Youth Community Health Assessment of Resources and Trends (CHART) Project

Needs Assessment of Fresno County and Sacramento County

Prepared by the Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco
Acknowledgements

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12. Executive Summary

Compared to older adults, sexually active young people ages 15–24 are at higher risk of acquiring an STI due to a combination of behavioral, biological, and cultural reasons (Centers for Disease Control and Prevention 2012). Chlamydia and gonorrhea are the leading causes of preventable infertility in California, particularly affecting younger women who are just entering their reproductive years (California Department of Public Health 2012). In 2012, nearly 79,000 cases of chlamydia were reported among California women ages 15–24, which represents 68% of all female cases reported (California Department of Public Health 2012). Moreover, rates of chlamydia, gonorrhea, and syphilis all increased in California in 2012 compared to 2011 (California Department of Public Health 2012).

Previous research has shown that individual as well as structural and community factors impact STI rates (Thomas, Clark et al. 1999; Cohen, Spear et al. 2000; Buffardi, Thomas et al. 2008; Lang, Salazar et al. 2010). STI rates among youth in California vary considerably by geographic location and by race/ethnicity. The disparity by race remains significant, with African-American females aged 15–19 having a chlamydia rate (6259.6) that was nearly 6 times higher than that of non-Hispanic white females of the same age (1067.3) in 2012 and rates of gonorrhea over 15 times higher (California Department of Public Health 2012).

The Adolescent Community Health Assessment of Resources and Trends (CHART) Project is a needs assessment conducted in Sacramento and Fresno counties—counties with some of the highest STIs rates among youth in the state—that sought to better understand these disparities in STI rates and to identify what programs and policies may help to reduce them. Using a social ecology framework (Bronfenbrenner 1979; Diez Roux and Mair 2010), this needs assessment examined community context, social norms, social networks, relationships and sexual behaviors, condom use, STI knowledge and attitudes, and access to existing STI testing and treatment services.

This report provides a summary of the results that were gathered through a mixed method approach. It offers an in-depth qualitative analysis of data gathered through interviews with 22 key community stakeholders and 14 focus groups with 91 youth in four communities in Fresno County and Sacramento County. In addition, it provides a quantitative overview of STI rates and other related variables at the county level statewide. The qualitative approach complements the quantitative component of this report by providing further insight into possible factors contributing to high youth STI rates as well as possible solutions.

Key themes

This report is structured around the main themes that emerged from the qualitative research with each chapter focusing on a key theme. The final chapter includes specific recommendations to improve STI prevention, testing, and treatment. The key themes include:

Community context: In Sacramento, slight differences emerged between the Del Paso Heights and South Sacramento/Center Parkway communities, yet
there were also many similarities. Both communities were historically predominantly African American, and are now ethnically diverse, with large Hispanic populations. Both are also generally socioeconomically disadvantaged, with lower income and education levels than residents in other areas in California. Adults and youth mentioned safety concerns related to poverty and gangs, with some neighborhoods described as less safe than others. In Fresno, the two selected communities are more distinct from each other, both socioeconomically and socially. Clovis/Tarpey is less diverse, with a larger non-Hispanic white population, and slightly better economic indicators, such as income and education, than other areas in the county. Respondents described Clovis as safer, more conservative, and more affluent than other neighborhoods, with residents attracted by higher quality public schools than are found in other parts of Fresno. In contrast, respondents described Tower District/ Roeding Park as extremely diverse, both demographically and politically. Adults mentioned tensions between older, more conservative residents and more liberal newcomers, who are drawn to the area for its multicultural, open, and tolerant environment. However, poverty, crime, prostitution, and homelessness are of concern for residents of this community.

Youth opportunities: Many adult and youth participants stated that youth face obstacles when seeking employment in their communities, due to difficult economic conditions and lack of job opportunities in their area. Fast food and retail jobs are the types most available to youth in these selected communities. Some participants noted that poor community and family role models influence youth, leading some to turn to government assistance instead of gainful employment. Many youth said people in their community do not finish high school. While some complete high school and attend community college or a local college such as Fresno or Sacramento State, this was not the norm. In all communities, adults and youth agreed that young people most commonly hang out in parks, at home or each other’s houses, in coffee shops, on the street, or in front of stores. Few of the social spaces youth frequented were supervised by adults.

Youth relationships and risk: Social media, public places, school, and parties were the most common places where youth reported meeting the people they have relationships with and/or have sex with. While many youth and adult participants agreed that casual sexual encounters or short-term relationships were the most common types of relationships for youth, some youth participants described the range of youth relationships from short term and casual to long-term and serious. Adults and youth from all four communities mostly agreed that multiple partners and unprotected sex are common risk factors for STIs among young people. Youth who are LGBT, homeless, with substance use issues, in foster care, or in juvenile detention are particularly vulnerable to sexual activities that put them at higher risk for STIs such as unprotected sex, transactional sex, and having older partners.

Substance use: Participants in all four communities overwhelmingly agreed that substance use is prevalent among young people. Marijuana, alcohol, and methamphetamines were the most common substances used and most likely to be associated with risky sexual behaviors by respondents. Participants mentioned parties as an occasion where youth were most likely to use drugs and alcohol and engage in risky sexual behaviors, such as unprotected sex or
sex with multiple partners.

**Condoms and contraceptives:** Respondents believed that contraceptive and condom use among younger individuals is often inconsistent, but as youth mature, use may increase. The top reason mentioned for condom non-use was the real or perceived lack of pleasure, followed by the desire for spontaneity and “being in the moment.” Condoms were used less often once a relationship was established or if a partner does not want one used, but were more likely to be used in short term and non-monogamous relationships, or with a new partner. Many participants noted that women requesting condom use is an important factor in their use and also listed challenges in communicating about condoms or other contraceptives. Access to condoms was not generally a barrier, though free and low-cost condoms were not always trusted.

**STI information:** Most youth received some type of sex education during middle or high school. However, the content and quality of instruction differed among youth, with some receiving more comprehensive information and skills for prevention than others. Topics covered included HIV/AIDS, common STI symptoms, treatment and transmission, and contraceptive methods. Youth often relied on other sources of information for sexual health, such as friends, parents, mass media, and the internet. Adults described youth knowledge of STIs as low or very low, with negative consequences for youth risk behaviors and sexual health. In some settings, budget cuts have led to a reduction or lack of comprehensive sex education for youth, fewer programs, or smaller program capacity. Adults also expressed concerns about mixed community support for sex education due to political and funding barriers among school administrators and lack of understanding among parents.

**Attitudes about STIs:** Youth and adult participants in Sacramento and Fresno agreed that avoidance of talking about STIs, fear of getting infected, and stigma are common attitudes toward STIs in their communities. These attitudes could act as barriers to accessing information, testing, and treatment. In addition, both male and female youth were generally more concerned about pregnancy than STIs. However, some males may be more worried about STIs given their perception that pregnancy prevention was the female’s responsibility.

**Access to sexual health services:** Youth and adult participants in Sacramento and Fresno agreed that there are barriers at the community, family and individual level that prevent youth from accessing STI testing services. Some of these include fear of knowing their STI status or denial that they may test positive, confidentiality concerns, lack of knowledge about STI testing, cuts in funding for STI services, and not being aware of STI symptoms. Nevertheless, they also recognized that partnerships and collaborative efforts are essential to improve testing in their communities.

**Recommendations**

These findings highlight several recommendations that are applicable not only within Fresno and Sacramento but in a broader context. Recommendations
based on a synthesis of these findings and suggestions from participants include improving the frequency and content of sexual health education; involving young adults in the design of outreach and awareness campaigns; increasing access to condoms, particularly in locations where young adults use substances and gather for parties; increasing access to testing through mobile services; and focusing efforts on the most at-risk youth including homeless and runaway youth, youth in foster care, and youth engaged in transactional sex. To maximize the reach and impact of limited resources, expand collaborative activities around STI education and prevention to new organizations including faith-based institutions, organizations working with transgender youth, foster care facilities, and substance treatment. In addition, interventions should be better coordinated to maximize reach and impact.
1. Introduction

Chlamydia and gonorrhea are the leading causes of preventable infertility in California, particularly affecting younger women who are just entering their reproductive years (California Department of Public Health 2012). In 2012, nearly 79,000 cases of chlamydia were reported among California women ages 15–24, which represents 68% of all female cases reported (California Department of Public Health 2012). STI rates among youth in California vary considerably by geographic location and by race/ethnicity. The disparity by race remains significant, with African-American females aged 15–19 having a chlamydia rate (6259.6) that was nearly 6 times higher than that of non-Hispanic white females of the same age (1067.3) in 2012 and rates of gonorrhea over 15 times higher (California Department of Public Health 2012). Moreover, rates of chlamydia, gonorrhea, and syphilis all increased in California in 2012 compared to 2011 (California Department of Public Health 2012).

This report provides a summary of results from the Adolescent Community Health Assessment of Resources and Trends (CHART) Project. The CHART Project is a needs assessment conducted in Sacramento and Fresno counties—counties with some of the highest STIs rates among youth in the state—that sought to better understand these disparities in STIs and to identify what programs and policies may help to reduce them. Using a social ecology framework (Bronfenbrenner 1979; Diez Roux and Mair 2010) this needs assessment examined community contexts, social norms, social networks, relationships and sexual behaviors, condom use, STI knowledge and attitudes, and access to existing STI testing and treatment services.

This needs assessment used a mixed method approach. It offers an in-depth qualitative analysis of data gathered through interviews with 22 key stakeholders and 14 focus groups with 91 youth in four communities. Interviews and focus groups were conducted in two communities in Sacramento County and two communities in Fresno County with high rates of STIs among youth (four communities total). In addition, it provides a quantitative overview of STI rates and other related community variables statewide. The qualitative approach complements the quantitative component of this report by providing further insight into possible factors contributing to the high youth STI rates as well as possible solutions.

Specific aims

The specific aims of the project were:

- To determine neighborhood and community factors associated with elevated STI rates in California communities.
- To explore qualitative perceptions of adult stakeholders and youth about STI awareness and services in their communities.
- To examine demographic and socioeconomic factors associated with gonorrhea and chlamydia rates among youth by county.

Background
Previous research has shown that individual as well as structural and community factors impact STI rates (Thomas, Clark et al. 1999; Cohen, Spear et al. 2000; Buffardi, Thomas et al. 2008; Lang, Salazar et al. 2010). Thomas (1999) used qualitative methods to examine factors associated with syphilis transmission and found that a complex web of sociophysical environmental factors at the individual, community, and structural level affect a person’s risk for STIs. Wikrama (2012) tested a longitudinal multilevel model predicting young adult risky sexual behavior and STIs and found that individuals who experienced early-life community disadvantages were at a higher risk for STIs as young adults. Similarly, Cohen (2000) found that deteriorated neighborhood conditions as measured by an index score of housing quality, abandoned cars, graffiti, trash, and public school degradation were associated with elevated rates of gonorrhea. This finding was independent of poverty levels.

Certain segments of the youth population are at a particularly elevated risk for STIs. In California, males and females 20–24 have the highest rates of gonorrhea and chlamydia (California Department of Public Health 2012). African-American youth have the highest risk for contracting STIs compared to all other racial/ethnic groups (Newman and Berman 2008; Dariotis, Sifakis et al. 2011; Owusu-Edusei and Doshi 2012; Pfieger, Cook et al. 2013). In 2012, African American adolescents aged 15–19 had rates (1010.4) of gonorrhea that were 15 times greater than that of non-Hispanic white adolescents (66.1) (California Department of Public Health 2012). One study examined data on young men’s history of STIs and their patterns and trajectories of sexual risk behavior during adolescence and early adulthood and found that young black men reported the highest rates of sexual risk and STIs at each point of observation (Dariotis, Sifakis et al. 2011). Additionally, Black and Latino men had higher odds of maintaining high sexual risk and increasing sexual risk over time compared to white men.

Nationally, other groups at-risk include youth in juvenile detention facilities (Robertson, Thomas et al. 2005; Dembo 2009; McDonnell, Levy et al. 2009), substance users (Tapert, Aarons et al. 2001), and young men who have sex with men (MSM) (Valleroy 2000; CDC 2003; Outlaw, Phillips et al. 2011). One study that looked at the relationship between substance use and STI risk behavior among young African American women found that women who consumed alcohol were more likely to have multiple partners and higher-risk partners, less likely to use condoms, and also have an increased likelihood of positive STI results (Seth 2011). Young MSM are at an elevated risk for most STIs, including HIV. In 2011, the greatest relative increase in observed rates of primary and secondary syphilis in the entire country occurred among MSM ages 15–19 (Su 2011).

Additional risk factors for youth include their sexual networks (individuals who are linked through sexual contact), type of sexual activity, and having an older partner (Youm and Laumann 2002; Ford 2004; Adimora 2005; Matson 2012). Kelley (2003) looked at patterns of sexual relationships and found that sequential (non-overlapping in time) or concurrent (overlapping in time) sexual partnerships posed a greater risk for STIs in comparison to single relationships. In an analysis of partner characteristics using the National Longitudinal Study of Adolescent Health, the odds of having eight different types of STIs were significantly and positively associated with having a
partner older by two or more years (Ford 2004).

Although the Centers for Disease Control and Prevention’s latest guidelines on treatment and prevention strategies (Workowski and Berman 2010), recommends annually screening for chlamydia and gonorrhea for all sexually active females younger than 25 years of age and routinely screening for common STIs among sexually active male adolescents, many sexually active youth are not regularly tested (Ellen, Lane et al. 2000) and may be asymptomatic. In rural California, where information and screening for STIs may be limited, a third of the youth who report being sexually active also report multiple sex partners within the past three months (Curtis, Waters et al. 2011). However, less than a third of these youth report getting tested for STIs. In focus groups with racially diverse youth, results showed that lack of knowledge of STIs and available services, cost, shame associated with seeking services, long clinic waiting times, discrimination, and urethral specimen collection methods were all perceived as barriers to seeking STI treatment and screening services (Tilson 2004).

**Report structure**

This report is structured around the main themes that emerged from the qualitative research and each chapter focuses on a key theme. Each chapter ends with a summary of the main findings. The final chapter includes specific recommendations to improve STI prevention, testing, and treatment.
2. Methods

This needs assessment builds upon state and local surveillance data by conducting in-depth qualitative research with youth and adults related to community context and opportunities, relationships and sexual activity, contraceptive use, health services, and STIs in four California communities.

Sample selection and design

Two counties were selected for in-depth qualitative research based on their chlamydia and gonorrhea rates among females 15–24. In addition to the overall rates, we prioritized counties with increasing rates and that actively expressed interest and support for the assessment.

Table 2.1: Selected counties, by selected STI rates

<table>
<thead>
<tr>
<th>County</th>
<th>Chlamydia rate Female 15–24</th>
<th>Rank</th>
<th>Gonorrhea rate Female 15–24</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>2905.4</td>
<td></td>
<td>285.4</td>
<td></td>
</tr>
<tr>
<td>Fresno</td>
<td>4418.5</td>
<td>1</td>
<td>651.3</td>
<td>3</td>
</tr>
<tr>
<td>Sacramento</td>
<td>4641.9</td>
<td>4</td>
<td>668.2</td>
<td>2</td>
</tr>
</tbody>
</table>

After selecting the two counties, we worked with the Department of Public Health in both counties to identify zip codes within each county with STI rates that were higher than the county average and that were not directly adjacent to each other. The following communities were selected:

- Fresno County: 93612 (Clove/Tarpy) and 93728 (Tower District/Roeding Park)
- Sacramento County: 95815 (Del Paso Heights) and 95823 (South Sacramento)

Study procedure and data collection

We completed a total of 22 interviews with 4–6 stakeholders per community and conducted 3–4 focus groups in each community with a combined total of 92 youth in Sacramento County and Fresno County. Interview and focus group tools were pilot tested prior to administration. Minor modifications were made based on these pilot tests. Fieldwork was conducted between November and December of 2013.

Interviews and focus groups were audio taped, and lasted an average of 60 and 75 minutes respectively. All interviews and focus groups were conducted in person. Typically, two UCSF researchers were present for the interview—one who conducted the interview and one note-taker. However, in some cases, one researcher would conduct the interview while also taking notes. For every focus group, one researcher was the lead facilitator while a separate researcher would take notes. All interviews and focus groups were recorded. All interviews and focus groups were conducted in English, although Spanish-speaking researchers were available.

Adults were asked a series of semi-structured questions focused on their
perceptions of youth sexual risk behaviors, knowledge of STIs, and available STI services. Youth focus group questions centered on their awareness of STI services and information, education provided in schools or other locations, perceptions of youth sexual risk behaviors, and youth recommendations for services or other support.

Most questions had follow up prompts, but researchers also could follow up with specific topics as appropriate. For the focus group, participants were asked to complete a confidential survey in advance of the focus group discussion. The survey consisted of demographic information as well as the respondent’s use and perceptions of sexual health services and contraception. Interviews and focus groups did not ask participants about their personal experiences, but rather about their perceptions of norms in their community and what it is like to be a young person in their community.

Upon completion of the focus group, all adult respondents and focus group participants received a $20 gift card to thank them for their time. Focus groups took place in a private location at community sites, schools, or recreation centers. Focus group participants also received a snack and a local resource guide. The protocol was approved by the California State Committee for the Protection of Human Subjects and UCSF’s Committee on Human Research.

Focus groups were professionally transcribed verbatim, and interviews were transcribed by a research staff member. Two researchers reviewed the consistency of the transcripts of the interviews and focus groups by comparing them to the original recordings.

**Respondents**

In each community, 4–6 adult stakeholders were interviewed, for a total of 22 adult interviews. Adult stakeholders were chosen based on their knowledge of the community, typically someone who lived and/or worked in the area for several years, as well as their interaction with youth and experience in providing services to adolescents. Key informants were identified in each county and helped UCSF researchers to make contact with community stakeholders for interviews and with sites for hosting focus group. UCSF researchers identified other potential respondents through online searches of relevant organizations.

Stakeholders from the following types of organizations or background were interviewed:

- Health officials
- Clinic staff
- Educators/school nurses
- Staff at community-based organizations working with youth
- Professionals working with foster youth
- Juvenile justice/law enforcement
- Staff at state or county agencies

At least three focus groups were conducted in each community, typically one with females 15–19 years old, one with females 20–24 years old, and one with young adult males. Researchers identified potential participants through the aid of staff at local clinics, schools, community centers, foster care facilities,
or other afterschool programs. Focus group participants were selected with the intention of speaking with individuals with differing demographic background (age, sex, sexual orientation, and race/ethnicity) as well as experiences. In particular, in each county, we tried to involve youth in high-risk groups including MSM, youth who had been in juvenile justice facilities, youth who had been homeless or runaway, and youth in foster care.

**Data analysis**

We used a modified social ecology framework to analyze the data. This framework recognizes that individuals’ development and health outcomes are shaped by the multiple nested environmental systems in which they live and with which they interact (Bronfenbrenner 1979).

We developed a mixed coding system that used a combination of structural and emerging coding (Potter and Levine-Donnerstein 1999). We created an initial list of codes using the main research questions, but added additional codes and sub-codes based on further review of the transcripts and fieldwork notes (Miles and Huberman 1994). The final codebook contained 35 codes and subcodes.

We tested the codebook using a selected subset of two interviews and two focus group transcriptions in order to assure consistency in the coding among the team members (Basit 2003). Two researchers independently coded two interviews (blinded to the coding of each other), and they met to comment on differences in the coding and get an agreement. We made slight changes in the codebook over time in order to improve the reliability of the codebook and the consistency in the coding process among the team members.

Three researchers conducted the coding and analysis in ATLAS.ti 7.0 (Scientific Software Development, Berlin, Germany). We identified patterns and relationships in each theme and between themes. The major themes identified during the analysis comprise the chapters in this report.

We sorted quotations by codes and themes among all the interviews and focus groups. Moreover, we conducted a close examination and reduction of the data by code to classify categories under each code, and to contrast and compare items. We identified recurring patterns and outlier situations, and similarities and differences in opinions and practices. We used ATLAS.ti tools such as diagrams and matrices to facilitate this process.
3. Community Context

This chapter provides an overview of the four communities selected in this needs assessment:

- Sacramento County: Del Paso Heights and South Sacramento/Center Parkway
- Fresno County: Clovis/Tarpey and Tower District/Roeding Park

Included are relevant sociodemographic indicators from the American Community Survey (ACS), as well as respondents’ perceptions of the communities. Specifically, youth and adults were asked to describe their communities in terms of the people living there, the main industries or sources of employment, and how well neighbors knew each other.

Sacramento

Two communities in Sacramento were selected for in-depth interviews: Del Paso Heights (zip code 95815) and the South Sacramento area (zip code 95823). Table 3.1 highlights sociodemographic characteristics for these two communities. Both communities are ethnically diverse, with large Hispanic populations (42% in Del Paso Heights and 33% in South Sacramento). South Sacramento has particularly large non-Hispanic black (23%) and Asian (22%) populations compared to Del Paso Heights and other parts of the county.

Compared to the state of California and Sacramento County overall, residents in both communities in Sacramento County are socioeconomically disadvantaged (See Appendix). Approximately one quarter of families live in poverty, and only about one quarter of adults have graduated from high school in both communities. Del Paso Heights has somewhat higher rates of unemployment than South Sacramento (15% vs. 11%) and lack of health insurance (21% vs. 19%). In both communities, over one third of households with children are headed by women.

Respondents described both areas as urban communities comprised of low-income families, with the main industry being the state government. An adult familiar with both communities noted that the economic downturn has impacted businesses in South Sacramento more than those in Del Paso Heights. In addition, she described the lack of social cohesion among neighbors in both communities.

Table 3.1: Sociodemographic characteristics by zip code, Sacramento County

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Del Paso Heights (95815)</th>
<th>South Sacramento (95823)</th>
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<tbody>
<tr>
<td>DEMOGRAPHIC FACTORS</td>
<td></td>
<td></td>
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<tr>
<td>Race/ethnicity (% of total population)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>33.0</td>
<td>15.4</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>11.8</td>
<td>23.4</td>
</tr>
<tr>
<td>Non-Hispanic Asian</td>
<td>8.3</td>
<td>21.7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>42.0</td>
<td>33.0</td>
</tr>
</tbody>
</table>

I think people are more isolated than they've ever been. I don't really know my neighbors... In general, that sense of community has been lost, not just in those communities, but in Sacramento in general... Just doesn't seem to have that sense of cohesiveness.

Health official, Sacramento
Other races 1.9 2.0
Two or more races 3.0 4.5

INCOME
Per capita income (Dollars) 16,704 15,916
Families in poverty (% of families) 27.0 24.5

EMPLOYMENT
Unemployment (% of population 16 years and over) 14.5 11.4

EDUCATION
High school graduate (% of population 25 years and over) 24.6 28.0

HOUSING
Home ownership (% of households) 39.9 47.9

FAMILY STRUCTURE
Family structure for children (% of households with children under 18 years)
Married couple household 51.5 45.7
Female-headed household 37.5 40.3
Male-headed household 11.0 14.0

HEALTH INSURANCE
Lacking health insurance (% of total population) 21.2 19.3

Source: U.S. Census Bureau, 2012 American Community Survey

The U.S. Census uses two different questions to collect data on race and Hispanic origin.

**Del Paso Heights**

Del Paso Heights, which encompasses the 95815 zip code, is located in northeastern Sacramento. Respondents described the community as low-income to middle-income. One service provider explained that the area has “pockets” of middle class residents, but is mostly low socioeconomic status. Respondents noted that Del Paso Heights is a very diverse community, especially compared to other areas in Sacramento. Historically, residents have been predominantly African-American, but the community now comprises more Latinos and Southeast Asians as well. In addition, one respondent who provides health outreach services identified a section of Del Paso Heights with several gay clubs, which attracts a large MSM community.

Two adults in Del Paso Heights responded that the area has a history of fewer or scarce resources, compared to other communities: “There are some good community resources around here [but] not enough for the community.” Both youth and adult respondents described community issues related to crime, homelessness, prostitution, and drug use. In particular, many participants identified the Mack Road corridor as being the setting for these activities. One adult noted, “In some pockets of the community, it’s well known as a high prostitution area.”

Due to these negative elements, respondents also discussed safety concerns. An adult who works with homeless youth described his practice for staying safe in Del Paso Heights: “During the day, go out and be okay, but during the night, stay away.” Many youth participants also shared fears about safety in...
their neighborhood, describing it as “rough,” “ghetto,” “loud,” and “scary.” As one male youth stated, “It’s like the people are tagging everywhere and just a lot of crime.” In some cases, youth connected these activities with local gangs: “It’s just like, probably gangs and drug dealing.” Youth in two focus groups mentioned hearing police helicopters at night, as evidence of the level of violence in their neighborhoods.

According to youth, issues of safety also impact friendliness and social cohesion among neighbors in Del Paso Heights. In a male focus group, some respondents explained their connections to their neighbors as related to theft and violence prevention:

> I talk to all the neighbors…I make sure I know them all and I have their number because in a situation where, uh, something could go down and could jeopardize me, I have people who I know I can trust that can help me and have my back and my family’s back.

**South Sacramento**

South Sacramento/Center Parkway encompasses the 95823 zip code and is located south of the city center, surrounding Highway 99. Historically, respondents described the community as better off than Del Paso Heights to the north, but noted that the economic downturn has affected the businesses here more dramatically. While families in South Sacramento are low- to middle-income, two adults mentioned that there are also “a lot of homeowners” compared to other areas in the city. Respondents described South Sacramento as diverse and “very mixed,” with predominantly African-American and Latino residents, and a more recent influx of Asian residents. While the industry in South Sacramento is dominated by the state government, one adult noted that residents here also work as manual laborers, day care providers, and nursing attendants, often part-time.

In terms of neighborhood safety in South Sacramento, three adults noted that poverty and gang violence are pressing issues for local residents. As a hospital staff member explained, “It’s fairly low [socioeconomic status]. In fact, the area around the hospital is not one we encourage people to walk around after dark, because it has a fairly high crime rate.” Similarly, a teacher responded:

> Some may say that it may not be safe at times in the night. Students say they [experience] racial profiling by the police officers when they walk down the street. Some gang violence, a lot of fights going on… There’s a lot of poverty, too.

Adults explained that safety issues have impacted social cohesion in the neighborhood. One stated, “I think they know their neighbors but don’t necessarily get along with their neighbors.” Another adult responded, “It’s just so different today, nobody wants to get involved with each other like they used to.” However, as one adult explained, the consequences of tragedy and violence can ripple throughout the community: “Someone got shot or jumped or some type of violence… And no matter what, somebody knows somebody that’s been affected by the situation.”

In one focus group, female youth described the impact of violence and gang activity on their sense of safety:

> P: It is very dangerous, but as long as you’re not where you’re not supposed to be, like if you’re in, in the wrong like part and you don’t know anybody, then it is...
dangerous.

UCSF: And this is during the day and at night, or—?
P: It’s I would say just any time of the day, ’cause I’ve walked home from school and I’ve had like—like I took one of my friends with me and he was like, "Oh, my god! How do you walk home?" Like there’s so many guys who try to pick you up in your car. Like it’s really bad. Yeah, I wouldn’t ever walk to Meadowview…

Similar to residents in Del Paso Heights, respondents in South Sacramento noted that some areas are safer than others. Adults and youth identified Mack Road and Florin Road as areas that are more dangerous due to drug use. As one male youth explained, “You know… the saying, ‘The south side of the tracks, you don’t wanna go over there,’ you know? So this is the south side.”

Fresno

Two communities in Fresno, Clovis/Tarpey (zip code 93612) and Tower District/Roeding Park (93728), were selected for in-depth interviews. Table 3.2 highlights sociodemographic characteristics for these two communities.

There are notable differences in the racial/ethnic composition of the two communities. Over half the population in Tower District/Roeding Park is Hispanic (55%), while over half the population in Clovis/Tarpey is non-Hispanic white (53%).

Table 3.2: Sociodemographic characteristics by zip code, Fresno County

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Clovis/Tarpey (93612)</th>
<th>Tower/Roeding Park (93728)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEMOGRAPHIC FACTORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/ethnicity (% of total population)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>53.2</td>
<td>34.1</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>2.8</td>
<td>3.7</td>
</tr>
<tr>
<td>Non-Hispanic Asian</td>
<td>8.0</td>
<td>5.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>32.5</td>
<td>54.8</td>
</tr>
<tr>
<td>Other races</td>
<td>1.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Two or more races</td>
<td>1.6</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per capita income (Dollars)</td>
<td>19,027</td>
<td>16,298</td>
</tr>
<tr>
<td>Families in poverty (% of families)</td>
<td>19.0</td>
<td>24.5</td>
</tr>
<tr>
<td><strong>EMPLOYMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment (% of population 16 years and over)</td>
<td>8.6</td>
<td>11.0</td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate (% of population 25 years and over)</td>
<td>26.5</td>
<td>23.9</td>
</tr>
<tr>
<td><strong>HOUSING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home ownership (% of households)</td>
<td>37.6</td>
<td>44.1</td>
</tr>
<tr>
<td><strong>FAMILY STRUCTURE</strong></td>
<td></td>
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</tbody>
</table>
Family structure for children (% of households with children under 18 years)

<table>
<thead>
<tr>
<th></th>
<th>Married couple household</th>
<th>Female-headed household</th>
<th>Male-headed household</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>52.1</td>
<td>30.1</td>
<td>17.8</td>
</tr>
<tr>
<td></td>
<td>56.7</td>
<td>35.2</td>
<td>8.1</td>
</tr>
</tbody>
</table>

**HEALTH INSURANCE**

<table>
<thead>
<tr>
<th></th>
<th>Lacking health insurance (% of total population)</th>
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<tbody>
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<td></td>
<td>19.2</td>
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</table>

Source: U.S. Census Bureau, 2012 American Community Survey

1 The U.S. Census uses two different questions to collect data on race and Hispanic origin.

Residents in both communities in Fresno are socioeconomically disadvantaged (See Appendix). Approximately one quarter of families live in poverty, and only about one quarter of adults have graduated from high school in both communities. Tower District/Roeding Park has a higher incidence of families in poverty, unemployment, lack of health insurance, and female-headed households than Clovis/Tarpey. However, a larger percentage of the homes are owner-occupied in Tower District/Roeding Park than Clovis/Tarpey (44% vs. 38%).

**Clovis/Tarpey**

Clovis/Tarpey consists of the 93612 zip code and is in the northeast part of Fresno County. Compared to the surrounding areas, respondents described Clovis/Tarpey as more affluent, more educated, more suburban, more politically conservative, and less ethnically diverse than the rest of Fresno. In several focus groups, youth called the community “boring,” “quiet,” “suburban,” and “safer” than other areas. In contrast to other areas in Fresno, a female youth stated, “I don’t worry about getting shot or anything.” Economically, adults described Clovis as more stable than other areas, with more businesses, more opportunities for employment, and less homelessness. One adult also noted that Clovis has more churches and a stricter police force than the neighboring communities. Regarding the socially conservative nature of the community, another respondent said, “I wouldn’t want to be gay and live in Clovis.”

Within the area, several adults distinguished between Clovis and Tarpey, with Clovis being more affluent. For example, one identified Tarpey as the “lower end” of Clovis, with more apartment complexes and more minority residents. Another adult stated, “The more north you go in this town, the more money there is.”

According to respondents, Clovis has a reputation for having better schools than other communities in Fresno. One health educator explained the pattern of families moving to the neighborhood specifically because of the high quality public education and increased safety it offers:

> With education, it’s pretty high…. I met a few families where they moved into this area because they say it’s a lot better area for their kid to go to school and even get away from the rougher parts of town.

While one adult described Clovis as being very family-oriented, noting the town motto, “Clovis is a way of life.” Another responded that neighbors do not seem to be very social: “There are some that really keep to themselves,
that they really don’t want nothing to do with building a community.”

In terms of community safety, youth and adults had few concerns about living in Clovis. However, one female youth explained, “My neighborhood is… more ghetto and like dirtier because of Section 8 houses and stuff. Like there’s bad people that live there.”

**Tower District/Roeding Park**

The Tower District/Roeding Park community, which encompasses the 93728 zip code, is located in northwest Fresno, closer to downtown. Respondents described this community as very diverse, “cosmopolitan,” and “eclectic,” with many different types of residents, including people of color, young families, urban professionals, artists, and LGBT communities. As one adult noted, “It is a community that represents diversity in terms of culture, race, ethnicity, [and] income levels.”

In addition, respondents described this community as being politically more active, liberal, and inclusive than other parts of Fresno, particularly in regard to LGBT issues. Several respondents mentioned Gay Pride and Transgender Day of Remembrance as annual community events. One adult explained:

> It’s more diverse, it’s a more open area… when it comes to, especially like LGBT issues, community awareness, community involvement…. We tend to have a lot of our LGBT youth, a lot more open and to hang out in this area a lot more because they’re not in fear. They’re more accepting of an area compared to the rest of Fresno.

Another adult described the diversity of viewpoints in this community, with some tension between newer, more liberal residents and older, more conservative residents:

> There’s something like 20 something different dialects spoken within this area, and lots of different races, creeds and everything within this area. And the Tower District itself is a very welcoming street and very LGBT friendly and you drive around and you’ll [see] homes and the rainbow flags. And at the same time, a lot of the families who live within the close area have a very traditional look on life on LGBT issues and while this street of Olive may be very welcoming and open, with families that live there, it may not be the case. That can be short of polarizing, within this area code and lot of moving a lot of people moving around.

In focus groups, youth participants called their neighborhood “ghetto” and “ugly,” with youth in several groups noting the predominance of poverty, violence, and drug use. One male youth explained:

> Like my peers saying “ghetto,” like, you know, gunshots every day. Like, just all kinds of stuff. Like you open the door and you smell marijuana. You walk down the street, you see people smoking crystal meth — like just real bad. Like nobody dressed nice, everybody in poverty. Like that’s my definition of “ghetto,” and that’s where I live.

Compared to Clovis, adults described the Tower District/Roeding Park as more mixed-income, with more affordable housing, fewer community resources, and more homelessness. Several respondents remarked on the wide range of socioeconomic status within the community, with pockets of both extreme poverty and extreme wealth. One adult noted, “In the Tower Theater… [there] are affluent old mansions that are very well taken care of…

> It’s a tossed salad of people from all different walks of life.

Adult, Fresno

> So we have everything from really conservative to extremely liberal, anarchist type of attitude. People are more tolerant of each other.

Adult, Fresno
but most of the majority is [poor].”

One adult mentioned a recent study by the Brookings Institute, which identified the Tower District/Roeding Park as a community with one of the highest concentrations of poverty in the country:

So that kind of gives you an idea of the challenges that the community faces and they face many, whether it has to do with poverty, crime, low education attainment rate, as well as neighborhood revitalization, as well as just taking pride in its community.

Another adult discussed the problem of “brain drain” in the community, with people leaving the area to find better opportunities for education and employment. While some residents commute elsewhere for white collar jobs or teach at the university nearby, the local employment opportunities are mostly limited to food service and retail. “How can we engage young people so that they stay instead of everyone leaving?” she asked, “[So that] we can create a city that we really want to be in.”

Regarding crime and safety, respondents shared concerns about certain parts of the community, such as Roeding Park and the Highway 99 corridor, which attract illegal activity including gangs, drug use, and prostitution. As one adult stated, “Crime rates in certain parts in this area are a little bit higher than the rest of Fresno… The Roeding Park area, we have little spikes, here and there.” He also noted that the police substation in the neighborhood was recently closed due to funding cuts, which “was a big loss to the area.” The combination of low-income housing, cheap motels, and closed businesses in the area around the highway, along with a larger homeless population and fewer community resources, has negatively impacted the neighborhood. One adult stated, “The 99 corridor… that’s where we are seeing a lot of potential [health and safety] issues.” Another adult called the area near Highway 99 “your drug and gang area and prostitution.”

The confluence of factors in the Tower District/Roeding Park — social, economic, and political — may exacerbate these issues of health and safety. One adult explained:

This area has historically and predominately always been really accepting of all types of people. Like there is this unspoken thing like this is where misfits, or not misfits, but people who don’t kind of fit in to the regular box will hang out, at least in the Tower District. And Roeding Park is a park that’s open, so it feels safe or at least when you need somewhere to stay or be. But it is also a little bit more removed ‘cause it’s closer to train tracks and closer to less housing. So the safety there is give or take. It’s also near a motel drive, which is known for sex work. Definitely big area for transient youth.

According to respondents, concerns about safety and the mixed income setting of the community have negatively impacted social cohesion. As one adult stated, “The more poverty-stricken areas, the lower income areas, I think there is a little more fear and being careful… Not reaching out to neighbors just because of the crime and poverty.” Another adult stated that, due to differing incomes and social class, neighbors in this community “know each other but may not hang together.”

While adults and youth often spoke of gang activity as contributing to

You see such a mix...You have one house and someone is sort of a professional and they have nice things and inside is sort of Pottery Barn-ish, you know. But then their neighbor has sort of, you know, everyone from grandmother to great-grandchild living in the same home, and they are renting for the last 15 years or last 20 years.

Health educator, Fresno

P: Pretty much, honestly, the only things I can say to do out there are get drunk, do drugs, and have sex...

P: There’s not that much [to do], so everybody ends up gang-banging or something.

Female focus group, Fresno
violence and isolation in the Tower District/Roeding Park, one male youth described the benefit of knowing gang members and living nearby for safety:

And the people next to me? They're like ex-Bulldog members. But they're really cool... They're like—they have my back... They're like in a gang. Yeah. But they're really awesome. Like we support each other 'cause we're neighbors you know, so we kind of have each other's back.

**Summary**

This chapter summarized the four communities selected in this study using both quantitative data on sociodemographic characteristics and qualitative data on residents’ perceptions and opinions about their communities.

In Sacramento, both communities—Del Paso Heights and South Sacramento—are ethnically diverse, with large Hispanic populations, and generally socioeconomically disadvantaged, with lower income and education levels than residents in other areas in California. Respondents described Del Paso Heights as underserved, with concerns related to crime, homelessness, prostitution, and drug use. Both adults and youth remarked on issues of safety; in some cases, fears about safety led to greater social cohesion among neighbors. Respondents described South Sacramento as similarly diverse, with more homeowners than other areas. Adults and youth mentioned safety concerns related to poverty and gangs, with some neighborhoods described as less safe than others.

In Fresno, the two communities are more distinct from each other, both socioeconomically and socially. Clovis/Tarpey is less diverse, with a larger non-Hispanic white population, and slightly better economic indicators, such as income and education, than other areas. Respondents described this community as safer, more conservative, and more affluent than other neighborhoods, with residents attracted by higher quality public schools than other parts of Fresno. In contrast, respondents described Tower District/Roeding Park as extremely diverse, both demographically and politically. Adults mentioned tensions between older, more conservative residents and newer, more liberal incomers, who are attracted to the area for its multicultural, open, and tolerant environment. However, concerns about poverty, crime, prostitution, and homelessness are also central for residents of this community.
4. Youth Opportunities

This chapter reviews the educational and employment opportunities available for youth, as well as the frequency of adult supervision of youth in the community.

Educational and employment opportunities

Several adult and youth participants described the difficulty youth face in obtaining employment in their communities (11 adults, youth in 4 focus groups). Only one participant, an adult in Sacramento, stated that jobs are readily available for youth. Many participants said youth seeking work during this economically depressed time face additional barriers. As one homeless youth advocate in Fresno state, “the challenges facing our young people is even greater because they’re competing against an adult who is now applying for the job at McDonald’s or at the retail store or a minimum wage job.” No one listed a well-paid or career-path position available for youth, though two adults and youth in two female focus groups described local organizations that helped youth find jobs through training, career readiness, and job fairs.

In both Sacramento and Fresno Counties, the types of jobs most often mentioned related to food service, both fast food (14) and restaurants (6). Retail positions were also commonly described (9). In Fresno’s Tower District, there are a number of small stores as well as coffee shops that employ youth. In Clovis, larger chain retail stores offered youth some job opportunities. The Roeding Park area in Fresno was the least likely to have employment opportunities as the park and zoo do not employ many people nor do the hotels and motels in the area. Two female focus groups in the Del Paso Heights neighborhood in Sacramento spoke about employment. Low income positions such as fast food or working in a mall were possibilities, though in one group the participants said if someone did not finish high school, “there’s the hood. That’s it.” Among the three adults and youth in four focus groups that spoke of job opportunities in South Sacramento, many listed retail and fast food positions. An HIV Program Manager in Sacramento shared, “[There are] not a lot [of jobs] because there’s not a lot of employers in this area. Sacramento, until pretty recently, has been quite economically depressed.”

In addition to earning income through employment, two adults and youth in one male focus group said youth sometimes seek government assistance. As one health educator in Fresno County explained, some youth “can walk you through the welfare system way quicker than they can apply for a job.” due to examples set by their family.

Youth’s lack of postsecondary and career aspirations was discussed in six youth focus groups in both counties, but only mentioned by one adult. After either graduating or dropping out of high school, some youth live with their parents and do not work. Some youth thought this was due to family norms or community influence.

In both Sacramento communities and in the Tower District/Roeding Park neighborhoods in Fresno, adult and youth participants said that the drop-out rate was high. As participants in one male focus group in Sacramento County
Youth in eight focus groups (in all communities) and one adult discussed youth attending college, though none said college attendance was the most common post-high school activity. Most often local colleges and community colleges were discussed, including Fresno State, Fresno City College, American River College in Sacramento, and Sacramento State. Participants in two focus groups said some youth go to college far away, perhaps even another state. Although college attendance was discussed, graduation and future opportunities were not. In fact, youth in two focus groups said they knew people who had dropped out of college or stopped attending the local community college, and one participant had dropped out of college.

Social spaces

Social spaces and adult supervision of youth are closely related. Some of the discussions about where youth “hang out” revolved around whether adults were present or not, especially as it related to younger youth that still lived at home and parties or “kickbacks” — small social gatherings, that may be held in abandoned houses or agricultural fields.

In all communities, adults and youth agreed that young people most commonly hang out in parks, at home, in each other’s houses, in coffee shops, on the street, or in front of stores.

In Fresno’s Tower District/Roeding Park neighborhood, youth most often hung out in the Tower District. There are small stores, coffee shops, and the area is seen as diverse and a pedestrian-friendly area. The Tower District was also noted to be “Fresno’s Castro” referencing the San Francisco neighborhood with a predominantly gay population. Roeding Park, which has an extensive green space and a zoo, was not viewed as a place that youth hang out, though some homeless youth did sleep there. Homeless youth also congregated in the Tower District. As a youth group leader shared:

There’s a lot of street kids that live in the Tower District. There’s a whole circuit of kids that cycle through the valley area that are on a circuit with those that are kind of hippie. They choose to be living on the streets. They’re termed “Tower Rats,” which is a term that they use for themselves. So they kind of float in and float out. They know exactly what corners or what areas to hang out and during what times of the day. They know what circuit the police are on and they know that they’ll go from this little corner here to this one over here to behind this building here. So they just kind of hang out that way.

In Clovis, participants said youth frequent the skate park, the Sierra Vista Mall, the movies, or go farther north to River Park, which was seen as a safe
area. Youth said they hang out outside, often in front of certain apartment complexes. A youth counselor said:

Most of those places are unsupervised. So if you go to the movies, you’re kind of on your own. Skate parks, I know those are supervised through the city through Parks and Rec. I know that the local parks, some of them don’t have staff there, so it’s really on your own. The other things that are supervised are probably just the mall, the skate park, and us, here at the Boys and Girls Club.

Youth and adults in Fresno County discussed the “Safe Place” program operated by Fresno Economic Opportunity Commission in which a network of designated locations offers youth immediate help and safety. Locations included community-based organizations, schools, youth centers, stores, and even the transportation system. Any teen can inform a driver of a Fresno Area Express city bus they are in need of a Safe Place and they will be transported for free to the closest location or be met by designated staff at a bus stop.

Participants in Sacramento listed malls as a common destination for youth. Although the Florin Mall had closed, people went downtown, to the Arden Mall, or to Roseville Galleria. Two adult participants stated that there was a lack of youth programs in these Sacramento communities.

A few adults in both counties stated that community based organizations offered safe, constructive places for youth. For example a homeless advocate in Fresno said:

The community based organizations in these neighborhoods served as places where children and families can go and receive support of services and then also go there and participate in organized activities. So I see a lot of opportunities for after school activities for our young people, again our community. I feel like our community has really stepped up to fill any voids that maybe the schools are not able to fill.

**Adult supervision of youth**

Most discussions about parental oversight related to reproductive health services, sexuality education, or drugs and alcohol, which are described in their respective sections of this report. However, parental monitoring, parental support, and supervision of youth by adults other than parents were discussed as well. Four adults and youth in two focus groups, from each of the four communities, described how parents are often unsupportive or unavailable for their children, either physically or emotionally.

Two adult participants and female youth in a focus group, all in Sacramento, said parents can be bad examples such as when a parent uses drugs, prioritizes their partner over their children, or encourages a child to seek government assistance instead of employment. Participants noted the negative outcomes for youth including not feeling loved, lacking self-worth, and lacking motivation. Male youth in Sacramento discussed their observations of parenting styles:

P: Nowadays, parents aren’t really parents. They’re more like friends than—

P: Friends to their kids. They don't want to —
P: Discipline them.
P: They don’t want to tell you, “No, don’t do that,” or such and such. They want to be like, “Oh, well, now that you’re older, we feel you’re able to handle yourself more, so you should be able to do it.” I’m raised old school... Drink, smoke, I would never do that around my parent because I respect my parent. Now, if I’m on my own and I want to do something like that, that’s on my time.

A few participants in focus groups in Sacramento shared how youth are supervised and supported by adults other than parents. As two male participants explained:

P: I got raised mostly... by my grandma... She has a saying, “I’ll let you dig your own hole,” you know. But at the same time, she helps prevent me from doing stupid things, even though she lets me do some things sometimes so I can learn a lesson in the end so I won’t do it again. Sometimes we got to mess up to learn from it and become stronger along the [way].

P: It’s, it’s a very, old-fashioned [neighborhood]... if your child is out past curfew, the neighbor — whoever’s outside — ‘And you better take your butt home, the lights just came on or you gonna get a whoopin’.”

An adult health educator and youth in a male and a female focus group, all in Fresno County, discussed that schools are not always adequately supervised. A health educator in Fresno said that youth recounted sexual activity on campus, and that teachers had called them to come to campus in the wake of discovering sexual activity on campus. Male youth in Fresno said they discussed smoking marijuana with the school security guards and that “the security guards at our school be, like, five years older than you. How you supposed to respect somebody like that?”

**Summary**

Many participants stated that youth face obstacles when seeking employment due to difficult economic conditions and lack of job opportunities. Fast food and retail are the jobs most available to youth in these selected communities. Some participants noted that poor community and familial role models influence youth, leading some to turn to government assistance instead of gainful employment. Many youth said people in their community do not finish high school or attend college. In all communities, adults and youth agreed that young people most commonly hang out in parks, at home or each other’s houses, coffee shops, on the streets, or in front of stores. Few of the social spaces youth frequented were supervised by adults.
5. Youth Relationships and Risks

This chapter provides findings on respondents’ views of a variety of different types of youth sexual relationships and sexual behaviors that put different youth populations at risk for transmission of STIs.

Meeting others

The most common places reported in focus groups where young people meet the people they date and/or have sex with were:

- through social media (12)
- public places such as parks, the mall, or on the street (10)
- school (9)
- parties (8)

Social media sites were most often stated as meeting places for casual relationships and sexual encounters. Participants mentioned Facebook, Twitter, Kik, Instagram, and Tinder as social media sites utilized for meeting people they are interested in dating and/or having sex with. The following social media sites, designed for men who have sex with men, were also mentioned: Grindr, BoyAhoy, Jack’d, Adam4Adam, and Scruff.

Relationships

This section explores participants’ opinions of the different types of relationships youth in their community have. The definition of what a relationship meant, how long it usually lasted, and whether it was exclusive or not varied from participant to participant. However, both youth focus groups (12) and adults (13) most often acknowledged that casual sexual encounters or uncommitted, short-term relationships were the most common types of relationships youth have. Youth in several focus groups (6) and a few adult interviewees (3) expressed that short-term, casual relationships and more long-term relationships were both common.

A director of a community-based organization in Fresno described the diversity of sexual identity and sexual relationships that LGBT youth may have:

I find that their sexuality is more fluid now than what we would have known in the past and that we will have both lesbian, bi, and pan-sexual that are crossing the barriers between sexes. Women that are identifying as young lesbians that are having a sexual relationship with someone that is identifying as a young gay male…We have kids that identity as pan-gender, pansexual…polyamorous… queer, a-gender, asexual. So we have a wide-ast group that come to the youth group…that end up identifying in all kinds of ways.

Longer-term relationships

What respondents considered longer-term relationships were sometimes labeled as “boyfriend,” “girlfriend,” “partner” (in LGBT relationships), or just simply, “I’m with” and varied from three months to several years. One female focus group provided examples of longer-term relationships:

I don't know, it's like a ride. Everybody's just like getting on, getting off, getting on, getting off, and they don't, dating doesn't seem very...traditional. It feels like sex is supposed to happen like that first night or it's the next day. There's no kinda wait period. It's just mess around and that's when you're serious. And that's it.

Male Focus Group, Sacramento
I mean, my friend’s been with her boyfriend for over a year. My brother’s been with his girlfriend for like two-and-a-half years. I mean, there are some—like I know of some really long-term relationships. But then there’s like the other end, where there’s people who just kind of hook up, and that’s the extent of their relationship.

**Casual relationships and sexual activity**

A casual relationship and sexual activity, which may or may not be defined as a relationship, was often described as a “hookup” or a “friends with benefits” situation. A few adult respondents described these types of sexual relationships as more common among older youth, 20 and older. A few adults also mentioned that these relationships are often lacking in emotion or care. One Fresno public health official elaborated:

Yeah, there’s just not an emotional connection with sex. There really isn’t that, “I’m invested in a relationship.” It’s really more the act…than it is investing in a relationship…The City College students, what I sense with them is more frequency and just the higher rate of, “I’m with this individual.” “Well, weren’t you dating so and so like 30 days ago?” “Oh yeah, but that thing’s over.” So…okay maybe they’re in a relationship, but it’s a 15-, 20-, 30-day relationship and they’re kinda moving on.

Participants in most (9) focus groups felt that having multiple casual relationships and sexual activity is common among heterosexual youth, yet not acceptable for young women, while accepted and even praised for young men. One Fresno female focus group discussed these gender norms around sex between two people who just met:

P: ’Cause if a girl does it, it’s—

P: It’s like you’re a ‘ho.

P: Yeah. You’re like a whore.

P: But if a guy does it, it’s like, ”Oh, you’re a player.”


**Risk factors**

Unprotected sex and having multiple partners were the most common risk factors identified by both focus groups and interview respondents among youth in their communities. In addition, some respondents mentioned the increased risk of having an older partner, engaging in transactional sex, or being vulnerable to sex trafficking or intimate partner violence.

**Multiple partners**

Both adults and youth (9) recognized that multiple partners or serial-monogamy is a risk factor for youth. Many respondents noted this as a risk factor for LGBT youth, particularly young MSM. A Fresno public health official elaborated on the risk of multiple partners in the MSM community:

Still yet, it’s a small community and it’s amazing, when you start drawing that circle around them, how fast they progress through 10 individuals through 60 days…That’s alarming to us. We can have someone who’s affected by gonorrhea...
Furthermore, a focus group with MSM youth in Fresno discussed polyamorous relationships, such as triads (a three-way sexual relationship), as a dating trend among gay males:

"Oh, well, let's not cheat on each other. Let's just find someone." It's not like that. It's more like, I—we like each other, so we should all go out, kind of thing.

Participants from one Fresno focus group expressed that lesbians they knew were more likely to have multiple partners than gay males because of a lack of awareness of transmission of STIs through oral sex and because of more acceptance of sex among young lesbians as opposed to among young MSM:

P: Well, I just have like a lot of homosexual friends and like I see the males and then I see the females and it just seems like lesbians are more likely to go around with like more other lesbians and then a guy would with other gays…

P: It's just like, when girls mess with girls…it's not a big deal…It looks different than when you're hooking up with a lot of girls rather than you're a girl hooking up with a lot of guys.

One male focus group in Fresno described relationships where youth have a “side” partner in addition to their primary partner:

P: They just together. They don't really like each other…

P: And they got side people.

P: They do that a lot.

UCSF: Side people meaning they're having sex with other people?

P: No, they just got this side girl.

P: No…it's more like — kissing and stuff like that…

P: But then there are some people that have like --

P: Side girls.

P: — sex buddies and stuff like that.

P: Mm-hmm.

UCSF: Like friends with benefits?

P: Mm-Hmm.

A respondent who works with homeless youth mentioned multiple partners and unprotected sex both as risk factors:

We see that, they're involved in multiple partners as well. I've met young people who brag that I've had 5, 10 partners in a month, for example. And often times, they tell me that they're not protecting themselves.

**Unprotected sex**

Many youth focus group (6) and adult (11) participants also stated that unprotected sex is a risk factor for youth in their community. As a substance treatment counselor articulated:

Unprotected sex and them having threesomes and parties. It's on and cracking
with them. They think sex is just another pen, it’s just nothing to them. There’s no guarding of themselves anymore. It’s just, ‘here come get me.’

Other reasons given for youth having unprotected sex include not taking responsibility for their health, low self-esteem, unequal power dynamics in the relationship (especially being with older partners), and low self-efficacy around condom negotiation. See Chapter 7: Condoms and Contraceptives, for more results on why youth use or do not use condoms.

Taboos around certain types of sexual behavior affected multiple populations in their decision to engage in oral sex or anal sex without protection. A clinical program manager elaborated:

“There are a lot of cultures … in which doing something beyond penile vaginal is what you’re doing with whores. It’s not normal human sexual behavior. Missionary position is what people are supposed to do. I think that stigma is still out there a little bit. It’s hard to get them to realize that those are ways you can get HIV and other STIs. Not a lot of knowledge that women get anal cancer as often as men from HPV.”

Older partners

Participants in many focus groups (9) and some adult participants (6) acknowledged that some young people in their community have older partners. Common reasons stated for having older partners were to fulfill unmet socio-emotional or financial needs, such as the need for love and acceptance from a “father” or “mother” figure who may provide money, shelter, food, or transportation. A few participants expressed that having older partners creates an imbalance in power dynamics. Female participants in one Sacramento focus group elaborated:

P: So, basically, the female is basically looking for a father figure. And it’s like that goes a long way, you know, in a relationship ’cause they teach you what you don’t know and you, you mature more with them…

P: But sometimes the culture, too, because my culture for real ’cause my dad, he’s got friends like, what, 18, 17? I don’t mind because [his girlfriend] she’s from our country.

P: I think also older men choose younger women, too, ’cause they can kind of control them, too…Since they’re younger and they got that mentality, “Oh, my gosh, this man likes me.” And then he can see that, “Oh, wow! She has no self-esteem. Let me see what I can do with that.”

A few participants explained that it is a norm in certain Hispanic and Asian cultures to have much older partners. Some adult participants expressed that youth who identify as MSM, are homeless, in foster care, in juvenile justice, or affiliated with gangs are particularly prone to have much older partners, five years older or more. One respondent who works with youth in foster care explained:

Yes there is a high risk. We do have a lot of girls that end up with older men, not so much with guys. Some of them older than I would want my daughter to date. Some of them so much older, they’re more of a father figure.

One MSM focus group in Sacramento talked about young men, described as “trophy boys,” dating and having sex with older men for a variety of reasons:
P: [They're probably] just looking for stability or lookin' for a place to go for, you know, and this older gentleman can provide a home for them and provide them...with something to...start their own life...

P: ...I think sometimes it is money but I think sometimes people just are attracted to older people and I feel like in our community it's not as frowned upon whereas if like a girl dates an older guy like all this, "Oh, she's just doing it for the money."

**Transactional sex**

Respondents in both counties mentioned that transactional sex for money, food, protection, or shelter occurred among youth. Some participants also identified certain areas in their communities where signs of transactional sex were more common including the Highway 99 corridor in Roeding Park in Fresno and Stockton Boulevard and Mack Road in South Sacramento. According to participants, youth populations at higher risk of engaging in transactional sex included LGBT youth, youth aging out of foster care, and homeless youth. A director of a youth-serving organization discussed survival sex among homeless youth in the Tower District:

*We do have a large component of kids that may not necessarily identify as gay or bisexual but are having sex with other men. A lot of survival prostitution going on, particularly between the kids that really are doing the survival prostitution thing—have some food, have a place to sleep for the night. We do see a lot of that activity. Those kids don't necessarily identify as gay or lesbian or bisexual.*

A focus group with homeless youth in Sacramento used the term “playing” to describe transactional sex. One female participant explained, “Like a female using their crotch just to get whatever you got in your pocket, your wallet, your money, your credit cards, your EBT card, your food stamps.”

According to several adult respondents, reasons that youth in foster care and youth in juvenile detention are vulnerable to engaging in transactional sex include economic necessity, a history of abuse and neglect, low self-esteem, and a desire for acceptance and love. An educator working with youth in foster care stated:

*I also think that because many of them go from home to home that sex can be love to them and acceptance. And the dire need to wanting to feel love and accepted that they will put themselves more at risk. I would say that probably 60% of the girls that I work with that are in the high-risk foster area have prostituted at the ages of 12 and 13. [In exchange of?] I think it’s an exchange for, mostly for acceptance, especially if they have a pimp, feeling like there is a sense of belonging. In addition, a lot of them say they do it for money, ’cause their foster parents won’t give them money or runaways, a lot of them will run from the system and they end up in prostitution.*

**Intimate partner violence**

Several adult and youth respondents spoke about the presence of intimate partner violence among youth in their community. One focus group with homeless youth in Sacramento talked about reasons why a young woman who is homeless may stay in an abusive relationship with someone who provides her shelter and protection:
P: You know he's like, "You-you fuckin' around with that guy that—" But oh my God, I'm like, "No, I'm not." And he'll just like flip out and like, start swinging.

P: And if we stick up for ourself, we get hit worse.

P: Hit twice as worse…

P: Like you know it's a bad situation to be livin' with them or whatever, but you know it would be worse if you were out on the street…

P: Yeah…it's kind of like—

P: What you can handle.

P:—like a sense of protection, almost. 'Cause it's like, "Okay, if I have this person with me, then other people aren't going to fuck with me. But if I'm by—"

P: It's a personal bond.

**Sex trafficking**

Several respondents acknowledged the presence of sex trafficking networks in Sacramento. An HIV/AIDS program director in Sacramento explained:

My understanding is that they're incredibly local and then they are trafficked up and down California, Oregon, and Nevada. If there are a couple of girls picked up in Sac, they may take them to LA where they're not known. We've gotten phone calls from young people who are from Sacramento and have ended up in Oregon. Who ended up there through sex trafficking.

Some young women who end up in juvenile detention for prostitution were trafficked, according to an adult working in juvenile detention:

I think one thing that needs to be recognized is that Sacramento has a very large traffic for prostitution rings. And this is kind of “the hub” is what I'm hearing. So we get a lot of girls that are here, what they call “working the circuit.” So, um, it's not your teenager, 'well you know Susie has five different boyfriends.' This is more of, 'Susie is told you need to earn money and we're bringing in these people and we're going to take you from motel to motel to ply your trade and then move you to another area of town or Las Vegas or somewhere and bring you back.'

**Summary**

Social media, public places, school, and parties were the most common places where young people meet the people they end up having relationships with and/or have sex with. While the majority of youth focus groups and adult participants agreed that casual sexual encounters or short-term relationships were most common types of relationships among youth, some youth participants expressed that youth had both short term, casual and long-term, serious relationships. Adults and youth from all four communities mostly agreed that multiple partners and unprotected sex are common risk factors for STIs among young people. LGBT youth, homeless youth, and youth in foster care and juvenile detention are particularly vulnerable to sexual activities that put them at higher risk for STIs such as transactional sex, unprotected sex, and having older partners.
6. Substance Use

This chapter explores respondents’ perceptions of the prevalence and type of substance use among youth and adults, as well as substance use as a risk behavior in transmission of STIs among young people in the selected communities.

Prevalence

This section explores participants’ reports of different types of substances most commonly used and locations where youth are more likely to use substances. Participants in all interviews (20) and in all but one focus group acknowledged that substance use was common in their communities. In one Fresno focus group, the participants did not come to an agreement of whether substance use was common in their neighborhood.

Types of substances

Participants in all focus groups (14) and almost all (18) interviews mentioned the types of substances that youth most commonly use. Marijuana (30), alcohol (24), and methamphetamine (12) were most frequently reported among adults and youth. Other substances mentioned included prescription drugs and over the counter drugs (9); MDMA, also known as ecstasy (9); tobacco, including e-cigarettes (6); heroin (3); cocaine (3); designer drugs, such as “Spice” (1); synthetic marijuana sometimes marketed as incense (1); and “bath salts” (1). The use of “spice” and “bath salts” were only mentioned in Fresno County.

One adult participant from Fresno working with homeless and transient youth commented on how the political movement to legalize marijuana influences youth attitudes to use:

They’re still smoking pot. Their attitude is that everyone’s doing it, no one’s died from using pot...Kids have this attitude if we’re trying to legalize it, then it must be okay. Not realizing a lot of times these drugs are tainted with other drugs.

A male focus group in Clovis commented on an alcoholic drink called “Real Turn Up,” surreptitiously brought to school:

P: They be puttin’ it in like juice boxes and stuff, make it look like juice, but it’s not juice. We know it’s not juice.

UCSF: They’re putting vodka into the juice boxes?

P: Yeah, we know it’s not juice.

A few of the focus groups (2) and interviews (2) mentioned the use of a combination of prescription or over-the-counter drugs with other substances, such as marijuana or alcohol. Participants from a female focus group in Sacramento describe the trend of consuming marijuana with promethazine and codeine at parties:

P: …Nowadays they, they dip the weed. Or they drink — they’re drinking, they’re sipping on some Lean [Promethazine] and stuff. And they’re crunching up the pills —
P: Cough syrups, too.

One Fresno County mental health professional described the negative impact of designer drugs on the mental health of the youth he works with:

Right now, the most scary for us…is Spice, which is a synthetic marijuana. But the one that’s even harder for us to deal with are the kids on the bath salts, which is another designer drug that they’ve not been able to regulate in any way, so when the kids are using that, their behaviors are really off the rector scale — very odd behavior, very aggressive, very violent, bizarre type things that they do.

**Location**

Participants reported a variety of different locations where youth access and use substances including: parties (10), public areas such as streets or stores (7), schools (6), bars or clubs (6), liquor stores or smoke shops (5), and in a car (1).

The types of parties mentioned included raves; smaller parties at friends’ houses often called kickbacks; and large, family celebrations. One Fresno focus group discussed teenagers’ ease of access to alcohol during family celebrations:

P: Or at…big parties like Quinceñeras…parents fill um buckets with beer and alcohol [P: Right] and it’s up for anybody to grab.

P: It’s like, ‘Go ahead, mi hijo.’

P: Like basically when they’re drunk already, they don’t notice so kids are like grab —

P: So kids grab it.

While participants acknowledged substances to be an issue overall in Fresno County, a few (3) adults from Fresno differentiated Roeding Park as having more of a visible culture around substance use compared to Clovis.

One health educator elaborated on the reason for this difference:

I think there is a little more out there [in Roeding Park] for many reasons. It’s a little more accepted. It’s more impoverished so nobody really says anything. You can walk in the street and do it. I know in Clovis, the cops are very strict and if they see you, they’ll definitely fine you or pull you over…In the Roeding Park area, you do see meth bags, little baggies in the streets, off the sidewalk. I would see that more than in Clovis, but I know Clovis has a problem also… [In] the Roeding Park area, [there’s] a lot more bars in the area. Kids congregate in more areas out there; it’s a little more liberal whereas Clovis area is more conservative. There are not a lot of bars in the area and things are not as visible.

**Substance use as a risk behavior**

This section highlights participants’ responses around youth substance use and sexual behaviors that may put them at risk for STIs. Most of the interviews (17) and focus groups (11) made the connection between risky sexual behaviors and substance use. The most frequent substances mentioned in relation to risky sexual practices were alcohol (13), marijuana (5), and methamphetamines (4). A common theme across several (13)
interviews and (9) focus groups was that substance use is an STI risk because it lowers inhibitions and, therefore, youth are more likely to engage in risky sexual behaviors. Male focus group participants in a substance treatment program in Sacramento explained this link:

P: Yeah, everything is more common when you're drinking and doing drugs. You do a whole lot of crazy stuff.

P: Anything that someone would have second thoughts about is a lot more common to happen on drugs or alcohol.

UCSF: What do you mean by that?

P: Like if some girl's like, 'Yo, I don't want to have sex with like these two guys,' but — or like this guy and this other girl. But if she gets drunk, she might not give a shit.

**Unprotected sex**

Sexual activity without a condom while under the influence of substances was the most common sexual risk behavior mentioned (14). One Sacramento focus group with gay males described the phenomenon, "drunk dick," and why that leads to having unprotected sex:

P: Like dead. When you get so drunk the feeling is very desensitized...

P: So chances are they're not going to put on a condom 'cause they need more feeling to get it up.

Participants in one Sacramento female focus group explained how alcohol can affect someone’s judgment to use a condom:

P: They got...uh, the condom with them, like they --

P: They planned on using it.

P: ...they plan on doing the right thing, but then when they start drinking and partying and doing all the extra stuff, hormones just start to kick in and [Note: snaps fingers].

**Transactional sex**

Sex in exchange for substances, survival sex, or prostitution was identified more often as a risk behavior in Sacramento (5) than in Fresno (2) among focus group and interview participants. Homeless youth, foster care youth, and youth in juvenile justice were identified as youth at risk for having sex in exchange for substances or engaging in prostitution while under the influence. Female youth in a Fresno substance use treatment program gave examples of how a young woman may not be fully aware that they are exchanging sex for drugs:

P: Then there's a bag chaser, where they fuck whoever they want just to get a bag of drugs.

P: Drug whore.

P: Yeah, they — they follow — they follow the dealers around and they hang out, yeah.

P: They've gotta pay their daily dues. [P: Yep.] [Laughter]

**Multiple partners**
Also discussed as a risk behavior when combined with substance use was having multiple partners (6). One adult working with pregnant and parenting youth in Fresno elaborated on this type of risk as related to gangs:

_In pockets with gangs, girls are usually coerced at a very young age to start having sex and to have sex with multiple partners...I've had girls who are so under the influence they tell me later, 'I have no idea how many people I've had sex with,' or you know, 'I have no idea who my son's father is,' and it's not just between one and another person. It's between that person and like seven other people and she's 15._

**Sexual violence**

Both focus group and interview participants linked substance use and sexual violence (5). Homeless youth, youth with gang affiliations, and foster care youth were all identified as groups of youth being at risk for substance use and sexual violence. One family therapist working at a foster care agency explained how common it is for youth he sees to use substances and described a situation in which sexual violence has occurred:

_It's at least 50% of our clients are involved in some kind of substance use. One of the more serious cases [was when they] went to a party and [were] getting pimped out. In those situations it was definitely substance use where all of a sudden, 'I'm drunk' or 'I'm high' and maybe I'm not quite aware of the fact that I'm having sex with multiple people._

**Summary**

Participants in all four communities overwhelmingly agreed that substance use is prevalent among young people in their neighborhoods. Marijuana, alcohol, and methamphetamines were the most common substances mentioned and most likely to be connected to risky sexual behaviors. Participants discussed parties as an occasion where youth were most likely to use drugs and alcohol and engage in risky sexual behaviors, such as unprotected sex and sex with multiple partners. Youth affiliated with gangs, in foster care, homeless, in juvenile detention, and with substance use issues are particularly vulnerable to engaging in survival sex or prostitution. Those working in STI prevention should consider these populations, locations, and risk factors in their programming.
7. Condoms and Contraceptives

This chapter analyzes respondents’ discussion of condom and contraceptive use, reasons for non-use, knowledge and attitudes, access in their community, and communication about contraception.

Use of condoms and contraceptives

Contraceptive use was viewed as dependent on a number of variables. While condom use was the focus of most discussions, use of hormonal methods also was discussed frequently. Female participants stated that they personally used hormonal methods because they were in a monogamous relationship and therefore, did not use condoms. However, young women in another focus group noted you should use both condoms and another method because one could “always forget to take the pill.”

In addition to condoms and oral contraceptives, Depo Provera was also mentioned frequently by youth in both counties. Withdrawal was withdrawal, three times in Fresno focus groups but only once in Sacramento and not discussed in any interviews. Other methods mentioned less frequently (less than three times) included Plan B, the patch, implants, IUDs, and the vaginal ring.

Adults and youth mostly described condom and contraceptive use as taking place either rarely or inconsistently, “some of them are [contracepting] and some of them aren’t”. Some adults wondered if the youth they work with were truthful when stating they used contraception. Adults most often attributed contraceptive use to maturity; younger teens were viewed as least likely to use, and young adults in their early 20s more likely, but still not consistent. As one health educator in Fresno stated, “I would say, the older you are, the more common it is.” Another health educator from Fresno explained, “They’re more confident and be able to go into a clinic and not be ashamed and not be scared and not be judged. And of course, they can afford it, they can afford transportation.”

Reasons for use

Young people most often replied that contraceptives were used in order to prevent a pregnancy and/or STIs but also included other factors, such as in this exchange in a female focus group in Fresno explain reasons for using condoms:

P: Because they don’t want to get pregnant or —

P: They don’t know what that person has and they just —

P: — They don’t really know that they’re hooking up with.

UCSF: So it’s more common to use a condom if they don’t know the person versus being in a relationship?

P: I think so.

P: Yeah.

P: Especially if you know that person has been around.
P: Yeah. If they’re smart, they’ll use a condom.

Female participants in four focus groups said a condom is used for dual protection against pregnancy and STIs. The participants in a focus group of young men who have sex with men in Fresno agreed, but clarified that women use condoms for pregnancy prevention while young gay men use them for STI prevention. Some youth also said that condom use depends on the person, with some people using condoms and others not. Relationship type often was closely tied into contraceptive and condom use. Not being in a monogamous relationship, having a “random hook up,” knowing someone has “been around,” or beginning a new relationship were all listed as reasons for use.

**Table 7.1: Reasons for condom use, by respondent type**

<table>
<thead>
<tr>
<th>Reason Condoms Used</th>
<th>Female Focus Groups</th>
<th>Male Focus Groups</th>
<th>Adult Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent pregnancy and STI</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Prevent pregnancy</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Maturity</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Random hookup</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Not monogamous</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Educated</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Partner insists</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Not using other method</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Non-use of condoms and contraceptives**

There are myriad reasons young people do not use condoms or other contraceptives. Though some institutional barriers, such as access, were described, most often the reason was personal: seeking greater pleasure, being “in the moment,” or being careless, lazy, or embarrassed. Table 7.2 lists the reasons adults and youth provided as to why young people do not use condoms.

**Table 7.2 Reasons why young people do not use condoms, by respondent type**

<table>
<thead>
<tr>
<th>Reason Condoms Not Used</th>
<th>Female Focus Groups</th>
<th>Male Focus Groups</th>
<th>Adult Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms do not feel good</td>
<td>8</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>In the moment</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Partner does not want to use</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Not necessary because know/trust partner</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Use other method</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Access is an issue / don’t have a condom</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Careless / lazy / stupid</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Embarrassed to use</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

When it was just me and my baby daddy, I knew what he was doing, so—and I was on my birth control for a while, so I wasn’t really worried about it. But I feel like if ... we had different partners, then that’s where condoms are serious and come in hand.

Female Focus Group, Sacramento

Something that I know that we are really trying to promote is for young men to be more active in the birth control decision-making and to always have condoms. Because historically, the young men have kinda been cut out of the picture and it’s very much like, “Young women protect yourself. Don’t get pregnant.”

Health Educator, Fresno
Lack of education / Do not know condom is necessary | 0 | 1 | 3
Wrong sized condom | 0 | 2 | 1
Using substance | 1 | 1 | 0
Want to have children | 0 | 2 | 0

Additionally, the following reasons were mentioned once:
- Not worried about pregnancy
- Condom use is up to other partner
- Young people do not define what they are doing as sexual activity
- Condoms do not work
- Bravado: a young person may say they are not using a condom in order to show off
- Use of and/or having a condom indicates you are “easy”

Lack of pleasure whether perceived or real, is a serious issue surrounding condom use, as shared during a female focus group in Sacramento:

P: It doesn’t feel—doesn’t feel, like—doesn’t feel normal.
P: It don’t.
P: I can’t feel anything with the condom. You know?
P: It feel rubbery.
P: Yeah.
P: I’m dead serious.

Additionally, participants said sometimes sex “just happens” perhaps because someone encounters a former boy/girlfriend, or because they are at a party and it is late at night. As participants from a female focus group in Fresno stated:

P: When you have the, the urge or the horniness for it, it’s just like—bam—I need it now.
P: And they don’t have a condom.

Several participants, including in both male and female focus groups, said condoms are not used because of stupidity, carelessness, “or you’re just too lazy to take the 10 seconds of your time to put one on.”

Both adults and youth noted the importance of partner dynamics in negotiating contraceptive use. If someone asks their partner to use a condom, it might be perceived as an act of distrust. As one health educator in Fresno explained, they “don’t ask the person to wear a condom because they don’t want to put that person down and they don’t want to hurt that person’s feelings.” Adults and both male and female youth thought that young women specifically do not always ask for a condom to be used. An HIV clinic manager said, “I don’t think women are saying, ‘No, I’m not doing it unless you put on your raincoat.’” Several respondents stated that knowing and trusting a partner led to less frequent or non-use of condoms. Trust was defined as being monogamous or feeling that a partner would not have an STI.

A lot of girls put so much faith into their boyfriend or their baby’s dad that even though they have been unfaithful and have cheated, they will still have unprotected sex with that person and it’s sad because you know, the guys will say, “She’s my baby’s momma. I’m not gonna wear protection.” And the girls won’t and there seems to be this level of comfort even though they know that person has been unfaithful and that is a risk, they will still put themselves at risk.

Health Educator, Fresno
Youth in one male and one female focus group thought that some young men and young women do not want to use a condom because they want to “trap” their partner by having a child with them.

Most often when a participant said a condom was not used, but another method was, the method was either the male pulling out before ejaculation or the female was on a hormonal form of birth control.

There was a discrepancy between participants’ perceptions of condom use among young MSM. Some (5) expressed that MSM are not very concerned with protecting themselves from getting HIV by using condoms while others (3) said they were. Others stated young gay men did not use condoms because they aren’t worried about getting pregnant. As one health educator stated, for a lot of young gay men “condom use is at a very low importance because, again, that whole, ‘Oh we don’t get pregnant, so what’s the point?’ kind of thing.” (See also Chapter 9: Attitudes about STIs.)

**Access**

There are many factors related to accessing contraception including cost, location, transportation, and personal “agency” or empowerment. The most common locations listed were:

- Clinics, including school-based clinics
- Stores and drugstores
- Community-based organizations
- Family doctor
- Family members

Other locations mentioned by one respondent included outreach efforts and a county building. While some respondents reported condom availability in schools, youth in four focus groups and one adult said that condoms are not available in schools in their community. In fact, one health educator in Fresno said their clinic does not bring condoms to schools when teaching sex education despite student requests because it is “hard enough for us to just get through the doors because a lot people think we’re going to go into a school and just preach abortion”

While the juvenile detention center in Sacramento provides condoms, the one in Fresno does not. A health educator in Fresno who works in the Juvenile Justice Center noted that youth in juvenile justice facilities are allowed weekend furloughs, but are not allowed to receive condoms at the juvenile justice facility despite her agency’s efforts.

Specifically in Fresno, respondents mentioned that access to clinics is difficult due to lack of transportation. An adult who works with youth said that even if transportation exists, “how do you really explain to your mom and dad that you’re traveling all the way downtown when there is nothing downtown and it has such a Skid Row type of image to so many people?” This was deemed to be less of a problem for older youth who have transportation, but also because older youth are more confident and use the clinic without the same level of embarrassment.

> When you think about being young, and going into a clinic by yourself and filling out a form and everyone there, you feel like they’re looking at you. I think that is
really, really deterring. As an educator, I can tell them about the importance about wearing a condom every single time and why it’s important and they can agree with me and they will use their critical thinking skills to say it’s so important, but then there is not that other piece of, “I can easily get condoms.”

Three participants mentioned that family members provided or facilitated access to contraceptives. Young men in two focus groups explained they could get condoms from family members such as brothers, cousins, and fathers. A clinic employee stated in higher income areas:

The mom would take her daughter to get birth control and not tell the dad and they would never talk about it. I wouldn’t think that condoms would be… I think they would be more focused on protecting against pregnancy then they would be protecting against STIs. The mothers taking their daughter, they’re not educated on chlamydia or gonorrhea or how high the rates are.

Several respondents explained that local health departments, health educators, and outreach workers may put special effort into contacting and providing condoms to high-risk populations, such as prostitutes or homeless youth. As one health educator in Fresno shared when asked how receptive prostitutes were to their outreach efforts:

It’s a lot of fear. Because of being caught by police with condoms on them, that fear of prosecution, fear of their pimps. They might be receptive and wanting to hear it, but… some women will tell us, “I don’t want to get caught with condoms because then if a police officer pulls me over, they’ll just assume I’m...” They’ll say, “Turning tricks” and stuff like that. And they’re fearful of just that being proof against them.

Adult participants in both Fresno and Sacramento named locations that were part of the Condom Access Project, easily accessible locations that provide condoms to youth without requiring speaking with an adult or completing any paperwork. These locations included county facilities, clinics, youth-serving organizations, and other community based organizations.

**Communication about contraception**

Most participants discussed communication about contraception or condom use between partners, though a few shared thoughts on communication about contraception within the family or community context. Two adult respondents in Clovis described the conservative nature of their community and the lack of parental communication regarding contraception. A third adult from the same community stated, “I think that’s a really good discussion to have with your child ‘cause, hey everybody runs their family differently.” In a focus group with young gay males in Fresno, participants believed there was considerable communication about condom use in their community:

It’s always thrown in our face definitely [P: Uh-huh] to use condoms ‘cause everywhere you go that’s like for gay people there’s something there like a flyer or just, or condoms, so.”

Power dynamics within a relationship also impacted condom use. As stated in two focus groups, the difference in power dynamics may be due to gender—the male may determine use in a heterosexual relationship; or age and
maturity, where the older partner may determine use. A young gay male said a boyfriend may not always feel comfortable negotiating a condom with an older man:

No, I don’t think all the time because it could jeopardize where his financial stability is ‘cause if this guy’s paying for his rent, his car, his clothes, like he never has to worry about anything and he moves out of his parent’s house. So he basically is dependent on this guy. So he’s using his, his looks and his body to entertain him. You’re gonna kinda probably go with whatever the guy wants to do because he has the power.

A lack of discussion about condoms or contraception can occur when each partner is relying on the other to take responsibility, as stated in two focus groups, the first with males in Sacramento and the second with females in Fresno.

I wanna say I also feel like people try to put the responsibility on someone else to say something about it. It’s like, “Oh, well, if I don’t mention it, he doesn’t mention it, we must both be fine.” Or if like, “If he doesn’t bring it up, he’s obviously not worried about it.” I feel like people don’t really want to take responsibility if anything did come up and they can blame it on the other person.

They’re depending on their partner to go out and go out of his way to go buy condoms or something. It’s kind of vice versa, like the man’s depending on the woman to take care of herself and the woman’s depending on the man to take care of themselves.

Many youth participants said that if you know your partner, you are more likely to discuss condom use and feel comfortable about it. Yet, as stated in the previous section, when asked why condoms are used, having a new or unknown partner was a main reason for using condoms.

Communication about condoms did not always lead to use, and some of the youth participants noted that it can be an awkward conversation. A number of youth participants said that excuses could be made for non-use or not having a condom, and that a partner can be convinced not to use contraceptives.

I used to make up an excuse and be like, “I didn’t have time to go get one.” You know, I could have just said, "Hold up, wait five minutes," walk down to the store to get some and come back.

As noted in reasons for not using a condom, asking for a condom to be used can be seen as accusatory or an admission of being unfaithful.

Condom knowledge and concerns

Youth in several focus groups discussed their concerns about condom effectiveness and quality. Youth in seven focus groups (5 female, 2 male) discussed condom and contraceptive inefficacy. Additionally, distrust of free and low-cost condoms was discussed in some focus groups. In a female focus group a participant explained to another participant that condoms from Planned Parenthood are “basic condoms. They break.” Condoms from dispensers in schools and from the 99-cent store were also distrusted.

Individuals in a couple of male focus groups mentioned brand name condoms and noted they are trustworthy, and an adult thought that the
Trojan ad campaigns were very successful and made their brand of condom seem cool.

Other concerns about condoms included incorrect condom application and misunderstanding condom sizing.

Participants thought more education about condoms and other forms of contraception needed to be available for youth. Many noted that youth are eager for knowledge, and that increased and personalized knowledge would directly contribute to increased contraceptive use.

**Summary**

Respondents believed that contraceptive and condom use among younger individuals is often inconsistent, but as youth mature and get older, use may increase. The top reason for condom non-use was the real or perceived lack of pleasure, followed by the desire for spontaneity and “being in the moment.” Condoms are used less often once a relationship was established or if a partner does not want one used, but were more likely to be used in short term and non-monogamous relationships, or with a new partner. Many participants noted that women requesting condom use is an important factor in their use and also listed challenges in communicating about condoms or contraceptive use. Access to condoms was not generally a barrier, though free and low-cost condoms were not always trusted.
8. STI Information

This chapter provides an overview of respondents’ perceptions of STI information among adolescents and young adults in the selected communities, including receipt and content of sexual health education, other sources of information about STIs, and community support for sex education.

Sexual health education

This section describes youth and adult perspectives of sexual health education, including the length and timing of classes, the educational content, youth reactions to classes, and other sources of information about STIs.

Receipt of sex education

According to the survey completed prior to each focus group, 75% of youth answered they had taken a sexuality education class. Note this varied widely by location with youth participants in Sacramento reporting much higher responses to receipt of sex education.

Table 8.1: Focus group respondents who received sex education, by community

<table>
<thead>
<tr>
<th>Location</th>
<th>Total</th>
<th>Percent</th>
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<tr>
<td>Fresno 93612</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Fresno 93728</td>
<td>24</td>
<td>14</td>
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<tr>
<td>Sacramento 95815</td>
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<td>19</td>
</tr>
<tr>
<td>Sacramento 95823</td>
<td>31</td>
<td>26</td>
</tr>
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The majority of youth participants responded that they received sex education during school, the majority during either middle school or high school. For youth who received sex education in high school, most took it during their freshman or sophomore year. Several youth noted that it was a requirement for high school graduation, and one youth stated that it was a requirement during middle school. Three youth responded that they received sex education several times in school, during elementary, middle, and high school, yet most youth responded that they received it only once.

Youth in six of the seven focus groups in Sacramento, but none in Fresno, mentioned receiving sex education in elementary school, and noted that the content was focused on puberty and other age-appropriate topics. Beyond these school settings, some youth also reported receiving sex education at college (3) and in juvenile justice facilities (2). A small number of youth, virtually all in Fresno, stated that they had never received sex education, or had not received it yet (because they were still in high school).

According to youth participants, the length of sex education classes received varied widely, from one single presentation to an entire school year of weekly classes. The majority of youth received sex education for a full semester. One participant responded that she received sex education for six weeks during summer school.

Content of sex education
Most students received sex education as part of a health class which included other topics, such as nutrition and physical health. In some cases, this mixture of topics came at the cost of sex education. One male youth in Sacramento stated, “Our class was combined… it was just health and driver’s ed., but driver’s ed. took up the whole semester and then we never got anything of health.”

For specific sexual health topics covered during sex education, participants responded that they learned about STIs (8), including gonorrhea (4), herpes (4), chlamydia (2), HIV/AIDS (2), and syphilis (2). Other topics related to STIs included symptoms (4), transmission (2), and risks (2). Additional subjects mentioned were: contraception (4), such as condoms and dental dams (4); visiting a clinic or doctor for sexual health care (2); puberty (2); reproductive anatomy (1); and healthy relationships (1).

While many of these topics were covered in some way during class, the level of instruction and detail differed by topic. For example, one female participant in Fresno explained:

I think we only talked about certain STDs. The ones that were the most common, instead of the overall. All they did was hand out a lot of paperwork and just a list of different ones, but they only covered like AIDS, HIV, gonorrhea, and chlamydia.

Similarly, female youth in another group from Fresno noted the type of information she received about STI symptoms:

It was briefly, like, she didn’t have a whole lesson on them. But it was briefly, she described ‘em. Like, what to look for. What to expect, and if you don’t fix it, how you’ll feel. How your body will shut down and stuff like that. She explained, um, the symptoms, kind of.

Some youth in six groups responded that their class included a condom demonstration. Of these groups, five were female and none were in the Clovis area. Youth in five groups responded that their class included information about homosexuality and bisexuality. However, the quality of instruction, level of detail, and type of messages about these topics seemed to vary among youth. As one male youth in Sacramento explained:

I mean, for the most part, no, but they did, I do remember they mentioned, you know, like the word “homosexual” and you know, some people are attracted to the same sex, but not really any detail.

Similarly, a male youth in a different group expressed frustration that his class did not contain more prevention information for LGBT youth: “There’s homosexuals and lesbians out there that need to know [more details] in order to take precautions.” In another group, a female youth responded that the instructor attempted to bring up the topic of homosexuality, but was interrupted by a student and did not follow up:

At the end of our class period, she tried to say something about it. And then it was kind of pushed down by someone in the class… It was like really rudely put down. And that’s what bothered me. It’s like, not that I am [gay], but like, I have friends [who are].

As for the format of educational materials in sex education classes, youth mentioned that they saw pictures of STIs (8), watched videos on various topics, such as pregnancy and birth (3), and had guest speakers in their class (1). Youth participants often had strong reactions to the visual materials in their classes,
responding, “It was gross,” “It was funny,” or “The photos and videos are excruciating.”

**Reaction to sex education**

Overall, many youth responded that their sex education classes could have been improved by incorporating more direct explanation about how pregnancy occurs, how infections are transmitted, and about how contraceptive methods work, as well as more concrete skill-building activities, such as how to use a condom. As one female youth in Fresno stated, “They don’t even like tell you how they [condoms] really work. They’re just like, ‘Use them.’” Another female participant, also in Fresno, responded, “But we never like, like talked about like the process of pregnancy, of sex, and all that stuff.”

In some cases, according to youth, the length of the course may have limited the amount of information taught; in other cases, the quality of instruction may have been a limiting factor. A female youth in Sacramento stated:

> The sexual ed part should have been at least a little bit longer [P: Yeah.] and go into a little bit more detail. ‘Cause we really did rush over that within like a week… Like a week or a half or so. And it was just like—it was just to make sure we knew what was gonna be on the final.

Another challenge for sex education, according to youth, was students not taking the information or the class seriously. As one young woman responded, “The class was just a joke… More people laughed at what they were trying to teach us, than actually taking it seriously.” In another group, a female youth explained the limitations of classroom learning about sexuality: “It’s good that they teach you that, but you still—we’re gonna experience things on our own.”

To make sex education more useful, female youth in one group in Fresno suggested including more instructions about how to be safe and protect yourself, rather than just the message of not having sex:

> P: When people are just like, ‘Don’t do it, don’t do it,’ most kids are like, ‘Yeah, whatever. Like, what do you know?’ and that kind of thing.

> P: Yeah. I feel like kids—actually, I feel like a lot of like people our age would be more protected if they weren’t like, ‘Don’t have sex,’ [but] instead directed… more of like, ‘Well, if you do have sex, these are safe ways to do it.’

**Other sources of information**

In most focus groups, youth responded that they used other sources of information to fill in the gaps of their sex health knowledge. The most common sources mentioned were friends (8); parents or siblings (8); mass media (7), such as television and movies; and the internet (6). Youth mentioned both mothers and fathers as potential sources of information, although, as one female stated, “I think it’s a 50/50 thing… Some people like talking to their parents… and some people don’t.” In addition to these sources, a few youth also mentioned getting information from other sources such as doctors, clinics, and a youth conference.

Youth in several groups discussed seeking information online to supplement their sex education, as shown in this exchange from a female focus group in Fresno:

> UCSF: You learned symptoms?

> P: Yeah. I think Google was my best friend.
Although youth acknowledged the risk of finding information on the internet that may not be accurate, they also described the benefits of having an anonymous source of information:

P: Yeah.

P: And it’s so much easier… to go on your phone, to go on Google, than it is to go to a doctor and ask…

P: People are embarrassed about that type of stuff. They’ll Google it all day. But they won’t go into a doctor for five minutes.

In addition, youth noted that various mass media, such as television commercials, popular music, and movies, may misrepresent sexual health information—but that these sources are quite memorable for youth:

P: Movies. [Laughter] …Like every time I think of, like, my health class, I think of the part in [the movie] Mean Girls where he’s like, ‘Don’t have sex, you will get pregnant and you will die.’

[MANY] ‘You will die.’ [laughter]

Youth STI knowledge

Among adult participants, the majority described youth knowledge of STIs in their communities as low or lacking. In particular, many adults noted that youth often lack an understanding of how infections are transmitted, which ones are treatable and which aren’t, and the long-term effects, beyond initial symptoms. As one health educator explained, “There’s a lot of craziness on how it gets passed and how to get tested and not tested.” Another health educator stated, “The kids tend to know most of the [physical symptoms], the burning, the itching, but they don’t know about the other stuff, such as you can become infertile.”

Several adults explained that youth are familiar with condoms as a prevention strategy, but not other strategies for prevention. An outreach worker in Sacramento stated, “They know that condoms are the most effective [method]…but other than that… they probably don’t know a whole lot more.” A program director, also in Sacramento, responded:

A condom is a great idea if you’re having the kind of sex that a condom matters, but explaining the difference between fluid exchange versus skin-to-skin contact and how the STDs differ. They don’t have that kind of detail.

In some settings, adults felt that youth lack knowledge about simple reproductive anatomy, such as how pregnancy occurs: “A lot of these teens think you can get pregnant by a touch, believe it or not.”

Regarding low youth knowledge of STIs, several adults mentioned how youth turn to their friends for information, which often results in myths or misinformation being spread without any fact-checking. As one health education teacher said, “They get information from each other. And so, that is never a good thing.” In addition, youth attitudes can contribute to the lack of knowledge about STIs. A program director in Fresno explained, “I think they know [what puts them at risk], but they are still in denial. Developmentally, what we learn, they think they’re invincible.”

Overall, adults noted that youth gain more knowledge about STIs and sexual health as they get older, either through personal experience, exposure to
educational programs, or access to other sources of information. Two adults responded that sex education programs are more accessible during college than during high school. However, another person who works at a community college in Sacramento noted that there was no longer funding to have Planned Parenthood provide STI information on campus, so students mostly learned from their peers. Interestingly, one adult who works with homeless youth in Fresno explained why these young people often know more about health risks than their peers:

I’m really surprised [at] how educated our homeless youth are. And they are aware and they educate me… Because it’s a matter of survival… Every day, they’re in survival mode and so being aware of their risks is something that is a part of their survival instincts.

**Barriers to sex education**

According to adults, a major reason for low STI knowledge among youth is the lack of consistent, comprehensive sex education in middle and high schools in their communities. Even in communities that have historically provided sex education, funding cuts to programs in recent years have resulted in fewer community programs, smaller programs with fewer education staff, and more youth without the skills to prevent pregnancy and infections. As a program director in Sacramento explained:

There have been so many reductions in programs, [youth are] missing some of that foundational stuff so it’s spilling over. They are not aware of some of those things sexually that we would have thought they were. Their sophistication level has kind of regressed. It’s symptomatic when we pull services away, because we aren’t doing sex ed. classes in certain middle schools. When they’re getting [to age] nineteen, they’re not as informed as we would have expected them to be.

Adults noted that funding cuts to sex education and outreach programs affect certain populations of youth more than others, such as youth in foster care, youth in migrant communities, and youth who are developmentally or physically disabled. For school districts that continue to provide sex education classes, teachers may lack the necessary training or knowledge to successfully teach youth on these subjects. As a Fresno educator explained:

They dismantled that [comprehensive sex education] program because of funding, and the biology teachers are now supposed to be the ones giving that information… I don’t think they truly talk about everything they’re supposed to talk about.

A health education teacher noted a dramatic rise in new HIV cases among teens aged 15–19 in Fresno, from one per month to five per month, and blamed the lack of funding for sex education:

That’s five kids we could have saved had they had this class. So I think they need to be aware of it. They need to be told that it’s worth the money to pay the teachers to have the class. That it’s worth the investment. They need to understand that. The class needs to be reinstated. It needs to be a requirement again.

**Community support for sex education**

In addition to funding challenges, adults described other barriers to community support for sex education, including reluctance or opposition among school administrators and/or parents. A Fresno program manager explained that a single session requirement for sex education, which may seem sufficient to school
administrators, doesn’t adequately meet the needs of youth:

_Honestly there aren’t conversations going on with STIs in our community. The schools are hesitant, they’re reluctant. It’s that one session and that’s it. Everybody [says], ‘Okay, I wash my hands of it. I met my requirement. I’m done.’ So yeah, if there’s no consistent messaging, they’re [youth] not gonna know._

Parental support for sex education is quite mixed, according to adults, with opposition usually stemming from a lack of understanding of what the classes entail and what messages are being relayed to youth. A program manager in Sacramento described the response a health educator received from parents in the community where she worked:

_She time and time again had parents really angry at her saying, ‘What are you doing here? That is up to us. That’s our job. You have no business talking to our children or telling us to talk to our children. We know our children, we know they’re good, we know they’re not having sex, we know they aren’t doing anything that will lead them to get HIV or one of those other diseases, so you don’t need to be here, go!’ And that wasn’t just one isolated person; she kept running into that all over._

While some parents may prefer sex education to happen at home, an educator in Fresno noted that parents don’t necessarily have the skills to impart this information comprehensively and objectively to their own children:

_I think parents talk to their children about sex, [but] I don’t think they talk to them about STIs. I think it’s more of, ‘You don’t have sex until you’re married and don’t get pregnant,’ in that realm._

However, she and several other adults stated that parents “would be more supportive if they truly, truly were given the intent of comprehensive sex ed.”

**Summary**

This chapter presented data on receipt of sex education among youth, including class content, youth reactions, and suggestions for improving sex education. It also presented adults’ perceptions of youth STI knowledge and the impact of sex education receipt and program support in the community.

Most youth received some type of sex education during middle or high school. Youth participants described quite varied sex education experiences, from a one-time presentation to regular classes lasting an entire semester. Topics covered in sex education included HIV/AIDS, common STI symptoms, treatment and transmission, and contraceptive methods. In some cases, sexual identity and skill-building activities were included. However, the detail and quality of instruction differed among youth, with some receiving more comprehensive information and skills for prevention than others. Youth often relied on other sources of information for sexual health, such as friends, parents, mass media, and the internet.

Adults described youth knowledge of STIs as low or very low, with negative impacts for youth risk behaviors and sexual health. While some adults felt that youth knowledge was extremely poor, such as misunderstanding basic concepts about pregnancy and disease transmission, others thought that youth in their communities were only missing some detail, such as long-term effects of STIs. In some settings, budget cuts have led to a lack of comprehensive sex education for youth, fewer programs, or smaller program capacity. Adults also expressed
concerns about mixed community support for sex education, due to political and funding barriers among school administrators, and lack of understanding among parents.
9. Attitudes about STIs

This chapter explores respondents’ perceptions of attitudes about STIs and their impact on access to testing and treatment services. Youth and adults shared multiple attitudes or reactions towards STIs and their level of concern about getting STIs compared to their concern about getting pregnant. The following sections present the responses mentioned most frequently in the interviews and focus groups discussions.

People avoid talking about STIs

Youth from half of the focus groups and ten adults discussed the silence surrounding STIs in their communities. In the opinion of participants, this silence is associated with the taboo and stigma around sexual practices and STIs. Male and female youth participants mentioned that youth usually do not talk about STIs among themselves for fear of being stigmatized by their peers:

P: You don't really hear too many kids say that they have something.

P: And like, who's going to be proud to say, 'Oh, hey, guess what guy? I've got herpes. Yea.' Nobody's going to be proud about saying that.

In both Sacramento and Fresno, one of the reasons that several youth mentioned for not disclosing their concerns about getting or having STIs is being afraid of youth spreading rumors about others’ STI status and dating relationships: “You’d be, like, embarrassed to tell the people 'cause you’re afraid that they’re gonna go tell people and then it gets around that you got this or whatever.”

In addition to fear of stigma, adults mentioned other factors that contributed to a lack of communication about STIs including religious beliefs and conservative attitudes from the community that condemn sexual relations outside of marriage, parents’ denial about youth sexual activity, and school policies and staff attitudes toward sex education. An outreach worker at a youth-serving organization in Sacramento said:

I’ve learned a lot about how it’s really kind of a taboo kind of thing for high school students to be taught about sex and stuff. Parents get upset about it. I just wonder why are we not in more schools… and it’s a real issue with people for high school-aged kids to have access to free condoms and knowledge on STDs and how to prevent them. For some reason, it’s not really acceptable.

(See also Chapter 8: STI Information regarding attitudes toward sex education.)

Youth are afraid of having an STI and its consequences

Eight adults and youth from six focus groups mentioned that youth are afraid of contracting STIs because of the symptoms and the complications associated with them. Some noticed that fear is a factor that prevents youth from accessing health care services, while others mentioned that fear might encourage youth to look for and access friendly health care services. As an
adult in Sacramento explained:

They might not be as informed as they should be, but they are concerned about the possibility that they could become infected. They’re not lackadaisical about it in that regard, ‘Oh I don’t care if I get an STD.’ When given the resources to come and test, they will as long as they know it’s discreet and confidential, meaning my parents are not going to find out. They’re very receptive to being involved and finding out.

In some focus groups, youth mentioned that the fear of getting STIs might be more present among specific populations who are at a higher risk of infection, such as men who have sex with men, homeless youth, and drug users, among others.

**Youth denial that they can contract STIs**

Youth from four focus groups and five adults mentioned that youth sometimes have an attitude of denial about the risks of infection either because they think they are invincible, or think that “that would happen to others, but not to me.”

This theme was mentioned more frequently by adult participants who work with vulnerable populations, such as the homeless, foster care youth, youth in justice facilities, and those in drug recovery programs. One respondent who works with foster care youth mentioned that besides the attitude of being invincible, foster care youth are careless because this issue has a low priority compared with more pressing needs such as obtaining food and shelter.

Interestingly, this theme only emerged in male focus groups and three of the four focus groups who discussed this topic were conducted with high risk populations, such as gay males and youth at a drug treatment center. In addition, youth from one of the focus groups mentioned that younger youth are more likely to have this attitude as compared with older youth, who are more conscious about the risk of having STIs. As a male youth in Fresno stated:

I think it depends on the age group. ‘Cause the 15 to 18, 15 to 17, you’re a little bit more careless and you think you’re invincible. But, I think once you hit the 20s and stuff, you become so much more aware.

**Lack of knowledge or awareness about STIs**

Youth from four focus groups and six adult respondents mentioned that some youth are not aware that they can get infected with STIs. In addition, they discussed that youth sometimes are unable to identify viral and bacterial STIs and symptoms for each. As this health educator from Fresno said:

‘I don’t want to catch something.’ I think that’s also their level of exposure. Like saying, ‘You don’t want to get the clap or syphilis.’ And that’s if they have seen a movie where it’s talking about that, but not really coherently understanding what that would mean or what the symptoms are, or how even how an STD is transmitted.

Adults and youth also talked about misconceptions that youth hold about
Youth CHART Project

STIs, such as the perception that only certain groups get infected with HIV or that the physical appearance can be a predictor of having an infection. The director of a LGBT organization from Fresno said:

And a lot of them still kind of have this idea that AIDS really isn’t something they need to be concerned about. It happens to older people, and you can just now take a pill and be okay…. But it’s for older gay men. It’s not really straight. It’s not really for people that are young. Or that, I get this a lot with the gay males that will tell me that, ‘Well, he was cute.’ Well, what does cute have to do with getting an STI or contracting HIV?

Moreover, misinformation and taboos about other types of sexual practices that are not vaginal-penis intercourse, such as anal and oral sex, can also put youth at risk of contracting STIs, as this HIV case manager explained, “Teenagers [believe] that penile/vaginal sex is sex. Anything else is not sex.”

**Negative associations of having an STI**

A theme that emerged in virtually all of the focus groups (12), but was only mentioned by one adult, was the association of having STIs with being “dirty, gross, messy, or nasty”. “Dirty” was defined by youth participants as somebody who has poor hygiene or as a person who has promiscuous behavior. The following quotes from male and female youth exemplified that:

P: I don't [want] to be messing with dirty girls, but I know I'm clean.

UCSF: What do young people think of somebody who has an STI?

P: They probably think they're dirty.

P: Yeah.

P: Yeah, they're dirty.

P: If you're a girl, they're [men] like, ‘She's a 'ho, or she's this.’

**Comparative concern about getting an STI**

Adult and youth participants were asked if youth were more concerned about getting HIV, pregnant, or some other STI. This section summarizes the main responses.

**Youth are more concerned about HIV than other STIs**

Four adults and youth from three focus groups discussed that youth are more concerned about getting infected with HIV than other bacterial or viral STIs. Participants—female and male youth and adults—mentioned that HIV and herpes carry more stigma than chlamydia and gonorrhea because they are not curable. One female youth in Sacramento explained, “I don't want to have AIDS/HIV for the rest of my life. But a STI, I could use—take antibiotics and it'll go away. But [AIDS], that's what I'm terrified of.”

Some participants felt that MSM youth were more concerned about getting
HIV because of awareness that their group is more at risk.

**Youth are more concerned about getting pregnant**

All adults and youth from all focus groups (with the exception of one) said that youth are more concerned about getting pregnant than about getting an STI. In the opinion of participants, several reasons contribute to this including:

- Youth are more aware of pregnancy as a potential consequence of having unprotected sex compared to contracting an STI. As this health educator said:
  
  *They’re not concerned about getting an STI. I would say they’re more concerned about getting pregnant than they are of STIs. Probably ‘cause of when we have this discussion, a lot of them will say that ‘cause they don’t see people who have STDs. They don’t come out and say it. They don’t know who has an STD. They know of a few friends that might had it, if any, whereas somebody’s pregnant, they always know someone who’s around them that’s pregnant. It’s more visible.*

- There have been limited efforts by public health departments to disseminate information about the risk of contracting STIs in comparison to the teen pregnancy prevention programs which have conducted more visible prevention education and outreach activities. A staff member from the Fresno Department of Public Health said:
  
  *I think pregnancy’s still number one. I think the teen pregnancy program has done a lot better in getting the word out. And I think because the messaging has been real consistent with that and STI is probably secondary.*

**Youth concern varies by situation**

In nine focus groups, some participants mentioned that youth might be worried about both pregnancy and STIs or talked about reasons for youth being more concerned about one outcome or another. For example, youth in one focus group said that the type of relationship that they have can influence their concerns about getting pregnant or getting STIs. If they are in a stable relationship, they are more concerned about pregnancy, but if they are in a casual relationship, they are more concerned about STIs:

*I feel that if you know your person is clean and you physically really know who you’re sleeping with, then—and you’re only sleeping with that person—then you should be thinking more of the pregnancy, more than you should be thinking of getting an STD.*

In a female focus group with parenting and pregnant teens, participants discussed that youth under 19 years old might be more worried about getting pregnant. In contrast, older youth might be more worried about contracting STIs since some of them already have had the experience of being parents and are already using contraception.

Furthermore, one female focus group discussed that they would be more afraid of having an STI than a pregnancy because they are aware that a pregnancy could be interrupted, but not all STIs can be cured:

*P: Uh, I would say the group that I hang out with is more scared of getting an*
Three adult participants talked about the variability in the concern about pregnancy or having STIs depending on the demographics of the population. For example, a HIV program manager in Sacramento said that female patients tend to be more worried about getting pregnant. However, male patients tend to be more concerned about getting STIs because they attribute the responsibility of pregnancy prevention to their female partners.

Summary

Youth and adult participants in Sacramento and Fresno agree that avoidance of talking about STIs, fear of getting infected, and stigma are common attitudes toward STIs in their communities. These attitudes could act as barriers to accessing information, testing, and treatment. In addition, both male and female youth were generally more concerned about pregnancy than STIs. However, some males may be more worried about STIs given their perception that pregnancy was the female’s responsibility.
10. Access to Sexual Health Services

This chapter explores respondents’ perceptions on youth’s access to sexual health services, including STI testing and treatment services, and the facilitators and barriers that they face in accessing care. We asked the following main and follow-up questions to youth and adults:

Youth and adults shared multiple views towards STI testing services available in their communities, as well as facilitators and barriers to accessing care, and strategies to improve services. The following sections present the themes mentioned most frequently in the interviews and focus groups.

Local service providers

Youth and adults mentioned several clinics where youth can obtain STI testing and treatment in their communities (see Table 1). Many youth and adults mentioned Planned Parenthood. Some youth in Fresno mentioned that they get services at Fresno Barrios Unidos and Clinica Sierra Vista; and in Sacramento at UC Davis Pediatrics. Only adults mentioned the other providers included in the table.

Table 10.1: Area clinics offering STI testing and treatment, mentioned by interview and focus group participants

<table>
<thead>
<tr>
<th>Sacramento</th>
<th>Fresno</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Parenthood</td>
<td>Planned Parenthood</td>
</tr>
<tr>
<td>Harm Reduction Services</td>
<td>Fresno Barrios Unidos</td>
</tr>
<tr>
<td>CARES</td>
<td>Clinica Sierra Vista</td>
</tr>
<tr>
<td>Women’s Health Specialists</td>
<td></td>
</tr>
<tr>
<td>Sacramento County Health Department</td>
<td></td>
</tr>
<tr>
<td>UC Davis Pediatrics</td>
<td></td>
</tr>
</tbody>
</table>

The majority of adults and youth participants in Fresno and Sacramento stated that youth often attend Planned Parenthood clinics to get tested for STIs. The majority talked about the friendly, confidential, and comprehensive services offered there, including sexual education, pregnancy testing, and STI diagnosis and treatment. Other places where youth received services—mentioned by several adults and youth in both counties—were community clinics run by non-profit organizations or on-site clinics located at non-profit organizations that target homeless youth and other vulnerable populations.

One of the advantages of these services—discussed by some adults and youth participants—is that they are accessible to uninsured youth through the Family PACT program. However, many more youth could be reached if school policies supported such strategies. This reflected the finding noted by some participants from Sacramento and Fresno who mentioned that some of the Family PACT-affiliated community clinics used to advertise...
their services in high schools, but recent policies have banned them from doing it. A health educator in Fresno stated:

They used to [come] when we would have Sociology for Living. We would have them [Barrios Unidos] come in and talk to the kids and they would show them the Green Card [Family PACT] they could have for free services... and everything they could get for free and after they would come, they would say, “Oh yeah, we got a whole bunch of students came in.” So once they know about it, they go. Now there is no way they know about it.

Other organizations provide mobile services for STI testing near high schools and in neighborhoods with high STI rates. Participants mentioned that in some schools they face barriers to offering services, such as the requirement to get parental permission. An adult in Sacramento shared:

At Hiram Johnson [high school] we took our mobile testing unit and parked in the parking lot, and the kids had to get a permission slip signed by their parents, and then they had to walk out of the school grounds out to the RV which is sort of like, that becomes a barrier.

Collaborations between organizations

In the opinion of some adult participants, collaborations between organizations to improve access to testing services are occurring in Sacramento and Fresno. Some of these collaborations are between CBOs working with vulnerable youth and clinics, while others have been developed between high schools, CBOs, and clinics. For example, in Sacramento, a staff member of an organization that serves homeless youth talked about a partnership for improving access to STI testing:

I do outreach with Harm Reduction Services, they do STD testing. So I go and do STD and HIV testing with them. We’ve been collaborating with them for probably four and half years. I go out with them on outreach regularly.

In Sacramento, the director of a CBO that offers STI testing services and sexual education explained their collaboration with a high school:

In my opinion [Luther Burbank high school] is the model school for Sacramento in terms of allowing services to come on campus and giving youth the real information that they need. They had me teaching HIV/STD 101, but I was there all day. I was loving it... the kids were getting a ton out of it... the teachers wanted me to keep coming back. But it’s not something that we get paid to do. I did a train the trainer and the teachers that were interested; I gave them all my material.

Another participant talked about an initiative at the county level in Sacramento called “We Help Youth” that consists of a network of 50 agencies that provides resources and referrals for vulnerable youth:

We try to collaborate with all of them. There are times when we go to Women’s Health Specialists. Planned Parenthood is going into Luther Burbank High School. That’s actually getting bigger, they’ve been going more. It’s happening. There’s a lot of collaboration like that going on, but at the same time, it can seem like it is not enough. It could go either way. That could go back to the example of high schools not really being able to allow Planned Parenthood or...
**Barriers for accessing STI testing services**

Data from the surveys that focus groups participants filled out at the beginning of the focus groups shows that almost half (46%) have never being tested for an STI. Reasons that youth provided for not gotten tested are summarized in the following table (more than one reason could be given).

**Table 10.2: Reasons for not being tested provided by youth (n=34)**

<table>
<thead>
<tr>
<th>Reasons for not being tested</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have never had symptoms of an STI</td>
<td>85.3</td>
</tr>
<tr>
<td>I was scared</td>
<td>17.6</td>
</tr>
<tr>
<td>I have never had sex</td>
<td>11.8</td>
</tr>
<tr>
<td>I was too embarrassed or afraid to be seen</td>
<td>8.8</td>
</tr>
<tr>
<td>I did not know where to go</td>
<td>5.9</td>
</tr>
<tr>
<td>There is no place to get tested near here</td>
<td>2.9</td>
</tr>
<tr>
<td>I didn’t want my partner to find out</td>
<td>2.9</td>
</tr>
<tr>
<td>I didn’t want my parents or other family to find out</td>
<td>2.9</td>
</tr>
<tr>
<td>Other **</td>
<td>14.7</td>
</tr>
</tbody>
</table>

*Percent total equal to more than 100% since participants could mark more than one response

**Includes: never thought about it, it had never been brought to their attention, they wanted to be tested, laziness, they’d never slept with someone dirty, and they’d never heard of it.

The qualitative data from focus groups and interviews corroborates the poor access to testing services, and provides insights about the several reasons that prevent youth from accessing STI testing.

**Fear of knowing their STI status or denial that they can test positive**

Youth from all focus groups and some adults mentioned that youth are afraid of having STIs and therefore, they avoid or delay getting tested. Some youth mentioned that the denial that they can test positive might be associated with an attitude of being invincible or careless. (See Chapter 9: Attitudes about STIs). Male youth participants in Fresno shared:

- P: They’re scared to—scared to find out the truth.
- P: Also they’re scared.
- P: Denial.
- P: They’re lazy.

**Confidentiality concerns**

Youth and adult in Fresno and Sacramento mentioned that youth are embarrassed and worried about being seen at an STI testing service. They are not only concerned about their parents finding out that they are sexually active and seeking reproductive health services, but they are also worried about their friends seeing them and spreading rumors about their STI
status.

**Lack of knowledge about STI testing**
Youth and adults recognized that the lack of information about the clinics that offer STI services and the availability of programs that cover the cost of the services, such as the Family PACT program, as well as misinformation about the procedures to get tested, are all barriers that prevent youth from accessing services.

**Logistical barriers**
The most common barriers discussed were lack of transportation and long waiting times to get an appointment and waiting in the clinic. Adults who work with vulnerable population, such as foster care and homeless youth, mentioned this issue more frequently: “It could be limited access because youth are transient or mobile. They’re on foot.” One female youth in Sacramento also discussed this:

> I guess it depends on the person. Some people aren’t mobile. Some have to take the bus and that’s even more inconvenient. And also, the waiting time and making the appointment.

**STI testing has low priority compared with other needs**
This barrier was mentioned by adult interviewees who work with vulnerable populations, such as homeless and runaway youth, youth in foster care, and youth in juvenile justice facilities. The manager of a homeless youth organization in Fresno said:

> They don’t see it as being a priority [STI testing] and I’m trying to access the only health clinic that does confidential health services or HIV or whatever, and they’re not open… in their opinion… that was a waste of time because that could’ve been the time where they could’ve been looking for food, clothing, shelter.

**Cuts in funding for STI services**
One third of adult participants, but none of the youth, mentioned that there are fewer STI testing and outreach programs supported by the county departments than in the past. Several mentioned the elimination of mobile testing programs that used to offer services in areas with high STI rates. Some participants mentioned that community clinics and CBOs are still offering these services in the community, but with less funding and more limited reach. A health educator from Fresno said:

> Everyone in this area knows where Planned Parenthood is. I mean we also get young adults coming into this area. Especially with the county losing funding and certain services being offered by the county diminishing even more, everything from HIV testing to all that, the accessibility to HIV testing in the community with the county health departments. It’s gotten harder, so it brings more people to our services.

**Not being aware of STI symptoms**
This theme emerged less frequently compared with the ones previously mentioned, and it was raised by youth and adults in Sacramento. A few participants mentioned the fact that some STIs are asymptomatic, are
symptomatic in only some stages, or that some of the symptoms are not perceived as possible indications of infection by some young people. This situation might prevent youth from accessing testing services when needed. A participant from a female focus group said, “They don't know that they don't have symptoms and stuff. And then since they don't have symptoms and they're scared to go, then that's another reason not to go.”

**Strategies and facilitators to improve testing**

Fourteen adults and youth from 13 focus groups mentioned a combination of strategies to improve testing services in their communities including:

- improving access to testing services in different settings
- enhancing parent-youth communication about STI testing
- fostering collaborations and coordinated efforts between youth organizations, high school and clinics
- improving the confidentiality and environment of testing services
- increasing awareness about the availability of confidential and low-cost testing services
- “normalizing” or reducing the stigma around STI testing
- increasing the number of free testing services
- decreasing logistical barriers to access STI testing services

The following section presents detailed information about the strategies recommended most frequently by adults and youth participants.

**Improve access to testing services in different settings**

Nine adults and youth from six focus groups mentioned the importance of having testing services in or near places where youth spend their time, such as high schools, colleges, boys’ and girls’ clubs, shopping malls, and other recreational spaces. In addition, some adults and youth from two focus groups mentioned that providing mobile testing services would encourage people to get tested, especially in areas with high STI rates or where vulnerable populations gathered. Some adults talked about the closing of mobile STI testing programs and county clinics—that used to be very effective in reaching out vulnerable youth—due to funding shortages. A health educator who works at an alternative high school in Sacramento said:

*Bring back the van, the caravan. I think that’ll be awesome to bring that back and they can go to the school and that’ll be a big help. Or have some medical clinics and they have so much technology, it takes like, what, 20 minutes to find out anything these days.*

Youth from four focus groups agreed that having STI testing services in high schools would be a good approach to improve testing, and in two female focus groups, participants mentioned that it should be mandatory. The following conversation among female youth in Sacramento exemplifies this perspective:

*P: I think everyone should be tested that goes to school.*

*Many: Yeah.*

*P: Make them test them in high school.*

**Providing satellite clinics where we can go and provide testing out in Roeding Park, down the street from where the prostitution might be happening. Target the homeless population, have a mobile site there. We have a satellite site on the other side of town; it’s literally located right across the street from a high school and we get a lot of youth using those services. Why? Because it’s so easy access and they don’t have to travel across town to access those services.**

Manager of a homeless youth organization, Fresno
Moreover, several youth and adults recommended having testing services embedded in other recreational and cultural activities in order to encourage youth to use them and decrease the stigma around its use. As one program manager from a health center stated, “Making it really easily available and part of the culture of what they do. You know, ‘Before we go to the show, let’s all go get our HIV test.”

**Enhance parent-youth communication about STI testing and sexual health**

Three adults and youth from three focus groups mentioned that youth might be more likely to get STI tests if parents would see STI testing as another health service that is part of a regular medical check-up. Moreover, youth talked about the lack of parent-youth communication about sexuality, and their concerns about disclosing that they are sexually active and that they need to access STI services. A health educator from Fresno said:

> It will be nice if parents take their kids to the clinics…These kids really need that support in this area with the STIs, the oral sex, and that topic needs to be talked about. And if parents are more involved with just being aware of what their kids are doing and having a discussion and being really open minded with it, it’ll be a lot easier for the testing to get done. For parents to say, “I will take you and see if you’re okay.” It’s more of a checkup, rather than saying, “What are you doing wrong?”

**Increase awareness about the availability of confidential and low-cost STI testing services**

Youth from four focus groups and a few adults mentioned that more efforts should be made to inform youth about the availability of confidential and low-cost services. In addition, youth from other four focus groups—three in Sacramento and one in Fresno—complained about the lack of free STI testing in their communities, which corroborates the lack of awareness about and limited availability of local clinics that offer STI testing.

**Improve the confidentiality and environment of testing services**

Female and male youth from four focus groups recommended improving the privacy and confidentiality of the services as a strategy to increase testing. Suggestions included changing the space, such as “keep the windows tinted so nobody could see in” or by having clinic staff who are friendly and less judgmental. A participant from a gay male focus group said:

> P: And I feel like the testing environment, too, ’cause like sometimes it’s in like a, in a room where it’s like the lights are dim and it’s like, I feel like it’s
in an office where it's like kinda cold and boring.

UCSF: What would be better?

P: Something more inviting. Like when they're testing, they hardly ever say really anything, they just ask you questions and it's kinda like a scary, a whole scary experience I feel like.

**Foster collaborations and coordinated efforts between youth organizations, high school and clinics**

Three adults mentioned that it was essential to foster collaborations between the different actors and organizations involved in STI prevention. This strategy was seen as particularly needed due to the lack of funding and the reduction in resources in the last decade.

**Summary**

Youth and adult participants in Sacramento and Fresno agree that there are barriers at the community, family and individual level that prevent youth from accessing STI testing services. Nevertheless, they also recognized that partnerships and collaborative efforts are essential to improve testing in their communities. Recommendations based in part on these suggestions are further detailed in the final chapter.
11. Discussion and Recommendations

This report summarized the key themes that emerged during stakeholder interviews and focus groups with youth in Fresno and Sacramento counties. In many ways, the issues raised in the four selected communities reflect the underlying structural factors identified in previous research as contributing to high STI rates including poverty and community disadvantage (Wickrama 2012, Lang 2010) as well as individual risk behaviors including substance use and sexual networks (Seth 2012, Ford 2004).

Both communities selected in Sacramento had higher levels of poverty than the rest of the county or the state average and also suffered from a decrease in health services due to funding cuts. Several respondents noted, however, that part of the comparatively high rates of youth STIs in the county may be due to ongoing efforts to test and report cases. The two communities in Fresno appear to have less in common with each other. In the Tower District, part of the reason for high rates among youth may be that the neighborhood attracts youth from several high risk groups including homeless and runaway youth, sex workers, and young MSM. In the Clovis/Tarpey area, Clovis is economically more prosperous than Tarpey, but also has a school district that provides extremely limited sexual health education.

While the CDC identifies consistent condom use as the most important approach to prevent new STIs, our results show several of the significant barriers that remain to use. Although we identified a number of missed opportunities to provide condoms to youth and several respondents suggested making them more readily available, most youth were able to identify locations where they could access condoms. The greater barriers to use appear to be perceived lack of pleasure, substance use, partner dynamics, and a lack of serious concern of contracting an STI. While most youth are generally concerned about the consequences of an STI, including the possible stigma associated with it, they are more worried about getting pregnant or HIV. Among youth who may be homeless or in other unstable situations, STIs remain a lesser concern than other immediate needs, including safety, food, and shelter.

Similarly, while respondents noted significant barriers to testing and treatment, most youth could identify locations where services are provided. Organizations providing health care and other services appeared more connected to each other and accessible to youth in Sacramento than in Fresno. Barriers to utilization include the accessibility of the services in terms of location and schedules, providers’ willingness and protocols to discuss sexual health and STIs with young adults, and the youth-friendliness and confidentiality of services. These barriers are similar to those identified in other research including a recent study in San Francisco showing that STI-related stigma was associated with decreased odds of getting tested or notifying non-primary partners (Morris 2014).
In this needs assessment, we deliberately interviewed young adults and stakeholders from a variety of backgrounds. In some cases, the young adults were purposively selected from high risk populations and do not represent the general risk behaviors or experiences of all youth in their communities. We found differences by gender, sexual orientation, and age — with older youth more sexually experienced and comfortable discussing their health needs with providers, but also concern about the actions of younger youth. In many cases, youth with similar characteristics, such as young MSM or youth with substance issues, had more in common across the communities than with other youth within their same community. Because not all youth experience the same risks, different prevention approaches and messages may resonate better with some populations than others.

These findings show that truly transforming young adults’ sexual health requires a comprehensive approach. While clinical and biomedical improvements, such as improved testing and treatment, are necessary, they are not sufficient to address the underlying reasons for condom non-use and other risky behaviors. In both Fresno and Sacramento counties, the county health departments and local agencies already are working to address these issues and have implemented several promising programs. In some cases, a lack of funding rather than a lack of ideas is limiting further efforts.

**Recommendations**

This section presents the recommendations that key stakeholders and youth in Sacramento and Fresno proposed in order to improve the primary and secondary prevention of STIs in their communities. The recommendations are based on a combination of the data analyzed in each chapter and the answers to questions that we asked participants at the end of the interview and focus groups discussions regarding their suggestions for STI prevention, information, testing, and treatment. Note that while the recommendations are based on findings from Sacramento and Fresno, many of the suggestions are applicable in other locations. For many of these recommendations, policymakers as well as providers need to work together to enhance and advance policies and interventions.

**Improve the content and quality of youth sexual health education**

Comprehensive sex education should address the issues and risk factors identified in this needs assessment as well as linkages to reproductive health services. Schools should provide more consistent, comprehensive sex education for youth, starting with basic biology and puberty in elementary school and continuing with age-appropriate information through high school. Curricula should include information on the relationship between substance use and sexual risk behaviors, more direct and detailed information about disease transmission, contraceptive methods, and safe sex behaviors (beyond condom use). Specific modules should be developed as part of sex education programs that emphasize the responsibility of preventing STIs as well as pregnancies, and the importance of using dual
protection (condom and another contraceptive method for heterosexual couples) to avoid contracting and spreading infections, and linkages to local reproductive service providers. More information about sexual orientation and different types of relationships and the risks associated with them should be included in the sex education programs, including a discussion of healthy relationships and power dynamics.

Supplemental training and tools need to be provided to teachers and facilitators on an ongoing basis to improve overall content and quality.

**Expand the settings where sexual health education is provided**

Continue promoting programs that include comprehensive sex education, healthy relationships, and contraception negotiation skills in different settings, such as mainstream and alternative schools, afterschool programs, drug treatment centers, foster care and homeless shelters, and juvenile detention centers, among others. School administrators and parents should have the opportunity to learn about the curricula to improve community support.

Given the varied quality and content of sex education provided in the public schools, information and programs also should be offered to young adults in community colleges, vocational training centers, and other colleges and universities.

**Segment interventions**

Messaging and prevention efforts for different groups may need to be more targeted. For example, among some populations, a harm reduction strategy of regular testing and treatment when necessary may be more realistic than promoting condom use. Similarly, different age groups require information that is developmentally appropriate and relevant for them. Focus limited resources on interventions that impact youth populations most vulnerable to engaging in high-risk sexual behaviors including youth in juvenile detention centers, youth in foster care, MSM youth, and youth who are homeless.

**Encourage routine testing**

Normalize testing for common STIs as a routine part of medical care for sexually experienced young people. This includes training health care providers to discuss a patient’s sexual history, provide appropriate information, and answer questions with adolescents and young adults. In addition, parents should support and discuss STI testing with their children as they become sexually active.

**Increase access to testing through mobile clinics**

Many adults talked about the need to improve the funding for mobile testing services that target youth at high risk of contracting and spreading STIs such as youth in alternative high schools, foster care and homeless programs, drug treatment centers, and juvenile detention center. Many of these youth are transient who face logistical barriers to access health care facilities, and when they do utilize services, are less likely to return for their STI results and treatment. Therefore, mobile clinics that go to areas where services are limited can provide basic testing, outreach, and referrals to
additional services.

**Reduce need for multiple clinic visits**
Some respondents noticed a gap between testing and treatment services. Hence, we recommend that clinics and mobile testing services improve their strategies to refer clients to other services, to follow up with those referrals, and to verify that patients who tested positive receive treatment for themselves and their partners. The use of incentives to attract youth to health services was another strategy mentioned by a few adults and youth; this strategy could also be applied to encourage youth to return for their treatment.

**Increase STI awareness**
Changes in attitudes toward STI testing as well as increasing awareness about the availability of confidential and low cost STI testing services are essential to improve testing and treatment. Therefore, we recommend conducting educational campaigns that address STI risks and stigma reduction at the community, family, and individual levels. Promote programs that help parents and youth to clarify misconceptions around contracting and transmitting HIV/STI, such as only specific groups are at risk of STIs and highlighting that many STIs may be asymptomatic.

**Conduct more prevention programs and campaigns designed by youth**
Two adults and youth from six focus groups mentioned that youth should be more involved in the designing of STI awareness campaigns in the community, schools, social media, and mass media. They stated that campaigns should use the creativity and insights from youth in order to make them appealing to that population by using jokes, cartoons, comic strips, and appealing messages. Messages that youth thought would be appealing to youth are those that would encourage them to be more aware of risky behaviors, and to use testing services. Youth also mentioned that it would be very useful to have an app that provides information about the symptoms of each STI and shows places near you where you can get testing and treatment.

Some youth thought that messages are more convincing if they are delivered by other youth who have had STI. As this female youth from Fresno shared: “So I think hearing it from someone their age that’s been through it would be a little more real for them than seeing a picture or seeing a video.” A few adults from Sacramento also noticed that school or public events, and health fairs used to be an effective way to provide STI information and testing, but due to reduction in funding they are no longer occurring.

**Recognize the role of power dynamics in relationships and safety**
For youth in unsafe situations or in relationships with unequal power dynamics, many may not feel able to negotiate condom use or other sexual acts. Youth should receive information about healthy and unhealthy relationships, practice role playing to discuss condom use, and learn about their rights and the laws and services that can support them. Increase education and training opportunities for adults working with youth in a
variety of sectors to better identify and provide support and resources for youth who engage in transactional sex. For some people, trading sex for money, protection, or other items may be seen as necessary. Promote connections and referrals among shelters, food banks, and other service providers working with these populations. Include information about the laws and community resources around sexual violence and sex trafficking.

**Improve partnerships among organizations**
Foster new partnerships with actors and organizations that have not been involved in STI prevention or in collaborative efforts. These findings show the potential for improved collaboration and communication with organizations working in substance treatment and with disenfranchised youth.

Four adults, three from Fresno and one from Sacramento, mentioned that churches and faith-based organizations have been reaching out and organizing youth toward social and health issues in the community such as drug prevention. Nevertheless, so far they have not addressed STI prevention. Some participants mentioned that efforts should be made to encourage their participation on conversation about STI prevention.

**Increase coordination among providers**
Many adults recognized the efforts and collaborations that the county health departments, community clinics, community-based organizations, schools, and colleges are conducting to improve STI prevention and testing; but also acknowledged the need to use their resources more effectively. Improved coordination of interventions can maximize the reach of limited resources, decrease segmentation, and improve referrals.

**Improve access to condoms**
Offer condoms and STI prevention information at parties, bars, clubs, and other locations where youth tend to use substances and engage in STI risk behaviors. Condoms should also be available without requiring an appointment at post-secondary education locations, health centers, and clinics.

**Address the intersection between substance use and risky sexual behaviors**
Promote substance use treatment and sexual health services linkages, particularly for at-risk populations such as foster care youth, homeless youth, youth in juvenile detention centers, and youth with gang affiliations. Implement dual-messaging campaigns on substance use (particularly alcohol, methamphetamines, and marijuana) and sexual risk behaviors.

This needs assessment provided preliminary findings and suggestions regarding ways to improve the prevention, testing, and treatment of STIs among youth. Further research would help to focus potential interventions and ensure messaging and efforts are appropriate for the particular population. Current outreach efforts and services should be evaluated for impact and youth perception. In addition, the content and frequency of
sexuality education provided in local schools and colleges should be assessed. Focus groups or surveys with youth in juvenile detention and community colleges would help to gain a better understanding of available services and use, risk factors, and needs. Other areas for research include collecting quantitative data on certain risk factors including the housing situation of youth receiving testing, examining the impact of power dynamics on condom negotiation and other risky behaviors, and exploring generational differences in health activism among MSM. Due to the complexity of the situation, a range of qualitative, participatory, and quantitative data can provide a deeper understanding of the underlying issues and potential solutions.
13. References


