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Understanding Gender Roles in Teen Pregnancy Prevention among American Indian Youth

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Abstract

Objectives—To examine the impact of gender norms on American Indian (AI) adolescents' sexual health behavior.

Methods—The project collected qualitative data at a reservation site and an urban site through 24 focus groups and 20 key informant interviews.

Results—The reasons that AI youth choose to abstain or engage in sexual intercourse and utilize contraception vary based on gender ideologies defined by the adolescent's environment. These include social expectations from family and peers, defined roles within relationships, and gender empowerment gaps.

Conclusions—Gender ideology plays a large role in decisions about contraception and sexual activity for AI adolescents, and it is vital to include re-definitions of gender norms within AI teen pregnancy prevention program.

Keywords

teen pregnancy; American Indians; gender norms; sexual health

Teen pregnancy has major public health ramifications for teen mothers and their children. For example, teen mothers are less likely to utilize timely prenatal care, increasing the risk for premature birth and low birthweight.¹⁻³ Teen mothers are also less likely to breastfeed,⁴ which is concerning because breastfeeding has numerous health benefits for both the mother and her baby.⁵ In addition, young mothers are more likely to drop out of school,⁶ which holds unfavorable consequences for their long-term financial prospects.⁷ Teenage pregnancy, therefore, results not only in social costs, but economic costs as well.⁸

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Likely due to prevention efforts and more affordable contraception options, teenage birth rates have fallen to a historic low, and rates of teen pregnancy have generally been decreasing.^{9,10} However, American Indian and Alaska Natives (AI/AN) teens had the lowest decrease in pregnancy amongst females aged 15-19 in 2012.¹¹ In addition, AI/AN teens had the largest single-year increase in teen pregnancy rates of any racial group in 2007 (rising 7%), a glaring disparity when compared to the 1% increase for non-Hispanic black teens, 2% increase for non-Hispanic white teens and Asian/Pacific Islander teens, and 2% decrease for Hispanic teens.¹² Further, over one-fifth (21%) of AI/AN teen girls will become a mother compared to 16% of girls nationwide.¹³

Rates of teen birth rates among AI/AN vary by region in the United States, likely due to geographic, ecological, and cultural variation.¹⁴ In addition, AI/AN youth likely have higher rates of teen pregnancy because of social and economic disparities, such as poverty,^{15,16} drug and alcohol use,¹⁷⁻²⁰ and physical/sexual abuse.^{16,21-23} Evidence also suggests that AI/AN youth initiate sex at earlier ages when compared to other ethnic groups.¹³ For example, one study of AI youth in Minnesota found that almost 70% of 16-to-18 year-olds and 42% aged 13 to 15 reported they had ever had sexual intercourse,²⁴ compared to a national US study that found 32% of 15-to-17 year-olds had ever had sex.²⁵

Evidence also shows that AI/AN youth are less likely to use contraception when compared to other ethnic groups.¹¹ One national survey with urban AI/AN women ages 15-24 found that 26% had had an unintended pregnancy and 38% had unprotected sex at first intercourse.²⁶ Whereas AI/AN teens have similar knowledge about reproductive health, AI/AN youth between the ages of 18 and 26 were less likely to report using contraception the last time they had sex.¹³

Perspectives on Gender

Given the discrepancies in sexual behaviors by race/ethnicity, understanding potential factors that may exacerbate these differences, such as gender norms and ideologies, is an important direction for prevention research. Gender ideologies, or the socially constructed beliefs regarding how men and women should act, are consistently seen in the social messages aimed at adolescents.²⁷ For example, socially constructed beliefs about femininity often encourage virginity and discourage sexual activity for young women, whereas beliefs about masculinity often encourage the opposite, valuing young men's sexual virility and promiscuity, even if they themselves prefer to be monogamous or abstain from sexual activity.^{28,29}

The impact of gender ideologies is further apparent in contraception decision making and behavior. For example, adolescent females who adhere to traditional female ideologies in upholding sexual abstinence are often encouraged to be passive in their sexual knowledge and behaviors.²⁸ In an attempt *not* to appear sexual, many girls report that their first intercourse was not planned, hindering their use of any kind of contraception.³⁰ Further deterring the use of contraception is a strong desire for relationship intimacy, often demonstrated through not utilizing contraception in hopes of preventing partners from seeking other sexual outlets.²⁹ In addition, adolescent males are more likely to indicate that

using birth control is a woman's responsibility, particularly if they hold to traditional attitudes of masculinity.^{27,31}

These findings suggest the importance of addressing socially-constructed gender norms when examining adolescent contraception use and sexual behaviors. However, to our knowledge, the impact of these gender ideologies has been overlooked for AI youth. Given the disproportionate rates of sexual activity and contraception use in AI adolescents, understanding the role gender expectations have in decisions to have sex and use contraception appears vital. The current study, part of a larger federally funded grant project to develop a community-based teen pregnancy prevention program for AI communities, uncovered the role that gender has on sexual activity and contraception utilization for AI youth. These findings will inform teen pregnant prevention efforts specific to Northern Plains AI youth.

Methods

Qualitative research methods were chosen for this study to capture Northern Plains AI's unique points of view.³²⁻³⁴ The use of qualitative methods is important when working with AI participants, as cultural elements are best revealed and understood through open-ended methods.^{32,35-37} Prior to conducting this study, all study procedures were approved by institutional review boards and by the local tribe through a tribal resolution for the reservation site. Tribal anonymity is required; therefore the specific tribal community is not identified in this study.

Data collection occurred at one reservation site where almost all participants indicated one tribal affiliation and one small, urban site with participants who indicated various tribal affiliations. Data were gathered from a diverse range of perspectives using: (1) focus groups with AI youth (parents and nonparents aged 16 to 25 years old) and elders (aged 40 or older), with 5 to 11 participants per group and stratified by age, sex, and parental status; and (2) one-on-one key informant interviews with healthcare providers and high school personnel from health facilities/high schools with a high representation of AI patients/students.

The focus groups and key informant interviews had similar questions and were facilitated by the local community research associates hired for this project. The formulation of focus group and interview questions were the result of collaborative efforts among study staff and the communities involved such that, throughout all phases of the research process, community advisory boards consisting of local AI individuals were consulted in the development of data collection instruments and implementation of project protocol. Measures focused on cultural influences, social norms, access to reproductive services, adolescent sexual risk behaviors, and contraceptive use.

Local community research associates recruited participants by means of flyers, community contacts, and word of mouth. The focus groups and interviews were conducted in private rooms at local community health buildings or libraries. Written consent or assent was obtained from all participants, and parental consent was obtained for participants younger

than 18 years of age. Participants were offered a \$40 gift card to a retail store for their participation in the focus group or interview. The focus groups and interviews were tape-recorded and transcribed verbatim.

Analysis

Transcripts were stored and analyzed using the NVivo 10 software program.³⁸ Data were analyzed using a traditional content analysis in which themes were uncovered through reading all transcripts, making notes on initial impressions, and letting the codes emerge directly from the text.^{39,40} Recurrent team meetings were held for in-depth discussion and negotiation of the coding structure as it evolved throughout the preliminary analysis of transcripts.

The codebook was developed by operationalizing coding definitions and coding decision rules through multiple coding manual revisions.⁴¹ This process involved the systematic review of codes by 2 independent coders to determine the utility of the codes and consistency in their application. Specific sections of unique text were coded by the coders independently, and a meeting was then held to review codes and to discuss discrepancies. Inconsistencies were reviewed by the coders and the principal investigator; problems with code definitions and/or coder errors were identified and discussed and the codebook was clarified as needed. All previously coded text was then reviewed and, if necessary, recoded to maintain consistency with revised definitions.

Another important piece of the qualitative data analysis was the calculation of inter-rater reliability. As recommended by Lombard, Snyder-Duch, and Bracken,⁴² 2 coders separately coded a random selection of 300 lines from the transcripts using the final draft of the codebook. The Cohen's kappa value was 0.62, "substantial" (0.61 to 0.80) when interpreted using the benchmarks set by Landis and Koch⁴³ and also when considering the large number of categories in the project's codebook.

In addition to the use of the community advisory board, validity and reliability of the qualitative data were established through the use of a diverse range of participant perspectives to describe the reality of teen pregnancy amongst AIs, as well as using verbatim responses so that little was left up to interpretation outside of the creation of categories and qualitative coding. The results and discussion relate closely to the actual written responses of the participants and therefore, are deemed to have strong validity.

Present Study

Given that the goal of the present study was to analyze the role that gender norms and expectations have on Northern Plains AI youth's sexual health decisions, the specific codes focused on sexual activity (ie, *don't have sex* and *have sex*) and contraception use (ie, *don't use contraception* and *use contraception*). The text under these 4 nodes was analyzed and subthemes created to highlight specific statements on the role that gender ideologies have on decisions to have sex and use contraception. Table 1 shows the list of questions.

Results

There were 24 total focus groups (12 per site) and 20 total interviews (10 per site), with a total of N = 185 participants (90 from the reservation site and 95 from the urban site). Table 2 describes the demographics of the participants. Based on input from the focus group and key informant interviews, the reasons that young AI women and men choose to abstain or engage in sexual intercourse and utilize contraception vary based on gender ideologies defined by the adolescent's environment. These include *social expectations* from family and peers, *defined roles* within relationships, and gender *empowerment gaps*.

Social Expectations

The data revealed that *family* assumptions about AI youth impact their decisions about sexual activity and contraception. Adolescent AI females might avoid sex because they are expected to care for younger siblings and relatives, and therefore, are motivated to avoid a pregnancy given their first-hand experience of the many facets of childcare. As one elder woman stated: "Yeah, some girls that grow up, I mean, they don't even get to be kids, they have to go right into watching kids. And me, that's how I was." Participants reflected that teen AI girls may want to "change the cycle" and "not be another Indian girl getting pregnant." Family sometimes pressure AI teen girls to remain virgins or to "wait for the right guy." The data reveal that compared to boys, girls also can receive a stricter upbringing, especially from grandmothers or elder women.

Contrasting this notion are other data that showed some AI female youth feel actively pressured by family members to have a baby. A school personnel interviewee stated that for one of her students "it was an expectation... from her parents that you will get pregnant and we're going to take care of him...just like our parents raised you." Likewise, as they have friends or relatives who have children at a young age, being a teenage mother is "a normal thing to do." This may be how AI adolescent females find the unconditional love and acceptance they feel is missing at home. In addition, participants concluded that some AI parents or caregivers may not be aware their daughters are sexually active and subsequently do not help them obtain contraception. Also, participants felt that AI girls might be scared to tell their parents or caregivers they are sexually active, and therefore, wait until they are "old enough to get birth control themselves."

Families also impact young AI men's decisions regarding sexual intercourse. Parents and caregivers were cited as having an impact on a teen AI boy's decision to have sex; as one female youth concluded: "Or maybe they were just taught not, or maybe they were, he was a good guy and he was taught not to like have sex, or his parents taught him..." Adolescent AI males might have a role model, such as an older brother or father, who did well in activities such as sports, and these young men have aspirations to do the same. For example, one elder man stated that having positive role models is important: "They look at that and say, 'I'm going to do like my dad did, you know, and my older brother. He was a star player, and I'm going to be one too.'"

Contradicting this is the negative impact family members can have on contraception use and sexual activity among young AI men. For example, as concluded by a female youth: "...if

his older brother got a girl pregnant, he's like, 'Oh well, he did it so...' cause if he really looks up to him, he will do it, or like following in his footsteps." If a father, brother, or other male relative of an AI male youth is a "player," the AI adolescent boy "learn[s] that's how to treat women." Further, the young male might grow up in a household where there is no father, and therefore, no male influence to guide his decisions on sexual intercourse in a positive manner.

Peers also impact decisions about sex and birth control for AI youth, although the expectations of peers are often contradictory. On one hand, AI female youth fear the possibility of being labeled a "slut," or "whore" and AI male youth being named as a "player" (which had both negative and positive connotations) if they do become sexually active. In fact, there appears to be peer support for young AI women abstaining from sex. For example, a female adolescent concluded: "Cause I think if a girl wasn't doing it, people would be like, 'Oh, well, that's cool.'" These same labels also impact use of contraception among young AI women. AI female youth are often embarrassed to get birth control and do not want to be "judged" by peers if they choose to access contraception. Many fear they will get called derogatory names if their peers find out they are on birth control.

On the other hand, expectations from peers can play a significant role in adolescent AI decisions to have sex. For example, several focus group participants stated there is a stigma about virginity and that many young AI women want to "keep up" with their peers and are pressured by friends to have sex (ie, "everyone is doing it"). Having sex is often seen as a means of gaining acceptance for AI adolescent females from both their male partners and also from peers (ie, "girls want to be popular"). As one elder woman stated: "...it used to be the good thing to do is to be a virgin. I know it seems like it's changed, and they think it's strange if you're still a virgin at a certain age. Or you're strange to want to wait until you get married." Likewise, focus group and interview participants stated that many AI boys become sexually active to fit in and may feel pressured to have sex to avoid being teased and to be seen as "cool." Often, they "have sex to let people know you've had sex" and feel enormous social pressures to have sex to "fit in" with peers.

Misinformation from peers also can impact contraception utilization, such as misconceptions regarding the effectiveness and potential side effects of various forms of contraception. AI adolescents might hear negative things about certain types of birth control from friends or be influenced by information from the media about various side effects and be afraid to use these types. For example, one female adolescent focus group participant stated: "don't say Mirena [an intrauterine device, or IUD] because I don't want to die." Another participant stated that someone could "become bipolar if they take too many of them [birth control pills]." In addition, many times AI boys are reluctant to use condoms as birth control because of the belief that a condom will impact sex by taking away physical pleasure from intercourse.

Expected Sexual Roles

There are often clear and distinct roles for AI youth within romantic and sexual relationships. Many focus group and interview participants, both males and females, believed it was up to adolescent AI girls to protect themselves against pregnancy through the

use of birth control, with some believing it's simply because they are “more aware” and “more responsible.” One elder woman participant stated: “Birth control [is] forced on [the] female gender.” A healthcare provider concluded: “... we as females assume, whether it's right or wrong, that it's the woman's choice or responsibility because she would ultimately be carrying the pregnancy.” A male parent sums this belief up with: “...she [significant other] wanted to have sex but then knowing that we should use like a condom or something. But then she should have been the one to have been like, ‘Hold on man.’ She was the one who could have just, you know, just stopped.”

This belief of greater responsibility of birth control for AI adolescent females likely stems from the consequences of unprotected sex (unplanned pregnancy). The focus group and interview participants stated that the consequences are more impactful when AI girls have unprotected sex: “She's got the most to lose” and a young AI woman is “tied down” raising the child with little help from the father of her children. One elder woman summed this sentiment up: “...because I had a girl that got pregnant. She said, ‘He [father of the baby] said it was my fault. It was my fault.’ She was crying.”

Traditional definitions of masculinity also play a role in birth control use among AI boys as summed up by one school personnel interviewee: “...even if there's a swagger with the boy and he thinks that he's a player...um...I don't think that kind of thinking in the end, those are lonely, confused young men who are playing a role they think they have to play.” For many adolescent AI boys, sex means being a man, something that is often learned from the media and social surroundings. A male parent stated: “...if I was trying to use a condom and I didn't have one and she didn't have one and she's telling me, ‘Well, who cares?’ I wouldn't want to seem like a big puss and say no and not do it. So that's a pretty big role [in not using a condom].” Beliefs about “being a man” also relate to pregnancy and childbearing for AI male youth. The ability to create children is “macho” and “manly” (ie, “I got her pregnant”).

Expected sexual roles also extend to perceived benefits that having children has to the community-at-large for both men and women. Many times AI men see having multiple children as populating their community and supporting their tribe. As one male elder reflected: “I was going to leave a little tribe behind.” AI women, too, feel this need. As an elder woman stated: “...she was saying that they wanted to keep the population high on our reservation. And that they wanted more Indians being born.”

Empowerment Gaps

Participants indicated that a lack of empowerment within many AI girls ultimately impacts their sexual activity. For example, many AI teenage girls are pressured into sexual intercourse “to please their boyfriend, even if they don't want to.” There appears to be an “obligation” for AI girls to be sexually active with their boyfriend; for instance, they will have sex “if he's a nice looking guy and that's what they [male partners] want.” Participants indicated that AI girls are often significantly younger than their male partners, and therefore, are greatly influenced, either because it's “cool to date older guys,” the “guy leads her on,” or they are “overcome” by boys, indicating they are either implicitly or explicitly forced to have sexual intercourse. Alcohol and other substances also impact decisions to be sexually active, with young AI women often being provided with alcohol or drugs to “loosen up” to

have sex and male youth sometimes “[taking] advantage of a girl under the influence of alcohol or drugs.” As one male youth in this study pointed out: “it’s about being drunk and getting bitches.”

For young AI men, sex may be seen as a conquest or a game/competition. Quotes from participants such as “notch in their belt,” “I got that one,” “badge of honor,” and “bragging rights” indicate that many male AI youth are taught to have competitive attitudes toward sex. In fact, some focus groups described a literal competition where “guys like to place bets” and “get virgins because it gives them more points.” Physical attraction is not always necessary (ie, “boys don’t care what a girl looks like”) and participants described frequent cheating on partners: “cool...to have sex with a girl and your girlfriend will still be there.” Male AI youth want to “try something new and find somebody different” and “girls get used, boys get satisfied.”

Empowerment in negotiating birth control use with a sexual partner also can impact utilization for AI adolescents. Many participants concluded that discussing birth control with a partner is awkward and that it “kills the mood” to request condom use. Oftentimes, a young AI male expects his female partner to be on birth control and will therefore not regularly carry or use condoms, or male AI youth may also be anxious about purchasing or asking for condoms. A male elder stated it is “easier [for young women] to just take a pill” (than for a male to use a condom), and a female youth concluded that AI girls need to be “brave enough to ask for it [a condom].” Some also felt that it is difficult for young AI females to negotiate condom use with a male partner so they themselves need to be on a type of birth control. However, AI females are “less open and forward” compared to young AI men and may not be comfortable discussing birth control options. As one female parent stated: “He said that he would just pull out, and I was...when I’m in the mood, I don’t care. And I believed him and I let him talk me into crap, and now I have a...I love her [daughter], but I’m not ready for her.”

In addition, some participants discussed the significant role that male youth play in AI females’ use of birth control, citing a “power situation” where “boys have the upper hand.” AI female youth may be pressured and convinced by a partner not to use any type of birth control and the adolescent AI female is “scared of him getting mad.” A boyfriend might get upset if the female partner is on birth control, as it indicates to them she either doesn’t love them or doesn’t want to bear his children. A healthcare provider concluded: “If they have that kind of pressure, I can see the girls not, you know, ‘I’m only going to be with you if...’ You’re going to give in to that pressure of wanting that boyfriend and wanting him to like her.”

With many of these power differential beliefs in mind, participants viewed AI male youth as playing a critical role in the prevention of teen pregnancy. As one female parent stated: “But then he’s [uncle] like...always wrap it up [use a condom] unless you want, unless you want them to be there forever.” There is a need to “protect doubly,” with both the male and female partner utilizing contraception to avoid pregnancy. Some participants felt that adolescent AI males should be more responsible for contraception because of the side effects of birth control pills and shots and the relative ease of obtaining condoms. The participants

also believed that because “women are more shy,” young AI males should have “courage and go get condoms.”

Discussion

Using input from focus groups with AI youth and elders and key informant interviews with healthcare providers and school personnel, the goal of this study was to analyze the role that gender ideologies have on Northern Plains AI youth's decisions about sexual activity and contraception use. As we have reported, there are varying reasons that AI youth choose to abstain or engage in sexual intercourse and utilize contraception, including social expectations, defined roles within relationships, and gender empowerment gaps.

For young AI girls, the pressure to take on the role of “mother” for their younger siblings may cause them to avoid pregnancy through either abstinence or use of birth control. Conversely, some young AI women have children for this same reason: a baby indicates they are growing up and is how they find unconditional love and acceptance, especially when they are already regularly caring for young children. Study participants did not describe this same phenomenon for adolescent AI males, indicating traditional views of childrearing where, if the biological parents are not available physically or emotionally, childcare responsibilities fall to the eldest female child. Nationally, the percentage of households that have these childcare arrangements vary, with between 4% and 16% of adolescents helping to provide childcare to younger siblings.⁴⁴ Information provided by participants in the current study implied that this occurs much more often for young AI women, which may impact sexual and reproductive health decisions more so than for other populations.

There were also social pressures for AI female youth to have children at a young age. One notion suggests that having a child is an escape from a stressful home life, as many female AI adolescents feel there are few other options such as higher education, extracurricular activities, or stable employment. Indeed, other findings suggest that pregnancy desire among female adolescents is significantly related to perceived stress, often linked to factors within the home and surrounding environment.⁴⁵ Previous research also has found that there appears to be less shame about teenage pregnancy in lower socioeconomic areas, which may relate to feelings, and likely reality, that there are fewer opportunities for viewed success (besides parenthood) in poorer neighborhoods.⁴⁶ Again, this appears to be a phenomenon more common in adolescent AI girls compared to boys—teenage pregnancy is a way to escape stress and home conflict.

Besides escaping a stressful home environment, many AI adolescent girls may feel pressure from family and friends to have a child at a young age, as it is seen to be the normal thing to do, and therefore, is viewed more positively. Previous research has found that a positive orientation toward pregnancy is related to a need to assert responsibility and improve interpersonal relationships, such as those with family and boyfriends.⁴⁷ Adolescent teens with an *intended* pregnancy are more likely to perceive a supportive childbearing environment, where there is social support for early motherhood.⁴⁸ A previous study with AI youth found that care of a newborn did not lead to much interruption in a young teen

parent's life.²⁰ On the other hand, research on pressure and expectations for early/teenage *fatherhood* was not found. Together, these findings further highlight the difference in expectations for adolescent AI girls and boys.

For young men of varying racial and ethnic backgrounds, including male AI youth, definitions of masculinity strongly impact decisions about having sex and using contraception.^{28,29} Attitudes toward sex and birth control use may stem from male AI youth feeling like they have a role to play, such as needing to fit in to their peer group by being sexually active. In addition, adolescent males often feel birth control utilization is their female partner's responsibility,^{27,31} suggesting that the ramifications from *not* using contraception (teenage pregnancy and childrearing) is of little to no burden to them. One previous study found that adolescent boys were significantly less likely to report embarrassment at the prospect of a teenage pregnancy when compared to their female counterparts.⁴⁶ In the current study, findings further suggested that young AI men might talk their female partner out of using birth control and having a child young so “they have some sort of hold on them.”

Finally, one unique finding within this data collection is that male and female AI youth may feel they are providing some type of benefit to their tribe by having multiple children, thereby populating their community and supporting their tribe. This may relate to the external pressures that many young AI women face in becoming pregnant at an early age and also why teenage pregnancy may be viewed as normal. In addition, it may impact AI adolescent males' attitudes toward sexuality, making it a positive thing to have multiple partners and to be sexually experienced, without a need for contraceptive use.

Limitations

There were a few limitations to this study. First, the participants in the focus groups and many of the key informant interviews were primarily Northern Plains AI, and therefore, were not necessarily representative of all AI. Further, whereas data collection was conducted on both a reservation and an urban site, there were no analyses conducted to compare similarities or differences between these 2 diverse geographic locations. This is, in part, because in reviewing the data and running preliminary analyses, there were no evident patterns suggesting distinct findings between the urban and the reservation sites. A future study could address gender norm differences between a rural, reservation community and AI living in an urban setting, especially as there may be differences in access to healthcare and family planning services, as well as enculturation differences, at the reservation site when compared to an urban site.

Conclusion

Gender ideology may play a large role in decisions about contraceptive use and sexual activity for AI adolescents. It appears vital, therefore, to include redefinitions of gender roles and norms within a teen pregnancy prevention program specific to AI youth. Prevention programs should work to empower young women who choose to be sexually active to have the self-efficacy and confidence to insist on condom use from male partners and not be discouraged from seeking out birth control method regardless of the stigma surrounding

female sexuality and contraceptive use. This could be done by including skill building activities that practice communicating difficult issues with one's partner. Equally, an adolescent female should feel empowered to abstain from sex and young motherhood, even if it is a role she automatically sees herself taking.

Likewise, a young man should feel emboldened to abstain from sex, regardless of gender norms that being a man means being sexually active. Young men also should understand the full consequences of teenage pregnancy, the result often being raising a child at a young age and the monetary, social, and emotional toll this can take for both partners. This could easily be incorporated in prevention programs by providing young men with a realistic view of teen pregnancy and the impact it has for the long-term.

In conclusion, the lack of empowerment for AI adolescent females and males impacts their natural development into sexual beings as they internalize family and peer pressures and behave according to external societal expectations. Understanding the gendered role that young women and men are taught and overcoming these expectations, while also being empowered to take control of their own sexuality, only can improve adolescent sexual health for all populations and should ultimately be a goal in efforts to prevent teenage pregnancy.

Human Subjects Statement

Prior to conducting this study, all study procedures were reviewed and approved by the lead organization's institutional review board, the Indian Health Service agency that oversees research approvals for this particular geographic area, and by the local tribe through a tribal resolution for the reservation site.

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Table 1
Qualitative Questions

Focus Groups		
Elders (50 or older; self-identified as AI)	1	What are some reasons youth decide to have sex?
	2	What do you think are some reasons youth decide <u>not</u> to have sex?
	3	What do you think are some reasons youth decide to use contraception (condoms, pill, etc.) to prevent pregnancy?
	4	What do you think are some reasons youth decide <u>not</u> to use contraception to prevent pregnancy?
	5	How are reasons for both using and not using contraception different...for girls and boys?
Youth (ages 16-24; self-identified as AI; parents and non-parents)	1	What do you think are some reasons your friends or people your age decide to have sex?
	2	What do you think are some reasons your friends or people your age decide <u>not</u> to have sex?
	3	What do you think are some reasons youth decide to use contraception (condoms, pill, etc.) to prevent pregnancy?
	4	What do you think are some reasons youth decide <u>not</u> to use contraception to prevent pregnancy?
	5	How are reasons for both using and not using contraception different...for girls and boys?
Key Informant Interviews		
School personnel	1	What reasons do you feel influence Native American youth to decide to <u>delay</u> parenting until after their teenage years?
	2	What do you think are some reasons Native American youth decide to use contraception (condoms, pill, etc.) to prevent pregnancy?
	3	What do you think are some reasons Native American youth decide <u>not</u> to use contraception to prevent pregnancy?
	4	How much of these factors differ for Native American boys versus Native American girls?
Healthcare provider	1	What do you think are some reasons Native American youth decide to <u>delay</u> parenting until after their teenage years?
	2	What do you think are some reasons Native American youth decide to use contraception (condoms, pill, etc.) to prevent pregnancy?
	3	What do you think are some reasons Native American youth decide <u>not</u> to use contraception to prevent pregnancy?
	4	How much of these factors differ for Native American boys versus Native American girls?

Table 2

Demographic Characteristics of Study Sample (N = 183)

Method	N	Age ^d mean (range)	Sex ^b		Race ^c		
			Female	Male	AI/AN ^d (alone)	AI/AN (multiple)	White (alone)
Focus Groups (24 total)	163	33.5 (15-79)	91 (55.8)	71 (43.6)	135 (82.8)	24 (14.7)	2 (1.2)
Youth	48	18.7 (15-24)	26 (54.2)	22 (45.8)	36 (75.0)	9 (18.8)	2 (4.2)
Parents	57	21.8 (17-25)	34 (59.6)	22 (38.6)	44 (77.2)	13 (22.8)	0
Elders	58	58.5 (44-79)	31 (53.4)	27 (46.6)	55 (94.8)	2 (3.5)	0
Interviews (20 total)	20	48.4 (28-69)	19 (95.0)	1 (5.0)	9 (45.0)	0	10 (50.0)
School personnel	10	47.5 (28-69)	9 (90.0)	1 (10.0)	5 (50.0)	0	4 (40.0)
Healthcare provider	10	49.3 (31-59)	10 (100.0)	0	4 (40.0)	0	6 (60.0)

Note.

^aThree participants from the elder focus group did not report their age.^bOne participant from the parent focus group identified as both male and female.^cOne participant from the youth focus group did not report their race. One participant from the elder focus group identified as Hispanic only.^dAI = American Indian; AN = Alaska Native