger, and 59.7% of those in the 25-44 age group (Figure 34 on the next page). (The clinics they identified going to for family planning generally followed the same pattern as where they

* The survey did not ask respondents to disclose if they were currently sexually active.

reported going for their last health check-up; see discussion on page 33). While private physicians were the source for 18.5% - 20.3% of most respondents, a smaller proportion, 13.0%, of the 18-24 age group cited doctors as their source; the 18-24 year-olds also reported a higher use of drug stores as their main source for accessing birth control methods.

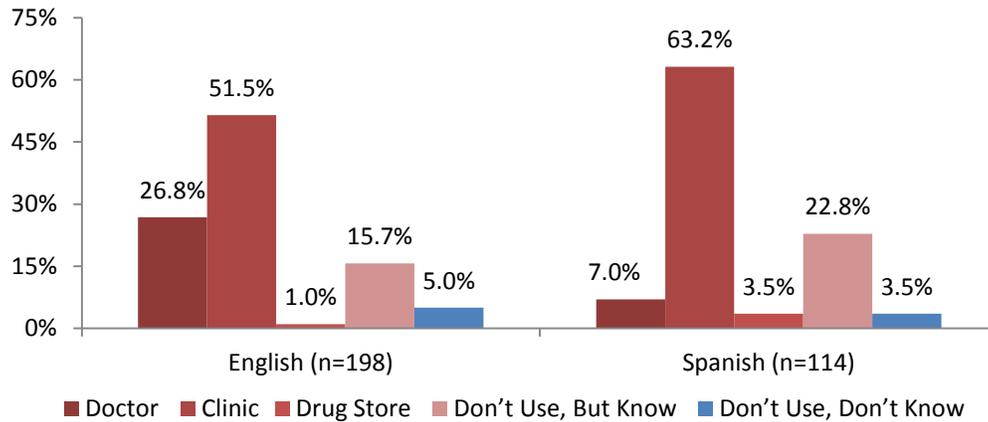
Close to one-fifth of the respondents (17.7%) reported not using family planning services but *knowing* where they could go if they wanted to, while 4.2% not using family planning services said they did *not know* where they could go if they wanted to use the services. Figure 34 shows the variations by age group who reported not using family planning and *not knowing* where they could go (the red-shaded bars in the graph); this was reported by 8% of teens age 17 and younger; 13% of age 18-24; and 2.2% of age 25-44—a potential at-risk group for unintended pregnancy.



Note: Only single response choices are included in the analysis, therefore percentages will not add up to 100%. An additional 0.9% reported “doctor+clinic” and “clinic+drug store,” and 0.8% reported “doctor+clinic+drug store.”

Respondents who completed the form in English were much likelier to use private physicians for family planning services than those who completed the form in Spanish, 26.8% vs. 7.0%, whereas Spanish-language respondents reported higher use of clinics, 63.2% and 51.5%, respectively (Figure 34 above). The Spanish-language respondents not currently using family planning services were more aware of where they could go if they wanted to than the English-language respondents; 5.0% of English-language respondents, compared to 3.5% of Spanish-language respondents, not currently using family planning services reported they did *not* know where they could go.

Figure 35. Source for Family Planning Services and Knowledge of Resources, by Survey Language Type



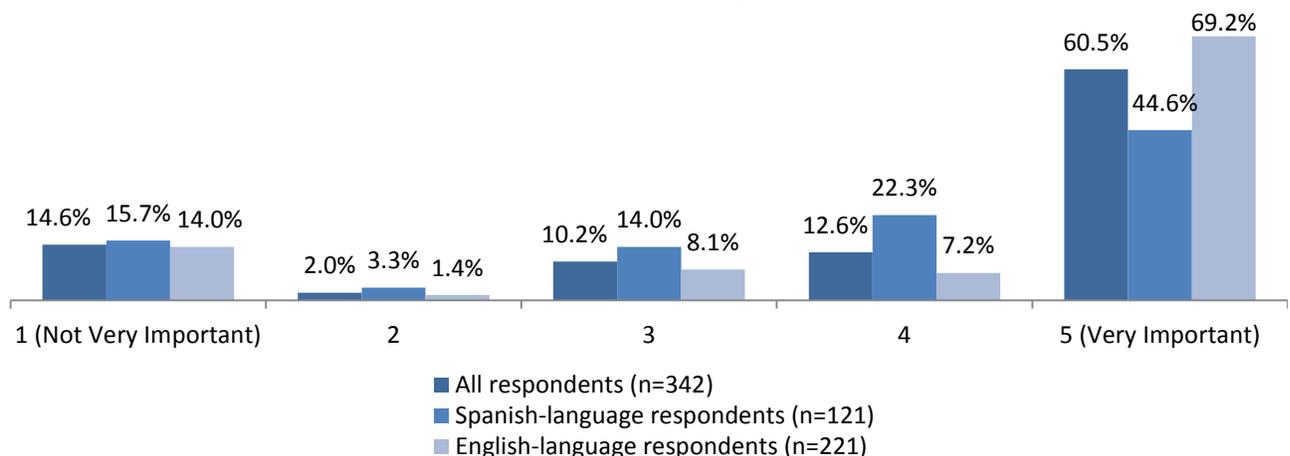
Note: Age group >45 not included. Only single response choices are included in the analysis, therefore percentages will not add up to 100%.

The Relative Importance of Family Planning-Related Concerns

The survey described 5 family planning-related concerns and asked respondents to rate on a scale of 1-5 the relative importance of these issues to themselves. Their responses are shown in Figures 36 - 40 below. Because in some cases family planning services, including outreach and educational efforts, may need to be customized, data are shown separately by survey language group. (Note that one of the concerns, Figure 40, is displayed only for the 2 youngest age groups, i.e., respondents age 24 and under.

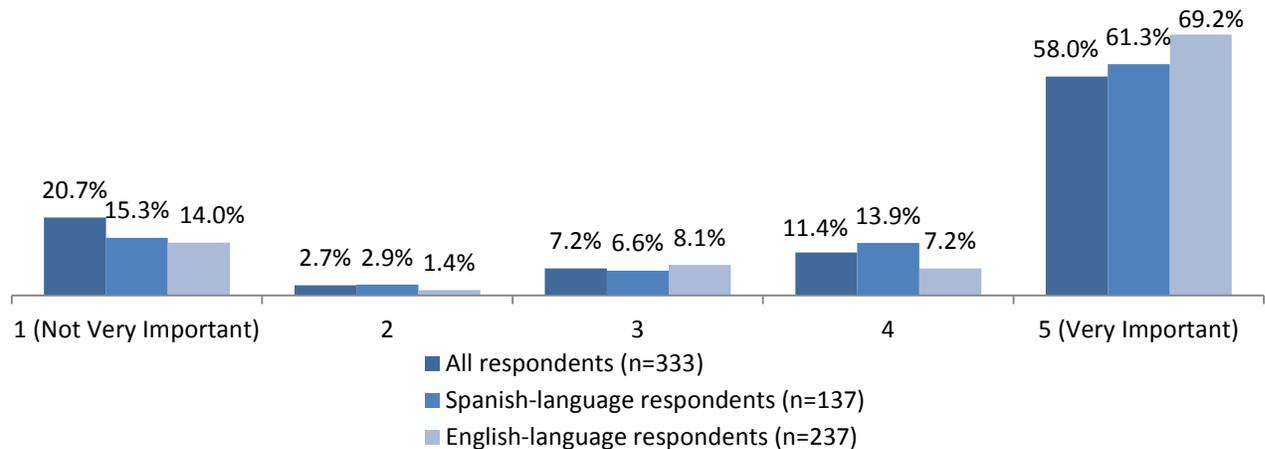
While learning how to communicate with one's partner was viewed as "very important" to 60.5% of the respondents overall, those who completed the survey in English viewed the issue as more important than individuals completing it in Spanish, 69.2% vs. 44.6% (Figure 36). About the same proportion of all respondents considered the issue as "not very important."

Figure 36. The Relative Importance of "Learning How to Talk to My Partner (Spouse, Boyfriend/Girlfriend) About our Relationship"



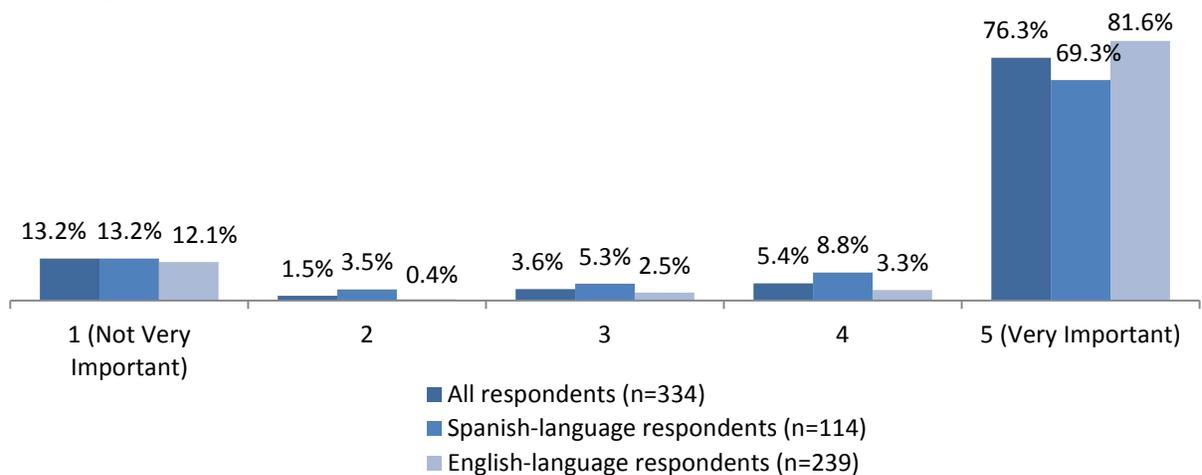
While slightly more of those who completed the survey in English viewed not getting pregnant as “very important” than Spanish-language respondents did (Figure 37), when the importance ratings of “4” and “5” were combined, individuals completing the form in Spanish were slightly more liable to report this issue as important, 75.2% vs. 71.7%.

Figure 37. The Relative Importance of “Not Getting Pregnant”



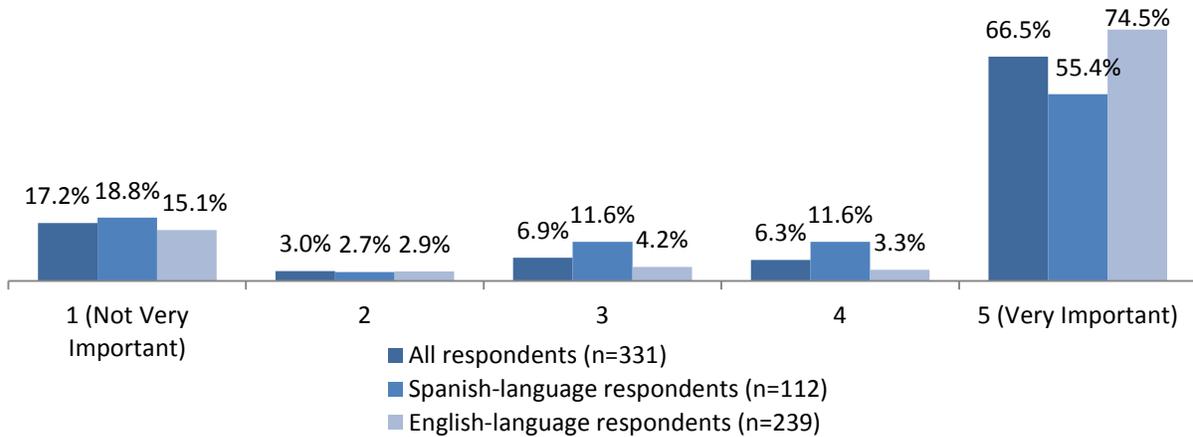
Among all issues rated for importance, not getting an STD/HIV received the highest rating of “very important” by survey respondents overall. Spanish-language respondents rated this concern as less important than English-language respondents did, 69.3% vs. 81.6%, a difference of approximately 18% (Figure 38). About the same proportion of all respondents considered the issue as “not very important.”

Figure 38. The Relative Importance of “Not Getting a Sexually-Transmitted Disease (STD)/HIV”



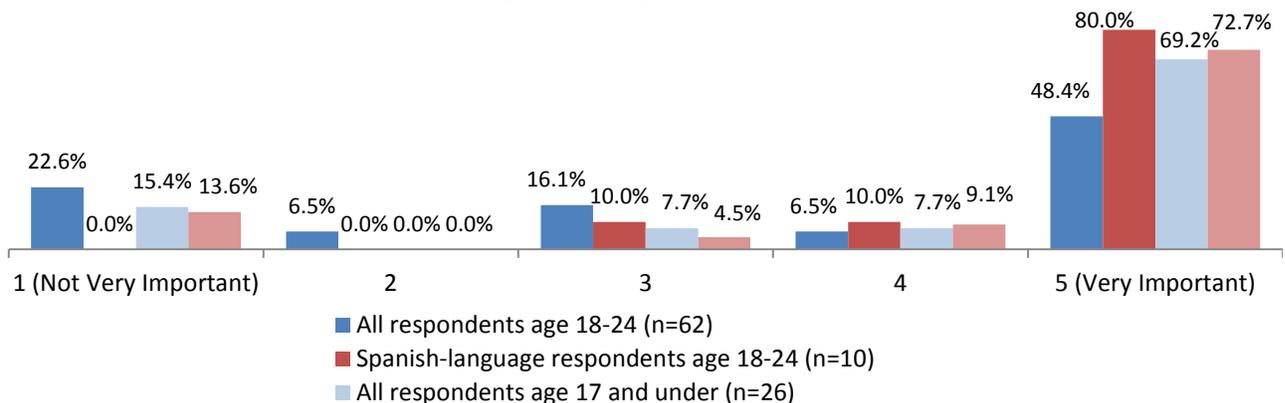
A lower proportion of Spanish-language survey respondents rated getting tested or treated for STDs/HIV as “very important” than English-language respondents did, 55.5% and 74.5%, respectively, a difference of about 35% (Figure 39). The proportion was nearly the same when combining the ratings of “4” and “5.” These findings may indicate a greater need for awareness about these services, or it may be that individuals who viewed this concern as relatively less important did not see themselves to be at the same level of risk as those who rated the concern as more important.

Figure 39. The Relative Importance of “Getting Testing or Treatment for STDs/HIV



As a group, a higher proportion of adolescents and young adults (ages 24 and under) who completed the survey in Spanish viewed learning how to talk to their parents about healthy relationships and sexual choices as “very important.” This was especially the case for those ages 18-24, which could have implications for needed services, though the sample size was very small. About 15% of the age group 17 and under and 22% of the age group 18-24 viewed this concern as “not important,” perhaps because they were uncomfortable with the idea of talking with their parents about sexual matters, did not see the issue as relevant or felt they’d already learned how to talk to their parents about these issues.

Figure 40. The Relative Importance of “Learning How to Talk to My Parents About Healthy Relationships and Sexual Choices”



Additional Input

About one-third (32.2%), or 119, of the survey respondents wrote in comments to offer “suggestions for improving family planning services in your area.” The Spanish-language respondents, who represented 37.3% of the total surveys received, submitted a slightly higher proportion of the written-in comments, 41.5%.

The comments that were legible, understandable and related to the question (about 90% of them) were summarized and are displayed by frequency count in Table 15 below. While the types of comments between the English- and Spanish-language surveys do not appear to be substantively different, they have been separated by language type as this information or the quantity of it may be meaningful to Altura and its partner organizations. There were virtually no meaningful differences in respondents’ general comments based on their city of residence; Table 15 and the paragraph immediately following it note some exceptions.

Table 15. Summary of Survey Respondents’ Suggestions for Improving Family Planning Services in Their Area

Comment	English Frequency¹ (n=59)	Spanish Frequency (n=49)	Total (n=108)
Offer more information about FP responsibility/sexuality broadly	15	12	27
Provide more/better sex education and information in schools	11	6	17
Increase awareness about BC methods and where available	9	7	16
Make appts easier/quicker to get; need later & weekend clinic hours ²	5	4	9
Have more health fairs; promote awareness of when these are	3	2	5
Get MDs to ask more FP-related questions	3	0	3
Nothing needs to be improved	3	0	3
Increase communication w/in families; between partners	3	9	12
Increase community/school education about STDs	2	4	6
Give out contraceptives at school; give out free condoms	2	1	3
Provide sex education for young parents/parents of young children	1	1	2
Provide more activities for teens to counteract negative influences ³	0	2	2
Provide more information about FP in Spanish	0	1	1
Make it clearer FP is a personal choice; let patients decide for self	2	0	2

¹In frequency order by English-language surveys.

²Tulare respondents.

³Woodville respondents.

Some of the verbatim comments listed on the next page are informative and supplement the summarized comments, offering additional insight into respondents’ views. The statements make it clear that for some family planning is still viewed as a female vs. male responsibility, and that only young people are in need of learning how to communicate about sexual matters with their family or partner.

Spanish-Language Surveys

- *“More communication with the fathers that are anti-contraceptives would be helpful.” (Woodville)*
- *“We need classes for prevention of pregnancies and diseases and the risk of them.”*
- *“A program in the community that can help inform us about contraceptives and how long we can use each one.”*
- *“That they talk to us about diseases in young people and how to prevent sexually transmitted diseases.”*
- *“To talk with girls about the methods of contraception and about STDs.”*

English-Language Surveys

- *“Take time with your kids and enjoy them when they are talking to you.”*
- *“I plan to make better choices for my future. “*
- *“I am not really sure what more is needed because there are a lot of clinics that one can go to if needed.” (Tulare)*
- *“Have tubes tied when want to, not when MD says it is time.”*
- *“Online chats for those who are fearful of going in person because there is already plenty of tools and services that are available and even free out there.”*
- *“Health care providers need to be more honest about side effects patients have with certain birth control methods when educating you.”*
- *“Stop making it taboo to talk about sex.”*
- *“Make more events in the area for kids and parents in a little town like where we live so they won’t have bad influences.” (Woodville)*

Focus Groups

Characteristics of the Sample

A total of 69 individuals attended one of the 4 community focus groups held at a variety of host organizations. While no one group was expected to be representative of individuals living in Tulare County, or even necessarily the geographical areas served by Altura, *in the aggregate* the groups generally reflected similar characteristics to residents with family planning-related needs.⁶⁴ Overall, as Table 16 shows, women and men were represented in fairly equal numbers. The participants were typically 25-45 years of age.

Table 16. Focus Group Characteristics

Site/Community	Main Characteristics	Participants
Woodville Child Development Center	Most were ages 25-45; primarily Spanish speaking Hispanic/Latino labor camp families; 9 men, 10 women (primarily husbands and wives).	19
Tulare Head Start	Most were ages 20-35; primarily Spanish speaking, all were Hispanic/Latino parents; 2 men, 9 women.	11
Tulare Adult School	Most were ages 18-35, Literacy/GED students; mixed ethnicity, about half were Spanish speaking; 11men, 18 women.	29
United Way of Tulare	Most were ages 30-60; mixed ethnicity; all women; mix of staff and volunteers, and participants invited from a business next door.	10
Total		69

The focus group participants were generally candid during the discussions and most actively participated; several individuals asked many questions. While a few, especially in the larger groups, remained silent, in general all of the participants seemed to be very engaged in the topic—men as well as women—particularly when it concerned how to talk with their children about sexuality.

Knowledge and Use of Family Planning Resources

Between half and two-thirds of the participants, across all 4 groups, said they were aware of one of the Altura Centers for Health clinics though there was some confusion about what services were offered at which clinic site (e.g., prenatal care). In general, the groups were equally divided between going to Altura, Family Health Care Network and private physicians for their source of health care and/or family planning services. The largest majority of women reported having had

⁶⁴ As was mentioned earlier, an important group underrepresented in these data is adolescents; 2 additional focus groups of high school students had been planned and scheduled; ultimately, however, the school was not able to generate interest among the students and parents (who had been asked to explicitly approve students' participation) and the sessions were cancelled.

a Pap smear (or “woman’s examination”) within the last 1-3 years, similar to what was reported to CHIS as described on page 19.

Similar to the Community Survey respondents, the focus group participants reported “the doctor” (which likely also referred to the clinic providers) as the main source of information when they had questions or concerns related to family planning or reproductive health. A handful said they also accessed the Internet and 2 or 3 stated they sometime turned to family and friends (“...but they probably don’t know any more about these things than I do”).

Reasons for Unintended Pregnancy

Participants at the Tulare Adult School and the United Way of Tulare tended to be the most vocal in sharing their personal experiences and opinions about why they or females (or couples) they knew had gotten pregnant unintentionally. While a couple of individuals said their birth control method had failed, the pregnancies were due to avoidance or nonuse of a method before their unintended pregnancy or birth. The most common reasons are examined in Table 17.

Table 17. Most Common Reasons for Unintended Pregnancy among Focus Group Participants

Reason	Explanation
<i>“I didn’t think I could get pregnant.”</i>	A very common reasons for not thinking they could get pregnant was due to lack of accurate information: <i>“wrong time of the month to get pregnant;”</i> <i>“only did it once;”</i> <i>“doing it standing up;”</i> and, <i>“just starting my periods.”</i>
<i>“I didn’t expect to have sex.”</i>	The passion of the moment (or, as one young woman stated as many heads nodded in agreement, <i>“No, not passion, lust”</i>) and the unanticipated opportunity (<i>“My mom was at work”</i>) largely accounted for being unprepared, though some shared that they wanted to become sexually experienced. Giving in to pressure by a boyfriend or a date (<i>“If you really loved me you would...”</i>) was also a reason.
<i>“I didn’t really mind if I got pregnant.”</i>	Despite was what typically described as <i>“being from a conservative Catholic family,”</i> some female participants indicated they were ambivalent about pregnancy or were <i>“OK with taking a chance.”</i> In some cases, they had seen their older sisters become pregnant during high school (or junior high) and the baby –because the pregnancies usually resulted in births— <i>“wasn’t a disaster”</i> for them.
<i>“I was worried about the side effects of birth control methods.”</i>	A few of the participants (including one male, on behalf of his wife) indicated that they were concerned about side effects, including long-term consequences, of some methods so chose to depend on condoms exclusively or natural family planning methods

Table continues on next page

Table 17, cont.

“My partner failed to use a condom [he said he’d use].”

While studies have shown that nonuse of contraception can sometimes be because a woman’s male partner did not want *them* to use a birth control method, or the male partner refused to use a method, this was not mentioned in any of the groups. A couple of the female participants, however, reported depending on males who did not follow through with their stated intention to use a condom or what they had assumed was “*his responsibility because he said he would take care of it.*”

Concerns about Sexual Health and STDs/HIV

We did not specifically inquire about engaging in risky sexual behaviors, such as sex following alcohol or drug use and number of partners, but in each focus group participants expressed concerns about STDs and HIV. In general, when asked about condoms, most participants linked them with HIV as well as STD prevention, though the extent of their use solely for that purpose was unclear.

Goal Orientation

Avoiding unintentional pregnancy by setting and working toward achievement of personal life goals for which unintended pregnancy and childbearing can be a derailment—such as finishing high school and going to college or training for a business—did not seem to be a strong motivator for some of the young adult participants. When the facilitator asked how an unintended/unwanted pregnancy could be associated with “interfering with your goals for your life,” there were very few responses among the older adolescent/young adult participants, especially in the largest focus group. Despite repeated encouragement to engage in this discussion, it was unclear whether the low response was due to not understanding or disagreeing that there could be negative consequences of unintended pregnancy, not having set life plans or thought much about doing so, or not wishing to discuss personal plans in front of acquaintances.

The groups were also asked to comment on the observation “some traditional families don’t have goals for their daughters beyond becoming wives and mothers,” that had been shared by a couple of the key informants during the interviews for this study. While most of the participants said they had not heard about or observed this—with some parents saying that educational achievement *was* important for their daughters as well as their sons—there were a few women in the groups who acknowledged this had been true for themselves (“*I am that girl; those were my parents*”).

Communication about Sex

One of the main topics discussed during the focus groups—and what appeared to be of most interest to the participants who were parents—was talking with one’s children about sexuality; for example, responding to their inevitable questions about sexual development and

reproduction. While many of the parents stated they were uncomfortable knowing at what age to start and what to say, it was very clear they *wanted* to learn these skills to *become* comfortable (“*How do you even start the conversation about this?*” Mother of a 10-year old son). When the facilitator asked for a show of hands of how many parents would be interested in attending a series of classes on “talking with your kids about sex” if this was offered in their area, nearly every hand went up.⁶⁵

Comments parent made that reflected their understanding of the importance of communicating with their children about sex, relationships, and reproductive health included the following:

- *“It’s really important to be open with them, stay calm.”*
- *“We should talk to them earlier than we think.”*
- *“As a parent, we are the best person to educate our child about sexuality.”*
- *“My son [aged 10 or 11] asked me what the HPV vaccine was for. I didn’t know a lot about it, but I told him it was for when he would have sex. I don’t know if he really got that.”*
- *“Most schools don’t offer such good sex education programs, so kids get much of their information about sex from their friends I think.”*
- *“Kids aren’t learning what their parents would like them to learn about sex, or what they are doing, watching the things they show on videos/movies/TV.”⁶⁶*

Focus Groups’ Recommendations for Improvement

Focus group participants offered the following specific suggestions Altura could help with to improve access to family planning-related services, in order of frequency mentioned:

1. Offer or arrange to offer classes to help parents communicate more effectively with their children about age-appropriate sexual matters. Tailor the classes to a conservative community. Offer them by a well-informed native Spanish speaker.
2. Present local statistics about teen pregnancy and STD rates at community forums and public policy meetings.
3. Put up theme-related posters and put out flyers about the availability of family planning services (including eligibility criteria) at schools and other appropriate community places, especially where teens congregate.
4. Encourage K-12 schools to offer comprehensive, age-appropriate family life/human sexuality classes (“*not just one-shot lectures or talks by the coach*”), starting early.
5. Have more mobile and school-based family planning clinics.

⁶⁵ The question was only asked at the Tulare Head Start and Woodville Child Development Center groups.

⁶⁶ For example, see Collins RL, Elliott MN, Berry SH, Kanouse DE, Kunkel D, Hunter SB, Miu A. Watching sex on television predicts adolescent initiation of sexual behavior. *Pediatrics*. 2004 Sep;114(3):e280-9.

Key Informant Interviews

Thirteen key informants identified by Altura Centers for Health agreed to participate in an interview (Attachment 1). The interviews were conducted by telephone and generally lasted 30-40 minutes.

The key informants represented a cross-section of Tulare County as well as a focus on the cities of Tulare and Woodville, and included health and human service professionals, community-based organization representatives, school administrators, and other individuals with an informed perspective about the Tulare County population and needs related to reproductive health services. While most of the interviewees spoke to the issues they knew best from their professional roles, many were also able to consider and offer suggestions when prompted with questions to help them think about the region’s population characteristics, cultural and political landscape and other factors that influence access to and use of family planning services.

Highest Unmet Needs

Nearly every key informant identified the need for more preventive education as the major unmet need in the county relative to family planning (Table 18). Their remarks primarily concerned middle and senior high school students in light of the county’s high teen pregnancy rate, a community indicator well known to all the interviewees. About one-third of the individuals also mentioned how uninformed many parents were about family planning and reproductive health services for themselves, much less having accurate information (and *comfort*) to be able to share with their children about these issues.

Table 18. Unmet Needs for Family Planning Identified by Key Informants, Rank Order (n=13)

Issue	Frequency of Mention
Preventive education for teens and pre-teens (especially through school)	13
Education for parents (for themselves and vis-a-vis their children)	5
Better access to services: transportation	2
Better access to services: more clinic sites in rural areas	2
Bilingual clinic staff for appointment-making as well as for clinic services	1

An important point was made about the need for more cultural competence in the family planning education that *is* offered—and especially *community* education (vs. in a clinic setting) such as what is offered through parenting classes and home visitation programs. For example, using bicultural/bilingual educators who have been well trained about and are themselves comfortable with reproductive health issues for families whose primary language is Spanish.

A couple of people who agreed that there was a broad need for more preventive education remarked that “*It helps some kids but some are too naïve,*” which speaks to the need for tailoring education to the type of students one is trying to reach, i.e., one model or one approach does not fit all.

One individual thought that schools “provide enough” information, and commented that it was parents not taking the time or making the effort to talk with their children about values and expectations that represented the greatest need for change.

Additional comments that reflect the key informants’ perspectives include the following:

- *“There’s relatively poor education provided that is embedded in the conservative nature of the county.”*
- *“Students can’t receive the information when they need it – some only much later, in college, if they go.”*
- *“There’s a perception among teens and young adults that there’s no place for young people to go [for family planning], and they’re skeptical about confidentiality; they don’t want to go where their parents go.”*
- *“We tell students about condoms, but we don’t always demonstrate it to them but just assume they will know how [to use it]; even the clinic education about this isn’t always consistent.”*
- *“Kids just need the ability to talk with someone one-to-one when they need help going through stuff; the right person isn’t always there, or is there but doesn’t have enough information.”*

Identified Barriers and Other Challenges

Without question, the number one challenge mentioned by nearly all of the key informants for meeting more of the family planning need was “the conservative nature of Tulare County—politically, socially and religiously.” When prompted to expound, the interviewees talked about cultural norms, influence of the Catholic and evangelical churches, and “overly cautious” politicians as presenting the greatest barriers to more accessible family planning information and services in the county. Table 19 explains these comments.

Table 19. Main Barriers Related to Family Planning Identified by Key Informants*

Issue (Broadly Defined)	Perspectives
Cultural	<ul style="list-style-type: none"> ■ Hispanic culture is more conservative; many parents don’t feel comfortable or “properly educated” to approach the subject. ■ Cultural tolerance or acceptable in Hispanic culture may be different, e.g., may be less “distressed” by unintended teen childbearing in their family. ■ Multigenerational problem: teen pregnancy “not such a big deal” because mom or older sister also bore children when teens/when not married. ■ Too few people (especially girls) not goal oriented, e.g., some traditional

	<p>families, such as Hispanics and Muslims, don't have high educational expectations for their daughters or encourage their going away to college (<i>"They expect them to become wives and mothers and stay home"</i>).</p> <ul style="list-style-type: none"> Teens' own values about dating: <i>"Does it always need to mean going to bed with someone?"</i> Small rural communities where people know one another makes confidentiality more of a concern.
Political	<ul style="list-style-type: none"> Some on the Board of Supervisors <i>"have their heads in the sand"</i> and won't touch the issue (<i>"It's a convoluted matter here in the county"</i>). Some school administrators <i>think</i> (<i>"but don't really know"</i>) that parents would oppose sex education for their students. <i>"The culture of Tulare County is that no one wants to talk about sex."</i>
Religious	<ul style="list-style-type: none"> <i>"Families who go to church think they're safe [from teen pregnancy in their family]."</i> Some of the more traditional families (e.g., foreign-born Muslims, Catholic Hispanics) not open to engaging on the issue.
Other	<ul style="list-style-type: none"> <i>"Sex is the one thing parents don't want to touch [as a subject]."</i> Kids get their education from friends; much is misinformation. Other more basic needs, <i>"like clean drinking water,"</i> intervene as a priority. Parents working so kids not being supervised after school. Kids who are depressed (e.g., need for more mental health services for students) and turn to risk behaviors for validation, relief, etc.

*Italicized words or phrases in quotation marks are verbatim remarks.

Additional comments and perceptions that help shed light on areas that could be addressed with improvement strategies included:

- "It's really hard to get fathers involved in this subject."*
- "No one really seems to care about this [teen pregnancy] or take it too seriously in our county."*
- "The clinics don't do as much as they could to provide the kind of informed decision making about sex and family planning that makes people really think about relationships, personal goals, personal responsibilities; they tend to just focus on 'here are the choices of birth control methods.'"*
- "When it's even offered, the quality of sex education in the schools here is really low."*

- *“Parents’ own relationships aren’t always that great so it makes it more difficult to talk to your kids about these things.”*
- *“Kids think if they use a condom ‘it should be ok;’ but they don’t use it properly or use it all the time.”*
- *“Teens don’t always see the caution about choosing just 1 partner—or who the partner is.”*
- *“There’s a misconception that once you’re pregnant ‘your life is over’ when you get pregnant, but that’s not true because there are a lot of services to help.”*

Opportunities for Improvement

The key informants were asked to think about the communities served by Altura, and identify recommendations for improving reproductive health and family planning services to address the issues they had identified. Their suggestions are summarized in Table 20 and discussed below. Note that some of the recommendations are not mutually exclusive and support for one could positively impact another. Some are relatively low-cost strategies that could be undertaken even with limited dollars and good coordination and effective collaboration, while other improvements could require policy change, more public/private cooperation and increased funding.

Table 20. Priority Improvement Recommendations Offered by Key Informants (n=13)

Community Oriented
<ul style="list-style-type: none"> ▪ Embed family planning messages in all kinds of programs that reach pregnant women, families and young people. ▪ Assign only people who are comfortable talking about reproductive health issues to provide community education. ▪ Establish more family planning services via school-based clinics (<i>“schools are the hub of the community”</i>). ▪ Expand family planning services countywide; Ducor and Lindsay were given as examples. ▪ Use more non-traditional approaches to sex education; be frank; make it more “real” for adolescents and young adults. ▪ Integrate human sexuality/family planning in non-traditional places, starting early such as at Head Start. ▪ Include more outreach and emphasis on male responsibility.
Policy Oriented
<ul style="list-style-type: none"> ▪ Establish a multidisciplinary Coalition or Task Force with a long-term commitment to change. ▪ Engage community leaders (and politicians) from various cultures to champion family planning issues. ▪ Connect the problem to mental health and well-being to set it in a broader whole-life context.

None of the key informants could recall that there had ever been a countywide coalition or task force dedicated to the issue of addressing the county's inordinately high teen pregnancy (and STD) rate. All of the interviewees enthusiastically agreed this was a critical step when told that some interviewees had suggested establishing such a group to tackle the problem. They thought this was one of the best uses of Title X funds that Altura (and others) could help to support. They stressed the need for a concerted effort among a multidisciplinary group (that includes engagement of community leaders, stakeholders, parents and youth) to increase awareness of the data, hammer out the problem and commit to a doable plan, identifying what it will take to reduce the incidence of these high rate—*“assuming there is the political will to do so.”*

Those who made suggestions regarding parent education stressed the need to make the approaches culturally appropriate (see above), as well as look for ways to help students form deeper relationships with trusting adults. To increase the potential for attendance of parents they offered practical suggestions based on experience: do not schedule programs at times in the evening when many in the Hispanic/Latino community are watching “novellas” (turnout would be low) and offer food, music, prizes (such as could be donated by vendors) and childcare as incentives (*“parents will respond when hosted properly”*). Targeting certain families with educational efforts who may need more tailored approaches, such as migrant workers and English Learners, was also suggested. Eventually some of the “hard to reach” parents would show up, they said, because of positive word-of-mouth endorsement by others.

Specific comments relative to this recommendation included:

- *“We need to quit throwing it [sex education] off on people who aren’t comfortable teaching it.”*
- *“Use nurse educators; they aren’t embarrassed about it.”*
- *“We can’t change things the parents do in the home.”*

SUMMARY

- Women in Tulare County have cervical cancer screening rates similar to the statewide average; rates of mammogram screening are somewhat lower.
- The 3-year (2012-2014) case rate of chlamydia for the county was slightly higher than the statewide rate, 493.9 vs. 447.0. Although the overall number of cases for gonorrhea and syphilis in the county are lower than that of chlamydia, the 6-year trend for each of those STDs is on the rise.
- Tulare County's birth rate is about 25% higher than the statewide average.
- Pregnancies that start less than 18 months after giving birth are associated with adverse maternal and child health outcomes. Inter-pregnancy intervals are shorter for Tulare County women than for women statewide.
- Tulare County women and teens who have unintended pregnancies from nonuse or inconsistent use of contraception may be unprepared for it and thus may be slower to obtain needed prenatal care and less aware of other changes they should make (such as improving nutrition or quitting smoking), compared with women with intended pregnancies. These factors may result in less favorable outcomes.
- Dependence on condoms as their main contraceptive method was the most common for the age group 18-24 reported in the Community Survey; only 2% said they used the pill.
- 45 of 268 (17%) of Survey respondents reported their pregnancy goal as "not get pregnant now" yet reported not using a birth control method; this cohort could constitute an at-risk group if they are sexually active.
- 13% of ages 18-24 Survey respondents not using family planning services said they did *not know* where they could go if they wanted to use the services, representing another potential at-risk group.
- The county's 3-year average (2012-2014) adolescent birth rate of 43.8 was nearly twice the statewide rate of 23.4, ranking the county 56th worse in the state on this indicator; though rates *are* declining, the gap between the local and state rate hasn't significantly changed in the last decade.
- 31% of the births in the county in 2012 were to mothers with no high school completion, compared to 20.3% statewide.

- Between 16%-20% of 9th graders and 11%-12% of 11th graders at Tulare Joint Union High School reported to the CHKS they disagreed they were cared about, listened to or were thought of as becoming a success by adults at school. School connectedness, like alcohol and drug use, is a marker for sexual behavior.
- Focus group participants, regardless of gender or ethnicity, shared that they needed and *wanted* help learning how to talk with their children about sex, family planning and reproductive health, implying they will be receptive if offered *tailored* classes and *effective* community education efforts.
- Parents expressed much concern about where and how their children and teenagers were learning about sex, with media being a major source of information. (According to research, the average child will have viewed over 14,000 sexual simulations and sexual innuendos each year.⁶⁷)
- Avoiding unintentional pregnancy by setting and working toward achieving personal goals for which unintended pregnancy and childbearing is often a derailment seemed to be a foreign or far-off concept for some of the young adult participants in the focus groups. Goal setting is a “family planning” concept that can be incorporated into a child’s life early on.
- Health care providers can help by using every patient encounter as an opportunity to integrate reproductive life planning into every clinical encounter, including acute care and prenatal visits. The American College of Obstetricians and Gynecologists, for example, encourages providers to do this and suggests how this can contribute to the goal of reducing unintended pregnancy.⁶⁸
- An understanding of how to improve the delivery of reproductive health services in Tulare County has the potential to increase consistent contraceptive use and reduce high rates of unintended pregnancy. The recommendations of the community—through surveys, focus groups and interviews—that emphasized the need for more timely preventive education and support services for young people and their parents make these goals clear.
- Establishing a multidisciplinary countywide coalition or task force dedicated to the issue of addressing the county’s inordinately high teen pregnancy (and STD) rate is overdue. This appears to be the next critical step for Tulare County Title X grantees, their partners and stakeholder groups.

⁶⁷ See, for example, Brown JD, Steele JR, Walsh-Childers K, editors. *Sexual teens, sexual media*. Mahwah, NJ: Lawrence Erlbaum Associates; 2002, and Derksen DJ, Strasburger VC. Children and the influence of the media. *Primary Care*. 1994;21:747–758.

⁶⁸ <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-Life-Planning-to-Reduce-Unintended-Pregnancy>.

ATTACHMENTS

Attachment 1

List of Key Informants

(In Alphabetical Order by First Name)

Name	Affiliation
Barbara Rose	Regional Coordinator, Planned Parenthood Mar Monte
Beverly Furnier	Head Start Supervisor (Lindsay, Porterville, Woodville Strathmore, Ducor)
Cheryl Cereghino	Inmate Programs Manager, Tulare County Sheriff Department
Cheryl Duerksen	Former Director, Tulare County Health and Human Services Agency
Christina Saucedo	Senior Program Officer, First 5 Tulare
Diana Rogers	Chronic Care Manager, Family Healthcare Network
Herman Villarreal	Vice Principal, Woodville Union School
Isabel Valenzuela	Head Start Supervisor (Dinuba, Orosi, Visalia, Tulare, Earlimart)
Jason Britt	Director, Tulare County Health and Human Services Agency
Manuel Cosio	Area Manager, Housing Authority of Tulare County
Michelle Nunley	Principal, Tulare Union High School
Pattie Alvarez	Health Center Coordinator, College of the Sequoias, Tulare Campus
Tim Zavala	Executive Director, Tulare Youth Service Bureau



COMMUNITY SURVEY

Please take a few minutes to complete this family planning health survey. Your opinions will help us learn how we can provide better services for you. Thank you!

First, please tell us about yourself:

- 1. What is your age group? ___ 17 and under ___ 18 – 24 ___ 25-44 ___ 45 and older
2. What is your gender? ___ Female ___ Male
3. What city/town do you live in?
4. Are you of Hispanic/Latino(a) origin? ___ Yes ___ No
5. What kind of health insurance do you have? ___ Medi-Cal ___ Private ___ Uninsured/self-pay ___ Other
6. When you want to get information about your or your family's health, where or who do you usually turn to? ___ Internet ___ Doctor/clinic ___ Family member or friend ("word of mouth") ___ Teacher ___ Other (Where?)

Please answer the following questions:

- 7. When was your last health check-up? ___ In the last year ___ About 1-2 years ago ___ More than 2 years ago
8. Where did you go for your last health check-up?
9. Do you know where you can get family planning services in your area? (For example, birth control, pelvic exams and Pap smears, testing or treatment for sexually-transmitted diseases) ___ Yes ___ No
10. Where do you go for family planning services? [✓ only 1]
___ Private doctor
___ Clinic (Which one?)
___ Drug store
___ I don't use family planning services – but I know where I could go
___ I don't use family planning services – and I DON'T know where to go

11. Has a doctor or nurse ever talked with you about:

Table with 2 columns: Question, Yes, No. Rows: Family planning, Spacing births, How to avoid getting pregnant.

12. What are your pregnancy goals now? ___ Not get pregnant now ___ Trying to get pregnant now

13. If you answered “Not get pregnant now,” what method of birth control are you using? [**Circle** all that apply] Oral Contraceptive (Pill) Condom Sponge Diaphragm Patch Vaginal Ring
 Intrauterine Device Rhythm Method Emergency Contraception Not Using Any Birth Control
 Other: _____

14. How important are the following concerns for you? [On a scale of 1 – 5, **circle** the best number in the box below]

	1		3		5
	<i>Not Important</i>				<i>Very Important</i>
a) Learning how to talk to my partner (spouse, boyfriend/girlfriend) about our relationship.	1	2	3	4	5
b) Not getting pregnant.	1	2	3	4	5
c) Not getting a sexually-transmitted disease (STD)/HIV.	1	2	3	4	5
d) Getting testing or treatment for STDs/HIV.	1	2	3	4	5
e) Learning how to talk to my parents about healthy relationships and sexual choices.	1	2	3	4	5

15. Please write 1 or 2 suggestions for improving family planning services in your area:

Thank You!

Please return this survey to the person who gave it to you when you are finished