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Situating Contraceptive Practices and Public Health Strategy in the Bronx: Perspectives from Female Youth, Healthcare Workers, and Reproductive Health Leaders

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Situating Contraceptive Practices and Public Health Strategy in the Bronx:
Perspectives from Female Youth, Healthcare Workers, and Reproductive Health Leaders

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
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DEDICATION

To my parents, who instilled in me a healthy dose of skepticism, and taught me to question the familiar.

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ABSTRACT

In the United States, concerns about adolescent childbearing and its perceived corollaries – negative health outcomes for mother and child, the disintegration of the nuclear family, and “over-dependence” on public resources – began to circulate widely in policy spheres and popular media in the 1970’s, resulting in a proliferation of policies, programs, and services designed to address its prevention. Although national birth rates among adolescents are currently at their lowest since peaking in the early 1990’s, this decline masks persistent and significant disparities between groups of young people by race, ethnicity, geography, and poverty level. The concomitant existence of social and economic inequities that contribute to these differences is particularly striking in New York City; an urban center of vast extremes in health, wealth, and opportunity, but which boasts extensive reproductive health services for young people, including confidential care and availability of free or low-cost contraception. Within this setting, the promotion of hormonal and long-acting reversible contraceptive methods, specifically aimed at young women deemed at high risk of pregnancy and with less access to health care, has emerged as a key primary prevention strategy to reduce both overall adolescent pregnancy rates and disparities between adolescent groups. Using ethnographic methods, this research examined the promulgation and interpretation of this strategy by reproductive health leaders and healthcare workers as well as contextualized these perspectives with the reproductive decisions and fertility desires of female youth for whom this strategy is intended. As a result, this study elucidates broader political and socio-cultural contexts in which young women negotiate intimate

relationships and contraceptive use. Recommendations are subsequently offered for clinical practices attuned to female youths' lived experiences, educational programs for healthcare workers, and reproductive health policies reflective of the broader factors that influence contraceptive behaviors.

CHAPTER ONE

INTRODUCTION

Since reaching their peak in the early 1990's, birth rates among adolescents have been declining in the United States, although they remain substantially higher than those in Western Europe and other industrialized nations (CDC 2014). This downward trend has not been experienced uniformly by all populations of female youth, however. Significant disparities persist by poverty level and "race/ethnicity," with adolescents in high-poverty areas and Black and Latino teens being more likely to become pregnant and give birth than higher-income and white teens (CDC 2014). These incongruities are particularly striking in New York City (NYC), an urban center with persistent inequities in reproductive health outcomes among youth that coincide with vast differences in wealth, educational and employment opportunities, and health care access. Nowhere are these disparities more evident than in the Bronx, which consistently reports the highest pregnancy and birth rates among adolescents living in the five boroughs of NYC and is ranked the poorest urban county in the nation (NYC DOHMH 2011; American Community Survey 2013; U.S. Census Bureau 2015).

Recently, the Centers for Disease Control (CDC) identified adolescent pregnancy as a "Winnable Battle," a priority public health issue with significant health impacts and identifiable interventions (CDC 2014). Moreover, an effort to distinguish between pregnancies that are "intended" versus those that are not has shifted policy emphasis toward the prevention of "unintended" pregnancies, of which the vast majority of adolescent pregnancies are classified.

Within this framework, the promotion of highly effective forms of contraception, including hormonal and long-acting reversible methods, among sexually active females has emerged as a key population health strategy.

This research seeks to elucidate the multi-faceted and complex landscape within which sexually active female youth make decisions about and use contraception. Broadly, it explores how experiences with and patterns of use are shaped in an urban environment at a time during which there is considerable debate and attention paid to contraceptive access and unintended pregnancy prevention for adolescents. Specifically, the study examines contraceptive decisions and experiences among female youth in the Bronx, exploring how these practices intersect with and are shaped by clinical interactions, peer, family, and romantic relationships, as well as broader institutions and discourses. It also interrogates the framing and interpretation of adolescent reproduction and pregnancy prevention strategies by healthcare providers who offer contraceptive services and reproductive health leaders in New York City in order to reveal a more comprehensive understanding of its politically and socially constituted landscape. In-depth semi-structured interviews were conducted with 26 female youth between the ages of 15 and 19, 18 healthcare workers, and 12 leaders in adolescent health in order to illuminate the political, socio-cultural, and clinical contexts that broadly shape the reproductive lives of female youth. More specifically, this research seeks to contextualize their contraceptive experiences in a setting where pregnancy rates are high, contraceptive services are widely available, and teens are able to self-consent for reproductive healthcare.

This chapter will introduce the study setting and briefly summarize the epidemiology of adolescent pregnancy and childbearing in New York City. It will also provide an overview of literature pertaining to contraceptive decision-making and determinants of contraceptive use

among youth. The study's aims, research design, and definitions of key terms will also be highlighted. Lastly, this chapter will outline and briefly describe the forthcoming chapters.

BACKGROUND

Each year, approximately 17,000 pregnancies occur among adolescents between the ages of 15 and 19 in the city, with the majority considered unintended (NYC DOHMH 2013). Mirroring national trends, pregnancy rates in the city have declined significantly over the past decade. Between 2000 and 2009, the rate decreased from 101.4 to 81.1 pregnancies per 1,000 15 to 19 year-old females; however, the rate in NYC is still over 20% higher than the estimated pregnancy rate nationally for this cohort (NYC DOHMH 2011). Similarly, national disparities in pregnancy rates based on income, race or ethnicity are reflected in the occurrence of pregnancy in NYC, with youth living in high-poverty areas and Black and Latina teens being two to three times more likely to become pregnant than those teens who live in low-poverty areas or are white (NYC DOHMH 2011).

Results from the 2011 Youth Risk Behavior Survey (YRBS) administered in NYC indicated that approximately 38% of 15 to 19 year-olds attending public high schools have ever had sexual intercourse, with higher percentages reported for upper grades and among males (NYC DOHMH 2011). Among New York youth who had sex within the three months prior to the survey, 65% reported use of a condom, alone or with other methods, at last intercourse. Additionally, 27% reported use (or partner use) of a hormonal or LARC method at last intercourse (NYC DOHMH 2011).

With a population of approximately 1.4 million, Bronx County is home to a diverse population of residents, approximately one-third of whom were born outside of the United States (U.S. Census Bureau 2015). Between the years 2009 and 2013, the percentage of individuals

living below the federal poverty level (FPL) was consistently higher in the Bronx than in NYC overall, at about 31% versus 20%, with a median income of about \$34,000 compared to the citywide average of \$52,000 (U.S. Census Bureau 2015). Additionally, one-third of Bronx residents under the age of 18 live below the FPL (American Community Survey 2013).

In 2009, as in previous years, the pregnancy rate among adolescents living in the Bronx was higher than the NYC average, at 105.6 per 1,000 females (NYC DOHMH 2011). Figure 1.1 (page 5) shows pregnancy rates by United Hospital Fund¹ neighborhoods in NYC, demonstrating that the highest rates are in the South and Central Bronx, East Harlem, and Central Brooklyn (NYC DOHMH 2011). The darkest areas on the map also reflect neighborhoods with the highest levels of neighborhood poverty and some of the poorest health outcomes on a number of other health indicators, including children's hospitalizations due to asthma, diabetes, and HIV prevalence (Karpati et al. 2004).

Waddell and colleagues (2010) report that adolescents attending school in the South Bronx, North and Central Brooklyn, and East and Central Harlem are more likely to report sexual activity and less likely to report contraceptive use than their peers citywide (427). Their analysis of city-level YRBS data found that neighborhood context appeared to be a significant force in shaping differential rates of sexual debut, even when parental education level, family income, "race/ethnicity," age, and family structure were controlled (Waddell, Orr, Sackoff, and Santelli 2010:436). Data also show that elevated pregnancy rates in low-income Bronx neighborhoods co-occur with high clusters of chlamydia cases among youth (Guilamo-Ramos, Lee, and Husiak 2011), suggesting that a confluence of political, economic, and social inequalities shape the uneven distribution of sexual and reproductive health behaviors and outcomes among youth.

¹ United Hospital Fund neighborhoods are comprised of adjacent zip codes with "similar characteristics," intended to estimate the city's Community Planning Districts. In all, there are 42 UHF neighborhoods (United Hospital Fund 2002).

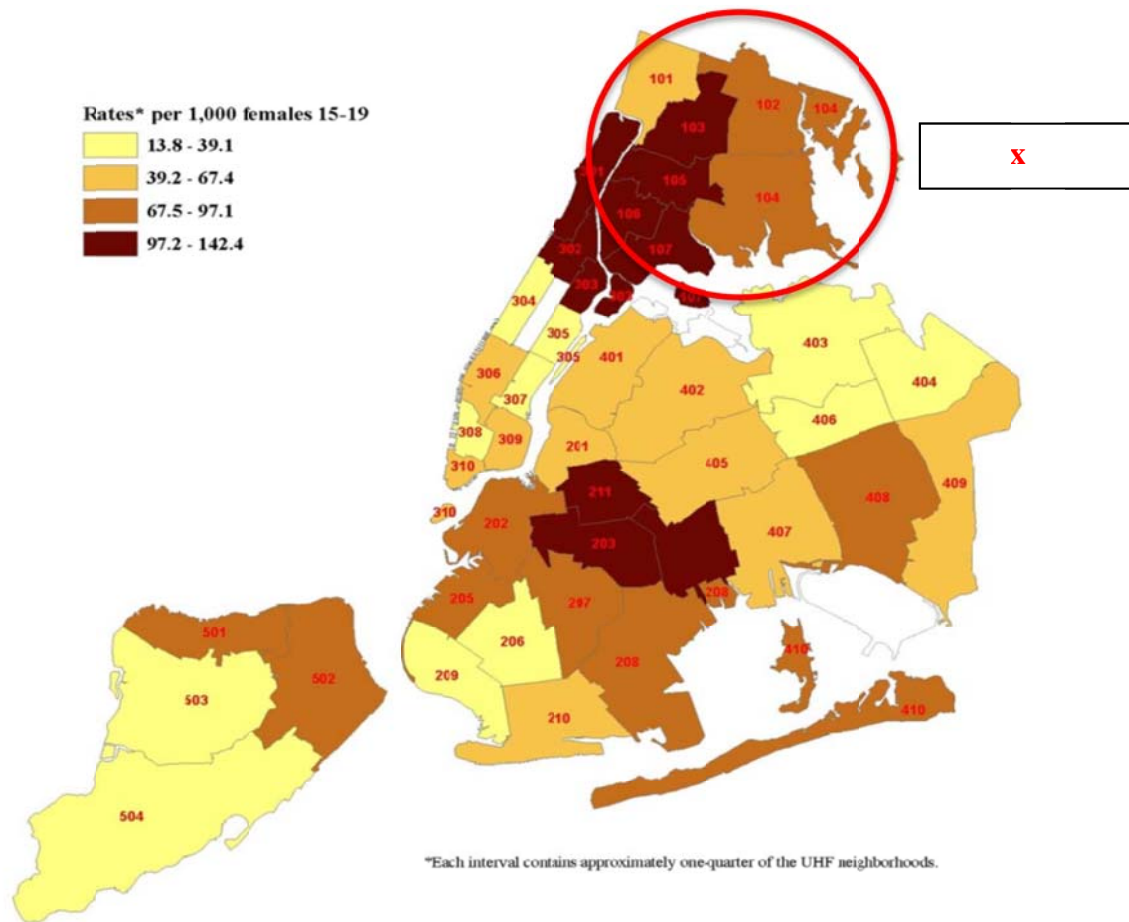


Figure 1.1. Teen Pregnancy Rates in NYC by United Hospital Fund Area, 2009 (Source: “Teen Pregnancy in New York City: 2000-2009.” New York City Department of Health and Mental Hygiene, 2011)

Despite prominent public health policy goals to encourage contraceptive use among sexually active female youth, literature on contraceptive decision-making among this population is limited (Dempsey, Johnson, and Westhoff 2011; Cheung and Free 2005; Noone 2004; Sable and Libbus 1998; Kuiper et al. 1997). Available studies tend to employ cognitive behavioral models in order to predict behavior and identify the relative importance of psychosocial constructs of interest that may shape behavior (Dempsey, Johnson, and Westhoff 2011; Esacove 2008; Sable and Libbus 1998; Weisman, Plichta, Nathanson, Chase, Ensminger, and Robinson 1991). While instructive in their ability to identify and evaluate the importance of several predetermined cognitive domains for a particular behavior, these models limit the extent to which emic explanations can

emerge. Moreover, while certainly a component of how individuals make decisions, a cognitive behavioral focus elides the intersecting structural factors, social determinants, and systems that shape what are often simplistically reduced to “individual behaviors.”

Despite the fact that the majority of sexually active youth will try or use a method of contraception in the U.S., little anthropological work has examined the political, social, and legal contexts of family planning services or explored contraceptive decision-making among young women. This study endeavors to fill that gap and draws from several theoretical perspectives within anthropology and related social science disciplines to situate its findings. Broadly, this research is located at the intersection of clinical and critical medical anthropology traditions, as it seeks to examine the ways that provider and clinic-level influences converge with broader structures and processes to shape the contexts within which marginalized female youth negotiate and make decisions about their reproductive lives. Specifically, I tie together scholarly writing on disciplinary perspectives of adolescence and youth; the anthropologies of reproduction and contraception; socio-cultural constructions of risk; and the anthropology of policy to support the theoretical approaches used. It is important to note that in New York State, youth 12 years of age and older are able to access family planning services, including abortions, without parental consent or notification under the legal framework of minors’ rights. An implicit assumption underlying this provision is the recognition that “under certain circumstances minors are capable of making independent judgments and that this emerging decision-making capacity should be respected” (Society for Adolescent Medicine and Health 2003: 407). While youth may be regarded by the state as autonomous individuals within particular settings and for specific types of healthcare, they are simultaneously considered “dependent” in a multitude of other systems, institutions, and relationships; a paradox that will be explored further in this dissertation.

RESEARCH DESIGN AND QUESTIONS

The majority of U.S. studies about contraceptive choices and use among youth rely on survey data, which, while instructive in demonstrating trends on key indicators of interest, are limited in their ability to explicate meanings, values, and motivations underpinning these decisions. In addition, public health and social science literature on contraceptive use and childbearing among youth tend to be devoid of the broader contexts within which such phenomena occur, focusing exclusively on individual-level behaviors. To situate perspectives from various stakeholders in NYC, as well as the interactions between broader national discourses and local interpretations of the “problem” and appropriate solutions, I employ the “vertical slice” framework, a “geospatial metaphor” to describe what Laura Nader defined as studying “up, down, and sideways” (Nader 1972:8; Nader and Gonzalez 2000; Gonzalez and Stryker 2014). This approach seeks to examine relationships and interconnections between “ordinary” individuals and decisions and policies enacted by institutions and people in positions of influence and power in order to develop a more holistic account of contemporary phenomena (Gonzalez and Stryker 2014:11; Nader 1972). In this research, it allows for the opportunity to engage intended recipients of pregnancy prevention messages, programs, and policies using ethnographic methods to elicit their experiences and priorities, while also examining the values and ideologies underpinning clinical practices and local and national health policy. With consideration of this context and approach, the following research questions guided this study:

1. **Politico-Legal Landscape of Adolescent Sexual and Reproductive Health:** What is the socio-cultural, political, and legal context of adolescent sexual and reproductive health service provision in New York City?
2. **Values, Policies, and Practices:** How do reproductive health stakeholders and health care workers characterize youth sexuality, intimate relationships, and sexual decision-making? What causes and outcomes do healthcare workers and stakeholders attribute to pregnancy and childbearing during adolescence? In what ways do these ideas inform

public health discourses and clinical practices and policies relating to pregnancy prevention in New York City?

3. **Healthcare Worker Perspective:** What role(s) do healthcare workers in primary care settings play in contraceptive counseling, uptake, and use among sexually active female youth in the Bronx?
4. **Sexual and Reproductive Lives of Female Youth:** How do female youth negotiate and make decisions about using contraception? Specifically, what multi-level factors shape method selection and use? How do female youth envision their social and reproductive future(s) and in what ways do contraceptive decisions relate to these goals?

DEFINITION OF KEY TERMS

In examining the public health strategy to increase the use of highly effective contraception among female youth, and relatedly, the latter's negotiation of reproductive decisions, it is necessary to define and clarify the uses and meanings of several key terms.

YOUTH, ADOLESCENTS, TEENAGERS, AND MINORS

First, "young people" are alternatively referred to as youth, adolescents, teenagers, and minors by literature from a multitude of disciplinary vantage points and the participants in this study. All of these terms have, of course, unique histories and various associations. For example, adolescent is often associated with cognitive-behavioral and developmental perspectives that privilege the biological underpinnings of the life stage. The term youth is originally derived from sociological work on deviance, though its uses over the past several decades have focused more on the cultural practices and structural positions of young people (Bucholtz 2002). Alternatively, minor is generally a legal term in the United States associated with those individuals who are below the age of 18. Because the experiences and explanations of young people, *from their own perspectives*, is sorely lacking from research on reproductive practices, I have intentionally chosen the more philosophically-aligned term *youth* when describing these study participants as a group. However, as the construction of the adolescent, the teenager, and the minor have so powerfully shaped our collective perceptions of this age

group and are used ubiquitously and often interchangeably by researchers, professional organizations, and the adults in this study, their exclusion would fail to reflect the cacophonous and often paradoxical identities subsumed within them. Therefore, in descriptions of the literature and findings from reproductive health stakeholders and healthcare workers, I retain the original terms used.

UNINTENDED PREGNANCY

Second, when the phrase “unintended pregnancy” is used in the literature, it is defined as an unwanted or ill-timed pregnancy at conception, which is the most widely used operational description (Guttmacher Institute 2012; Trussell, Vaughan, and Stanford 1999; Santelli et al. 2003; Santelli et al. 2009; Luker 1999; Fordyce 2012). However, this definition is one that many scholars argue is difficult to measure and differentially interpreted by women and men. For example, in the available literature and among participants in this research, the term “unintended” is often conflated with unwanted or unplanned as it pertains to pregnancies and births. Discussion about the conceptual and methodological imprecision of this phrase will be explored further in subsequent chapters.

SEXUAL AND REPRODUCTIVE HEALTH

Lastly, the phrase sexual and reproductive health is one that merits clearer delineation, as it is used widely in the literature from which this research draws. It emerged on the global stage at the 1994 International Conference on Population and Development Conference in Cairo as part of a broader discussion about sexual and reproductive rights (United Nations Population Fund 2008). As such, the phrase also tends to reference a positive, rather than stigmatizing or problem-based, approach to human sexuality (WHO 2015). While the services included within the scope of sexual and reproductive health may vary slightly, they are generally considered to

be family planning, including abortion; pre- and post-natal care; infertility treatment; prevention and treatment of reproductive infections, STIs, and HIV; and education and counseling on sexuality and reproduction (United Nations Population Fund 2008). For this research, sexual and reproductive health encapsulates the above definitions, although given its focus, more attention is paid to particular aspects of the related services; namely, family planning, abortion, and education and counseling. One final note about terminology is necessary. In an attempt to condense lengthy phrases that are used repeatedly throughout the dissertation, a number of acronyms and abbreviations are used². While introduced in the text, they have also been compiled into a list, which can be found in Appendix C.

DISSERTATION OUTLINE

Chapter Two provides an overview of literature from primarily biomedical, public health, and psychosocial perspectives on the effectiveness and use of hormonal and LARC methods, multi-level influences on contraceptive decision-making, and determinants of contraceptive method selection among adult and young women. It also presents findings on the ways in which clinical settings and healthcare providers shape information and services offered to youth about contraception. This chapter concludes with a discussion regarding the limitations of available studies to contextualize and holistically explicate contraceptive choices and decisions made by female youth and young women.

Chapter Three situates the exploration of female youths' reproductive lives and contraceptive choices within various theoretical traditions and areas of scholarly inquiry from anthropological literature. First, it traces the development of the clinical and critical medical anthropological approaches and their relevance for the study. Next, the chapter provides a brief history of

² Aside from reasons of brevity, it can be argued that the pervasiveness of acronyms in adolescent reproductive health also serves to depoliticize its focus and professionalize vertical interventions enacted on groups of young people (see Nader and Gonzalez 2000 for a discussion of adolescent health as a recent cultural invention).

anthropological perspectives on adolescence and sexuality, followed by a review of prominent debates within the disciplinary poles of adolescence and youth. Lastly, relevant theoretical developments from the anthropologies of reproduction, risk, and policy and their relevance to the study of youth sexuality and reproduction will be presented.

Chapter Four presents the research design, guiding questions, and objectives of the dissertation study and provides a justification for the methodological framework selected. Semi-structured in-depth interviews were conducted with female youth in the Bronx, healthcare workers who provided contraceptive services to this population, and local leaders in adolescent and reproductive health. A description of data collection methods, study procedures, and plans for analysis is included, followed by demographic information for each group of interviewees. The chapter concludes with a discussion of relevant ethical issues, the author's positionality vis-à-vis research with youth, and study limitations.

In order to frame the context of reproductive healthcare and associated policies nationally and in New York, Chapter Five outlines significant events and debates in family planning and youths' access to such services. Next, the chapter provides an overview of the reproductive health policy climate in New York State and prominent policies, approaches, and initiatives recently undertaken to promote youth sexual and reproductive health. Lastly, this chapter presents an epidemiological snapshot of reproductive health indicators for the city overall and the Bronx, specifically, highlighting the significant and persistent socio-economic and health inequities evident in this comparison that contribute to higher rates of pregnancy and childbearing among youth in the case of the latter.

Chapter Six, the first of four results chapters, presents themes that emerged from interviews concerning influential aspects of the political, legal, and socio-cultural landscapes within which

youth sexual and reproductive health behaviors and outcomes in New York City occur, such as the framework of minors' rights. Then, it proceeds to discuss population- and community-level approaches considered to be the most effective in promoting contraceptive use and reducing unintended pregnancies among female youth deemed at higher risk of this outcome. Finally, an examination of barriers that were perceived to limit the extent to which youth could or would access reproductive health services is presented. Findings are drawn primarily from interviews with reproductive health stakeholders, with perspectives from healthcare workers included where relevant.

Chapter Seven presents research findings from various types of healthcare workers situated in primary care settings where youth access reproductive health services, elucidating particular values, beliefs, and ideologies that inform their constructions of sexually active youth and the delivery of such care. It then describes the range of information and strategies covered in contraceptive counseling sessions with youth, highlighting areas that are emphasized or omitted. Finally, this chapter offers explanations from healthcare workers about the perceived influences of contraceptive method selection, use, and discontinuation among their female youth patients.

In an attempt to deepen often limited explanations of contraceptive method adherence and discontinuation, Chapter Eight offers youth participants' rationales, priorities, and preferences that shape contraceptive method selection and patterns of use. In particular, themes and perspectives from female youth are offered on the ways in which reproductive decisions and contraceptive choices are negotiated within the broader web of social, familial, and intimate partner relationships. In so doing, this chapter examines the subjective and often shifting evaluation of costs and benefits posed by particular options.

Chapter Nine, the final results chapter, addresses perspectives on and values regarding reproduction, and in particular, among youth, incorporating themes that emerged on these topics from all three interview groups. It first examines how reproductive health stakeholders and healthcare workers conceptualize proximal and distal causes and consequences of pregnancy and childbearing among young women, as well as their perceived relationships with poverty. The chapter also examines meanings and values ascribed to planned pregnancies, highlighting areas of divergence among reproductive health stakeholders, healthcare workers, and female youth.

Finally, Chapter Ten returns to the research objectives and vertical slice methodological framework to review prominent themes that emerged from the interviews. The chapter then evaluates these findings in light of the literature presented earlier in the dissertation. Next, it presents clinic and policy-level recommendations for youth sexual and reproductive health, broadly, and contraceptive services, specifically. The chapter concludes with a discussion of the study's limitations and future avenues of research exploration.

CHAPTER TWO

LITERATURE REVIEW OF CONTRACEPTION

In 2012, teen birth rates in the United States dropped to a record low of 29 out of 1000 adolescents between the ages of 15 and 19 (CDC 2014). Experts cited delays on the onset of sexual activity and improvements in contraceptive use as the primary drivers of the decline (Guttmacher Institute 2011:2). This decrease, however, was not experienced evenly among all groups within the age range. Significant disparities continue to exist between racial and ethnic groups with regard to rates of pregnancy, birth, and abortion (Kost and Henshaw 2012:4). The prevention of adolescent pregnancy in the United States has tended to emphasize policies on sexuality education and programs in schools, community, or clinic-based settings, family planning services, youth development programs, and media campaigns (Bearinger et al. 2007; Schultz 2001; Ward 1995; Luker 1996; Geronimus 2003). Reflecting a significant departure from the emphasis on abstinence-only messages and funding that characterized the 1990's and 2000's, a prominent mid-level strategy that has emerged on the national stage to reduce unintended adolescent pregnancy is the promotion of highly effective forms of contraception (i.e., hormonal and long-acting reversible methods) among sexually active teens.

This chapter will first provide a description of FDA-approved contraceptive methods, their mechanisms of action, and rates of effectiveness at preventing pregnancy. Next, I review prominent themes in the literature regarding influences on contraceptive decision-making, broadly, determinants of hormonal and long-acting reversible contraceptive method selection,

specifically, and multi-level factors associated with contraceptive use patterns and discontinuation. I conclude with a discussion regarding the limitations of available studies to contextualize and holistically explicate contraceptive choices and decisions made by adolescents and young women.

MECHANISMS OF ACTION FOR HORMONAL AND LONG-ACTING REVERSIBLE CONTRACEPTION

Various hormonal and long-acting reversible contraceptive methods are currently FDA-approved for use in the United States. This brief review presents effectiveness rates and describes the mechanism of action for those methods which are most commonly used by adolescents: the hormonal implant, three types of intrauterine devices (IUDs), a hormonal injectable, and combined hormonal contraception (CHC) in the form of pills, a transdermal adhesive patch, and a vaginal ring. Nexplanon is the brand name of the hormonal implant that came on the market in 2011, although previous versions of this method have been in use in the United States since 1990 (e.g., Norplant and Implanon) (Anderson 2005; Roberts 1997; Hatcher et al. 2011; AAP 2014). The hormonal implant is a small flexible plastic tube containing a progestin hormone that is inserted under the skin in the upper arm to prevent pregnancy for up to three years. This method prevents pregnancy through pre-fertilization mechanisms; namely, by suppressing ovulation and thickening cervical mucous, making it difficult for sperm to pass through the cervix. Of the available methods, the hormonal implant is considered as effective as sterilization at preventing pregnancy (Hatcher et al. 2011). See Table 2.1 for an overview of selected contraceptive method effectiveness rates.

Table 2.1 Effectiveness of Contraceptive Methods at Perfect and Typical Use

Contraceptive Method	Perfect Use Rate	Typical Use Rate
<i>Hormonal Implant</i>	>99.9%	>99.9%
<i>Hormonal IUD</i>	99.8%	99.8%
<i>Copper IUD</i>	99.4%	99.2%
<i>Depo Provera</i>	99.8%	94%
<i>Vaginal Ring</i>	99.7%	91%
<i>Patch</i>	99.7%	91%
<i>Oral Contraceptive Pills (OCPs)</i>	99.7%	91%
<i>Male Condoms</i>	98%	82%
<i>Withdrawal</i>	96%	78%
<i>Fertility Awareness Methods*</i>	95%-99.6%	76%

*These methods include periodic abstinence, body temperature methods, and cervical mucous methods (table adapted from Guttmacher 2014).

There are currently three IUDs available in the United States, which are small polyethylene framed devices that are placed in the uterus to prevent pregnancy (Hatcher et al. 2011). While the notion of inserting a small object into the uterus to prevent pregnancy has a long history spanning several civilizations and thousands of years, the “modern” T-shaped IUD has been in existence since the 1960’s (Anderson 2005). Two IUDs that were recently introduced on the contraceptive market in the 2000’s, Mirena and Skyla, contain progestin, while the Copper T 380A IUD, introduced in the United States in 1988, does not contain hormones but rather is made of copper (Hatcher et al. 2011; AAP 2014). While Hatcher and colleagues (2011) report that the exact contraceptive mechanism of action for IUDs is not known, these methods prevent pregnancy pre-fertilization by a combination of the device’s “foreign body effect” and the medication’s specific effect (e.g., levonorgestrel or copper) that creates a toxic environment for sperm and inhibits their functioning and movement (150). Additionally, levonorgestrel thickens cervical mucous and impairs ovulation. Studies indicate that IUDs do not interrupt an already implanted pregnancy, however, it is hypothesized that the copper IUD (Paragard) has a post-fertilization (but pre-implantation) mechanism of action that results in changes to the uterine

lining when used as emergency contraception (Hatcher et al. 2011:121). Skyla can be left in place for up to three years to prevent pregnancy; Mirena up to five years, and Paragard up to 10 years³ (Hatcher et al. 2011; AAP 2014). Like the hormonal implant, the effectiveness of IUDs at preventing pregnancy is on par with sterilization (Hatcher et al. 2011).

The hormonal injectable most widely available in the U.S. is Depo-Provera, which was approved for use as a method of contraception by the FDA in 1992 (Anderson 2005; Hatcher et al. 2011; AAP 2014). Depo-Provera is a progestin-containing method that inhibits ovulation and thickens the production of cervical mucous. It is administered by subcutaneous or intramuscular injection and each dose provides about three months of contraception (Hatcher et al. 2011; AAP 2014). It is important to note that while return to fertility is immediate with all other methods, the effects of Depo-Provera wear off more gradually and may anywhere from four to 18 months (Hatcher et al. 2011; AAP 2014).

Oral contraceptive pills (OCPs), the transdermal patch, and vaginal ring are considered CHC because they contain both estrogen and progestin⁴. The oldest of the three CHCs is the pill, which was first approved for use in the U.S. in 1960 (Anderson 2005; Hatcher et al. 2011). While the original OCPs contained excessively high doses of hormones that were associated with life-threatening adverse reactions, subsequent formulations contained lower doses and various permutations of hormone combinations, resulting in less severe side effects (Hatcher et al. 2011). Alternatively, only one type of vaginal ring and contraceptive patch are currently FDA-approved for use, in 2001 and 2002, respectively (Hatcher et al. 2011). OCPs must be taken every day, with some formulations including a week of placebo pills and others allowing for continuous use

³ While manufacturers of Mirena and Paragard indicate the use of their products for five and 10 years, respectively, clinical studies have demonstrated that these IUDs are effective at preventing pregnancy for longer periods of time; up to seven years for Mirena and 12 years for Paragard (Hatcher et al. 2011).

⁴ Progestin-only pills (POPs) are also available but were not included in this review due to their limited use.

of pills containing the hormones that prevent pregnancy (Hatcher et al. 2011; AAP 2014). The patch delivers the hormones transdermally by affixing its adhesive side to the skin, which must be replaced once a week, while the vaginal ring is a flexible hormone-releasing CHC that is inserted into the vagina and left in place for three weeks (Hatcher et al. 2011; AAP 2014). All CHC work through established pre-fertilization mechanisms: by suppressing ovulation and making the cervical mucous impervious to the movement of sperm past the cervix (Hatcher et al. 2011). It is also hypothesized that changes to the endometrial lining may affect implantation, although this is not a primary mechanism of action (Hatcher et al. 2011).

Hormonal contraceptive methods such as pills, vaginal ring, patch, and Depo-Provera rely on repeated and consistent use in order to be highly effective in the prevention of pregnancy (Whitaker and Gilliam 2008; AAP 2014). With the exception of Depo-Provera, they are considered “user-reliant” because while they require interaction with a medical provider for consultation, counseling, and dispensing such methods, their subsequent use is managed by the individual depending on their needs, preferences, and personal assessment of risk of pregnancy. Depo-Provera does not require ongoing monitoring of use by the individual, but it does necessitate making and attending clinic appointments every three months in order to avoid a lapse in coverage (Whitaker and Gilliam 2008). Alternatively, long-acting reversible contraception (LARC) such as IUDs and the hormonal implant are considered “forgettable” methods due to low user involvement once a medical provider has inserted them (Hatcher et al. 2011).

Table 2.1 (see page 17) shows the effectiveness of hormonal and LARC methods at preventing pregnancy for perfect and typical use⁵, in addition to male condoms, withdrawal, and

⁵ Perfect use indicates the probability of method failure when used correctly and consistently by couples, while typical use references effectiveness for all experiences with use, factoring in those that are inconsistent and

fertility awareness, among women who use the method for one year (Guttmacher 2014). As is evident by these percents, perfect use for hormonal and LARC methods are ostensibly equivalent; however, the reduced effectiveness associated with typical use for user-reliant methods such as Depo-Provera, the vaginal ring, patch, and OCPs reflect the impact of consistent and correct use on effectiveness. It is in large part because LARC methods do not rely on user “motivation” or adherence to achieve high efficacy that they have received renewed attention in family planning and public health spheres as key technologies to combat unintended pregnancy (Kavanaugh et al. 2013; Deans and Grimes 2009; Whitaker et al. 2013; Russo, Miller, and Gold 2013).

CONTRACEPTIVE METHOD USE AMONG YOUTH

Data on adolescent use of contraception are routinely collected through the National Survey for Family Growth (NSFG) (Martinez et al. 2011; Abma, Martinez, and Copen 2010). Recent rates show that virtually all adolescents between the ages of 15 and 19 who are sexually experienced have used a contraceptive method. Condoms, followed by withdrawal, represent the two most commonly used methods among this age cohort, at 96% and 56%, respectively (Martinez et al. 2011; Abma, Martinez, and Copen 2010). On the whole, use of hormonal methods and long-acting reversible contraception (LARC) is much lower, although reported usage of most methods has increased over the past two decades: approximately 56% of sexually experienced female adolescents reported use of an oral contraceptive pill (OCP); 20% used the Depo-Provera injectable shot; 10% reported use of the patch, an adhesive transdermal method of hormone delivery; and 5.5% used the vaginal ring (Martinez et al. 2011; Abma, Martinez and Copen 2010; AAP 2014; Stewart et al. 2007; Epstein et a. 2008; Raine et al. 2009). Data from

incorrect, such as missed pills, failure to change a patch in the correct timeframe, and so on (Guttmacher 2014; AAP 2014).

the NSFG also indicate low but increasing use of the intrauterine device (IUD) and hormonal implant among 15 to 19 year-olds, from 1.5% in 2002 to 4.5% in 2009 (Finer, Jerman, and Kavanaugh 2012). Notwithstanding these trends regarding the *uptake* of contraception, consistency, accuracy, and continuity are also essential components of use that may present challenges for many women, including adolescents, a point to which I return later in this chapter (AAP 2014; Lamvu, Steiner, Condon, and Hartmann 2006).

CONTRACEPTIVE DECISION-MAKING

Despite prominent public health policy goals to promote contraceptive use among young women, there is a dearth of contemporary literature on contraceptive decision-making among women, and in particular, adolescents (Noone 2004). A study conducted by Matteson and Hawkins (1997) found that in chart reviews of over 800 adult women seeking contraception, no one discernible pattern could be detected or predicted based on previous use of contraception or method efficacy (see also Noone 2004). These findings underscore the highly individualized and complex process of decision-making that encompasses multifactorial intra- and interpersonal, social, and environmental considerations, as well as attributes of contraceptive methods themselves (Mattheson and Hawkins; Noone 2004).

Further, theoretical approaches to contraceptive use are often lacking in both research and interventions, perhaps owing to the inadequacy of any one theory to accurately capture the host of potential influences (Lopez, Tolley, Grimes, and Chen-Mok 2011; Cheung and Free 2005; Kuiper, Miller, Martinez, Loeb, and Darney 1997; Noone 2004). A recent Cochrane review evaluated randomized controlled trials (RCTs) that tested the application of theoretical approaches to elucidate contraceptive decisions, encourage contraceptive use, or promote contraceptive adherence (Lopez, Tolley, Grimes, and Chen-Mok 2011). The most common

theoretical basis for the 14 eligible studies⁶ was Social Cognitive Theory (SCT); other models used included the Theory of Planned Behavior and Reasoned Action, Motivational Interviewing, and the Transtheoretical Model (Lopez, Tolley, Grimes, and Chen-Mok 2011).

Social cognition models such as these are employed to better predict individual health behavior and identify the relative importance of predetermined constructs of interest that may shape the behavior (Weisman, Plichta, Nathanson, Chase, Ensminger, and Robinson 1991; Dempsey, Johnson and Westhoff 2011; Sable and Libbus 1998). The Theory of Reasoned Action (TRA) and its extended version, the Theory of Planned Behavior (TPB), are health behavior models focused on motivational factors at the individual level that predict the likelihood of carrying out a specific health behavior (Montano and Kasprzyk 2002). In these models, social norms and attitudinal perceptions are believed to shape intention, which is considered the most important determinant of an individual's behavior (Montano and Kasprzyk 2002; Fishbein 1967; Sable and Libbus 1998; Noone 2004). Primary constructs in the TRA thought to influence behavioral intention (and behavior) are attitudes towards the behavior, which are informed by beliefs about the particular behavior or associated outcome and value(s) attached to it and subjective norms about the social acceptability of a particular behavior and the extent to which the approval or disapproval of "important referent individuals" matter with regard to the behavior (Montano and Kasprzyk 2002:69-70). To these concepts, the TPB contributes the extent to which an individual feels they are able to control a particular behavior (perceived behavioral control) in an attempt to account for factors beyond an individual's control that may impact behavioral intention (Montano and Kasprzyk 2002:74). The TRA and TPB have been applied in a variety of health contexts. Of relevance to this research, Sable and Libbus

⁶ Eligible studies spanned the globe and included adult and adolescent populations recruited from a range of healthcare settings, including family planning clinics, primary care centers, schools, and community-based organizations (Lopez, Tolley, Grimes, and Chen-Mok 2011:7).

(1998) explored contraceptive decision-making among low-income women of childbearing age. Their application of the TPB uncovered salient beliefs that influenced decision-making, including embarrassment about the procurement and use of condoms and concerns about the risks and side effects associated with the use of hormonal methods (Sable and Libbus 1998:262). Importantly, these models “assume that all other factors, including demographics and environment, operate through the model constructs and do not independently contribute to explaining the likelihood of performing a behavior” (Montano and Kasprzk 2002:67).

Lastly, the Transtheoretical Model (TTM) postulates that individuals are at varying stages of readiness to make and maintain behavior change, the identification of which is critical to “move” someone from one stage to the next (Prochaska, Redding, and Evers 2002; Lopez, Tolley, Grimes, and Chen-Mok 2011; Dempsey, Johnson and Westhoff 2011). Initially applied in tobacco cessation studies, the TTM’s use has expanded to substance abuse, obesity, HIV/AIDS, pregnancy prevention, and other health issues (Prochaska, Redding, and Evers 2002:99). In the TTM, behavior change is understood as a cyclical process that unfolds over time, with five stages identified: pre-contemplation, during which an individual does not intend to take action in the next six months; contemplation, where action is intended within the next six months; preparation, which includes an intention to take action within the next month and some steps taken towards behavior change; action, which entails “overt” behavior change for less than six months; and maintenance, where behavior change has taken place for over six months (Prochaska, Redding, and Evers 2002:101). Influential in determining one’s stage of change are the perceived costs and benefits attributed to the particular behavior and the self-confidence to engage in the behavior in “high-risk” situations without reverting back to “unhealthy” behaviors (Prochaska, Redding, and Evers 2002:101-103). Recently, Dempsey, Johnson, and Westhoff

(2011) used the Transtheoretical Model to predict continuation of OCPs among young women at six months post-initiation based on the stage of change in which participants were classified. The authors found that participants who did not rate advantages of OCPs highly and reported low self-efficacy to use OCPs in situations where adherence may be difficult were at higher risk for method discontinuation (Dempsey, Johnson, and Westhoff 2011:27).

Social Cognitive Theory (SCT) is an interpersonal health behavior model, which posits that current behaviors, personal factors, and the environment interact to produce subsequent behaviors, or what is referred to as the concept of reciprocal determinism (Lopez, Tolley, Grimes, and Chen-Mok 2011:4; Baranowski, Perry, and Parcel 2002; Bandura 1986). The implication of this interaction is that behavior is dynamic and dependent upon features of the environment, broadly conceived to reference factors outside of the individual, and personal thoughts, experiences, and emotions in an iterative cycle (Baranowski, Perry, and Parcel 2002; Lopez, Tolley, Grimes, and Chen-Mok 2011). The concept of reinforcement is foundational in SCT and has various forms, including direct, vicarious, and self, further categorized as intrinsic or extrinsic reinforcement (Baranowski, Perry, and Parcel 2002:171). Intrinsic reinforcement is the result of an individual's perceptions or experiences that a particular event or outcome has value (e.g., a personal desire to avoid getting pregnant in high school), while the extrinsic form references an event that is believed to incur an expected outcome (e.g., using condoms because a partner requires them) (Baranowski, Perry, and Parcel 2002:172). Bandura and other social learning theorists believed that self-efficacy, or the level of confidence an individual feels in their ability to perform a particular behavior, is the most important behavior change concept, as it "affects how much effort is invested in a given task and what level of performance is attained" (Baranowski, Perry, and Parcel 2002:173). In SCT, a combination of observational and

participatory learning techniques are often employed to enhance self-efficacy to achieve a specific behavior, with subsequent success strengthening expectations that behavior change is possible (Baranowski, Perry, and Parcel 2002). In the realm of pregnancy prevention, this may include practicing condom negotiation skills or learning how to correctly put a male condom on a penis model.

While able to identify and evaluate the importance of several influential domains on health behavior(s) and behavior change, these models pose several significant limitations to the study of contraceptive use. First, reproductive behaviors are embedded within a larger socio-cultural context that may be difficult to capture in discrete, largely individual-based constructs (Price and Hawkins 2002). A more holistic exploration of contraceptive decisions, experiences, and practices cannot be easily reduced to specific behaviors or actions, as such an approach would be overly narrow in focus and compartmentalized in scope. Additionally, these models are predicated upon a rational choice framework, which presumes that actions are taken through a prospective weighing of costs and benefits of particular decisions (Esacove 2008:378; Weisman et al. 1991:131). Moreover, they assume that individuals always make choices based on reasons or logic that are consistent with the theoretical perspective of the model. Lastly, the majority of constructs within these domains are cognitive. While certainly a component of how individuals behave and make decisions, this focus elides the structural, external and situational factors that must also be considered in order to elucidate the complex environments in which youth live (Eyre 1997; Wagstaff, Abramson, and Pinkerton 2000).

Alternatively, several exploratory qualitative studies have employed a grounded theory approach in an attempt to elucidate user-identified domains that influence contraceptive uptake and use, which highlight the multitude of factors that may be relevant to decision-making.

Luker's seminal work (1977) on contraceptive "risk taking" among a sample of predominantly unmarried, white, middle class women highlights the numerous factors, other than the availability of contraception, that intersect to shape decisions around method use. Subsequently, a pattern of logic with "decision junctures" was developed that included the values assigned to pregnancy and contraception; the social costs and benefits of using contraception consistently; the perceived likelihood that a pregnancy would result from inconsistent or non-use; and attitudes towards abortion if benefits or risk of pregnancy were incorrectly calculated (Luker 1977:192). Luker concludes that primary determinants of the pattern described above are social in nature – namely, contradictory attitudes and expectations about women's sexuality and limited economic opportunities available (1977:195). While the research was conducted almost 40 years ago, several of the same findings have been reiterated in other studies.

More recently, Kuiper and colleagues (1997) conducted focus groups and interviews among adolescents about the contraceptive implant Norplant. Three influential domains were identified that shaped participants' decision-making processes about this long-acting reversible method. The first was the social context, which included peer perceptions of various methods, sexual stigma, relationships with males, and the broader class and racial contexts within which decisions were made. For example, adolescents noted that the visibility of the implant could index a user's sexually active status to peers and potential partners, which may result in assumptions about and stigmatization of her sexuality. Relatedly, participants noted that male partners of implant users might assume their partner was being unfaithful (Kuiper et al. 1997). The second area was information sources, which encompassed the main ways through which adolescents acquired information about Norplant: clinical, direct media, and social network channels (e.g., peers and family). Of these sources, implant users were more likely to regard the

legitimacy of clinical information highly, while non-implant users found information gathered from peers and adults in their social networks to be influential in their decisions (Kuiper et al. 1997). The third content area pertained to personal traits and experiences such as future aspirations and goal setting and the importance of “control” over their bodies and lives (Kuiper et al. 1997). A similar more recent study conducted by Cheung and Free (2005) explored salient factors that may influence contraceptive decision-making for OCPs, Depo-Provera, and implants among young women in the UK (427). Cheung and Free found that women’s decisions were not only shaped by whether side effects were experienced, but were also reflective of underlying beliefs about the appropriateness of hormones in contraceptives, the value of menstrual control and “natural menses,” and the relative importance of avoiding pregnancy (2005:430). Lastly, Noone (2004) developed a grounded theory of contraceptive decision-making based upon interviews with adult women. The core theme most applicable to contraceptive decision-making processes was “finding the best fit,” which was comprised of three major categories: becoming aware, or learning of pregnancy prevention options; weighing the options against personal preferences, or identifying the method that best fits the woman’s current life circumstances; and navigating a course, or figuring out options and strategies to access and use the method (Noone 2004:16-19).

DETERMINANTS OF CONTRACEPTIVE METHOD CHOICE AND USE

Numerous studies have attempted to explicate the antecedents, both distal and proximal, that are associated with behaviors such as adolescent sexual debut, contraceptive use, and pregnancy outcomes (Kirby 2002; Miller 1995; Moore, Miller, Gleib, and Morrison 1995; Santelli and Beilenson 1992; Mosher and McNally 1991). Kirby’s 2002 systematic review of over 250 studies published between 1975 and 2002 on factors that are associated with these behaviors and

outcomes uncovered over 100 that are potentially significant. Moreover, Kirby's review explicates correlations, not causative relationships, between various factors. For example, individual level protective and risk factors identified as influential on contraceptive use are psychosocial, developmental, and behavioral in nature, and include: age; religiosity; relationships and communication with partners; cognitive skills; the presence or absence of "healthful" and "risk-taking" behaviors; one's emotional state; and sexual beliefs, attitudes, behaviors, and skills (Kirby 2002:477; see also AAP 2014; Sable and Libbus 1998; Manlove, Ryan, and Franzetta 2004; Manlove and Terry-Humen 2007). Several additional elements attributed to the individual are likely proxies for broader phenomena, such as social deprivation, structural vulnerability, and socio-cultural variation in attitudes towards contraception and fertility timing norms, which are more difficult to measure. Such factors include "race" and/or ethnicity, family dynamics, and school attachment and achievement (Kirby 2002).

Environmental and/or contextual antecedents that may influence contraceptive use include: neighborhood "quality" (e.g., safety, availability of services and programs); age of male partners; characteristics of peers; parental income and education; family structure; and parental attitudes towards contraception (Kirby 2002:277). For example, some studies have shown that parental communication (or lack thereof) about sexuality and reproduction influences adolescents' comfort regarding and willingness to use contraception (Advocates for Youth 2009). To Kirby's factors, Sable and Libbus (1998) add a number of additional variables pertaining to clinical services, including hours of operation, geographic proximity and transportation access, lack of child care, and clinic visit costs (263).

While not able to clarify relationships among antecedents, Kirby (2002) argues that because such a large number of factors are associated with adolescent sexual behaviors, it is

unlikely that a substantial number are highly related. Instead, many are likely causally related to each other with others having modest degrees of relation (475). For example, economic structures and availability opportunities may impact an individual's attitudes towards avoiding pregnancy. Likewise, peer, family, and partner attitudes and beliefs about sexual behaviors likely affect an individual's perspectives on contraception (Kirby 2002:475). The extent of potential antecedents identified demonstrates that the picture of adolescent sexual behaviors and outcomes is exceedingly complex and thus no one single theoretical framework will be able to sufficiently predict or describe it (Kirby 2002:479). Kirby identifies two summary themes based on his review of the literature. First, many of the risk factors relate in some way to economic and social disadvantage, both at the community and individual levels. Second, the physical and social environment, including that of families, peers, communities, and schools, has a powerful influence on adolescent sexual behaviors. Further, such institutions and settings offer opportunities for the existence of both protective and "risk" factors with regard to contraceptive use (Kirby 2002:482).

FACTORS ASSOCIATED WITH CONTRACEPTIVE USE PATTERNS AND DISCONTINUATION

Over 40% of unintended pregnancies are estimated to be the result of inconsistent, incorrect, or discontinuous use of predominantly user-reliant methods of contraception (Kavanaugh et al. 2013; Dean and Grimes 2009; Whitaker et al. 2013; Russo, Miller, and Gold 2013; Moreau Cleland and Trussell 2007; Frost and Darroch 2008; Kost et al. 2008; Woodsong Shedlin and Koo 2004; Smith and Oakley 2005:380; Cheung and Free 2005). Thus, considerable attention has been paid to the reasons for and challenges associated with consistent and correct contraceptive use in the clinical and public health literature, which are diverse, often poorly

understood, and appear to influence both the selection of methods and patterns of use (Frost and Darroch 2008; Frost, Singh and Finer 2007b:91; Skinner, Smith, Fenwick, Hendriks, Fyfe, and Kendall 2009:51). Broadly, these include individual-level characteristics such as concerns about health risks and side effects of contraception, fertility goals and desires, pregnancy ambivalence, and infrequent sexual activity; partner dynamics and relationship characteristics; social and economic characteristics; family, peer, and community relationships; health service access and provision; and individual experiences with contraceptive methods (Woodsong, Shedlin and Koo 2004:63; Gilliam, Warden, Goldstein, and Tapia 2004:299; Frost and Darroch 2008:94; Frost, Singh, and Finer 2007a; Manlove, Ryan, and Franzetta 2004; Manlove and Terry-Humen 2007). Moreover, recent analyses estimate that 46% of *all* women of reproductive age who had ever discontinued contraception did so as a result of method dissatisfaction, a finding that has been reiterated in other studies (Moreau, Cleland, and Trussell 2007:267; Frost, Singh and Finer 2007b:98). The importance of method satisfaction to continuous and consistent method use underscores the limitations of available contraceptive methods, as each may present particular drawbacks to users.

Additionally, some research suggests that adolescents have unique challenges towards consistent contraceptive method adherence, although the parameters used to define “consistency” vary and are often unclearly stated in the available literature. Studies have shown that among young women and those in less enduring sexual relationships, phases of contraceptive nonuse, method switching, and intermittent method use are relatively common (Frost Singh and Finer 2007a; Raine et al. 2011; Rosenberg et al. 1995; Smith and Oakley 2005; Frost and Darroch 2008; Moreau, Cleland and Trussell 2007). For example, some researchers have found that an average of three pills are missed per cycle among adolescent users, with an estimated third of

adolescents missing at least one pill each month (Whitaker and Gilliam 2008:272; see also Smith and Oakley 2005). Another study found that discontinuation of OCPs is estimated to be approximately 50% within the first three months of use among adolescent girls, which is considerably higher than the discontinuation rate for all women (32% at one year) (Whitaker and Gilliam 2008:272).

While overlapping, issues associated with inconsistent contraceptive use and discontinuation vary depending upon the method. Numerous determinants have been associated with inconsistent use of OCPs among adolescents, including ambivalence towards pregnancy, pregnancy desires, multiple sex partners, and a low evaluation of personal health (Whitaker and Gilliam 2008:272; Davies et al. 2006). Discontinuation of OCPs may result from various factors, most notably side effects (Whitaker and Gilliam 2008:272; Cheung and Free 2005). Due to the delivery system and length of time during which it is effective, Depo-Provera has very low perfect use and typical use failure rates (Whitaker and Gilliam 2008:273). Popular features of the method are that it is hidden and does not require user-attention or partner “cooperation” to be effective (Whitaker and Gilliam 2008:274). However, discontinuation rates for Depo hover at around 55% for adolescent users at one year, due in part to side effects such as irregular vaginal bleeding, weight gain, depletion in bone mineral density, potential exacerbations of depression, and a longer return to fertility after stopping use (Whitaker and Gilliam 2008:274; Raine et al. 2011:363).

Relative newcomers to the contraceptive market, the transdermal patch and vaginal ring have been touted for their ease of use, longer acting delivery systems, and lack of daily user attention relative to OCPs (Whitaker and Gilliam 2008:273; Stewart et al. 2007). Both have associated side effects characteristic of other combined hormonal contraceptives, such as

headaches, weight gain, nausea, intermenstrual bleeding⁷, and changes to menstrual flow (Whitaker and Gilliam 2008; Hatcher et al. 2011). In addition, specific considerations for these methods include skin irritation for the patch and discomfort with vaginal insertion of the ring (Whitaker and Gilliam 2008:273).

Several studies have compared both adherence to and acceptability of these methods with more widely used options such as OCPs among adolescent and young women (Raine et al. 2011; Gilliam et al. 2010; Stewart 2007; Sucato 2011). Gilliam et al. (2010) conducted a randomized controlled trial to ascertain this information among young women using the vaginal ring and OCPs at three and six months post-initiation. Both groups reported relatively equal satisfaction with the method they were assigned in the follow-up assessments. However, they also found that while participants assigned to the vaginal ring group were more likely to report “perfect use” of the method at three months than their OCP counterparts, less than a third of participants were still using either method at six months post-uptake (Gilliam et al. 2010:503). A similar study conducted by Stewart and colleagues (2007) found no significant differences in the degree of compliance for vaginal ring versus OCP users in their sample of adolescent women. Positive evaluations of the vaginal ring pertained to its ease of use and perceived reduced health risks, while negative assessments related to the ring’s interference during sexual intercourse and partner preference for OCPs (Stewart et al. 2007:345). Sucato and colleagues (2011) conducted a prospective longitudinal study exploring method satisfaction, side effects, adherence to, and use of the patch and OCPs among adolescents for up to nine months post-initiation. There did not appear to be significant differences in self-reported use or experiences with either method; however, the continuation rates were 38% and 60% for the patch and OCPs at the end of the

⁷ Intermenstrual bleeding refers to bleeding that occurs between periods (also known as spotting).

study, respectively (Sucato et al. 2011:197). Finally, Raine and colleagues (2011) conducted a 12-month longitudinal cohort study among 15-24 year olds who initiated OCPs, the patch, the vaginal ring, or Depo-Provera. At one year, continuation rates for all methods were low, with Depo-Provera and the patch being the lowest, and younger women being more likely to discontinue all methods. Side effects were the most commonly cited reason for discontinuing a method, particularly for Depo (Raine et al. 2011:367). Moreover, rates of pregnancy were highest among patch and vaginal ring users and comparable among Depo-Provera and OCP users (Raine et al. 2011:363).

Although IUDs and hormonal implants are the most effective methods at preventing pregnancy, their use among all women of reproductive age, and in particular, adolescents, remains low in the United States⁸. The perceived underutilization of LARC by young women has been attributed to a host of patient, provider, and health-system level issues, including low patient awareness and knowledge about these methods; clinical provider concerns about the risks of infection, effects on future fertility, and difficulty with insertion; FDA labeling of IUDs for parous women and those in “mutually monogamous” relationships⁹; and difficulties with stocking and being reimbursed for these methods, which have higher upfront costs than other options (Teal and Romer 2013). However, in recent years, LARC have gained increased prominence and legitimacy as “first-line” contraceptive options for adolescents and nulliparous women¹⁰, with endorsements by professional organizations such as the American College of

⁸ See an earlier section of this chapter subtitled *Contraceptive Use among Youth* for current rates of LARC use among adolescents.

⁹ In 2005, FDA labeling for the copper IUD Paragard was changed to remove non-monogamy and nulliparity as contraindications to use; however, these conditions remain on the label for the currently available levonorgestrel IUD (Mirena) (Teal and Romer 2013:536).

¹⁰ Nulliparous refers to women who have never given birth.

Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP) (ACOG 2007, ACOG 2011; AAP 2014).

Studies examining LARC uptake and use among adolescents are limited, in part due to the low prevalence of these methods among this population. Whitaker and colleagues (2008) demonstrated that when adolescent women were given a brief educational intervention about IUDs, they were significantly more likely to be interested in this methods, although these findings were contrasted by another study that found minimal interest following review of a printed description of the IUD (Fleming et al. 2010). Recently, a large study recently conducted in St. Louis, Missouri offered participants no-cost hormonal and LARC contraception for three years and found that 62% of adolescent participants (14-20 years of age) selected a LARC method, demonstrating widespread acceptability of these methods among the study sample (Mestad et al. 2011). LARC continuation rates tend to be higher than those for shorter-acting methods for women of all reproductive age, with bleeding, pain, and cramping among the most commonly reasons cited for discontinuation (Deans and Grimes 2009; Russo, Miller, and Gold 2013).

Several qualitative studies have explored both perceptions of hormonal or LARC methods and barriers to their use among adolescents (Gilliam et al. 2004; Epstein et al. 2008; Raine et al. 2009; Brown, Arden, and Hurst 2007; Potter, Rubin, and Sherman 2014). Similar to the quantitative studies described above, they tend to focus exclusively on issues of side effects and adherence. A study conducted by Epstein et al. (2008) attempted to understand attitudes towards the vaginal ring among female youth of color. Salient findings included concerns about insertion and removal of the device, safety of the method, and interference with sexual activity; however, after initial stages of discomfort, most of the adolescents they interviewed reported

positive experiences (Epstein et al. 2008:68). Focus groups with young women using the vaginal ring and the patch revealed several important themes for both methods and those that were unique to each option. Participants indicated concerns about effectiveness and mechanism of delivery for both methods and cited additional concerns about vaginal insertion, cleanliness, and partner perceptions for the ring and visibility, risk of blood clots, and ease of remembering the method for the patch (Raine et al. 2009:264). Gilliam et al. (2004) conducted focus groups with low-income Latina women in order to better understand perspectives and attitudes regarding contraceptive side effects (299). Results revealed that both personal and anecdotal experiences with contraceptive methods influenced their non-use and/or discontinuation. Importantly, findings suggested that stories and information gathered from family and friends were valued more highly by many participants than information provided by healthcare providers (Gilliam et al. 2004:299). Brown, Arden, and Hurst (2007) conducted interviews with middle-class British adolescent women and men regarding their rationalization of contraceptive decisions and use of such methods. Salient themes uncovered included mistrust of the pill, varied interpretations of risk reduction, and issues with communication about contraception to partners (Brown, Arden, and Hurst 2007:269). Similar to findings articulated by Gilliam et al. (2004) among Latina women, many adolescents described negative experiences of peers, highlighting the role that social networks and anecdotal evidence may play in conceptualizations of and attitudes toward contraception (Brown, Arden, and Hurst 2007:272). With regard to IUDs specifically, Potter, Rubin, and Sherman (2013) found that adolescents in the Bronx with prior knowledge about this method had concerns about the pain of insertion, discomfort with the idea of a “foreign body” inside them, the risks IUDs may pose to their physical or reproductive health, and a lack of control about when it is removed. While positive attributes of the method were also noted,

namely, its high efficacy at preventing pregnancy, these benefits were largely outweighed by the perceived risks (Potter, Rubin, and Sherman 2013).

CONTRACEPTIVE USE AND INTIMATE PARTNER RELATIONSHIPS

In addition to the aforementioned determinants of contraceptive use, an increasing number of studies have suggested that decisions about method selection and use among adolescents are informed by and considered within the context of relationship dyads (Manlove, Ryan, and Franzetta 2004; Manlove and Terry-Humen 2007; Manlove, Welti, Wildsmith, and Barry 2014). In particular, researchers have identified several salient relationship dimensions believed to influence contraceptive use: levels of intimacy, commitment, and conflict, and length of relationships (Manlove, Welti, Wildsmith, and Barry 2014:2). Generally, studies with adolescents and young adults have shown that condom use declines as duration of relationships increase, believed to be the result of a reduced perceived risk of STIs. Additionally, uptake of hormonal methods of contraception increases with relationship duration, although some studies have shown that in long-term relationships it may actually decrease (Manlove, Welti, Wildsmith, and Barry 2014:2). Moreover, analysis of data from the National Longitudinal Study of Adolescent Health demonstrate that teens in relationships with higher levels of reported intimacy and communication about contraception before sex were more likely to subsequently use or consistently use contraception (Manlove, Ryan, and Franzetta 2007:603). Reduced condom use and increased uptake of hormonal contraception is also associated with high levels of commitment and emotional attachment among youth (Manlove, Welti, Wildsmith, and Barry 2014:2). Finally, conflict in relationships are associated with reduced condom use, and some studies have found a reduction in contraceptive use when age differences and other power asymmetries between adolescents and their partners increase and in relationships with less

communication (Manlove, Welti, Wildsmith, and Barry 2014:2; Manlove, Ryan, and Franzetta 2004:365; Manlove and Terry-Human 2007:4; Schwartz, Brindis, Ralph, and Biggs 2011). Data also suggest that condom and contraceptive use patterns established within relationships tend to be repeated (Manlove, Ryan, Franzetta 2007).

Additionally, while some women report being the sole decision-maker over whether and when to use hormonal contraception, others report sharing this decision with a partner (Wyatt et al. 2000; Cox, Posner, Sangi-Haghpeykar 2010:254). In a recent study on partner involvement in contraceptive decision-making, over half of young adult and adult female survey respondents indicated joint responsibility with their partners. Factors that were correlated with partner involvement included dual condom and hormonal contraceptive use and being involved sexually with a partner for less than two years (Cox, Posner, Sangi-Haghpeykar 2010:254). Few qualitative studies have examined the influence of male partners on female contraceptive decision-making. One recent study (Schwartz, Brindis, Ralph, and Biggs 2011) asked pregnant Latina adolescents to offer their perceptions of their male partners' attitudes towards contraception. Echoing similar findings among other studies with Latina youth, teen in this study indicated that their partners expressed concerns about the safety of hormonal methods and their effects on fertility (Schwartz, Brindis, Ralph, and Biggs 2011:881-882).

CLINICAL AND PROVIDER-LEVEL FACTORS

Because women must interact with the healthcare delivery system in order to obtain hormonal and LARC methods, it plays a central role and may wield considerable influence on contraceptive access, method availability, and provider recommendations (Harper et al. 2010; Jaccard and Levitz 2013). Contraceptive and family planning services are available in a range of clinical settings, including in primary care and publicly funded family planning clinics, and

within the specialties of pediatrics, family medicine, and obstetrics and gynecology (AAP 2014; MMWR 2014; Kavanaugh, Jerman, Ethier, and Moskosky 2013; Herbitter et al. 2011; Jaccard and Levitz 2013). For many young women, adolescence can represent a time of transition in healthcare seeking, as they begin to see providers other than their pediatrician and may seek contraceptive services from obstetrician-gynecologists, family physicians, and other pediatricians (Jaccard et al. 2013). Healthcare available under the rubric of reproductive and sexual health services in these settings vary, but most commonly include STI/HIV testing and treatment, pregnancy testing, the availability of contraception onsite, by prescription, or through referral, pregnancy options counseling, prenatal and obstetrical care, and reproductive health education (Advocates for Youth 2009).

Though providers of different types play key roles in the promotion, adoption, and adherence to contraceptive methods among their patients, their influence on contraceptive uptake and continued use is not well understood (Lee et al. 2011; Harper, Brown, Foster-Rosales, and Raine 2010; Landry, Wei, and Frost 2008). A recent study among family medicine and obstetrics-gynecology physicians recruited from national and regional medical society meetings found that providers' age, practice type, and specialty most strongly predicted recommendation of particular contraceptive methods, suggesting that patients may receive different information depending on their provider (Dehlendorf et al. 2011). Further, although the importance of the patient-provider relationship has been well documented, a systematic review of counseling approaches in U.S. clinical settings published between 1985 and 2000 found that no existing studies were able to demonstrate a particular strategy's effectiveness in preventing unintended pregnancy. Available studies measured widely varied outcomes and were conducted with heterogeneous populations. Among the 13 included studies, seven were specifically focused on

teenagers, the majority of whom were recruited in urban clinics (Moos et al. 2003; Dehlendorf et al. 2013a).

Despite the lack of evidence-based counseling strategies, professional associations such as the WHO and the U.S. Preventive Services Task Force cite their pivotal role in the provision of quality contraceptive care (MMWR 2014; Landry, Wei, and Frost 2008; Moos et al. 2003; Harper, Brown, Foster-Rosales, and Raine 2010). Barriers identified by a recently convened health service provider working group toward their ability to provide contraceptive counseling and services were manifold and included a lack of contraceptive education; limited opportunities for providers to obtain continuing education on advances in contraceptive technologies and protocol changes; and issues with contraceptive dispensing, including reimbursement, cost, and insufficient quality assurance for particular methods (National Campaign to Prevent Teen and Unplanned Pregnancy 2008:2; see also Akers et al. 2010). Further, provider discomfort with the discussion of sexual health topics, particularly with adolescent patients, may result in the failure to assess sexual history and counsel accordingly (National Campaign to Prevent Teen and Unplanned Pregnancy 2008:10; see also Akers et al. 2010). Moreover, a study on the perspectives of providers in primary care settings found that the most common barrier to the provision of contraceptive counseling was the use of “informal risk classification schemes” based on a subjective categorization of patients’ risk of pregnancy to determine the need for counseling and services (Akers et al. 2010:1163). For example, contraceptive counseling was less likely to be offered to patients who were not currently sexually active, although there was widespread agreement about the need for it to be routinely offered to adolescents and young adults (Akers et al. 2010:1166).

A recent national study conducted by Landry and colleagues (2008) on the perceptions of public and private providers with regard to contraceptive services, counseling practices, and protocols found considerable contrasts in these areas. Specifically, variation with regard to the content of contraceptive counseling visits, such as taking a sexual history, discussing patient satisfaction with a method and experiences with side effects, and discussions about pregnancy intention was found (47). Additionally, the delivery of contraceptive services differed as well, including the clinic hours offered, languages spoken by staff, and use of appointment reminder systems (Landry, Wei, and Frost 2008:47). There were also sizeable differences with regard to the adoption of reproductive health protocols that had recently changed, such as the use of Quick Start¹¹, advance provision of emergency contraception, and initiation of a method without a pelvic exam. Lastly, researchers found that across the national sample, significant variation existed with regard to coverage of a range of contraceptive methods, in counseling, prescribing, and dispensing practices (Landry, Wei, and Frost 2008:47).

This review of the relevant literature indicates that the influence of providers on contraceptive method selection and use is likely shaped by a multitude of factors. For example, studies have shown that contraceptive counseling and content is not uniform or standardized and may be influenced by other factors in addition to provider training, professional association guidelines, and institutional structure (see Harper, Brown, Foster-Rosales, and Raine 2010). However, as Abdel-Tawab and RamaRao (2010) highlight in their review of client provider interaction and contraceptive continuation, women may continue to seek out information and

¹¹ Quick Start is considered a best practice in family planning, and involves immediate start of a contraceptive method at the point of patient request. Prior to Quick Start, women were told that they had to return to the clinic during menses or wait to start their birth control method until the Sunday after their period in an attempt to minimize the likelihood of pregnancy before method initiation (Hatcher et al. 2011). These waiting periods were seen to create unnecessary barriers to the uptake of contraception, and once sufficient evidence about the low risk of pregnancy resulting from Quick Start was gathered, the protocol became part of the routine standard of care.

compare contraceptive experiences with others in their social network. In other words, "...the clinic visit and other interactions with the health care system are brief moments in a largely social decision-making process" (385).

POLICY, LEGAL, AND SOCIO-ECONOMIC CONTEXTS OF CONTRACEPTIVE SERVICE PROVISION

In recent years, several major professional associations, including the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP), have endorsed the use of long-acting reversible contraception (LARC) as "first-line" options for adolescents, representing a major shift in the medical establishment's support of these methods for youth (ACOG 2007, ACOG 2011, AAP 2014). Echoing recommendations to offer these methods to virtually all adolescents without medical contraindications, recently released guidance from the CDC recommends the presentation of methods using a "tiered counseling approach," in order from most to least effective. In this framework, long-acting, reversible contraceptive methods such as the IUD, hormonal implant, and Depo-Provera are presented first, followed by less-effective second-tier methods such as the vaginal ring, patch, and pills (MMWR 2014).

It is also important to highlight that the delivery of such services is shaped by state and federal regulations that dictate when and under what circumstances minors may receive confidential care. Minors' rights laws are predominantly state laws that authorize a minor to self-consent for health care services (English 2007:573). Particular categories of minors able to self-consent for care vary based on the state, but most commonly they include emancipated minors, married minors, and pregnant or parenting minors (English 2007:574). Types of health care for which minors may self-consent also depend on the state statute, but are often emergency

care, family planning services, STD/HIV care, substance counseling and treatment, and outpatient mental health services (English 2007:574). In addition to minors' rights laws, the U.S. Supreme Court has determined that the constitutional right of privacy pertains to minors and their reproductive decisions (English 2007:577). An implicit assumption underlying these statutes and court decisions is the recognition that "under certain circumstances minors are capable of making independent judgments and that this emerging decision-making capacity should be respected" (Society for Adolescent Medicine and Health 2003: 407).

Lastly, it is imperative to note that in the U.S. significant and persistent disparities in rates of abortion, unintended pregnancies, and unwanted births by race, ethnicity and/or socioeconomic status have been observed (Dehlendorf et al. 2010a; Dehlendorf et al. 2013b). Two important antecedents that likely contribute to the unequal distribution of such reproductive health outcomes are contraceptive method selection and use, with women of lower socioeconomic status and Black and Latina women reporting higher rates of contraceptive failure, non-use, and use of less clinically effective forms of contraception as compared to white women and those of higher socioeconomic status (Dehlendorf et al. 2010a; Raine et al. 2011:364; Frost, Singh, and Finer 2007b:90). Complex and interrelated factors rooted in the cultural and historical particularities of family planning services in the U.S. have been cited to explain this disparate picture, including patient behaviors and preferences, provider-level factors, and features of the healthcare system (Dehlendorf et al. 2010a:214). For example, some studies have found that concerns about the safety of and side effects associated with contraceptive methods are more prevalent among women of color (Dehlendorf et al. 2010a:216). Additionally, evidence of inequities in family planning care between more and less socially and economically disadvantaged groups have been observed, with some research suggesting that women of color

and those of lower socio-economic status may experience pressure from physicians to initiate contraception and/or limit their family size (Dehlendorf et al. 2010a:217). The cost of contraceptive methods, issues with filling a prescription, and getting supplies in a timely manner have also been cited as potential deterrents of contraceptive use and may influence the type of methods selected as well as women's ability to use them correctly and consistently (Dennis and Grossman 2012:84; Landau, Tapias, and McGhee 2006; Frost, Singh and Finer 2007a). With consideration of these multi-level and intersecting determinants of contraceptive use, provision, and access, it is reasonable to conclude that while many young women use or will use hormonal or LARC methods over the course of their reproductive lives, there is substantial complexity involved in the adoption and selection of methods and the consistency and continuation of their use.

CONCLUSION

The literature on factors and determinants associated with contraceptive use and continuation, as described in the above sections, is expansive. While pointing to the myriad of potential issues associated with these behaviors among youth, available studies pose a number of limitations. First, many findings are not consistent across studies, pointing to methodological challenges and the diversity of research populations included that make comparisons difficult. Additionally, due to the often exclusive focus on a particular determinant or level of influence, such as individual attitudes towards contraception or broader policies that shape access, it is not clear how multi-level factors intersect and overlap. Moreover, few research studies have explored *why* they may be significant to contraceptive use, only that they are associated. This is due in large part to the fact that the majority of studies conducted are quantitative, which may help to identify potential variables of interest, but are limited in their ability to elucidate complex

human behavior. Further, much of the studies on predictors of contraceptive use are limited or even misleading in their explanatory value. For example, one recent review cited being Black, being between the age of 35 and 44, and having less than a college education as significant factors that may explain non-use of contraceptive methods (National Campaign to Prevent Teen and Unplanned Pregnancy 2008:3). These demographic associations do little to elucidate the complex and deeply contextualized nature of reproductive behaviors and decisions. Moreover, they are likely proxies for other variables that are more difficult to measure and reflective of structural vulnerability associated with social deprivation and marginality. Similar to critiques described in the literature on contraceptive decision-making, such studies also tend to present compartmentalized sets of influences rather than a holistic picture of the multitude of intersecting domains that exist with regard to contraceptive behaviors. As Luker (1977) has argued, based on her study of contraceptive use patterns, "...the utilities of both pregnancy and contraception are highly individual and are constantly being renegotiated within the larger context of a woman's life" (193). Thus, the values assigned to both pregnancy and contraception are not static or fixed (Luker 1977:193). Lastly, much of the literature on these topics places primary emphasis on the individual level, while ignoring the social and structural determinants that influence reproductive behaviors and associated health outcomes. The literature presented in this chapter provides an epidemiological perspective and point of departure for the issues that will be addressed in this study. The next chapter presents theoretical concepts from diverse strands within anthropology and related social sciences in order to locate this research on contraceptive decisions and attitudes towards reproduction within holistic and intersectional paradigms.

CHAPTER THREE

THEORETICAL FOUNDATIONS

While adolescent sexuality, associated behaviors, and pregnancy during adolescence have long been topics of interest in anthropology, these studies have tended to be concentrated among non-industrialized societies and thus have limited applicability to this research. Additionally, despite the nearly ubiquitous use of contraception among sexually active youth in the U.S., little anthropological work has examined the political, social, and legal contexts of service delivery or explored contraceptive decision-making among young women. Therefore, I draw from several theoretical perspectives within anthropology and related social science disciplines to situate this study and its findings. Broadly, this research is located at the intersection of clinical and critical medical anthropology traditions, as it seeks to examine the ways that provider and clinic-level influences articulate with broader structures and processes to shape the contexts within which marginalized female youth negotiate and make decisions about their reproductive lives. Specifically, I tie together scholarly writing on disciplinary perspectives of adolescence and youth; the anthropology of reproduction; socio-cultural constructions of risk; and the anthropology of policy to support the theoretical approaches used.

This chapter will provide an overview of the aforementioned theoretical traditions and areas of scholarly inquiry within which the research situated. First, I trace the development of the clinical and critical medical anthropological approaches and their relevance for the study. Next, I provide a brief history of the characterization of adolescence and sexuality within

anthropology. Because the ways in which youth are represented and perceived within various settings and institutions is of central importance to my argument, I follow this discussion with a review of the major debates within the anthropologies of adolescence and youth literature. Lastly, relevant theoretical developments from the anthropologies of reproduction, risk, and policy will be presented as they relate to the study of adolescent sexuality and reproductive health.

INTERSECTIONS OF CLINICAL AND CRITICAL MEDICAL ANTHROPOLOGY

This research draws from aspects of both clinical and critical medical anthropological traditions. First, it seeks to locate adolescent reproductive decision-making, broadly, and contraceptive experiences, specifically, within clinical encounters. It also explores the ways in which larger social dynamics, ideologies, and forces shape public discourses about adolescent reproduction, the delivery of reproductive health services, and contraceptive decision-making among female youth. Accordingly, the following section will briefly describe both approaches, the historical debate between them, and provide a justification for the productive interaction of both for the study.

In the United States, the emergence of interest in clinical issues in medical anthropology began in the 1970's (Good, Fischer, Willen, and DelVecchio Good 2010:2). It was during this time that anthropologists became increasingly involved in work that interrogated biomedicine and its underlying values, "unexamined assumptions," and interests, uncovered a range of patient beliefs associated with a variety of illnesses, and sought to improve clinical experiences (Lock and Nguyen 2010:3; Good, Fischer, Willen, and DelVecchio Good 2010:2-3; Kleinman 1973:88). Much of these efforts were situated in and derived from observations in biomedical settings, with the explicit acknowledgement that medical systems are a part of and informed by

the cultural contexts in which they are located (Good, Fischer, Willen, and DelVecchio Good 2010:2-3; Kleinman 1973:88). Largely influenced by Arthur Kleinman and drawing upon the symbolic interpretive anthropological tradition, a major focus of clinical medical anthropology was to understand meanings associated with the illness and healing experience, patient-centered explanatory models of illness, and the central role of narrative (Good, Fischer, Willen, and DelVecchio Good 2010:4, 80; Morgan 1990:946). As clinical anthropologists tend to work and/or conduct research in clinical settings, predominantly in the United States and including schools of medicine and hospitals, their areas of inquiry tend to be more situated in the micro-context of medical encounters and patient care (Morgan 1990:945).

Critical medical anthropology came into prominence in the discipline in the 1980's, as researchers and scholars began to examine macro-level structural factors, including political and economic relationships, alignments, and interests, which both shape and contribute to disease, illness, and access to health care (Good, Fischer, Willen, and DelVecchio Good 2010:2-3; Singer 1994; Singer 1990). This approach places the political economy of health at its center, while simultaneously interrogating the validity and explanatory strength of biomedical disease models and taken for granted assumptions, categories of import, and causal pathways (Baer 1990:1011; Singer 1994:933). Accordingly, the nature of biomedicine and its association with capitalism is of foundational importance to the tradition (Singer 1990:183). While emphasis is placed on an exploration of structural and global/national forces that contribute to and pattern health behaviors and outcomes, practitioners of this tradition also identify and make linkages between the macro-level and micro- or "local" level activities, relationships, and behaviors (Baer 1990:1012; Singer 1990:181). Singer articulates that critical medical anthropologists "...seek to locate the clinical relationship and the whole medical complex within its encompassing political economic

framework so as to remind us that physicians and patients alike are but two layers in a larger social dynamic characterized by inequality, dominance, and...struggle” (Singer 1987:251, quoted in Baer 1990:1012).

Given the divergent philosophical underpinnings and ideological perspectives, it is perhaps not surprising that there has been considerable debate between critical and clinical medical anthropologists. Opponents of the conventional clinical tradition such as Scheper-Hughes (1990) argue that one’s dual role as an anthropologist and as an applied clinical researcher are at odds. She asserts that, by engaging with and working within biomedical spheres, the researcher adopts an uncritical stance on biomedicine and in essence, represents the interests of a biomedical hegemony (Scheper-Hughes 1990:190). Other criticisms of the tradition pertain to a perceived limited understanding of society and culture, the ways in which broader political processes structure meaning in biomedical settings, and the over-medicalization of health (Singer 1990:179). Of particular concern, scholars have questioned the notion that the patient-provider interaction can ever be balanced because it ostensibly ignores the fact that such interactions are “...structured by a wider field of class and other power relations embedded within, but not always directly visible from, the narrow confines of the clinical setting” (Singer 1990:179).

A primary critique of critical medical anthropology has been its over-focus on macro-level structures and processes and insufficient attention paid to the micro context, and in particular, to individual agency and practice, patient-provider interaction, and “...the culture of ‘patienthood’ in specific cases of disease or illness” (Press 1990:1001). Moreover, critics argue that relationships between broader factors such as political and socio-economic structures and illness, disease, and health outcomes are imprecisely measured and the manner in which they exert influence on the individual level poorly understood (Press 1990:1001-1002). In addition, some

clinical medical anthropologists contend that a critical perspective can offer little to their work, which tends to take place in industrial, capitalist settings such as the U.S., as patients and clinicians in these contexts tend to share similar values about economic organization and the biomedical approach to health (Press 1990:1001).

While seemingly operating on two opposite ends of the medical anthropology spectrum, scholars have more recently argued that the two approaches need not be mutually exclusive or inherently at odds with one another (Morgan 1990:945; Baer 1997). Dialogue between critical and clinical medical anthropologists has tended to reflect more common ground and increased cross-fertilization of aspects of the other's work (Baer 1997:1565). Morgan (1990) articulates that "clinical anthropologists now acknowledge material constraints, and critical anthropologists recognize the meta-messages encapsulated in the briefest clinical encounter" (949). Paul Farmer's work on HIV/AIDS in Haiti provides an example of an approach that straddles both interpretivist and critical traditions (Baer 1997:1570), as he argues that the epidemic,

"...fits neatly into political and economic crisis, in ways that demand explication—patterns of risk and distribution, social responses to AIDS, and prospectives for the near future are all illuminated by a mode of analysis that links the ethnographically observed to historically given social and economic structures" (Farmer 1992:253; quoted in Baer 1997:1570).

Similarly, Wright and Morgan (1990) argue for a productive interaction between the two approaches, as demonstrated in their research exploring dynamics between "non-compliant" patients and medical staff (951). By examining the impact of institutional policies on clinical encounters and the disparate power relationship between patients and providers together with patients' explanatory models and belief systems, Wright and Morgan (1990) were able to synthesize multiple levels of influence on the issue of perceived patient compliance and the patient-provider relationship (958). The authors advocate,

“...expanding the gaze of clinical anthropology to include political and social influences on the clinical interactions...In turn, more cognitive analyses may reveal how macro-level issues, such as power and control, are enacted and modified within the framework of a particular interaction” (Wright and Morgan 1990:958).

Lastly, Maternowska (2000) explores family planning at a clinic in Port-au-Prince using a political economy of fertility framework, which incorporates history, culture, and power elements into more conventional demographic analysis. This approach links what happens on the local level with broader national and global forces, following Ginsburg and Rapp’s “politics of reproduction,” which “...explicates the multiple levels on which reproductive practices, policies, and politics so often depend...” (Maternowska 2000:107). Her long-term ethnographic study, via interviews and extensive observations of patient-provider interactions, reveals the ways in which the clinic serves as a microcosm of Haitian society and reproduces existing social inequalities and political struggles (Maternowska 2000:106, 108). Of particular relevance for this research, it also demonstrates the myriad of intersecting influences and forces that shape contraceptive behaviors, underscoring that “...low contraceptive use is far more than a simple ‘quality of care’ or ‘contraceptive uptake’ issue...” (Maternowska 2000:121).

Following scholars’ attempts to incorporate aspects of both clinical and critical medical anthropology, this study is situated within and draws from both traditions. Because uptake and adherence to hormonal and LARC contraception requires interaction with a biomedical setting, it is essential to explore how public health, clinic, and provider policies, practices, and perspectives help to shape access and use among adolescents. Moreover, it necessitates an interrogation of the underlying values, interests, and priorities of providers and adolescent patients with regard to contraceptive method selection, what constitutes acceptable risk, and expectations associated with fertility timing and circumstances. However, much of what influences contraceptive decisions and patterns of use (or lack thereof) is located outside of these biomedical settings,

comprising a complex constellation of interrelated factors, including fertility desires and attitudes toward pregnancy, peer, romantic, and familial relationships, and the broader political and economic landscapes within which reproductive decisions are made. An intersectional approach that incorporates the strengths of both clinical and critical medical anthropological perspectives can illuminate the biomedical and social contours of contraceptive decisions among youth and the clinical and public health imperatives intended to manage their reproduction.

ANTHROPOLOGICAL PERSPECTIVES ON ADOLESCENCE AND ADOLESCENT SEXUALITY

Most scholars credit G.S. Hall with developing the definition of adolescence in 1904 (Hall 1904; Bullough 2006; Montgomery 2009). Considered to be a period of emotional turbulence and instability (the “storm and stress” perspective), the years between childhood and adulthood were conceived of as a period of transition brought about by biological changes occurring at puberty (Bullough 2006; Montgomery 2009; Schegel and Barry 1991; Lesko 1996; Fabrega and Miller 1995; Fatusi and Hindin 2010). Margaret Mead famously challenged Hall’s characterization of adolescence as biologically driven and tumultuous in her study among Samoan youth in *Coming of Age in Samoa* (1928). Finding that adolescence took shape much differently there, she argued that culture was the driving force in determining the adolescent experience, not biology (Mead 1928). These conclusions have since been questioned and there remains debate within the discipline as to whether or not adolescence exists as a universal stage across all societies (Freeman 1983; Montgomery 2009).

Regardless, early ethnographers like Mead and Malinowski were instrumental in establishing the investigation of adolescence, and associated topics, as important areas of inquiry within the discipline (Buckoltz 2002). Barry and Schegel (1991; 1984; 1986) conducted a large

scale ethnological study of adolescence across approximately 175 pre-industrial societies in order to assess its universality, associated cultural features, and gendered dynamics. In general, ethnographic evidence cross-culturally seems to indicate that a period of time between childhood and adulthood is socially recognized in many societies, though the expectations and roles given to individuals differ greatly (Montgomery 2009; Schegel and Barry 1991; Dasen 2000; Choudhury 2010). Further, Whiting and Whiting emphasize the need to differentiate between biological and social puberty, as the former may constitute a universal experience, but cultural responses to it vary (1987; Montgomery 2009). Operationally, social adolescence is difficult to measure, as there do not appear to exist clear and consistent markers for boys and girls, nor among the multitude of non-Western societies studied by anthropologists (Montgomery 2009).

Montgomery asserts that in societies that lack a rite of passage into adulthood, adolescence will most likely be defined in bureaucratic, rather than culturally defined, terms, such as age of consent laws (2009). Further, adolescents in the West are confronted with a number of psychological, social, and economic adjustments and expectations, such as financial independence, which may be difficult to reach, thus extending the period of social adolescence (Montgomery 2009).

Anthropologists have long been interested in investigating the socio-cultural activities associated with adolescence, including puberty rites, initiation rituals, and the management of adolescent sexuality (Montgomery 2009; Schlegel 1995; Schlegel and Barry 1991; 1986; 1984). It has been such a feature of studies of adolescence that Irvine states: “The management and regulation of adolescent sexuality is as old as the category of adolescence itself” (1994:3). Extensive ethnographic research has demonstrated that the control of adolescent sexuality, and more specifically, reproductive ability, appears to be an important facet of adolescence in many

societies, though its management differs greatly across cultures (Montgomery 2009; Whiting & Whiting 1987; Schlegel 1995; Schlegel & Barry 1991; 1986; 1984).

In particular, anthropologists in non-Western settings have examined the interrelated topics of marriage, sexuality, and reproductive capacity in adolescence (Montgomery 2009; Burbank 1987). For example, Burbank's work with Aboriginal girls reflects changing constructions in the period between puberty and marriage called "maidenhood." While parents were once responsible for managing adolescent female sexuality by promising their daughters to men in the community, girls in more recent times are perceived to control their sexuality (1987; 1995). Alice Schlegel contends that, "the primary social function of adolescence across cultures is to prepare children for an adult reproductive role" and that adolescent pregnancy is a norm rather than an exception cross-culturally, though historically occurring within marriage (1995:29).

Whiting and Whiting's "Adolescents in a Changing World" Project at Harvard involved placing teams of anthropologists in particular field sites with similar methodologies in order to provide a more detailed picture of adolescence, and in particular, adolescent sexuality (1987; Dasen 2000). Fieldwork was conducted among Kikuyu youth, Australian aboriginal girls, Inuit youth in Canada, Moroccan youth, and two communities in Ijo society, Niger Delta (Worthman and Whiting 1987; Burbank 1987; Condon 1987; Davis and Davis 1989; Hollos and Leis 1989). All of their work examined the impacts of social change on aspects of adolescence, including pre-marital sexual attitudes and pregnancy, sex education, and parental involvement in the regulation of adolescent sexuality, among other relevant topics (Dasen 2000; Worthman and Whiting 1987; Burbank 1987; Condon 1987; Davis and Davis 1989; Hollos and Leis 1989). Regarding the lack of scholarship on adolescent reproduction in Western settings, Ginsburg and

Rapp (1991) argue that a potential explanation may stem from "...the preoccupation in Western industrial societies with categorizing teen sexuality and pregnancy as a 'social problem'" (320; Lancaster and Hamburg 1986; Breheny and Stephens 2007). The politicized nature of an already contested area of social life is especially amplified with regard to adolescent reproductive behaviors and outcomes, resulting in a proliferation of diverse disciplinary perspectives on adolescent pregnancy, a review of which will be described in detail in the Research Setting chapter.

ANTHROPOLOGY OF YOUTH

The study of youth as a cultural category has become of increasing interest to the discipline of anthropology, but it has been, until recently, eclipsed by the older and more expansive literature on adolescence (Bucholtz 2002:525). Contrasting the anthropology of adolescence, which Bucholtz (2002) characterizes as "a search for cross-cultural generalizations and variations in the biological, psychological, and social characteristics," the anthropology of youth positions young people as social actors who can exert agency, engage in forms of resistance, and are best understood from their own perspectives (Bucholtz 2002:528; Jeffrey and Dyson 2008; Amit-Talai and Wulff 1995). This view, often from the perspectives of youth themselves, challenges more traditional conceptions of youth as passive recipients of change who are in the process of "becoming," rather than "being" (Jeffrey and Dyson 2008; see also Maira and Soep 2005). Accordingly, questions of autonomy and agency of youth in various cultural practices and the tensions therein are of central concern. Davies, McKinnon, and Rains' (2001) sought to understand teen mothers' perspectives about sexuality, reproduction, and motherhood, contrasting their views with those in the dominant discourse, which tends to depict teen pregnancy as reckless and irresponsible (83). They write:

"It is difficult to think about teens as autonomous agents vis-à-vis sexuality and reproduction. But our data suggest that they are active agents in the area of birth control

decisions, in choosing to go ahead with pregnancies with or without support from boyfriends and family, and in renegotiating relationships and new family patterns” (Davies, McKinnon and Rains 2001:97)

By contrast, Butt’s recent ethnographic study (2007) on transactional and “secret” sex among Papuan young women and migrant Indonesian men challenges the use of the term agency to describe such behavior, arguing that cultural codes, parental intervention, and the commodification of sex in a liminal economy provide little room for agency. Geronimus’ work with African American adolescents on early childbearing suggests that the extent of youth agency is one that is better characterized as situated or constrained (1996). Her research attempts to understand the tensions underlying female youths’ decisions and the structural vulnerability within which they live by exploring the ways in which her participants’ socioeconomic realities and experiences help to shape fertility timing and associated behaviors (1996).

The anthropology of youth has grown out of the more robust sociology of youth, which, while significant, has been critiqued for its focus on white youth in the United States and the UK (Sefton-Green 2006; Bucholtz 2002; Willis 1977; Hebdige 1979). Two notable exceptions include recently published volumes portraying youth in the global south (Jeffrey and Dyson 2008; Hansen 2008). Bucholtz explains: “An anthropology of youth arose out of the need to examine shifting contexts brought on by modernity and globalization and the ways in which youth engage in local contexts” (2002:525; see also Neyzi 2001 and Durham 2000). Like adolescence, youth, as a cultural category, is flexible and difficult to define. It may be linked with age, responsibilities, and/or roles, and these are subject to change based on shifting and restructuring social and economic circumstances (Durham 2000; Bucholtz 2002). Bucholtz suggests a conceptual shift from adolescence to youth: “...instead of a focus on how bodies and minds are shaped for adult futures, the study of youth emphasizes the here and now of young

people's experience, and the social and cultural practices which shape their worlds" (2002:532). This conceptual shift has particular relevance to issues relating to sexuality among youth, as behaviors and outcomes considered pathological, such as adolescent pregnancy, may instead be considered "sites of cultural agency" (Bucholtz 2002:535). For example, adolescent girls may become pregnant strategically in order to gain autonomy from parents or present a social confirmation of womanhood (Bucholtz 2002; Burbank 1988). Schultz's ethnographic study (2001) in an urban California high school contrasts discourses and narratives about teen pregnancy among young women of color with those in the mainstream media. Her work reveals that simplistic explanations about teen motherhood, poverty, and success "...fail to acknowledge the complexity of the identities of adolescents living in poverty" (Schultz 2001:582). By talking with youth who are positioned in contemporary teen pregnancy public discourse as passive, Schultz (2001) discovered the complex and diverse sets of explanations youth held about the timing of their careers, the futures they envisioned for themselves, and the role of children, or not, in this vision (597). Moreover, the study demonstrates the importance of including voices of youth in order to understand how they conceptualize and interpret the meaning of pregnancy and develop messages and policies that are reflective of their lived experiences (Schultz 2001:583). A major strength that stems from an anthropology of youth lens is the primacy it gives to understanding the experiences of young people from their own perspectives. Cultural practices of youth are examined from within their unique socio-cultural and political contexts, and an emphasis is placed on understanding the ways in which young people may negotiate, subvert, and ascribe meaning to various cultural practices.

The diverse and oftentimes conflicting characterizations and representations of youth and adolescence represent important areas of exploration for this study. Principally, the fields of

biomedicine and public health attribute manifestations of sexuality and sexual behaviors among youth to fixed biological explanations undergirding cognitive and sexual development, with young people cast as “walking hormones” (Irvine 1994:7). Moreover, the public health, sociology, and social work literature is replete with research that approaches youth from a problem-based perspective, wherein their behaviors are typically characterized as irresponsible, deviant, or risky (hence the ubiquity and normalization of the term “at-risk youth”) (Finn 2001; Kemshall 2008; Ginwright, Cammarota, Noguera 2005). Nowhere is this more evident than in examinations of sexuality, and in particular, female sexuality, which has long been regarded as dangerous and requiring social control in the United States (Nathanson 1991; Irvine 1994). These perspectives have significant implications for how to best meet the sexual and reproductive health needs of adolescents, largely considered to be a developmentally “distinct” population.

ANTHROPOLOGY OF REPRODUCTION

Over the past several decades, reproduction has become an increasingly prominent area of inquiry within anthropology (Ginsburg and Rapp 1991). Expanding upon earlier disciplinary treatments of the cross-cultural aspects of human reproduction across the life span, more recent research has underscored the notion that reproductive behaviors, decisions, and outcomes, while personal, are situated within and the product of broader social, political, and economic contexts (Ellison 2003; Lopez 1993; Sargent 2005; Hunter de Bessa 2006; Siqueira, D’Antona, D’Antona, and Moran 2007; Fordyce 2012). Notions of power, domination, and stratification are intrinsic to scholarly interests of reproduction, as reflected in this quote by Ginsburg and Rapp: “By using reproduction as an entry point to the study of social life, we can see how cultures are produced

(or contested) as people imagine and enable the creation of the next generation...” (1995:1-2; see also Browner 2000 and Rapp 2001).

In particular, the concept of “stratified reproduction” has emerged as a key framework through which to articulate the differential social and political values ascribed to childbearing among categories of women, whereby the reproduction of some is encouraged and for others is reviled or deemed pathological (Ginsburg and Rapp 1995; Rapp 2001). First used by Shellee Colen in the context of social and physical inequalities of reproduction evident between West Indian childcare workers and their differently classed and raced employers, stratified reproduction has since been applied in a variety of contexts, including but not limited to lesbian motherhood, public discourse around the “hyperfertility” of particular groups, the “demonization of ‘welfare mothers’,” and, of particular relevance, teen pregnancy (Colen 1995; Mullings 1995:122; Lewin 1995; Ward 1995; Chavez 2004; Castañeda 2008). Underlying the trope of stratified reproduction are broader themes regarding the uneven intersection of global and local forces, citizenship (political, biomedical, and other forms), and social and political exclusion. In the section that follows, I present a brief overview of the predominant construction of teen childbearing as pathological in the United States, with the inclusion of research that interrogates this perspective.

ADOLESCENT CHILDBEARING AS UNDESIRABLE

In 1976, the Alan Guttmacher Institute published *11 Million Teenagers*, a provocative report on adolescent sexual activity, pregnancy, and births that ushered in the beginning of the teen pregnancy “epidemic” in the United States (Ward 1995:144). Since the 1970’s, a plethora of literature from social and health sciences has described and documented the causes, correlates, and effects of adolescent pregnancy and childbearing (Ward 1995; Luker 1996; Schultz 2001;

Konner and Shostak 1986). Often situated within a biomedical framework where a pregnancy during adolescence is, by default, an unwanted outcome, these studies framed the consequences of teen childbearing as problematic and costly for mothers, their children, and the state. For adolescent mothers, multiple negative morbidity outcomes have been reported, including unemployment, poverty, and low educational attainment (Breheny and Stephens 2007; Ward 1995; Kramer and Lancaster 2010; Luker 1996; Singh 1998). Effects on children in much of the literature have been equally negative, and include intellectual and emotional problems and economic disadvantage later on in life (Breheny and Stephens 2007; Luker 1996; Irvine 1994; Ward 1995). Perhaps due to what Ginsberg and Rapp call a “preoccupation in Western industrialized societies with categorizing teenage sexuality and pregnancy as a ‘social problem,’” socio-cultural studies of teen childbearing by anthropologists in the United States are limited (1991:320; Ward 1995).

Almost since its “invention” as a socio-medical problem, a small group of researchers have challenged the negative consequences of teen childbearing described above, arguing that the severity and cause of these outcomes remain unclear, pointing to methodological issues such as lack of appropriate comparison groups, confounding variables which complicate associations based on maternal age, and few trends that persist across multiple studies, particularly for older adolescents (Geronimus 2003; Kramer and Lancaster 2010; Ward 1995; Konner and Shostak 1986). There has also been attention paid to examining the ways in which outcomes are mediated by factors other than maternal age, including individual differences and contextual factors such as culturally mediated “fertility-timing norms,” religiosity, levels of social support, and racial or ethnic disparities (Geronimus 2003; Breheny and Stephens 2007; Luker 1996).

The issue of causality between adolescent pregnancy, subsequent birth, and the range of negative social, economic, and health consequences has become increasingly interrogated in recent literature on adolescent pregnancy in the United States and Western Europe (Kearney and Levine 2012; Sisson 2012; Geronimus 2003; Arai 2003). Scholarship in diverse fields, including economics, public health, and the social sciences, has pointed to the significant role that disadvantage and marginalization play in explaining rates of teen childbearing in the United States (Singh, Darroch, and Frost 2001; Sisson 2012; Kearney and Levine 2012; Geronimus 2003). Consequently, through analyses on both qualitative data and multiple national and state data sets, researchers have questioned the conventional wisdom that adolescent childbearing is a *cause* of poverty, and have instead positioned it as a *marker* of existing inequality and profound socio-economic marginalization (Kearney and Levine 2012; Grisson 2011; Geronimus 2003; Singh, Darroch, and Frost 2001:251). In other words, poorer outcomes seen for adolescents who have children, as compared with those who do not, can be considered a continuation of the already existing “low economic trajectory” for the former group (Kearney and Levine 2012:142). Viewed in this way, social and economic problems are the underlying causes of teen childbearing (Kearney and Levine 2012:142).

Lastly, several scholars have pointed to potentially adaptive consequences of adolescent childbearing for some young women, situated within the complex political, economic, and social milieu of their lives (Geronimus 2003; Geronimus 1996; Schultz 2001). For example, Schultz’s work with young women of color in an urban California school challenges the notion that adolescent pregnancy necessarily indexes failure and dysfunction, contending that for some, pregnancies may be planned, and bearing children can be seen as a motivation to stay in school and focus on a career that will support them (Schultz 2001). Her conversations with youth,

juxtaposed against media representations and state policies around teen pregnancy, highlight the potentially erroneous “common-sense wisdom” that links success with not having children for young women of color in the United States (Schultz 2001).

THE MEASURE OF PREGNANCY INTENTION

With consideration of the state of the literature on teen childbearing, the following section provides an overview of social science perspectives on pregnancy intention. Although minimally explored by anthropologists to date, the concept of pregnancy intention has been a cornerstone of modern family planning efforts worldwide for several decades. Specifically, measures of unintended pregnancy are used by demographers and public health practitioners to understand and project fertility trends, predict population growth, estimate the extent of “unmet” contraceptive need, and design and evaluate programs (Santelli, Rochat, Hatfield-Timajchy, Colley Gilbert, Cabral, Hirsch, and Schieve 2003:94; Klerman 2000:156; Santelli, Lindberg, Orr, Finer, and Speizer 2009:87; Kendall, Munsuz, Speizer, Avery, Schmidt, and Santelli 2005:298). The rationale for such classification and subsequent prevention efforts has been that intended pregnancies are more desirable than unintended ones due to the social and individual costs the latter incur (Barrett and Wellings 2002:545). For example, unintended pregnancy (UIP) has been implicated in the costs of abortion to health care systems, fewer opportunities for women to take advantage of preconception and prenatal care, and is traditionally said to result in poorer health outcomes for infants than intended pregnancies, including low-birth weight (Barrett and Wellings 2002:545; Klerman 2000:160; Trussell, Vaughan, and Stanford 1999:246). Given this framing, the justification for a policy and programmatic focus on pregnancy intention may appear logical and obvious; however, the concept is one that a growing number of scholars argue deserves further unpacking (Greil and McQuillan 2010; Fordyce 2012; Trussell, Vaughan, and

Stanford 1999; Kendall et al. 2005; Bachrach and Newcomer 1999; Santelli et al. 2003; Moos, Petersen, Meadows, Melvin, and Spitz 1997; Petersen and Moos 1997; Santelli et al. 2009; Luker 1999).

While the definition of UIP remains “elusive,” it is typically operationalized to reference an unwanted or mistimed pregnancy at conception (Trussell Vaughan and Stanford 1999:246). The former component of the measure references a circumstance when a woman reports that she did not want any [more] children, while the latter is meant to reflect when a woman wanted a child in the future but the pregnancy occurred too soon (Trussell, Vaughan and Stanford 1999:247; Kendall et al. 2005; Trussell and Wynn 2008). Conversely, an intended pregnancy is one that occurs at the “right” time and/or occurred later than desired (Santelli et al. 2003:94). Classification relies on several factors, including outcome of pregnancy (birth or induced abortion), the use/non-use of contraception, and the retrospective account of pregnancy intentions at the time of conception (Trussell, Vaughan and Stanford 1999:247; see also Santelli et al. 2003). For all women of reproductive age (15-44) in the U.S., almost half of all pregnancies are considered to be unintended (Whitaker et al. 2008; Trussell and Wynn 2008). Among women between the ages of 15 and 19, approximately 80% of pregnancies are unintended (Whitaker et al. 2008; Trussell and Wynn 2008). These rates have not changed substantially in the past several decades (Santelli et al. 2009:88). That the vast majority of pregnancies among adolescents are classified as unintended underscores its association with being undesirable and illustrative of a form of stratified reproduction, although it is important to note that until fairly recently, public and policy discourses have not distinguished between the prevention of adolescent pregnancies that were unplanned or unwanted versus those that were. Of all UIP, roughly 50% result in births, the other 50% in induced abortion (Santelli et al.

2009:88). Moreover, about half of UIP are believed to be the result of “contraceptive failure,” defined as self-reported use of a method at the time of conception, while the other half occurs when no action was taken to avoid pregnancy (Trussell, Vaughan, and Stanford 1999:246; Santelli et al. 2009:88).

Rates of UIP vary considerably by socio-economic status, with recent analyses indicating that the UIP rate among poor women was five times the rate of UIP among women in the highest income category (Santelli et al. 2009:88; Finer and Kost 2011). Further, while the UIP rate for higher-income women decreased between 2001 and 2006, the rate for poor and low-income women increased significantly during the same time frame (Finer and Kost 2011). These analyses also revealed that minority women held the highest UIP rates regardless of income level (Finer and Kost 2011; see also Santelli et al. 2009; Kendall et al. 2005). While it is clear that there are significant associations between a range of demographic variables and UIP, the mechanisms and processes by which these variables influence the rates are complex and remain poorly understood.

In the United States, the definition of UIP has changed over time, reflecting societal and political shifts with regard to women’s roles, family formation and marriage, and the development of contraceptive technologies that made the control of fertility and planning of births possible (Klerman 2000:156; see also Zabin 1999; Fordyce 2012). Prior to the 1960’s, pregnancies were classified as wanted if they occurred within a marital union, and unwanted if they did not (Petersen and Moos 1997:235; Klerman 2000:156). A number of studies and surveys regarding fertility proliferated in the period following World War II, as the population grew and demographers became interested in the projection of birth rates and exploring the effects of fertility timing on birth outcomes (Santelli et al. 2003; Santelli et al. 2009; Fordyce

2012). For example, the Growth of American Families Studies and National Fertility Studies, conducted in the 1950's and 1960's, included questions regarding the timing and desired number (e.g., "wantedness") of pregnancies (Klerman 2000:156; see also Luker 1999; Fordyce 2012). In response to the congressionally mandated Commission on Population Growth and the American Future, the National Surveys for Family Growth (NSFG) was developed in 1973. In this survey, the question of pregnancy intention was introduced for the first time (Klerman 2000:156; see also Luker 1999; Santelli et al. 2003; Santelli et al. 2009). In 1995, the Institute of Medicine (IOM) released a report, based on a Commission on UIP, entitled, "The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families" (Institute of Medicine 1995; Klerman 2000:157). According to the authors, the objective was for all pregnancies to be intended and "consciously and clearly desired" at the time during which they were conceived (Klerman 2000:157). The report spurred much programmatic, research, and policy activity around understanding the determinants of UIP. Moreover, an objective to increase the number of planned pregnancies was included in Healthy People 2000 (and subsequently included in 2010 and 2020 iterations) (Klerman 2000:157; U.S. Department of Health and Human Services 2012).

Kristin Luker (1999) has questioned both the comparability of the measure and estimates of UIP over the time period in which it has been assessed, arguing that what is actually being measured has changed. Questions in the NSFG arose from earlier surveys that, as described above, were reflective of their historical and demographic circumstances. Originally, the measure was meant to capture "excess" or surplus fertility towards the end of the reproductive cycle (Luker 1999:248). However, more recent series of the NSFG have increasingly included women at the beginning of their reproductive cycles and subsequently is capturing "early"

fertility. Concurrent with these social and demographic shifts, interest in political and policy spheres has also moved towards early fertility (Luker 1999:248). As a result, Luker asserts that the current measurement of pregnancy intention reflects a much more complicated social reality - that of *parenthood*: “To the extent that more and more women are contemplating, not “excess” births at the end of the family-building cycle, but unexpected pregnancies at the beginning, what is really being tapped into is the willingness to enter a new social role...” (1999:248).

Accordingly, Luker and others argue that pregnancy intention cannot be considered separately from the confluence of factors, including demographic and societal shifts such as non-marital fertility, that help shape its meaning and relevance to individuals and couples. (Luker 1999).

While the concept of UIP remains a powerful and ubiquitous biomedical marker through which to categorize births and direct health resources and initiatives, researchers have advanced a number of critiques regarding its meaning and use. First, several methodological issues in the measurement of UIP have been identified. Because surveys ask questions relating to the concept in different ways (both over time and across instruments), it is difficult to compare results and assess trends (Petersen and Moos 1997:234; Esacove 2008:379). Second, surveys typically evaluate UIP on the basis of retrospective accounts, which introduce recall bias (Petersen and Moos 1997:235; Santelli et al. 2003:96). Third, related terms and their dichotomous counterparts such as un/wantedness, un/planned, and un/intended are frequently used interchangeably in the literature and in many cases lack clear and distinct definitions (Petersen and Moos 1997:235; Klerman 2000:158; see also Esacove 2008). Researchers have also pointed out that unwanted and mistimed pregnancies likely result from very different life circumstances and considerations, but they are collapsed together into the measure of intention, obscuring the diversity of experiences (Vaughan, Stanford, and Trussell 1999:247; Santelli et al. 2003:96). Perhaps partly

due to such methodological challenges, findings from more recent literature on the effects of unintended pregnancy on maternal and child health are inconsistent across studies, more equivocal in their effects, and, like the studies presented above on teen childbearing, suggest that negative outcomes associated with UIP are more the result of pre-existing maternal socio-economic and physical status, rather than pregnancy intention (Santelli et al. 2009:97; Gipson et al. 2008; Santelli 2003:95; Trussell, Bimla Schwarz and Guthrie 2010:8).

A more conceptual critique was put forth by Trussell and colleagues (1999) and echoed by other scholars in the field (Santelli et al. 2003; Santelli et al. 2009; Bachrach and Newcomer 1999; Kendall et al. 2005; Petersen, Gazmararian, Clark, and Green 2001) with regard to the ambiguity of the measurement, how women conceptualize intention, and its relation to contraceptive use. Using the 1995 NSFG cycle data, Trussell and colleagues found that of the pregnancies classified as the result of “contraceptive failure,” (i.e., they reported use of a method at the time of conception), about one-third could be classified as intended. Additionally, 25% of women with contraceptive failures resulting in conception reported being happy or very happy to discover their pregnancy status (Trussell, Vaughan, and Stanford 1999:147; Trussell, Bimla Schwarz and Guthrie 2010:8).

Qualitative studies on the intersection of contraceptive use and pregnancy intention can help illuminate this apparent paradox. Kendall and colleagues (2005) conducted research with both pregnant and non-pregnant young women of color in New Orleans in order to identify salient domains that pertain to attitudes towards pregnancy. All respondents in their study had experiences with contraception, and of those who reported a pregnancy, over half indicated that they were using a method at the time of conception. Method switching, inconsistent use, and non-use of hormonal birth control methods were driven by experiences with side effects, beliefs

about their effectiveness and safety, and issues with access and payment (Kendall et al. 2005:306). Moreover, women's overall lack of communication with their partners about contraception meant that decisions were made within frequently unequal power and gender dynamics (Kendall et al. 2005:306).

Recently, scholars have also begun to deconstruct the assumptions and values that underpin the concept of UIP. Researchers have noted that the underlying logic of the intention measure presumes that pregnancy is a “conscious decision,” which is predicated upon a rational choice framework (Santelli et al. 2003:94; Esacove 2008). According to anthropologist Lauren Fordyce, the “rational choice” paradigm is informed by two fundamental components of “liberal subjects”: rationality and reason (2012:118). Correspondingly, neoliberal tenets of the modern era rely on self-regulation and personal responsibility of citizens in the regulation of behavior, including in matters of health (Fordyce 2012:118). According to this framework, there are a series of calculations made in order to prospectively weigh the costs and benefits of a particular decision (Esacove 2008:378). The subsequent outcome of this algorithm is what is believed to shape the woman's “fixed” intention, and actions taken are those which have the least cost and most closely align with women's preferences (Esacove 2008:378). When women deviate from this process, it is explained in one of four ways, according to the framework: decisions were not made “rationally”; the calculation of risks and benefits was not accurate; it is determined that the risks associated with the “rationally correct” decision outweigh benefits; and risks and benefits are calculated correctly, but the individual is unable to follow through with their preference (Esacove 2008:378). Public health interventions are then designed to “tip the scales” towards healthful choices and decisions (Esacove 2008:378). A predominant critique of these models is that they fail to take into consideration the wider (and considerably more complex) context in

which women's reproductive decisions and practices are situated and thus construct interventions that speak to a limited range of reproductive experiences (Esacove 2008:378; Petersen and Moos 1997:237; Kendall et al. 2005:299).

Importantly, qualitative explorations of the interpretation of planning among diverse groups of women have demonstrated that the notion holds limited meaning or value for some women and often does not reflect an emic category that women would apply in describing their pregnancies (Greil and McQuillan 2010: 140; Moos, Petersen, Meadows, Melvin, and Spitz 1997; Kendall et al. 2005; Barrett and Wellings 2002). For example, Barrett and Wellings (2002) elicited adult women's interpretations and understandings of planned pregnancies and found that four criteria must be met in order to apply the term: an intention to become pregnant; stopping contraceptive method use; consensus with a partner; and "reaching the right time in terms of lifestyle/life stage" (545; see also Kendall et al. 2005:308). Conversely, pregnancies that were considered "unplanned" encompassed a wide range of scenarios, including ambivalence towards pregnancy, the pregnancy not occurring at the right time, and a contraceptive method failure (Barrett and Wellings 2002:549).

Moreover, qualitative research on the meanings ascribed to pregnancy intention and related concepts among groups of women highlights the fact that interpretations of these concepts vary considerably and often has little to do with their lived experiences (Esacove 2008:379; see also Fordyce 2012; Greil and McQuillan 2010; Kendall et al. 2005; Barrett and Wellings 2002; Moos et al. 1997). Kendall et al.'s study (2005) among low-income young women of color in an inner city highlights the range of domains that influence unintended and adolescent pregnancy, including persistent poverty, dynamics in sexual relationships, family

formation, contraceptive access and use, and relationship contexts (298). They found that the classification of pregnancies among women in their sample proved to be a difficult task:

“...the material, gender, and other socioeconomic realities of the women in our study give rise to a world in which planning a pregnancy, in the traditional sense, or from the majority’s perspective, loses its force. This reality shapes, and to some extent, makes uncertain, the elements – sexual experience, contraception, timing of motherhood, relationships with partners – of women’s lives that make pregnancy planning salient” (Kendall et al. 2005:309).

The concept of pregnancy intention bears relevance on this research in several ways.

First, it is a historically situated concept that has been constructed, rather than “discovered” (Singer 1994:940). Largely defined by health institutions on a population-level, little has been researched on how individuals, and particularly adolescents, understand and interpret the concept. As articulated earlier in this chapter, an important aspect of a critical medical anthropology approach to health is an interrogation of taken for granted assumptions, categories of import, and causal pathways, of which ethnographic methods are uniquely suited to deconstruct. As Eric Wolf cautions, “We need to be professionally suspicious of our categories and models; we should be aware of their historical and cultural contingencies...” (quoted in Singer 1994:933). Singer’s examination of the historical conceptualization and definition of risk groups for HIV demonstrates that while categories such as homosexual or intravenous drug user may at first glance “seem to be meaningful and to label real types of people or at least types of behavior, a closer examination shows the fuzziness and constructed character of these epidemiological categories” (1994:937). Likewise, previous studies have demonstrated the conceptual “fuzziness” of pregnancy intention. As there is an increasing recognition in the literature of the diversity of experiences, interpretations, and perspectives that are subsumed within reproductive classification schemes such as planning and intention, a more in-depth

interrogation of the emic ways in which concepts are understood, managed, and used by adolescents, healthcare workers, and reproductive health leaders is warranted.

SOCIOCULTURAL PERSPECTIVES ON RISK

The discourse of risk and its role in in the domain of public health has been a topic of increasing interest to scholars, particularly in the neoliberal era (Lupton 1993; Lupton, McCarthy, and Chapman 1995; Petersen 1996; Borovoy and Hine 2008). Applications of the concept include the association of particular behaviors and/or groups as “high risk,” identification of individuals who may be “at risk” of acquiring a disease, and relative risk calculations in order to evaluate a range of “risk factors” for both populations and diseases (Lupton 1993:426). Lupton (1993) situates public health risk discourse into two camps: the first conceives of risk as an external source of danger – usually environmental – over which individuals can exert limited control (426). The second positions risk as an internal danger, brought about by “lifestyle choices,” over which an individual has, arguably, total self-control (Lupton 1993:427). In the latter case, it has traditionally been the role of public health education and promotion programs to make individuals aware of particular health risks, with the overarching goal of behavior modification. This perspective effectively does not consider individual belief systems about disease causation and health behaviors, thereby limiting the ability to explicate cultural factors that may impact behavior (Lupton 1993:427).

Douglas (1992) has argued that the concept of “health risks” should be interrogated and critically examined by anthropologists, as it has predominantly been the subject of epidemiological inquiry (see also Martinez, Chavez, and Hubbell 1997). Following Douglas, one such example is a study conducted by Martinez, Chavez, and Hubbell (1997), in which they compared perceptions of risk factors associated with cervical cancer among subgroups of Latina

women and physicians. They found that physicians tended to emphasize epidemiological risk factors, whereas women were more apt to conceive of the risks as situated within a broader set of cultural values, including sexuality, morality, and gender relations (1997:337). Similarly, McMichael and Gifford's study (2010) with refugee youth resettled to Australia examined their perceptions and understandings of a range of sexual health issues, including where they acquire information and how they conceptualize risk and protection (263). While there was an awareness of the ways in which various sexual health behaviors and decisions impact physical health, youth participants also noted the ways in which their social wellbeing may be affected (2010:265). Accordingly, the authors emphasized the necessity to consider the biomedical and physical dimensions of risk and protection within the broader context of socio-cultural meanings attached to sex and sexuality (McMichael and Gifford 2010:265). Lastly, Lupton, McCarthy, and Chapman (1995) explored the socio-cultural context of and discourses surrounding the experience of voluntarily having an HIV test among a "low-risk" population, how the results were used by participants, and individual motivations for seeking out the test (175). The dominant biomedical rationale for voluntary HIV testing posits that an individual does so because they have, on some level, accepted their possible exposure to HIV infection (Lupton, McCarthy, and Chapman 1995:174). This reasoning presumes that a rational thought process underlies the decision, which is not necessarily supported by the motivations offered by individuals who get an HIV test (Lupton, McCarthy, and Chapman 1995:194). In their study, prominent reasons discovered included pressure from a partner or parent to get tested, as a gesture of commitment in an existing relationship, to garner social currency before the start of a new sexual relationship and/or with future sexual partners, to disclose negative status with a partner, the value placed on "knowing," and conceptions of purity and responsibility (Lupton,

McCarthy, and Chapman 1995:173). The authors caution that a construction of risk that “...privileges rationality, logical decision-making, and concern for one’s health as important aspects of people’s lives...” does not account for the multiple meanings and discourses, including symbolic associations of contagion and bodily maintenance, which are implicated in having an HIV test (Lupton, McCarthy, and Chapman 1995:174; 179). The above study findings support the contention that “lay” perspectives of risk, and the extent to which they align and/or diverge with biomedical or “expert” perspectives, are important to investigate (Martinez, Chavez, and Hubbell 1997:338; Douglas 1992; Lupton, McCarthy, and Chapman 1995; Swora 2003:339).

Scholars have made numerous observations and critiques regarding the hegemonic values and interests underpinning health risk discourses and the broader political, economic, and social projects within which they are embedded and to which they contribute (Petersen 1996; Borovoy and Hine 2008; Lupton 1993; Lupton, McCarthy, and Chapman 1995). One such example is the way in which risk discourses support the goals of governmentality by the state. Particular institutions, such as governmental entities and the news media, have the power to define what constitutes risk, who is at risk, and where risk is located (Lupton 1993:430). In the domain of public health, Lupton (1993) writes:

“Risk discourse...allows the state, as the owner of knowledge, to exert power over the bodies of its citizens. Risk discourse, therefore...serves as an effective Foucauldian agent of surveillance and control that is difficult to challenge because of its manifest benevolent goal of maintaining standards of health” (432-433).

Risk discourses and the uses to which they may be put are also imbued with and derived from salient cultural values. Touching upon the moral connotations associated with risk, Lupton (1993) writes:

“Lifestyle risk discourse overturns the notion that health hazards in postindustrial society are out of the individual’s control. On the contrary, the dominant theme of lifestyle risk is the *responsibility of the individual* [my emphasis added] to avoid health risks for the sake of his or her own health as well as the greater good of society” (429).

This view of risk, which places a narrow focus on individual behaviors in the production of negative health outcomes, elides the structural and social factors which shape and impact them (Hayes 1992:403; Lupton 1993). Petersen (1996) expands these ideas further, noting that there has been an ideological shift in recent decades, resulting in a gradual retrenchment by the state of responsibility for protecting the health of individuals and a redirection of this responsibility to manage risk onto individuals themselves (49). Thus, he argues, more recent health education and promotion efforts position individuals as active agents and are emblematic of neoliberal forms of social administration, which “...target the individual-as-enterprise who is expected to manage his or her own relationship to risk” (Petersen 1996:45). This reconfiguring of responsibility and expectation means that good and poor health come to be “...signifiers...of one’s moral worth” (Petersen 1996:53). In essence, the failure to maintain one’s health reflects a failure to be a successful neoliberal citizen.

Social science scholars of risk argue that there is a need to shift the way in which risk is perceived, from a “rational cognitive process,” under the purview of and modifiable by health promotion efforts, to a critical interrogation into the meaning of risk by individuals in the modern era (Lupton 1993:433). Of the relevance of anthropological inquiry to accomplish this task, Douglas writes, “Cultural theory brings us somewhat nearer to understanding risk perception...Instead of isolating risk as a technical problem we should formulate it so as to include, however crudely, its moral and political implications” (1992:51).

This body of literature is relevant to the research conducted in several ways. As decisions about whether and when to use contraception are influenced by a personal assessment

of risk, an understanding of how that risk is constructed and defined by female youth is important to explore. Additionally, these calculations of risk can and do differ from those of healthcare workers and reproductive health leaders, who, by and large, employ biomedical and population-level definitions of risk. Thus, contrasting these perspectives allows for an examination of their social and material meaning. Likewise, understanding how healthcare workers and policymakers conceptualize and interpret the risks posed by teen and unplanned childbearing has clear implications for clinical and population-level interventions and public discourses.

ANTHROPOLOGY OF POLICY

Policy has recently emerged as a significant area of interest within anthropology due to its increasingly central role in the social organization of contemporary societies (Anderson-Levitt 2003; Shore and Wright 2005; Levinson and Sutton 2001; Wedel and Feldman 2005). Policy, though defined in a multitude of ways, generally refers to “the official guidelines implemented by a social institution intended to set direction for action” (Singer and Castro 2004:xi). As Shore and Wright explain, the predominance of policy on every aspect of life is paramount and all encompassing, particularly in the neoliberal era (2005:4). Prominent areas of inquiry within this emerging subfield include ideology, discourse, norms, institutions and power, and global/local intersections, all of which are key areas of interest to the discipline (Wedel et al. 2005:34; Shore and Wright 2005:4). According to Shore and Wright (2005):

“Policies are inherently and unequivocally anthropological phenomena. They can be read by anthropologists in a number of ways: as cultural texts, as classificatory devices with various meanings, as narratives that serve to justify or condemn the present, or as rhetorical devices and discursive formations that function to empower some people and silence others. Not only do policies codify social norms and values, and articulate fundamental organizing principles of society, they also contain implicit (and sometimes explicit) models of society” (6).

While dominant views conceptualize policy as rational and neutral, anthropological perspectives conceive of policy as core symbols, or "...analytic keys to understanding an entire cultural system and its underlying elements" (Shore and Wright 2005:6).

A reconfiguring of "policy as practice" attempts to document and incorporate "...understandings, responses, decisions, actions, reactions, and interactions of all of the people involved in making policy..." (Kendall 2008:27; Wedel et al. 2005). Of particular importance, this approach acknowledges and examines the ways in which local policy practices are situated within and result from broader socio-cultural, political, and economic contexts (Kendall 2008; Wedel et al. 2005; Shore and Wright 2005). It also allows for a nuanced understanding of the ways in which the state and other powerful actors aligning with the state interact with and relate to local populations, including through the construction and shaping of "normative" populations and the classification of "problems" (Wedel et al. 2005). While policies may be considered part of the political arena and landscape, they are often couched in "objective, neutral, legal-rational idioms..." (Shore and Wright 2005:7). It is this "masking of the political under the cloak of neutrality" that comprises a prominent feature of power among "modern" states (Shore and Wright 2005:7).

One arena in which policies have promulgated extensively since the nineteenth century is with regard to the health of the body politic, the stability of which rests on both the regulation of the social body and discipline of individual bodies (Scheper-Hughes and Lock 1987:8; Singer and Castro 2004:xi). In this vein, it is important to consider Foucault's notion of biopower. Described as a historical shift in power from a right to death, which was realized as sovereign power, to what he calls "power over life," biopower is manifested in two ways (1978:135). The first conceives of the human body as a machine that must be disciplined and turned into its most

optimal form in order for societies to be their most productive and efficient (Foucault 1978; Samuelsen & Steffen 2004:8). The second mechanism is through the regulation of a population via fields such as demography (Foucault 1978:140). This regulation includes births, morbidity and mortality for diseases, and life expectancy (Foucault 1978:140). The shift in power, according to Foucault, has resulted in the “management of life” through various disciplinary forms (1978). Governmentality, or “...the way in which the exercise of power by the modern state came increasingly to include the active management of the population to stimulate its vitality, and the adoption of codes and techniques by individuals to govern their own lives...” is particularly germane to the interests of an anthropology of policy (Lock and Nguyen 2010:24).

Health policy can be considered both stated and unstated guidelines and/or programmatic actions that pertain directly or indirectly to health, and may be put forth by a range of organizations, agencies, and individuals, such as health care providers (Singer and Castro 2004:xi). Nader and Gonzalez (2000) argue that adolescent health has become a highly controversial and politically contentious sphere in the U.S., with issues such as mental health, substance abuse, and teen pregnancy receiving considerable attention and scrutiny from the mass media, various academic professions, and in the policy arena (232). A range of policies, laws, and regulations has been enacted with regard to adolescent sexual and reproductive health, and in particular, teen pregnancy prevention. Brindis (2006) writes:

“Government policies influence teen pregnancy and its resolution in a myriad of direct and indirect ways. Policy decisions can have far-reaching consequences by simply increasing or reducing the resources available to support programs and services. Just as important, highly politicized public policy debates influence and often determine the types of services available, to which youth, and in what settings” (280).

Examples of historical and contemporary policy shifts which have had dramatic repercussions for adolescent sexual behavior and fertility include: FDA approval of the birth

control pill in 1960; the creation of the federal family planning program Title X; legalization of abortion in 1973; the HIV/AIDS epidemic and subsequent programmatic and policy responses; the delivery and content of sexuality education in public schools; government supported media campaigns; the growing focus on males with regard to reproductive behavior policies; increasing conservatism towards premarital sex; the availability of family planning services, including contraception and abortion; and the development of novel contraceptive technologies (Santelli and Melnikas 2010:374; Brindis 2006:280). More proximally, Trussell (2007) has noted the influential role of contraceptive coverage policies that may hinder or challenge the ability for some to afford the method and to use it consistently, citing high deductibles, co-pays, and refill restrictions (168-170). In a national study exploring the effects of government policies on the use of contraception among adolescent females, Averett, Reese, and Argys (2002) found that the existence of and state-mandated sex education programs, parental notification and consent clauses, availability of family planning services, and Medicaid funding for abortion had a potential influence on contraceptive behaviors (1773). For example, their analyses revealed a positive association between reported contraceptive use and greater access to and availability of family planning services (Averett, Reese, and Argys 2002:1773). Moreover, the interpretation and implementation of many policies, particularly those that pertain to reproductive health services and sexuality education, varies widely from state to state and even within the same state. For example, some states use public funds to provide a full spectrum of reproductive healthcare to teens, while others restrict coverage to certain services, such as STI or HIV testing (Santelli and Melkinas 2010:374).

Arai (2003) explored the degree of concordance between the national construction of unintended teen pregnancy as a social and health problem in the UK and associated policy

responses and perspectives from community stakeholders and adolescent mothers. She found two prominent discourses in contemporary policy approaches to teen pregnancy and use of contraception and abortion services: the first recognizes an association between early fertility and socio-economic deprivation, giving primacy to the structural determinants that shape fertility and pregnancy outcomes (2003:200-201). The second explanation for early pregnancy is that youth are lacking adequate sexual health education, including knowledge about contraception, and receive mixed messages about sex from the broader society (2003:200-201). Research, however, has consistently shown that the relationship between knowledge about contraception, sexual attitudes, health services use, and early pregnancy and birth is complex and equivocal (Arai 2003:201). However, according to Arai, it is the latter explanation that is given prominence in current policy work on adolescent pregnancy (2003:202). Thus, while "...the structural determinants of early pregnancy and fertility are recognized...the emphasis is primarily on changing the motivations that arise from these rather than on changing the determinants themselves" (Arai 2003:201). From this vantage point, solutions to address the issue of teen pregnancy include improvements to reproductive health services and sexuality education and increasing the proportion of youth using contraceptive methods (Arai 2003:201-202). By contrasting prevailing policy discourse with community public health workers and teen mothers, Arai (2003) reveals apparent incongruities at multiple levels in British society on the causes of and solutions to early fertility.

APPLICATION TO THE STUDY SETTING

A vast array and type of policies and legislation exists with regard to adolescent sexual and reproductive health services in New York City that significantly impact the nature of information shared and services offered (Averett, Reese, and Argys 2002:1773).

Moreover, youth in New York are able to self-consent for reproductive healthcare and services without approval from or notification of parents or guardians. While they may be regarded by the state as autonomous individuals within particular settings and for specific types of healthcare, youth are simultaneously considered “dependent” in a multitude of other systems, institutions, and relationships. This research examines the political, legal, and social landscapes within which adolescent sexual and reproductive health needs are defined and services are delivered from the perspectives of intended recipients of such services, healthcare workers on the frontlines, and leaders in adolescent and reproductive health. Furthermore, it employs a “policy-as practice” approach to situate and contrast the perspectives of key stakeholder groups in order to reveal alignment and disjuncture in values, beliefs, and ideologies. More detailed information about the political and legal environment of adolescent sexual and reproductive health in NYC will be provided in Chapter Five (Research Setting).

CONCLUSION

This research makes several important contributions to the scholarly areas of inquiry outlined in this chapter. First, this study adds to anthropological scholarship located at the intersections of clinically oriented and political-economic derived medical anthropological approaches in order to better understand the ways in which patient, clinical, and broader social and structural determinants and processes influence contraceptive decision-making within a setting that boasts considerable resources and access to such reproductive health services. It also extends disciplinary perspectives on teen childbearing as a form of stratified reproduction and contrasts epidemiological perspectives of the risks posed by unplanned reproduction with emic explorations of planning and meaning ascribed to pregnancies among youth. Lastly, this study adds to the growing body of literature on “policy-as-practice” by examining the ways in which

broader clinical and public health imperatives and funding streams shape locally enacted policy and recommendations, which are in turn interpreted and negotiated by healthcare workers and female youth.

The next chapter provides a description and justification for the methodological framework and strategies employed in this study. It also outlines the protocols, requirements for participation, and logistics involved in conducting the research. Demographic information for each group of interviewees – female youth, healthcare workers, and reproductive health stakeholders – is then offered, followed by a discussion of ethical issues involved in the conduct of this research, a critical reflection of my positionality as a researcher, and limitations of the study.

CHAPTER FOUR

METHODS AND DEMOGRAPHIC INFORMATION OF PARTICIPANTS

This research traces the promotion, provision, and use of contraception among teens living in the Bronx, from the perspectives of female youth, healthcare workers (HCWs), and leaders in adolescent and reproductive health. Specifically, the study examines teens' experiences negotiating contraceptive use and explores how these practices intersect with and are shaped by clinical factors, peer, family, and romantic relationships, and broader institutions and discourses. It also examines the framing and interpretation of adolescent reproduction and prevention strategies by HCWs and leaders in order to reveal a more comprehensive understanding of its politically and socially constituted landscape.

In this chapter, I present an overview of the study objectives and research design, including a justification for the methodological approach employed. I then provide a description of data collection methods and procedures, followed by the analysis plan used. This chapter concludes with a discussion of ethical considerations, with a particular focus on the informed consent process for adolescent participants, my positionality as a researcher, and limitations of the study.

STUDY AIMS AND RESEARCH QUESTIONS

The study aims selected for this research were informed by several factors, including a thorough review of available literature to identify recurrent themes and gaps in knowledge, conversations with colleagues working in adolescent sexual and reproductive health, and formative experience working on a citywide pregnancy prevention initiative. The project

partnered with school-based health centers (SBHCs) located in high schools to enhance the delivery of reproductive health services with the overarching aim of reducing unintended pregnancies among youth. As a research assistant and then project coordinator for this intervention, I gained valuable insight into prevailing public health and clinical practice strategies intended to affect this goal. In alignment with national recommendations, a prominent strategy enacted through this and other citywide efforts to reduce unintended adolescent pregnancy was the promotion of highly effective contraception (e.g., hormonal and long-acting reversible methods) for sexually active teens. Our project supported this strategy through the provision of technical assistance to address institutional and systems-level barriers, training for clinical partners, and fiscal support to dispense these methods onsite. Concurrently, efforts had been undertaken at both the city- and state-levels to advocate for increased awareness, expanded coverage, and provider reimbursement of hormonal/LARC methods to support the ability for teens to access them.

Given these efforts to make available a full range of contraceptive methods to teens who wanted them, I was struck by how little was known or understood about the ways in which young people negotiate these choices within the broader context of their lives and about the extent to which contraceptive efficacy was a salient factor in their decision-making processes. In other words, once teens get to a clinic and methods are available, what factors shape their use/non-use? Moreover, because policy, advocacy, and clinical services environments both influence teens' experiences and operate as key sites of discourse around teen sexuality and reproduction, it is imperative to include perspectives from multiple stakeholders to obtain a more comprehensive understanding of the politically and socially constituted landscape of unintended

pregnancy prevention efforts in NYC. With consideration of this context, I developed the research plan described below to address the following research questions:

1. **Politico-Legal Landscape of Adolescent Sexual and Reproductive Health:** What is the socio-cultural, political, and legal context of adolescent sexual and reproductive health service provision in New York City?
2. **Values, Policies, and Practices:** How do reproductive health stakeholders and health care workers (HCWs) characterize adolescent sexuality, intimate relationships, and sexual decision-making? What causes and outcomes do HCWs and stakeholders attribute to pregnancy and childbearing during adolescence? In what ways do these ideas inform public health discourses and clinical practices and policies relating to pregnancy prevention in New York City?
3. **Healthcare Worker (HCW) Perspective:** What role(s) do HCWs play in contraceptive counseling, uptake, and use among adolescent females in New York City?
4. **Sexual and Reproductive Lives of Female Youth:** How do female youth negotiate and make decisions about using contraception? Specifically, what multi-level factors shape method selection and use? How do female youth envision their social and reproductive future(s) and in what ways do contraceptive decisions relate to these goals?

METHODOLOGICAL APPROACH AND JUSTIFICATION

The majority of U.S. studies about adolescent contraceptive uptake and use rely on municipal and national surveys, which, while yielding important trend data on key indicators of interest, are limited in their ability to explicate meanings, values, and motivations underpinning contraceptive decisions. In order to elucidate the perspectives of reproductive health leaders, healthcare workers, and female youth who are most affected by contemporary pregnancy prevention initiatives in NYC, but whose voices are often absent from policy and clinical decision-making, a qualitative research design using ethnographic methods was selected. Qualitative methods are particularly adept at revealing emic perspectives and allowing for new topics and ideas to emerge from study participants. Creswell explains that such methodology is warranted when a detailed view of a particular phenomenon is desired; when clearly defined variables are lacking; and when local theories to explain phenomena are limited or absent (1998).

Given the exploratory nature of this research, the project relied predominantly on semi-structured in-depth interviews with the three distinct groups (female youth, health care workers, and reproductive health leaders). Advantages of using interviewing methods to gather information include the ability of the researcher to ask clarifying questions on information that may be incomplete or inconsistent (Wagstaff, Abramson, and Pinkerton 2000). Particularly with regard to sexuality research among adolescents, Eyre (1997) argues that interviews "...allow the greatest probing of individual knowledge," (9) as opposed to decontextualized information about sexuality received from more conventional methods such as surveys (see also Price and Hawkins 2002).

In addition, available public health and social science literature on contraceptive use and teen childbearing tend to be devoid of the broader contexts within which such phenomena occur, focusing instead on individual-level behaviors of adolescents. To situate perspectives from various stakeholders in NYC, as well as the interactions between broader national discourses and local interpretations of the "problem" and appropriate solutions, I employed the "vertical slice" framework, a "geospatial metaphor" to describe what Nader defined as studying "up, down, and sideways" (Nader 1972:8; Nader and Gonzalez 2000; Gonzalez and Stryker 2014). This approach seeks to examine relationships and interconnections between "ordinary" individuals and decisions and policies enacted by institutions and people in positions of influence and power in order to develop a more holistic account of contemporary phenomena (Gonzalez and Stryker 2014:11; Nader 1972). In this research study, it allowed for the opportunity to engage intended recipients of pregnancy prevention messages, programs, and policies using ethnographic methods to elicit their experiences and priorities, while also examining the values and ideologies underpinning clinical practices and local and national health policy. Further, anthropological

contributions to the study of contraception underscore the significance of including local and situated interpretations of contraceptive technologies and the utility of a multi-level perspective to elucidate how governmental policies, health care systems, and provider-level factors can shape individual contraceptive practices and behaviors (Russell and Thompson 2000).

Timeframes for the conduct of interviews overlapped between the three groups: HCW interviews were conducted from May through October 2013; RH stakeholder interviews were conducted from October 2013 through March 2014; and interviews with female youth were conducted from May 2013 through March 2014. Table 4.1 illustrates the primary and secondary methods used to address each research question.

Table 4.1 Research Questions and Methods Employed

Research Question	Methods Employed
1. Politico-Legal Landscape of Adolescent Sexual and Reproductive Health	Background research on confidentiality laws in New York State, Medicaid reimbursement and coverage of contraception, and existing programs and services addressing teen SRH; key informant interviews (n=6); RH stakeholder interviews (n=12); and HCW interviews (n=18).
2. Values, Policies, and Practices	Key informant interviews (n=6); reproductive health stakeholder interviews (n=12); and HCW interviews (n=18).
3. Healthcare Worker (HCW) Perspective	Key informant interviews (n=6) and HCW interviews (n=18).
4. Sexual and Reproductive Lives of Female Youth	Female youth interviews (n=26).

GAINING ENTRY TO A BRONX HOSPITAL NETWORK

After consultation with key informants and colleagues, it was decided that gaining access to a healthcare network with several types of primary care clinics would be the best way to reach female youth who had ever or were currently using contraception, as well as HCWs who provide related services to teens within these under researched sites of reproductive health service provision. In the summer of 2012, I began meeting with a physician with whom I had become connected through my professional work in adolescent sexual and reproductive health in NYC to explore the possibility of collaborating on the project. She worked at a large hospital network in the Bronx and expressed interest in the proposed aims of the research. After extensive

discussions about the feasibility of enrolling clinic patients and HCWs through the hospital's ambulatory care sites, it was decided to propose recruitment at three types of clinic settings: a family medicine clinic, a pediatric center, and school-based health centers. Upon approval of the hospital's IRB application, I completed steps to become a volunteer, which facilitated gaining smooth entry to the approved research sites. Data collection was carried out between May 2013 and March 2014 at these primary care sites in the Bronx. In-depth, semi-structured interviews were conducted with 26 female youth (ages 15 to 19), 18 HCWs, and 12 RH stakeholders for a total of 56 participants. See Appendix A for a timeline of all research activities.

INTERVIEW OBJECTIVES

All interviews were conducted using semi-structured interview guides that included predominantly open-ended questions about major topics of interest, tailored for use with each group of participants. Preliminary drafts of each guide were developed based on conversations and feedback from key informants and available literature and subsequently revised. Guides were then piloted with several members of each group and refined accordingly.

Interviews with female youth gathered information about demographic characteristics, family background, and dynamics; current and former intimate relationships and sexual history; knowledge and sources of information about contraception; reproductive and contraceptive use histories and decision-making; reproductive health services use and experiences; attitudes towards childbearing and perspectives on un/planned pregnancies; and current and future goals and aspirations. Semi-structured interviews with HCWs occupying medical provider, mental health provider, health educator, or clinical support staff roles elicited information about the structure and content of adolescent sexual and reproductive health visits, values and priorities underlying the delivery of contraceptive education and related services, and attitudes towards

teen childbearing. While there was some overlapping content between the HCW and RH stakeholder interview guides, interviews with the latter group were also intended to situate adolescent pregnancy prevention and contraceptive use in its historical and political context in NYC. Interviews with this group elicited information about participants' extensive experiences in adolescent reproductive health policy, advocacy, and programmatic areas and their perspectives on best practices, strategies, and challenges.

All interviews were conducted in English, audio recorded, and transcribed. Interviews with teens were conducted in-person at the clinic site where they were seeking services. With the exception of one interviewee who elected to participate by phone, all interviews with HCWs were also conducted in-person at locations of convenience to them; namely, at their clinic site. Half of the interviews with RH stakeholders were conducted by phone (n=6) due to preference and availability, with the remaining half taking place in-person at the participant's place of work.

PARTICIPANT SELECTION AND RECRUITMENT

Following IRB approval from the University of South Florida and the collaborating hospital, support was needed from site and/or program directors to begin recruitment at approved clinics. Additionally, the study required approval from a separate review board for the hospital's school health program. Presentations were delivered to staff at the family medicine, pediatric, and school-health programs to explain the research objectives and address questions and/or concerns, after which approval for study procedures was granted. At each recruitment site, a clinic staff person helped to familiarize me with the clinic, facilitate my introductions to staff, and assist with space and procedure logistics. I was also given use of a private room to conduct interviews at each clinic.

FEMALE YOUTH

A total of 26 in-depth, semi-structured interviews were conducted with female youth between the ages of 15 and 19 who attended one of the clinic recruitment sites for services, though it did not necessarily have to relate to reproductive health. Inclusion criteria for this group consisted of being female, between the ages of 15 and 19, able to communicate fluently in English, having had vaginal intercourse, and having ever used condoms or hormonal contraception (oral contraceptive pills, vaginal ring, patch, or the Depo Provera shot) for at least one month prior to the interview. Initially, condom use was not included in the proposal and IRB application, but an amendment was submitted in order to recruit teens who had only used condoms, as it was determined to be an important subgroup to interview.

Given the above inclusion criteria, a convenience sample was used to recruit eligible and interested youth participants. In order to reflect a breadth of experiences, I attempted to ensure that the study sample included representation from both younger and older teens, users of various contraceptive methods, including current and former use, and diversity of relationship status. Unfortunately, it was difficult to find eligible participants who were not currently using hormonal/LARC methods, as most of the female youth attending the clinic were there to obtain it, a limitation that will be described in more detail later in this chapter. Additionally, the latter specification regarding relationship status was difficult to achieve, as the majority of the sample reported currently being in an intimate relationship.

Teens were recruited in clinic waiting rooms and by referral from HCWs, with considerably more success using the latter approach. Recruitment at the pediatric clinic took place one afternoon a week during the site's "teen clinic hours," which had been initiated to provide nutrition, health education, and reproductive health services to adolescent patients. At

this site, as well as the school-based health center, it was likely that patients coming for services were between the ages of 15 and 19.



Figure 4.1. Bulletin board in a SBHC waiting room. Photo credit: Author.

Recruitment through the waiting room at the family medicine center, however, proved difficult, as the site served patients from infancy to old age. On any given day, particularly during the week, when most teens were in school, it was often impossible to find any eligible individuals to recruit into the study. Regardless of the site, young women approached in waiting rooms were asked if they were interested in hearing more about a study on “teen health.” If they responded affirmatively, and were within the specified age range of 15 to 19, they were brought to a private room, after informing the front desk clerk and their provider where they could find them, and given a more detailed explanation of the research. If after hearing this description they wanted to participate in an interview, I screened them for eligibility, and if eligible and interested in completing an interview at that time, I proceeded to the informed consent process. If at any point the teen indicated that they were not interested in hearing about the study and/or did not

want to participate, they were thanked and led back to the waiting room. Due to the inconsistent volume of adolescents at both the FMC and PED clinics and to the fact that patients were often called back and forth from the waiting room several times to visit with clinical support staff to obtain vitals, etc., before seeing their provider, it was difficult to recruit teen participants at these sites. Moreover, on several occasions, interviews with a teen patient began but could not be completed, as the teens were being called for their appointment. While I offered the possibility of finishing the interview after their appointment, the majority opted not to do so, as they had often been at the clinic for hours by the time they were seen by their provider.

More commonly, teen patients were referred to me by HCWs at the recruitment sites to assess their interest and eligibility to participate after completion of the patient's clinical appointments. This approach was adopted universally at the SBHC recruitment site, as it was deemed the best way to ensure teen confidentiality and be the least disruptive to the clinic's operational flow. In addition to these two main recruitment strategies, several teen patients at the three recruitment sites reported having heard about the study from friends who had already participated.

Interviews with teen participants ranged between 24 and 98 minutes, with an average of 54 minutes, and took place in private rooms within the clinic either before or after appointments with HCWs, based on their preference. Teens were also given an option to return to the clinic at more convenient time to complete an interview. For example, several teens recruited in the SBHC site opted to return to the clinic to complete an interview during lunch, a free period, or after school. Demographic information for female youth is displayed in Table 4.2 below.

Pseudonyms were used for all participants.

Table 4.2. Demographic Information for Female Youth Participants

Name (pseudonym)	Age	Borough of Residence	Self-identified Race/Ethnicity	U.S. or Foreign-Born	U.S. or Foreign-Born Parent/s	Interview Site
Daniela	19	Bronx	Latina/Dominican	U.S.	Foreign	Family Medicine
Justine	17	Bronx	African-American	U.S.	U.S.	Pediatric
Alyssa	17	Bronx	African-American /Caribbean	U.S.	Foreign	SBHC
Isabel	18	Bronx	Latina/Dominican	Foreign	Foreign	SBHC
Samantha	17	Bronx	Latina/Dominican	U.S.	U.S.	SBHC
Ana	16	Bronx	Latina/Dominican	U.S.	Foreign	SBHC
Brittany	15	Bronx	African-American /Caribbean	U.S.	Foreign	SBHC
Valeria	17	Bronx	Latina/Dominican & Puerto Rican	U.S.	Foreign	SBHC
Beatriz	17	Bronx	Puerto Rican	U.S.	U.S.	SBHC
Nicole	18	Manhattan	African-American /Caribbean	U.S.	Foreign	SBHC
Fabiana	15	Bronx	Latina/Dominican	U.S.	Foreign	SBHC
Carolina	17	Bronx	Latina/Mexican	U.S.	Foreign	SBHC
Alejandra	15	Bronx	Latina/Dominican	U.S.	Foreign	SBHC
Zoe	17	Manhattan	African-American	U.S.	U.S.	SBHC
Sofia	19	Bronx	Latina/Colombian	Foreign	Foreign	SBHC
Jazmin	15	Bronx	Latina/African-American	U.S.	U.S.	SBHC
Adriana	17	Bronx	Latina/Dominican & Puerto Rican	U.S.	Foreign	SBHC
Laura	16	Bronx	Latina/Mexican	U.S.	Foreign	SBHC
Veronica	17	Bronx	Latina/Dominican	U.S.	Foreign	SBHC
Ximena	16	Bronx	Latina/Dominican	U.S.	Foreign	SBHC
Kamilla	17	Bronx	African-American /Caribbean	U.S.	U.S.	Pediatric
Leah	18	Bronx	African-American /Caribbean	U.S.	U.S.	SBHC
Josefina	19	Bronx	Latina/Dominican	U.S.	Foreign	SBHC
Vanessa	17	Bronx	Latina/Caribbean	Foreign	Foreign	SBHC
Naomi	15	Bronx	African-American	U.S.	U.S.	SBHC
Lucia	16	Bronx	Latina/Dominican	U.S.	Foreign	SBHC

The vast majority of interviews (n=23) took place at the SBHC site. All participants were between the ages of 15 and 19, with a median age of 17. With the exception of two who lived in Manhattan, all teens resided in the Bronx (n=24).¹² While most participants reported being born in the United States, a majority (69%) reported at least one parent having been born outside of

¹² The two teens who resided in Manhattan attend school and were interviewed at a clinic in the Bronx.

the U.S., mirroring the broader demographic trends of the borough. Sixteen out of twenty-six respondents self-identified as Latina, with the majority considering themselves to be Dominican and/or Puerto Rican (81%). Of the remaining youth (n=10), 50% identified as African-American and/or Caribbean, with the remaining five females identifying as more than one racial and/or ethnic group. At the time of the interview, 31% (n=8) were using OCPs; 19% (n=5) were using Depo Provera; 8% (n=2) were using the patch; 19% (n=5) were using condoms; 4% were using the ring (n=1), hormonal implant (n=1), and IUD (n=1), respectively, and 12% (n=3) were not currently using any barrier, hormonal, or long-acting reversible methods of contraception. A more detailed contraceptive history of female youth will be provided in Chapter Eight.

Recruitment Sites for Teen Interviews

In order to situate the findings in the results chapters with regard to clinic environment, accessibility, and comfort, it is important to briefly describe the settings where teens sought healthcare and in which they were recruited for participation in this study. Adolescents can receive reproductive and mental health care without parental involvement or knowledge (as per minors' rights in New York State) at all three types of primary care settings represented in this research. However, if an adolescent patient has a non-reproductive or mental health-related issue for which they are seeking care (e.g., a sore throat, sports physical), a parent or guardian must give consent for their child to be treated. Although confidential reproductive healthcare was available at all sites, specific sexual and reproductive health services offered differed by clinic setting. Table 4.3 displays the availability of STI, HIV, and pregnancy testing, contraceptive and pregnancy options counseling, and a range of methods, either onsite or by referral. Of particular importance to this research, recruitment sites varied in their ability to dispense contraceptive methods onsite versus by prescription. At the time of this study, SBHCs received grant funding

from the NYC DOHMH to purchase contraceptive supplies for onsite dispensing to enrolled students. Alternatively, the FMC and PED recruitment sites rarely dispensed any medications onsite due to Medicaid stipulations about reimbursement in New York State. Specifically, Medicaid will not reimburse clinics to purchase and dispense medications; rather, they reimburse pharmacies to dispense. Due to the prohibitive expense associated with stocking contraceptive methods onsite, these clinics predominantly write prescriptions that patients must fill at a pharmacy. Further explanations and rationales for types of services available at the three types of recruitment sites will be described in more detail in the results chapters.

Table 4.3. Reproductive Health Services Available at Recruitment Sites for Female Youth Interviews*

	SBHC	FMC	PED
<i>Pregnancy Testing</i>	Onsite	Onsite	Onsite
<i>STI/HIV Testing</i>	Onsite	Onsite	Onsite
<i>Contraceptive Education/Counseling</i>	Onsite	Onsite	Onsite
<i>Pregnancy Options Counseling</i>	Onsite	Onsite	Referral Only**
<i>Condoms</i>	Onsite	Onsite	Onsite
<i>Emergency Contraceptive Pills</i>	Onsite	Rx	Rx
<i>Oral Contraceptives</i>	Onsite	Rx	Rx
<i>Patch</i>	Onsite	Rx	Rx
<i>Ring</i>	Onsite	Rx	Rx
<i>Shot</i>	Onsite	Rx	Rx
<i>IUD</i>	Onsite	Onsite	Referral Only
<i>Hormonal Implant (onsite or by referral)</i>	Referral Only	Onsite	Referral Only

*Rx indicates that prescriptions were given for these methods

** Referral Only indicates that particular service was made available by referral to another clinic

Initially, I began recruitment of teen participants at the FMC, an older three story building on a quiet street near a busy intersection in the Bronx. The clinic included an insurance assistance office and pharmacy as well as patient care, and was open at 8:30 am until 9:00 pm Monday through Thursdays, with shorter clinic hours available on Fridays and Saturdays. The FMC is the largest of the three recruitment sites, with a staff of approximately 90, comprised of front desk and clerical employees, clinical support staff, nurses, medical providers, mental health counselors, and health educators. Several patient support groups also convened at the FMC, including for the management of pregnancy wellness and chronic disease. The FMC is affiliated

with an academic teaching hospital, so there is a continuous rotation of interns, residents, and fellows cycling through the clinic.

Patients at the FMC must sign in with one of usually two front desk staff. At the intake area is usually flurry of activity, with patients checking in and out, scheduling future appointments, answering questions, and letting patients through the locked door when clinic staff is ready to see them. Patients often have to go between floors to see different providers during their visit, as well as to utilize the financial and pharmacy services on the bottom floor.

Generally speaking, the patient population seen at the FMC reflects that of the surrounding neighborhood: Latino, many of whom are from the Dominican Republic and Puerto Rico, African-American, Caribbean, and Cambodian. As mentioned above, the age of patients ran the gamut from newborn to the elderly, with a sizable number visiting for maternal and child health related issues. Spanish and English appeared to be the primary languages spoken in both the waiting room and among clinic staff, with signage around the clinic in both languages.

The volume of patients at the FMC varied considerably from day-to-day and morning to afternoon. Depending on the time of day, the waiting rooms could be quite bustling, and at times hectic, with a combination of babies in strollers, children playing, and elderly patients assisted by caretakers that is characteristic of a family medicine setting. Wait times were frequently quite long, with aspects of the visit often staggered over the course of several hours. For example, after patients signed in, they might be called back to the nursing prep area for vitals and blood draws fairly quickly, but then returned to the waiting room for a variable period of time before being seen by their provider. Providers' schedules were often backed up due appointments taking longer than expected, as well as seeing patients who were late, following up on lab results and tests for other patients, and consultations/referrals with their patients' other providers.

Teens comprised a fairly small proportion of the patients served at the FMC, which, as will be described later in this chapter, presented challenges for recruitment. Despite the volume, the consensus among staff at FMC was that most teen patients were in need of reproductive health services. As Table 4.3 reflects (see page 93), all contraceptive methods were available at FMC, although some by prescription only, and all services were available and at no cost to uninsured teen patients.

The SBHC recruitment site is a small clinic located behind an inconspicuous metal door on the bottom floor of a campus that serves several high schools. Students come from all over the Bronx, and in some cases, other boroughs, to attend one of the schools in the building. Demographically, the population served is predominantly Latino, African-American, Caribbean-American, and African. In this setting, any student in the building who is enrolled to receive services can be seen at the clinic, which is open during school hours. The clinic is the smallest of the recruitment sites, and is staffed by medical providers, mental health clinicians, community outreach and health educators, a nurse, clinical support staff, and front desk clerks. SBHC enrollment can be achieved in one of two ways. Ideally, the student's parent (if they are below the age of 18 and not otherwise considered a "mature minor" by law) reviews and signs a consent form authorizing the clinic to provide a full range of primary care services to their child, which includes reproductive healthcare. There is no "opt out" of particular services, so the parent either has to agree to everything or nothing. If parents do not elect to sign the consent, teens can *self-consent* for reproductive healthcare only, as is their legal right to do at any healthcare setting in New York under minors' rights. As one HCW described during our interview, this special treatment of certain kinds of services, while important and necessary for the reasons described by RH stakeholders and HCWs in the results chapters, can create confusion among teens, parents,

and school administration alike:

“Even when kids do come in to self-consent [for reproductive healthcare], our goal often is to try to get them to fully enroll, because it makes it a little tricky. You know, they’ll come in and self-consent and we do have that in the EMR [electronic medical record] that they’re self-consenting, but then they come in for a headache, and you know, it’s like, ‘Okay, well, we could give you your IUD but we really can’t give you a Tylenol.’ It makes a lot of sense in some ways; we are providing a very specific service regarding reproductive health care, but we want to...see the broader picture here too.” (Nancy, SBHC Medical Provider)

In addition to reproductive healthcare, which comprises a substantial amount of visits at the SBHC, patients are seen for immunizations, comprehensive physicals to be cleared for sports and for working papers, eye exams, acute care, chronic disease management, and mental health services, among other healthcare needs. Teens do not incur any out of pocket costs for receipt of these services. Coordination and communication with school administration is necessary to ensure that teens can leave class to visit the clinic, and passes are given out by clinic staff to account for their whereabouts when they return. During the time I spent at the SBHC site, the clinic was pretty consistently busy between 10:00 am and 2:00 pm, and the waiting room became full quite easily during these times. Visits by walk-in were possible, but depending on the time of the day and the nature of the visit, teens often had to wait or were asked to come back later. As Table 4.3 reflects (see page 93), virtually all services, including dispensing of a range of contraceptive methods, were available onsite at the SBHC.

Of the three recruitment sites, I spent the least amount of time at the pediatric clinic, which is located on a busy road in the south Bronx, at least a 10-minute walk from the nearest subway but with several bus stations nearby. Within the building that houses the pediatric clinic, there are also a variety of other healthcare and mental health services available, including obstetrics and internal medicine, as well as an insurance assistance office and a pharmacy. The building itself appeared very new and the PED clinic was bright and clean. Like the FMC and

SBHC sites, patients seen at the PED clinic were reflective of the surrounding neighborhoods' demographics; predominantly African-American, Caribbean, West Indian, African, and Latino. The clinic opens at 8:00 am most days, with extended evening hours available Monday through Thursdays. The PED clinic is smaller than the FMC but larger than the SBHC, and is staffed by pediatric and adolescent medicine clinicians, nurses, clinical support staff, and front desk clerks, with onsite referrals available to social work, OB/GYN, and health education.

As mentioned earlier, the pediatric clinic had recently instituted “teen clinic” hours one afternoon a week, in an effort to deliver a package of nutrition, health education, and reproductive health services to adolescents, although teen patients could receive these services any other time during the week as well. As with the other recruitment sites, teens did not incur any out of pocket costs for these services. During these afternoons, a standing sign was placed in the waiting room that indicated that the teen clinic was “in session.” Patients could be seen as walk-ins or by scheduling appointments. The volume of patients and bustle of the clinic varied considerably from week to week, particularly during days with inclement weather, of which there were many. Again, Table 4.3 (see page 93) displays contraceptive methods that were available without a referral to another clinic and/or onsite versus by prescription at the PED clinic.

HEALTHCARE WORKERS

A total of 18 in-depth, semi-structured interviews were conducted with healthcare workers (HCWs) at family medicine, pediatric, or school-based health center sites. Inclusion criteria for this group were as follows: between the ages of 18 and 64; able to communicate fluently in English; occupying a clinic role in one of four categories at the time of the interview – Medical Provider (Doctor of Osteopathy, Medical Doctor, Physician Assistant, or Nurse

Practitioner), Mental Health Provider (Social Worker, Therapist, or Psychologist), Health Educator, or Clinical Support Staff (Medical Assistant, Registered Nurse, Licensed Practical Nurse, etc.); having contact with an adolescent patient population; and is currently or previously involved with the delivery of contraceptive education or counseling for teens. These clinic roles were selected because they each have distinct functions in the clinic and different vantage points from which to view contraceptive use and pregnancy among adolescents. Additionally, available studies on provider attitudes tend to focus almost exclusively on medical providers, despite the fact that individuals in the above clinic roles regularly interact with and provide information to teens about contraception.

A convenience sample of HCWs was selected using a purposive sampling strategy. According to Bernard (2011), purposive sampling is appropriate in the qualitative study of specific or hard-to-find populations (145-146). As HCWs who offer reproductive health services in primary care settings to youth (and are employed through a specific healthcare organization) constitute a fairly narrow population, such an approach was deemed appropriate. Within the specified inclusion criteria, eligible and interested HCWs of varying ages and lengths of time in their respective fields were recruited.

HCWs were recruited to the study in several ways. First, as mentioned earlier, presentations on the research were given to clinic staff, after which HCWs would occasionally indicate their interest in participating. Additionally, medical directors at the family medicine and SBHC programs emailed all relevant staff with a description of the project and instructions to reach out to me directly with questions and/or to arrange an interview, which yielded most of the responses. Lastly, I would often broach participation in the study with HCWs in conversation

while at their clinic site. The majority of HCW participants opted to schedule an interview at a later date and time, although several completed an interview on the day of attempted recruitment.

Interviews with HCWs ranged from 25 to 86 minutes, with a mean of 52 minutes. Most often, participants opted to complete the interview at their clinic site, in between seeing patients, or towards the end of the day. One interview took place by phone with a medical provider who wanted to participate but could not fit an in-person interview into her schedule. Additionally, SBHC HCWs were recruited during the summer of 2013, when the volume of patients at their sites was particularly low. Table 4.4 displays demographic information for the HCW group.

As the below table indicates, 50% of HCWs were Medical Providers (n=9), with the remaining half a mix of Mental Health Providers (n=3), Health Educators (n=2), and Clinic Support Staff (n=4). Likewise, 50% of the participants worked in SBHC settings, with seven employed at a family medicine clinic and two at a pediatric center. With the exception of one interviewee, all participants were women. Ages ranged from 28 to 58, with a median age of 45. Six HCWs self-identified as white or Caucasian, seven as African-American and/or Caribbean, four as Latina or of a specific Latin American nationality, and one as South Asian. On average, HCWs had been in practice for 13 years at the time of the interview, with a range of one to 26 years in their respective professional roles.

Table 4.4. Demographic Information of Healthcare Workers

Name (pseudonym)	Gender	Age	Self-identified Race/Ethnicity	Professional Training*	Clinic Role	Clinic Setting**
Alisha	F	36	African-American	MD, Pediatric Residency	Medical Provider	PED
Alison	F	58	Caucasian	MD, Family Medicine Residency	Medical Provider	FMC
Bettina	F	55	Hispanic	BS	Health Educator	FMC
Brianna	F	49	West Indian	BSN, RN	Clinical Support Staff	PED
Carla	F	58	Black and Puerto Rican	LPN, RN, PNP, FNP	Medical Provider	SBHC

Table 4.4. (Continued)

Name (pseudonym)	Gender	Age	Self-identified Race/Ethnicity	Professional Training*	Clinic Role	Clinic Setting**
Cassie	F	51	African- American	Medical Assistant Degree	Clinical Support Staff	FMC
Carmela	F	56	Caucasian	MSN, MPH, FNP	Medical Provider	SBHC
Deborah	F	42	African-American	MD, Family Medicine Residency	Medical Provider	FMC
Emma	F	47	African-American	LPN	Clinical Support Staff	SBHC
Ethan	M	28	South Asian	MD, Family Medicine Residency	Medical Provider	FMC
Janina	F	30	Latina	MPH	Health Educator	FMC
Lisa	F	32	Caucasian	MSW, LCSW	Mental Health Provider	SBHC
Meredith	F	35	White	PsyD	Mental Health Provider	SBHC
Michelle	F	35	African-American	MD, Pediatric Residency	Medical Provider	SBHC
Nancy	F	51	White	RN, FNP	Medical Provider	SBHC
Olivia	F	37	Mexican-American	PsyD	Mental Health Provider	SBHC
Sandra	F	31	Western European and Puerto Rican	Medical Assistant Degree	Clinical Support Staff	FMC
Tracy	F	54	White	FNP	Medical Provider	SBHC

*RN is Registered Nurse; FNP is Family Nurse Practitioner; LPN is Licensed Practical Nurse; PsyD is Doctorate of Psychology; MD is Doctor of Medicine; PNP is Pediatric Nurse Practitioner; MSW is Master of Social Work; LCSW is Licensed Clinical Social Worker; MPH is Master of Public Health; BS is Bachelor of Science; MSN is Master of Science in Nursing; BSN is Bachelor of Science in Nursing

**SBHC is school-based health center; FMC is family medicine clinic; and PED is pediatric clinic

REPRODUCTIVE HEALTH STAKEHOLDERS

Twelve semi-structured interviews were conducted with stakeholders in adolescent and/or reproductive health (hereafter referred to as RH stakeholders) who occupied leadership roles at local public health, healthcare, and/or policy/advocacy organizations pertaining to adolescent sexual and reproductive health. Inclusion criteria for this group consisted of being

over the age of 18, able to communicate fluently in English, and currently and/or previously involved in policy, advocacy, or programmatic work in adolescent sexual and reproductive health, family planning, and/or teen pregnancy prevention for at least 10 years in New York. RH stakeholders were recruited using a snowball sampling design, with the objective of recruiting participants with a variety of roles and experiences, including involvement with family planning and/or the federal Title X program, the delivery of sexual and reproductive health care for adolescents in primary care, policy and legislative advocacy around teens' access to confidential services, and governmental roles in sexual and reproductive health work.

RH leaders were initially recruited through existing professional contacts and through the connections and suggestions of the study's key informants. If the individual was someone already known to me, I contacted him or her directly via phone or email to describe the study and assess interest in participating. If I did not know the person in question, a key informant would serve as an intermediary by contacting the potential interviewee on my behalf and obtain permission for me to contact them directly. Additionally, individuals who completed an interview were asked whether they could think of others in their professional circles who may also be interested in joining the study. In most cases, the interviewee reached out to people they had identified with an explanation of the research and an invitation to contact me directly. Interviews with this group ranged between 45 and 150 minutes, with an average of 80 minutes, and took place at locations of convenience to participants. For half of participants (n=6), interviews were conducted in-person at their office. The remaining half was conducted by phone to accommodate participants' busy schedules. Table 4.5 displays demographic information for RH stakeholders interviewed.

Table 4.5. Demographic Information for Reproductive Health Stakeholders

Name (pseudonym)	Gender	Age	Self-identified Race/Ethnicity	Last Professional Role	Approximate Years of Experience in Adolescent and/or Reproductive Health
Aimee	F	58	White	Director, Reproductive Health Training Program	30 years
Andrea	F	57	White	City Health Official	20 years
Christina	F	62	White	Senior Executive, Reproductive Health Service Organization	15 years
Diane	F	62	White	Medical Director, Teen Medical Clinic	30 years
Ellen	F	70	White	Former Executive, Reproductive Health Service Organization	40 years
Janelle	F	66	African-American	Former Director, Youth Development Program	40 years
Jeffrey	M	56	White	Medical Director, Hospital Adolescent Division	25 years
Linda	F	67	White	Policy Director, Reproductive Health Service Organization	20 years
Rosa	F	86	Latina	Former Executive, Reproductive Health Service Organization	30 years
Sonya	F	59	Latina	Medical Director, Teen Medical Clinic	30 years
Susan	F	59	White	City Health Official	30 years
Theresa	F	52	African-American	Medical Director, Federally Qualified Health Center	10 years

All but one of the RH stakeholders was female. Because the individuals recruited into the study were leaders in their respective fields with extensive career histories, the median age of the group, 61, was considerably older than for HCWs. The majority (66%) self-identified as white, while the remaining four self-identifying as Latina (n=2) and African-American (n=2).

Stakeholders held a range of occupational roles pertaining to adolescent sexual and reproductive health, with all individuals currently or formerly employed in leadership positions within health care, public health, policy, advocacy, and/or academic settings. While varied with regard to their missions, organizations represented by interviewees shared a desire to reach

socially and economically disadvantaged youth for related medical and mental health needs and the creation of healthy young adults through environmental support and preventative healthcare access. Specific organizational goals in adolescent sexual and reproductive health included reducing unintended teen pregnancies, providing resources and support for youth to make healthy decisions about their sexual and reproductive health, and working towards normalizing sexuality.

A majority of RH stakeholders (n=9) had clinical backgrounds. Other professional qualifications included degrees in public health, social work, and psychology. Additionally, half of the group (n=6) referenced previous experiences in community organizing, social and/or reproductive justice, and poverty reduction as being formative to the orientation and approach they brought to their work in ASRH. As illustrated in Table 4.5 (see page 102), the approximate length of time involved in ASRH varied, with the majority having 30 or more years of experience in the field. For most stakeholders, their careers took place predominantly, if not entirely, in NYC. It is important to acknowledge that the individuals comprising this group do not reflect an exhaustive picture of influential local leaders in ASRH. While attempts were made to broaden the sample to include elected officials, city agencies serving youth, and others, I was not able to connect with these other individuals. Thus, it must be pointed out that participants represent a self-selected group who are also fairly aligned professionally in their approach towards and values regarding ASRH. Despite these limitations, the group of RH stakeholders included for participation in this study occupied unique and distinct positions informed by historical vantage points and professional orientations. Moreover, while interviews with RH stakeholders revealed areas of concordance, important areas of divergence were also identified.

SAMPLE SIZE

According to Glaser and Strauss (1967), data saturation in qualitative research refers to the point at which “...no additional data are being found whereby the (researcher) can develop properties of the category...” (65). While no exact threshold for data saturation exists, as it is dependent on a number of factors, including the study scope, the quality of data, the nature of the topic, and the methodology and research design used, qualitative, ethnographic studies tend to have smaller sample sizes (Morse 2000:3; Bernard 2011; Guest, Bunce, and Johnson 2006). As Marshall explains, “An appropriate sample size for a qualitative study is one that adequately answers the research question” (1996:523). Suggestions for sample sizes in ethnographic studies have been offered in the literature and can range from 15 to 50 participants (Guest et al. 2006; Creswell 1998; Bernard 2011). A recent methodological analysis conducted by Guest and colleagues (2006) on a study among 60 sex workers in two countries revealed that the team had identified virtually all themes and reached data saturation by the twelfth interview (66; see also Bernard 2011). I utilized “...an iterative, cyclical approach to sampling, data collection, analysis, and interpretation” in order to determine the point at which I stopped collecting data due to data saturation for each of the three interview groups (Marshall 1996:523). Because RH stakeholders and HCWs tended to be more homogeneous groups due to their professional training and experience, saturation was reached more quickly. Generally speaking, teen participants had a more diverse range of perspectives and experiences; thus, more interviews were necessary in order to ensure that all emerging themes were identified.

DATA ANALYSIS

Detailed notes were written during and after semi-structured interviews, as well as field notes on the research settings and observations in waiting rooms, to facilitate a reflexive analytic process throughout the data collection period. Field notes were written as quickly as possible

after data collection, while ideas, interactions, and interpretations were recent (Bernard 2011; LeCompte and Schensul 1999). Ultimately, data for analysis included interview transcripts, interview notes, and field notes. All documents were transcribed and imported into MAXQDA (MAXQDA 2014) software for coding and analysis.

Analysis was conducted in an iterative process that began at the start of data collection and continued throughout the research. This approach allowed for a continual refining of the relevance and appropriateness of research questions, methodology, and theoretical framework (LeCompte and Schensul 1999:6; Keenan, van Teijlingen, and Pitchforth 2005:40). After a careful reading and re-reading of the transcripts and interview notes, codes were assigned both inductively, based upon dominant themes and narratives that emerged from the data, and deductively based upon relevant literature in order to facilitate the discovery of patterns within the data and their interconnections to broader socio-cultural themes (Patton 1987; LeCompte and Schensul 1999:46).

To facilitate a systematic inductive coding process, I used LeCompte and Schensul's approach, which employs three levels of analysis: item, pattern, and structural (1999:68). Distinct units of measurement comprise the item level analysis, while categories of related items make up the pattern level of analysis. In order to identify patterns that emerged, I took note of the frequency with which items and categories are mentioned, the lack of "expected" categories, correlations between categories, and the sequence or ordering of events used by participants to describe particular experiences (1999:99). During the structural level of analysis, I looked for broader sets of patterns and interrelationships among the data that were used to construct explanations for the perspectives, attitudes, and behaviors of participants (LeCompte and Schensul 1999:68). In addition, I employed the constant comparative method, developed by

Glaser and Strauss (1967), to compare new categories against existing ones, look for similarities and differences, and make inferences about why such differences may occur (see also LeCompte and Schensul 1999). This was particularly helpful in teasing out alignments and divergences in responses from the three interview groups, whose proximity and relation to contraceptive decision-making and attitudes towards pregnancy were often markedly different. It is important to note that while a single codebook was ultimately developed to facilitate my ability to compare and examine areas of overlap among female youth, HCWs, and RH stakeholders, several codes were used exclusively with one group due to the content of the interview. The interpretation of results was subsequently shaped by reviewing research questions, returning to the underlying theoretical corpus, and identifying the relevance of the study to particular adolescent reproductive health policies and programs (LeCompte and Schensul 1999:216).

FEEDBACK AND DISSEMINATION OF STUDY FINDINGS

Several opportunities for feedback and dissemination of this research have taken place and are planned. Preliminary results from the study were presented 2013 at the American Anthropological Association's 112th Annual Meeting in a session sponsored by the Association for Feminist Anthropology. In 2014, I was invited to contribute to a special issue of the Annals of Anthropological Practice journal on the topic of improving services for children and families, to be published in the fall of 2015. Currently, I am drafting an executive summary of the research findings to circulate to RH stakeholders and HCWs. In addition, I intend to present the study findings to staff at the partnering hospital network within the specified divisions with whom I collaborated (family medicine, pediatrics, and school-based health) and to other local audiences as requested in 2015. Several manuscript topics are also under development with the goal of publishing at least two additional papers by 2016.

ETHICAL ISSUES

Approval for this research was obtained from the Institutional Review Boards at the University of South Florida and the Bronx healthcare network that provided local oversight for the project, as well as from a committee that oversaw the hospital's school health program. The project followed the ethical guidelines set forth by the American Anthropological Association and the Society for Applied Anthropology (AAA Code of Ethics 1998; SfAA 1983).

Throughout the data collection period, I adhered to IRB-approved procedures regarding informed consent. The aims of the study, participation requirements, and interview process were reviewed with each participant during the initial meeting/point of contact. Upon discussing this information, individuals were asked if they were interested to participate, emphasizing that their involvement in the study was completely voluntary. For female youth specifically, I explained that their decision would not impact the quality or type of care they received at the clinic.

In order to alleviate concerns that HCWs and RH stakeholders may have had regarding the expression of their opinions about the interview topics and allow for the possibility for these interviews to be conducted by phone if preferred, a waiver of *written* informed consent was requested. Instead, an approved oral consent script was read and discussed with each potential interviewee prior to the start of every interview. Additionally, individuals received an information sheet electronically or in-person for their records which reiterated: 1) the purpose of the study; 2) contact information for the study team; 3) study procedures and measures taken to ensure confidentiality; 4) and participants' rights to decline participation in the study. After allowing adequate time to address any questions raised, RH stakeholders and HCWs were asked to provide their verbal consent. The informed consent script and information sheet were written in plain, straightforward language and were devoid of jargon to ensure comprehension of the

study aims, procedures, risks, and benefits. IRB approval was obtained to waive written informed consent and proceed with the oral consent process as just described.

The process of informed consent has particular nuances and considerations for adolescent participants. For this study, a waiver of parental consent was requested for several reasons. New York is a state that protects minors' rights with regard to reproductive health care and services, meaning they are able to self-consent for care without parental notification or consent. As the Society for Adolescent Medicine (2003) notes, "These state minor consent laws implicitly recognize that under certain circumstances, minors are capable of making independent judgments and that this emerging decision-making capacity should be respected" (407). Supporting this perspective, research has demonstrated that the capacity to understand research and cognitive ability to make decisions among middle and late adolescents (between the ages of 14 and 21) is similar to that of adults (Society for Adolescent Medicine 2003:399; see also Flicker and Guta 2008). Because I was recruiting youth attending clinical settings and using reproductive health services, obtaining parental consent to participate in this research would potentially violate their rights to confidential care (Flicker and Guta 2008). Waiving parental consent in these instances was supported by a report issued by the National Commission of Research on Children, which determined that parental permission may not be necessary depending on the nature of the research topic. In the report, health care for contraception was specifically cited as an example (Society for Adolescent Medicine 2003:405). More conceptually, several youth researchers have questioned the need for parental consent in health research with adolescents (Flicker and Guta 2008; Santelli et al. 1995), arguing that it impinges upon the autonomy of young people. As the research was also believed to pose no more than minimal risk to participants, defined as, "the probability and magnitude of harm or discomfort anticipated...are not greater...than those

ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests,” (Society for Adolescent Medicine 2003:403), the decision to waive parental consent was approved.

Relatedly, written informed consent requires that a document be signed and returned to the adolescent. If found by a parent or guardian, it could also jeopardize participants’ confidentiality. Thus, in order to ensure maximum protection of confidentiality for adolescent participants, IRB approval was obtained to allow for verbal informed consent to be given. In lieu of a signed consent document, all teen participants were given an information sheet written in lay language with a readability level (Flesch-Kincaid grade level) of <6.0 to ensure that the research study was described in terms that were understandable to all youth (Israel and Hey 2006). This document was reviewed carefully with all teen participants and as much time as necessary was given to address any questions and/or concerns. Some teens chose to leave this document at the clinic, as they were concerned that bringing it home could arouse suspicion by a parent who may find it. In all cases, I reiterated that participants should contact me by phone or email should they need any additional information, which the clinic staff could provide if they did not keep the study information sheet.

For all participants, ensuring confidentiality was of utmost concern. First, I will describe the general procedures undertaken to ensure confidentiality for all groups. Then, I will discuss particular measures taken to safeguard confidentiality for teens, given the potentially sensitive nature of the research. During the informed consent process, I reiterated that information shared during the interview would not be disclosed to anyone outside of the study team. Upon completion of the interview, all individuals were randomly assigned an alpha-numeric code, and any identifying data, such as names, were removed from hard copy data, which were

subsequently stored in a locked filing cabinet in a private office. All electronic data (digital audio recordings of interviews, transcribed interviews, and other data-related files) were stored on a password-protected computer. The audio-recorded data were saved in a digital format on this computer and subsequently erased from the audio-recording device. Coding and analysis files were also stored using this method. Transcriptions of interview audio recordings omitted all identifying data.

Additional precautions were taken to ensure the protection of adolescent participants' confidentiality during recruitment. No mention of the nature of the study was given when teens were approached in waiting rooms; rather, a generic invitation to hear more about a study on "teen health" was offered, and if interested, further information was provided in a private setting. Youth who were referred to me by HCWs were told that a researcher was conducting a study on birth control and asked if they wanted to meet with me that day or at another time to discuss further. Regardless of their response, HCWs emphasized that their participation was voluntary and would in no way impact the care they received, messages that were repeated if they decided to learn more about the study from me. While it is true that HCWs knew who had been referred to me, I did not follow-up with them to discuss or verify participation.

COMPENSATION

As an incentive for participation and a token of appreciation for sharing their time and experiences with me, female youth and HCWs were provided with gift cards to local stores in the amount of \$25. Studies with youth have offered a range of remuneration forms, including gift cards, movie tickets, and transportation passes. Prior research and conversations with adolescent health researchers in NYC supported that remuneration in the amount of \$25 for adolescent participation is non-coercive and appropriate for a single in-depth interview (see Raine et al. 2011; Sucato et al. 2011; Raine et al. 2009; Epstein et al. 2008; Stewart et al. 2007; Flicker and

Guta 2008). While the gift card amount for HCWs was low and likely did not incentivize anyone to join the study, participants showed appreciation for the gesture. It was determined that \$25 was too small of an amount to offer RH stakeholders, and after consulting with key informants, the decision was made not to offer incentives to this group.

Initially, I offered Target and Amazon gift cards to female youth and HCWs based on feedback from key informants, which worked particularly well for the latter group. Clinic staff at the SBHC mentioned several other stores that may be more appealing to their patients, so I began offering a variety of gift cards from which teen participants could choose (e.g., Bath and Body Works, Old Navy, and iTunes). Interviewees responded positively to having several choices. Gift cards were distributed to participants upon completion of the interview, although the incentive was discussed during the description of the study and prior to the informed consent process.

SENSITIVE TOPICS

Because researching sexual and reproductive health may lead to topics that are “deeply private, secretive, and taboo,” such work presents a range of ethical considerations that must be confronted and situated within local study settings (Seal, Bloom, Somlai 2000:11). I incorporated these considerations into the research methodology and approach with youth participants in several ways. First, the decision to conduct individual interviews, rather than focus groups, a common methodology used with teens, was informed by available research and feedback from key informants indicating that participants would be more comfortable discussing such personal matters in a private, confidential space. Second, the interview was structured to elicit information about a participant’s background, family dynamics, and educational and career goals prior to delving into more sensitive topics. This approach allowed the interviewee and

myself an opportunity to get to know one another and develop a rapport. Third, I continuously reminded participants that I was interested in hearing about the experiences about which they felt comfortable sharing, and that however little or much they decided to disclose was perfectly acceptable. I believe this served to relieve any apprehension about the interview digging into areas that the young women did not want to discuss, and also to let them know that they were in the “driver’s seat.”

As anticipated, painful, disturbing, and emotional events were disclosed in conversations with youth, including experiences with sexual assault, violent and abusive relationships, and family trauma. When these issues arose, I observed nonverbal communication and tone carefully, reiterated that we could take a break, stop discussing the topic, or terminate the interview if the participant desired it, and thanked them for deciding to share these difficult stories with me. No interviews were terminated or postponed in this study. Although it did not need to be used, a protocol had also been developed to refer participants to a mental health counselor should a participant display or express a need for emotional support.

RESEARCHER POSITIONALITY

My own positionality in the research process, particularly with regard to adolescent participants, must be considered in order to reflect upon both personal subjectivities and how others may have perceived me. Raby (2007) characterizes the position of youth in North America as a cultural category that is both valorized and “...subject to discourses that construct them [teenagers] as being at-risk, as social problems, and as incomplete, discourses that are in turn used in their regulation and control...and that provide them with little room in which to represent themselves” (48). It was, therefore, necessary to interrogate my own pre-conceived ideas about the developmental and social locations of youth. As a woman, I may have held a particular type of “insider” status with adolescent females; however, gender is only one aspect of

identity, and intersects with age, ethnicity, class, and sexuality to produce power differentials and inequalities of access, decision-making, and representation (Raby 2007:47). As such, it was important to develop an approach that attempts to understand the experiences and concerns of youth from their vantage points, while also reflecting critically on their developmental, social, and structural positions (Raby 2007:55).

This critical reflection turned out to be more difficult than I anticipated at times. My predilection to view youth as social actors with legitimate behaviors, motivations, and desires that ought to be considered from their political, economic, and social vantage points belied the emotional reaction and cognitive dissonance I experienced during a particularly memorable interview. At the time of the interview, Lucia was 16. She was bubbly, talkative, and engaging, and almost immediately began discussing the tumultuous relationship with her boyfriend of several years, who had cheated on her several times, resulting in, among other things, a chlamydia infection. As was the case with nearly all the interviews with youth, we jumped back and forth and sideways on a number of topics in fairly rapid succession, but even so, I was startled when she blurted out, “I wanna have a baby!” I smiled and told her that I definitely wanted to hear about that, and she explained further that she was not using birth control and in fact was using a mobile application that tracks fertility based on menstruation in order to have sex on days when she was the most fertile. My immediate internal reaction was a mixture of fear and concern, as I ran through the list of predictable questions that one might ask: What would happen when she got pregnant? Would she be able to finish school? Would her boyfriend, who was unaware of her plans, be able to help support her? Was it a good idea to have a baby with someone who appeared to tread her poorly? Despite having immersed myself in research and engaging in endless conversations with colleagues, friends, and family members about the need

to interrogate taken-for-granted assumptions about early childbearing, risk, and success, Lucia's plainly stated desire to become pregnant startled me. Fortunately, I remained silent, and she continued to share her thought process with me, even articulating some doubts and concerns about whether it would be the best time. As I heard her rationale and expectations, I was able to step back from *my* concerns (which, while perhaps understandable from my social and class position, were not appropriate to transfer onto her during the interview), and hear what was important to her.

In an effort to destabilize unequal power relations and social positions between interviewer and subject, Rebecca Raby advocates the use of feminist methodologies. In particular, she suggests the use of more open-ended interviews, disclosure of research objectives, and reflexivity of the researcher (2007:54). These ideals were further operationalized in my research in several ways. First, interviews were conducted so that the direction of the conversation and length of time spent on topics were co-determined by interviewer and participant. Second, I answered questions asked by participants about my background, education, relationship history, and fertility plans, which not only generated interesting reflections about our vantage points on these issues, but also helped mitigate the imbalances inherent in our relationship. For example, teens were often surprised to learn that I was in my early 30's, which prompted several to inquire about my relationship status and plans to start a family. After Justine, 17, learned that I was 31 at the time of the interview and did not have any children, she responded, "You better hurry up!" which resulted in an illuminating conversation about fertility timing norms within our families and communities. Furthermore, a number of teen participants who were juniors and seniors in high school were in the midst of college searches and applications. Many described this process as daunting and stressful, and several

youth elicited my experiences seeking higher education and choosing a career path as part of their broader efforts to gather perspectives on potential strategies and approaches.

METHODOLOGICAL LIMITATIONS

Several important methodological limitations of this study must be addressed. As the research design was qualitative, exploratory, and explicitly focused on the contours of these issues that are NYC-specific, results may not be generalizable to other adolescent populations or jurisdictions. In addition, since the point of interface with young women was in a clinic setting at a time during which they were accessing health services, these participants may have different needs and attitudes towards contraception and pregnancy than adolescents who are not seeking healthcare. I attempted to address this limitation by partnering with a Bronx-based community organization that held classes and after-school programming for teens; however, after several presentations to staff and youth attending the center, I was unable to generate any interest to participate. Likewise, due to logistic and practical considerations, adolescents who were not proficient in English were not eligible to participate in the study. While research with clinic-based samples of “high-risk” youth has been conducted extensively in social science and public health literature, this study departs from existing scholarship by employing qualitative, ethnographic methods to locate contraceptive decisions and meanings ascribed to pregnancy within the broader socio-cultural and political-economic contexts within which they are embedded.

As is frequently the case in multi-sited research, participants were only interviewed once; thus, methods utilized resulted in a particular snapshot in time, and while anthropologically informed, did not benefit from participant observation or long-term fieldwork (Sobo 2009).

Additionally, information about the content of contraceptive counseling visits was self-reported.

This research would have benefited from the opportunity to observe contraceptive counseling

visits between healthcare workers and adolescent patients. Lastly, while a number of intersecting domains beyond the clinic influenced youth participants' reproductive decisions, I was not able to talk to their families, interview their partners, or visit them in their homes. This is partly a function of conducting reproductive health research in clinical settings and within the context of minors' rights.

CONCLUSION

The research described in this chapter employed a qualitative, exploratory design using the methodological framework of the “vertical slice” to trace strategies, relations of power, and make connections between broader discourses and approaches about teen childbearing, HCWs who counsel about and dispense contraception, and intended recipients of pregnancy prevention initiatives. Semi-structured in-depth interviews were the primary data collection method employed. Interviews with female youth living in the Bronx, HCWs providing SRH services to teens, and RH stakeholders in healthcare, public health, policy, and advocacy roles addressed the multi-level influences shaping contraceptive decision-making and perspectives on reproduction.

The following chapter on the study's research setting provides an overview of the historical and contemporary landscape of family planning service provision and pregnancy prevention approaches in New York City. It will also present data on adolescent sexual and reproductive health indicators and trends for NYC, broadly, and the Bronx, specifically, to situate interview findings described in subsequent chapters.

CHAPTER FIVE

RESEARCH SETTING

INTRODUCTION

This study examines reproductive decisions within the broader contexts of adolescents' lives, exploring the ways in which contraceptive choices and patterns of use relate to and are shaped by multi-level interpersonal, socio-cultural, and structural factors. The city of New York serves as a compelling and unique setting in which to conduct this research, due to, among other reasons, its long history of family planning promotion and services; protection of minors' rights to confidential reproductive health services; citywide efforts to standardize and enhance the delivery of such healthcare; and a recent mandate to teach comprehensive sexuality education (CSE) in public middle and high schools. Additionally, as rates of teen pregnancy and childbearing are not evenly distributed across the city, activities undertaken to affect these outcomes have been concentrated in neighborhoods with the highest rates. This approach has resulted in considerable attention paid to the Bronx, a borough with large inequities in health that are widely believed to negatively impact adolescent sexual and reproductive health.

In order to frame the local context of reproductive healthcare and associated policies, this chapter first presents a brief historical review of major national milestones and debates in family planning and adolescents' access to these services. I then provide an overview of the adolescent reproductive health policy climate in New York State and prominent policies, approaches, and initiatives recently undertaken by the city of New York to promote adolescent sexual and

reproductive health. Lastly, I present demographic and reproductive health trends for the city and the Bronx, specifically, noting the particular confluence of issues that contribute to higher rates of teen pregnancy and early childbearing for the latter.

HISTORY OF FAMILY PLANNING IN THE UNITED STATES

By the time the first hormonal method to prevent pregnancy became available in the United States in 1960, the family planning movement had been well under way for over 60 years. However, as with many issues regarding sexuality and morality, its route has been circuitous and heavily subject to the political whims of the time. According to historians, contraception was widely practiced in all social classes by the mid to late nineteenth century (Powderly 1996). However, method availability and use varied by social class, with wealthier women more likely to rely on condoms, douches, and services obtained through doctors, while poorer women, lacking the financial means to pay for such options, practiced periodic abstinence and withdrawal. Breastfeeding was also relied upon as a method of fertility control (Powderly 1996:24; Solinger 2005). As part of a broader social movement centering on morality and temperance, the increased influence of the Roman Catholic Church in political life, and a pronatalist agenda driven by declining birth rates of “native born” Americans, the Comstock Law was passed in 1873 (Joffe 1986:18). This legislation classified information about contraception as “obscene” and banned the dispensing of products and information by mail (Joffe 1986; Roberts 1997; Anderson 2005). Around the same time, numerous states passed laws explicitly banning abortion (Solinger 2005).

Such was the socio-political context into which the family planning movement, begun in the early 20th century, originated. Margaret Sanger is considered to be the “mother” of this cause, founding the American Birth Control League in New York City in 1921, which eventually

became the Planned Parenthood Federation of America (Roberts 1997:57; Gordon 1976; Engelman 2011; Anderson 2005). Reportedly, Sanger's experiences as a public health nurse caring for poor immigrant women in New York City at the turn of the 20th century cemented her belief in and support of fertility control as a necessary step towards women's emancipation and equal participation in society (Roberts 1997:57; Gordon 1976; Engelman 2011). Initially, Sanger also publicly advocated the use of women-controlled methods of birth control as a tool to achieve their sexual liberation, a perspective that was at odds with the prevailing feminist movement of the time, which emphasized chaste behavior and the "moral superiority of motherhood" (Roberts 1997:72; Joffe 1986; Engelman 2011).

In 1916, Sanger opened the first family planning clinic in the country in Brooklyn, New York, run by Sanger and her sister, who were soon after arrested for violating the Comstock Law (Roberts 1997; Joffe 1986; Engelman 2011; Gordon 1976; Anderson 2005). A subsequent ruling by the New York State Board of Appeals firmly enshrined family planning within the domain of medicine, which dictated that birth control could only be dispensed by licensed physicians in order to control illness (Joffe 1986:19). In the years following World War II, due in part to the family planning movement's efforts, an easing of calls for pronatalism, broader societal approval of non-procreative sex, and the emergence of a global "population crisis," family planning became increasingly more accepted in the U.S. (Joffe 1986:21-22).

In 1960, the oral contraceptive pill arrived on the scene, marking a pivotal shift in women's reproductive autonomy and fertility control (Engelman 2011; Anderson 2005). Coinciding with this development was a growing national women's rights movement, in which debates over reproductive rights and women's full participation in civic life were central. In 1965, the Comstock Law prohibition against married couples using contraception was overturned in the

U.S. Supreme Court case *Griswold vs. Connecticut*; it would be several more years until unmarried women were guaranteed the right to access contraception legally (Flynn 2013; Anderson 2005; Roberts 1997; Joffe 1986).

Cognizant of the need for family planning and the role of government in subsidizing it, several federal programs, such as Medicaid, began covering contraception and related services in the 1960's (Flynn 2013). In the wake of domestic and global unrest and a federal priority to wage a war against poverty, President Nixon created the Title X Family Planning Program, under Public Law 91-572, in 1970¹³ (Vamos et al. 2011; Coleman and Jones 2011; Roberts 1997; Joffe 1986; Engelman 2011; Napili 2013). In 1973, the U.S. Supreme Court voted in favor of legalizing abortion based on the *Roe vs. Wade* case under the auspices of the constitutional right to privacy, although the legalization of abortion was enacted prior to this decision in several states, including New York (Forte and Judd 1998:267; Joffe 1986; Engelman 2011; Roberts 1997; Flynn 2013).

With a growing backlash to the liberalization of contraception and abortion, policies were subsequently put forth in an attempt to limit their availability. In 1977, the Hyde Amendment was passed, which initially banned the use of federal funds in clinics where abortion services *or* information, counseling, and referrals were provided, but was later modified to prohibit the use of federal funding for services only¹⁴ (Planned Parenthood 2014). In 1982, President Reagan issued a regulation requiring parental notification when adolescents were prescribed contraceptives in Title X settings, known by reproductive health advocates as “the squeal rule.”

¹³ Today, Title X remains “the only federal program dedicated exclusively to family planning, and one historically available to families of the working poor who often do not qualify for Medicaid” (Flynn 2013:2).

¹⁴ Federal funding can only be used to support abortion services in cases of rape, incest, or when the health of the mother would be jeopardized if the pregnancy continued. (Guttmacher 2015). At their discretion, states can elect to use Medicaid funds to pay for medically necessary abortions. New York is currently one of only four states that do so voluntarily (Guttmacher 2015).

Ultimately, the ruling was successfully challenged by New York State for forcing clinicians to violate their patient's confidentiality¹⁵ (Planned Parenthood 2014).

The legislative and executive branches of the federal government have also passed legislation to limit the content of and funding available for sexuality education for adolescents. For example, in 1981, Congress passed the Adolescent Family Life Act," which funded abstinence-only until marriage programs (SIECUS 2011; Planned Parenthood 2014). This trend continued through the George H. Bush and Clinton administrations, with exponential growth for such programs under George W. Bush (SIECUS 2011; Anderson 2005; Planned Parenthood 2014). Under President Obama's leadership, two-thirds of federal funding dedicated to abstinence-only programs was eliminated. In its place, funding to support comprehensive sexuality education, and for the first time, evidence-based adolescent pregnancy prevention initiatives, was made available (SIECUS 2011; NIRH and NARAL 2010).

Finally, a no-cost contraceptive mandate was incorporated into the Affordable Care Act (ACA), enacted in 2010, requiring health insurance companies to cover the costs of birth control with no co-pay for patients. While these recent developments represent a significant shift in federal support for family planning services, attempts to defund programs and carve out exceptions based on the constitutionality of particular provisions through the courts continue unabated (Sonfield and Pollack 2013). In addition, although the U.S. Supreme Court's federal ruling on the legality of abortion has been upheld, state enacted legislation to limit the availability of abortion has proliferated. Of particular relevance for adolescents, most states require parental notification or consent to obtain an abortion (Guttmacher 2015). New York is one of 13 states and the District of Columbia that do not require parental involvement

¹⁵ Today, 26 states and Washington, D.C. allow minors to consent to contraceptive services; an addition 20 allow consent for specific types of minors (e.g., emancipated, pregnant) and four states do not have relevant case law or policy (Guttmacher 2015).

(Guttmacher 2015). This review of the family planning movement and associated milestones, though not exhaustive, underscores the tumultuous, contested, and variable political and legal landscape in which it has been situated for most of its existence.

EUGENICS AND REPRODUCTIVE COERCION

It is also critical to acknowledge that the trajectory of family planning in the United States (and, likewise, internationally) is intertwined with and inextricably linked to national fertility control imperatives and the achievement of social objectives through the regulation of reproduction. These priorities are necessarily filtered through a historically specific lens in which prevailing and intersecting social values about race, class, immigration, and I would argue, adolescence, influence the shape and direction they take. In the case of the U.S., the family planning movement brought together the seemingly strange bedfellows of women's reproductive autonomy, sexual liberation, and the eugenics movement (Joffe 1986).

As mentioned above, while originally conceived by Sanger to further an explicitly feminist agenda that emphasized women's sexual liberation, this framing of the family planning movement was not able to garner adequate support from leading feminist groups (Joffe 1986; Roberts 1997). Concurrently, however, growing concerns about the shifting demographics of the country from white and native-born to Black and foreign-born, acceptance of the notion of scientific racism to explain the distribution of social characteristics and behaviors, and an economic depression coalesced, resulting in widespread support for the eugenics movement (Roberts 1997). Presented as a solution to these social "problems," and framed in eugenic terms, the family planning movement could align the promotion of birth control with national goals and interests (Roberts 1997:72). As a result, the movement's strategy shifted to one that highlighted the practical role of contraception in reducing birth rates for less desirable social classes, though

some historians argue that Sanger did not personally believe that differential levels of social “fitness” stemmed from genetic or “racial” deficiencies (Roberts 1997:81). Irrespective of her private beliefs, Sanger supported the view that social problems result from reproduction of the socially disadvantaged, and thus, their childbearing should be discouraged, which resonated with eugenic thinking¹⁶. As Roberts astutely observes:

“In a society marked by racial hierarchy, these principles inevitably produced policies designed to reduce Black women’s fertility. The judgment of who is fit and who is unfit, of who should produce and who should not, incorporated the racist ideologies of the time” (1997:81).

Unfortunately, numerous examples can be provided to demonstrate the ways in which family planning activities have been implicated in attempts to limit and control the reproduction of poor women, women of color and immigrant women. By the early decades of the 20th century, several states had passed laws to involuntarily sterilize institutionalized individuals considered to be a burden to society and those who would “pollute” the fitness of the race, including the “feeble-minded,” mentally ill, criminals, and those with developmental disabilities¹⁷, resulting in over 60,000 involuntary sterilizations during the 20th century (Roberts 1997:67; Stern 2005; Forte and Judd 1998; Dehlendorf, Rodriguez, Levy, Borrero, and Steinhauer 2010a). Mandatory sterilization laws began to be repealed in large numbers following World War II and into the 1960’s due to widespread public rejection of eugenic thinking. However, the fundamental interpretation of the relationship between reproduction and social inequality had a lasting effect on social policy in the United States (Roberts 1997:89). Further, the repeal of these laws gave way to widespread sterilization abuses documented across the country that disproportionately

¹⁶ According to Dorothy Roberts, eugenics refers to “the notion that society should encourage the procreation of people of ‘superior stock’ based on the belief that intelligence and personality traits are entirely genetically inherited” (1997:59-60). Ultimately, it hinges upon a fundamental belief about the immutability of race.

¹⁷ In many cases, these labels served as a convenient excuse to sterilize women with “questionable” sexual morality, such as those who engaged in pre-marital sex or had children out of wedlock (Roberts 1997:69).

affected tens of thousands of poor Black and Puerto Rican women (Roberts 1997; Joffe 1986; Forte and Judd 1998). Among other abuses, many women were sterilized without informed consent or through consent obtained coercively, received needless hysterectomies, and had medically unnecessary procedures performed for training purposes¹⁸ (Roberts 1997:90-91).

Communities of color are often portrayed one-dimensionally with regard to opinions about and support for family planning. In fact, various groups have held diverse and at times conflicting opinions about the utility and necessity of contraception and abortion services. Roberts (1997) writes that while some African American leaders and activists were opposed to family planning on the grounds that it amounted to racial “genocide,” others played instrumental roles in national debates about contraception, abortion and the creation of clinics in their communities. Additionally, the importance of spacing births has long been reflected in the usage of family planning clinics that were available to women of color (Roberts 1997). Moreover, Roberts argues that family planning held fundamentally different meanings for whites and Blacks:

“...For eugenicists and many white birth control advocates, improving the race meant reducing the number of births among people considered genetically or socially defective. But Blacks understood that racial progress was ultimately a question of racial justice: it required a transformation of the unequal economic and political relations between Blacks and whites. Although birth control could aid in this struggle, it could not cure Black people’s wretched living conditions by itself...White eugenicists promoted birth control as a way of preserving an oppressive social structure; Blacks promoted birth control as a way of toppling it.” (86)

More recently, moral and ethical issues associated with the use of Norplant, a long-acting reversible method of contraception, have been raised. Norplant, a progestin releasing hormonal implant system comprised of subdermal rods that must be inserted into and removed from the

¹⁸ Ultimately, rules restricting sterilizations performed using federal funds were issued in 1978 that dictated the process of informed consent and a required 30-day waiting period, as well as stipulating the prohibition of funds to sterilize adolescent, mentally incompetent, and institutionalized individuals (Roberts 1997:97).

arm by a medical provider, was approved for use in the U.S. in 1990 (Anderson 2005; Moskowitz and Jennings 1996a; Roberts 1997). Initially, its availability was regarded positively. Norplant was the first hormonal method to enter the market since the oral contraceptive pill, and while it provided five years of highly effective pregnancy prevention, return to fertility was immediate once the implanted rods were removed (Moskowitz and Jennings 1996a). It also offered an alternative to daily or sex-dependent methods like diaphragms, condoms, and pills, and was thus extolled for the freedom it afforded women (Roberts 1997; Moskowitz and Jennings 1996a). Almost immediately after FDA approval, however, Norplant was shrouded in controversy about the potential for reproductive abuse and coercion. Beyond efforts to make the method more accessible to low-income women by allowing for associated costs to be reimbursable by Medicaid in virtually all states, several legislatures proposed bills that would provide monetary incentives for use of Norplant by welfare recipients. Other policymakers recommended requiring Norplant use as a condition of receiving public assistance (Roberts 1997:108-109; Joffe 1986; Moskowitz and Jennings 1996a). In one state, a bill was proposed that would require women who obtain an abortion paid for by state funds to receive Norplant unless medically contraindicated (Roberts 1997:109). Norplant was also touted as a solution to the problem of teen pregnancy. Hormonal implants were considered to be particularly appropriate for young people because of their perceived irresponsibility and inability to consistently use methods requiring more regular attention (Roberts 1997). While none of the proposed legislation incentivizing or mandating the use of Norplant for particular categories of women passed, these efforts underscore the pervasiveness and persistence of attempts to address

political, social, and economic “problems” through the control of disadvantaged women’s reproduction.¹⁹

TEEN PREGNANCY PREVENTION AND FAMILY PLANNING POLICIES AND PROGRAMS IN NYC

Given the national context of family planning and sexuality education policies, it is instructive to examine the climate of adolescent pregnancy prevention initiatives in New York City. As described in the historical review earlier in this chapter, New York has played a central role in the family planning movement, both as a site of birth control advocates’ early work and by setting legal precedents, such as becoming the first state in the country to legalize abortion for residents and non-residents through the 24th week of pregnancy, several years prior to the *Roe v. Wade* decision (Roberts 1997; Boston Women’s Health Book Collective 2014). Accordingly, the state has a long tradition of service provision and policies that support the delivery of reproductive healthcare. Since the 1970’s, adolescents (12 years-of-age and older) have been able to access family planning and abortion services confidentially and without parental consent or notification in all healthcare settings that offer such care under the legal framework of minors’ rights (NYCLU 2003).

Additionally, while a great variety of male condoms are available for purchase in drugstores, pharmacies, and other retail outlets, several historical and contemporary developments have enabled the widespread availability of free male condoms in NYC. Condoms were first

¹⁹ In earlier decades, the IUD was also touted as a tool of development and population control, particularly in impoverished countries. This quote made by Alan Guttmacher in 1964, then president of Planned Parenthood-World Population, powerfully reflects the reasons the IUD was preferred:

“As I see it, the IUDs have special application to underdeveloped areas where two things are lacking: one, money and the other, sustained motivation. No contraceptive could be cheaper, and also, *once the damn thing is in the patient cannot change her mind [emphasis added]*. In fact, we can hope she’ll forget it’s there and perhaps in several months wonder why she has not conceived.” (Takeshita 2011:205)

distributed by the NYC DOHMH in 1971, initially in a more limited capacity through the city's STI clinics but eventually expanding to a multitude of venues citywide, including clinics, community centers, bars, and clubs (NYC Condom 2013; Kempner 2013). In 2007, the city's health department launched their own "NYC Condom," a Lifestyles condom with a NYC-branded wrapper, followed by the introduction of the Condom Finder smartphone application in 2011 to enable New Yorkers to find the nearest locations to obtain these free condoms²⁰ (NYC Condom 2013; SIECUS 2013; Kempner 2013). The city's Department of Education has also made free condoms available in public high schools since 1991 as part of its mandated HIV/AIDS Prevention Program (NYC DOE 2015a).

There are also several state Medicaid programs available for coverage of family planning and abortion services for which teens can apply on their own (NYS DOH 2015). For example, the Family Planning Benefit Program (FPBP) was enacted as part of the state's family planning expansion to cover comprehensive reproductive health services for individuals with incomes at or below 200% of the federal poverty level (NYS DOH 2015). As part of the program's eligibility criteria, advocates pushed for teens to be able to apply on their own, rather than with their "household," in order to ensure confidentiality of services received. While the above policies and programs pertain to the state as a whole, the following section will focus on the current approach and prominent initiatives that are taking place in New York City specifically.

The overarching framework within which adolescent sexual and reproductive health (ASRH), broadly, and pregnancy prevention, specifically, take place in NYC is derived from a public health approach that attempts to reconfigure the social and built environment to make

²⁰ In 2012 alone, the department distributed over 35 million NYC-branded condoms throughout the five boroughs (Kempner 2013).

“healthy choices the easy choices” for individuals and communities²¹ (Astone, Martin, and Breslav 2014; Alcorn 2012). In the case of ASRH, this has entailed “changing the context of decisions to engage in sexual activity and to contracept when sexually active” (Astone, Martin, and Breslav 2014:1). Various initiatives and programs have been implemented to affect SRH decision-making among youth, and in particular, low-income teens of color who are disproportionately affected by pregnancy and childbearing. These include the provision of comprehensive sexuality education for public middle and high school students, citywide media campaigns, increasing access to and availability of hormonal and long-acting reversible methods of contraception, and the provision of high-quality and standardized reproductive health services.

While too expansive a topic to describe in detail, it is important to note that the inclusion of sex education into NYC public schools has a long and tumultuous history. Sex education was first integrated into NYC public schools in 1967 with a curriculum called “Family Living, Including Sex Education” for grades Pre-K through 12 (NIRH and NARAL 2010). That same year, legislation was passed in the state requiring health education, a component of which was sexuality education, in public schools; however, the law incited considerable controversy, and the sexuality education requirement was removed (NIRH and NARAL 2010). In 1987, New York State mandated an HIV/AIDS curriculum for all public school students in grades K through 12, and in 1991, HIV/AIDS education and a condom availability program (in high schools only) were mandated by the NYC Department of Education (DOE) (NIRH and NARAL 2010). Despite mandates to deliver health education and HIV/AIDS-specific instruction, the quality, depth and consistency of education were criticized as inadequate by numerous advocates and

²¹ This approach has been adopted by the city for numerous health issues, most notably, tobacco cessation, which has dropped precipitously over the past 15 years concurrent with a public smoking ban, higher cigarette taxation, and “hard-hitting” media campaigns that depict the health risks associated with smoking (Astone, Martin, and Breslav 2014; Alcorn 2012).

community organizations. In response, the HIV/AIDS curriculum was updated in 2005 and the NYC DOE, with consultation from the Department of Health and Mental Hygiene (DOHMH), recommended the use of two comprehensive sexuality education (CSE) curricula for public middle and high schools in 2007 (NIRH and NARAL 2010). Finally, in 2011, then mayor Michael Bloomberg passed a mandate to require all public middle and high schools to use an evidence-based CSE curriculum for one semester in each level (Santos and Phillips 2011; NYC DOE 2015b; Astone, Martin, and Breslav 2014). Although the NYC DOE recommended the use of the CSE curricula identified in 2007, it is not mandated (2015b). City agencies have also adopted strategies to educate young people through various media channels in an attempt to shift social norms about sexuality, contraceptive decision-making, and teen parenthood, including through subway and bus campaigns, social media platforms, and a mobile app with information about where to access confidential reproductive health services across the city (Astone, Martin, and Breslav 2014).

Another targeted strategy, undertaken by the city's health department over the past decade, is efforts to identify and achieve alignment in best practice standards for the delivery of ASRH care across the city (Alberti, Steinberg, Hadi, Abdullah, and Bedell 2010; Labor, Kaplan, and Graff 2006; Astone, Martin, and Breslav 2014). One such example is the *Healthy Teens Initiative (HTI)*, which brought together medical providers in family planning to develop a toolkit of achievable steps clinics and practitioners could take to provide high-quality, comprehensive sexual and reproductive healthcare for adolescents, including: guaranteeing confidentiality, making facilities "adolescent-friendly," and providing contraceptive methods onsite (Labor, Kaplan, and Graff 2006). Building from the work of the HTI, the DOHMH put forth a series of best practice recommendations for ASRH care in 2012 that was subsequently endorsed by state

chapters of the American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG) (DOHMH 2012). Within this strategy, a key activity citywide has been the promotion of highly effective methods of contraception, including hormonal and long-acting reversible methods, by adolescents, a public health goal that is mirrored in national policy statements and recommendations from the CDC, ACOG, and AAP (MMWR 2014; ACOG 2007; ACOG 2011; AAP 2014). Given the aforementioned particularities and relative uniqueness of NYC's ASRH policy and service provision landscape, it is important to underscore that findings from this study cannot be generalized to other parts of the country, or even of New York State.

Lastly, it is important to highlight that the initiatives described above are taking place at a time during which local, and to a lesser extent, national discourses on the determinants and consequences of teen pregnancy are in flux. Echoing these data, which suggest that teen pregnancy and childbearing are markers of inequality, rather than causes of poverty, influential organizations and city agencies have begun to consider the implications of these findings for their teen pregnancy prevention work. In the following section, I present recent sexual and reproductive health trends among adolescents in NYC.

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH TRENDS IN NYC

Each year, approximately 17,000 pregnancies occur among adolescents between the ages of 15 and 19 in the city (NYC DOHMH 2013). The majority of pregnancies among adolescents between the ages of 15 and 19 are considered to be unintended, regardless of factors such as neighborhood-level poverty, race, ethnicity, or age. In 2009, about 87% of pregnancies among this cohort were classified as unintended (NYC DOHMH 2011). Over the past decade, pregnancy rates in the city have declined significantly. Between 2000 and 2009, the rate decreased from 101.4 to 81.1 pregnancies per 1,000 15 to 19 year-old females; however, the rate

in NYC is still over 20% higher than the estimated pregnancy rate nationally for this cohort (NYC DOHMH 2011). While pregnancy rates are higher in NYC than in the U.S. overall, the city reports lower birth rates than the national average, at 29.5 and 39.1 births per 1,000 teens in 2009, respectively (NYC DOHMH 2011). This is largely due to higher rates of abortion in the city than in the U.S. (51.3 versus 19.1 per 1,000 teens in 2005, respectively) (NYC DOHMH 2011). Like many health issues in New York, pregnancy rates vary significantly by neighborhood socio-economic status, so that adolescents in high-poverty areas are three times more likely to become pregnant than those in low-poverty areas (NYC DOHMH 2011). In addition, there continue to be considerable disparities in adolescent pregnancy rates by race and ethnicity, with Black and Latina teens more likely to become pregnant than white teens (NYC DOHMH 2011; see also Waddell, Orr, Sackoff, and Santelli 2010).

Two important antecedents to pregnancy that are measured at the city-level are sexual behavior and contraceptive use, which will be briefly described below. The NYC Youth Risk Behavior Survey (YRBS) is conducted in the city every other year and reports on sexual behaviors, including contraceptive use, among public high school students. Results from the 2011 survey indicate that approximately 37.8% of 15 to 19 year-olds have ever had sexual intercourse, with higher percentages reported for upper grades and among males (NYC DOHMH). On the national level, percentages of ever sexually active youth are higher, with 46% reporting having ever had sexual intercourse in 2009 (CDC 2012). Among New York youth who had sex within the three months prior to the survey, 65% reported use of a condom, alone or with other methods, at last intercourse. Additionally, 26.9% reported use (or partner use) of a hormonal or LARC method at last intercourse (NYC DOHMH 2011). Again, comparable data are not available on the national level for the most recent survey year in 2009 (CDC 2012).

BRONX COUNTY: DEMOGRAPHIC AND HEALTH TRENDS

Bronx County has a population of approximately 1.4 million and is the poorest urban county in the nation, according to results from the U.S. Census 2014 American Community Survey. Between 2009 and 2013, data show that the percentage of adults living below the poverty level is consistently higher in the Bronx than in New York City overall, at approximately 30% compared to 20%, with a concordantly lower median household income of approximately \$34,000 compared to the citywide average of \$52,000 (U.S. Census Bureau 2015). In particular Bronx neighborhoods, specifically the South and Central Bronx, the percentage of adults living in poverty is as high as 44% (Citizens' Committee for Children 2012). Furthermore, there are significant inequities in high school graduation rates and higher education attainment between the Bronx and citywide averages. Between 2009 and 2013, 70% of Bronx residents 25 and older completed high school compared to an NYC average of 80%. Inequalities in attainment of a bachelor's degree or higher are even more striking, with 18% of Bronx residents completing higher education compared to an average of 35% for NYC (U.S. Census Bureau 2015).



Figure 5.1. A busy intersection in the Bronx, NY. Photo credit: Author.

The Bronx is home to a diverse population of residents; approximately 55% are Hispanic, about 43% African-American, 10.5% Caucasian, 4% Asian, and 3% classified as two or more racial categories (U.S. Census Quick Facts 2015). Additionally, about one-third of Bronx residents are born outside of the United States. In order of community size, immigrants to the Bronx predominantly come from the Dominican Republic, Jamaica, Mexico, Ecuador, Guyana, Ghana, Honduras, Bangladesh, Trinidad and Tobago, and El Salvador (NYC Department of City Planning 2013). The Bronx is the only borough in New York City with a majority of Latino residents and is also demographically the youngest of the boroughs, with approximately one-third of the population 18 years of age or younger (Montefiore Medical Center 2011:5).

HEALTH INEQUITIES IN THE BRONX

A complex intersection and interaction of social, structural and political issues coalesce, which disproportionately impacts the health of Bronx residents compared to other New Yorkers. These phenomena include high rates of unemployment, entrenched poverty, residential overcrowding, environmental health risks, interpersonal violence, and poor access to quality health care (Singer 1994:933; Montefiore Medical Center 2011:5; Schupack 2011:40). Regarding the antecedents of health inequities in NYC, Wallace (1990) has argued that public health in NYC was significantly eroded as a result of "...increased overcrowding, the destruction of community social fabric, the greatly heightened mobility, and geographic incongruity between municipal service supply and demand, especially disease control and prevention..." (1221). Further, several researchers have noted the ways in which the retrenchment of municipal services, coupled with stagnant housing prices, resulted in a mass exodus of residents that devastated poor New York neighborhoods in the 1970s, including those in the south Bronx (Diaz 2011; Wallace 1990; Singer 1994). The profound effects of these large social and economic

events are still being felt in Bronx neighborhoods today. It is within this broader historical context that the social and health inequities, which continue to plague many parts of the Bronx, are best understood.

Compared with the rest of NYC, access to health care remains lower in the Bronx. The Health Resources and Services Administration (HRSA) has designated all of Bronx County as a Health Professions Shortage Area, with an overall decline of 9% in the number of physicians serving the borough (Montefiore Medical Center 2011:6). In four of seven neighborhoods in the Bronx, over 30% of adults are uninsured, and every single Bronx neighborhood has a 10% to 40% higher age-adjusted mortality rate than the city overall (Montefiore Medical Center 2011:6). In addition, HIV was identified to be the leading cause of premature death among neighborhoods in South and Central Bronx (Montefiore Medical Center 2011:6).

Of NYC's five boroughs, the Bronx consistently has the highest teen pregnancy rate. In 2009, as in previous years, this rate was higher than the NYC average, at 105.6 per 1,000 females (NYC DOHMH 2011). Waddell and colleagues (2010) report that adolescents attending school in the South Bronx, North and Central Brooklyn, and East and Central Harlem are more likely to report sexual activity and less likely to report contraceptive use than their peers citywide (427). Their analysis of city-level YRBS data found that the neighborhood in which the school was located and "race/ethnicity" independently influenced the risk of pregnancy (Waddell, Orr, Sackoff, and Santelli 2010). Further, neighborhood context appeared to be a significant force in shaping differential rates of sexual debut, even when parental education level, family income, "race/ethnicity," age, and family structure were controlled (Waddell, Orr, Sackoff, and Santelli 2010:436). Data also show that elevated pregnancy rates in low-income Bronx neighborhoods co-occur with high clusters of chlamydia cases among youth (Guilamo-Ramos, Lee, and Husiak

2011). With consideration of the contextual factors articulated above, these findings suggest that a confluence of economic, social and political inequalities, a lack of municipal resources, and historical contexts of neighborhood segregation influence and shape the uneven distribution of sexual and reproductive health behaviors and outcomes²².

CONCLUSION

This chapter offered historical and contemporary perspectives on family planning, teen pregnancy, and childbearing situated both nationally and in the local research setting of New York City. Although family planning policies and approaches have shifted over time, they remain controversial and tensions between reproductive autonomy and coercion in the provision of contraceptive services represent ongoing challenges. This chapter also presented data on the distribution and occurrence of pregnancies and births in the city, underscoring the political, economic, and social inequities that shape adolescent sexual and reproductive health overall and in the Bronx.

It is within this complex environment that youth make decisions about and use contraception. On the one hand, social and public health policies reflect a clear acknowledgment that a substantial percentage of youth will become sexually active during adolescence. Accordingly, numerous services and programs available in New York are geared towards making it easier for youth, and particularly for low-income youth of color, to access sexuality education and reproductive healthcare. However, while pregnancy rates have declined in all five boroughs over the past decade, there are persistent disparities by socio-economic status, neighborhood, and

²²Efforts to improve health outcomes in the Bronx and other poor neighborhood clusters in Brooklyn and Manhattan resulted in the creation of District Public Health Offices (DPHOs) in 2002 by the city's health department, whose mission is to enhance health equity through the administration of programs in priority health areas, policy changes, research and dissemination, and support of community organizations and residents (NYC DOHMH 2008). Current priority areas for the Bronx DPHO include asthma, obesity and physical activity, and teen sexual and reproductive health (NYC DOHMH 2008; Alberti, Steinberg, Hadi, Abdullah, and Bedell 2010).

racial/ethnic background. Likewise, rates of highly effective contraceptive use among adolescents appear to be increasing, but overall remain low, and the decision-making that influences uptake and use of these methods is poorly understood. Moreover, the vast majority of adolescents who give birth report it as being unintended, despite arguably greater access to reproductive health services than ever before. As hormonal and long-acting reversible contraceptive use has become a primary area of focus for the prevention of unintended adolescent pregnancy in NYC, it is imperative to better understand what shapes use *beyond access to services*. In particular, to assess how contraceptive practices and behaviors intersect with other salient domains in adolescents' lives, including meanings ascribed to pregnancy and the salience of planning. Drawing primarily from interviews with RH stakeholders, and where relevant, perspectives from HCWs, the next chapter presents themes that emerged relating to aspects of NYC's political, legal, and socio-cultural landscapes that shape the provision of adolescent sexual and reproductive health (ASRH). In addition, predominant strategies and approaches identified by interviewees to promote contraceptive use among sexually active youth and reduce unintended pregnancies among female adolescents will be provided.

CHAPTER SIX

POLITICAL, SOCIAL, AND LEGAL CONTEXT OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

This chapter presents themes from participant interviews that are related to the discourses, strategies and approaches that operate within the broader political context of adolescent sexual and reproductive health (ASRH), and specifically pregnancy prevention, in NYC. I begin by providing a brief description of particular features of NYC's political, socio-cultural, and legal landscape that interviewees identified as influential in shaping policy and programmatic responses to ASRH issues. This chapter then goes on to discuss prominent activities identified by RH stakeholders pertaining to ASRH, including approaches considered to be the most effective in encouraging pregnancy prevention. Finally, findings from interviews regarding access-level barriers towards the delivery of ASRH are presented. Results from this chapter are predominantly derived from RH stakeholders, but where appropriate, HCWs' perspectives are also included and will be indicated in the text.

THE NYC LANDSCAPE

This section presents prominent features of the research setting that RH stakeholders and HCWs believed shaped the content and delivery of adolescent SRH issues and services. In discussions with participants, four overarching themes emerged: social and economic inequality; diversity and immigration; social and political support for reproductive rights and health services; and minors' rights to confidential reproductive healthcare.

SOCIAL AND ECONOMIC INEQUITY

Broadly, participants often characterized NYC as a place of extreme inequities in wealth²³, education and opportunities that synergized with institutionalized forms of racism. These inequities were seen to influence the occurrence and distribution of reproductive health outcomes such as childbearing among teens in several ways. Of the adolescent SRH disparities observed by race and class, Ellen, a former executive of a reproductive health services (RHS) organization remarked:

“Well, in New York, there’s um, it’s really very clear. The educational system, in what opportunities are provided, and unemployment and employment for youth who want to work and really need to work, it’s very clear. The criminal justice system reeks with examples of disparities based on race and class. And then all the health indices, it’s sort of clear...that the disparities are there...and the connection to economics and opportunities is, you know, just glaring.”

Referencing what she perceived to be “un-benign neglect” of poor youth of color in our society as a major contributor to teen pregnancy and childbearing, Andrea, a city health official, explained:

“... You can’t make people care about people they don’t care about...And it’s compounded in NYC by our hyper segregated hyper poverty concentrated racist social system. You know, it’s hard to say it’s a system because it doesn’t appear to be one, but it must be a system because it’s working really effectively...I mean one of the things that seems so impenetrable, so there are areas of the south Bronx where 7% of the grown ups have been to college. 7%, so that’s basically zero. So that means that teens are growing up in a neighborhood...where no one has been to college. I can’t imagine that. So my kids, every single adult practically that they are in contact with has been to college...and more so, you know. So that’s just part of what their social norm is.”

The unequal distribution and occurrence of pregnancy and childbearing during adolescence and its overlap with socio-economic inequalities was discussed extensively by participants and will be explored more in-depth in Chapter Nine.

²³ Income inequality levels vary considerably across large cities in the United States. A recent Brookings Institute report ranked NYC sixth among the top 10 most inequitable cities, with households in the 20th percentile earning just over \$17,000 per year in 2012, compared with \$225,000 among households in the 95th percentile (Berube 2014).

DIVERSITY AND IMMIGRATION

The highly diverse population of residents in NYC was also considered as a salient feature of the ASRH landscape, which impacts the content and delivery of services and programs for youth. First, because the city is home to a large population of undocumented youth, the ability for service providers to recoup costs associated with reproductive health visits and services from federal and state-supported health programs such as Medicaid was limited. New immigrant populations in particular were often described by HCWs as a group with high medical needs, since they often do not have up-to-date vaccinations.

RH stakeholders and HCWs also frequently articulated the complexities of working with immigrant parents whose children are being raised in an often vastly different socio-cultural setting than their country of origin. Deborah, a family medicine physician who has known many of her teen patients and their families since they were young, explained:

“...[They] are...kids whose parents kind of roughed it and emigrated here and are sometimes abusive of that, you know, in not taking full advantage of the sacrifice their parents did for them to be here...One of my...teenagers...he’s now finally becoming an adult, but he was such a horrible child and he put his mom through the worst...as a parent she believed in corporal punishment and when he was bad she’d use an electrical cord...she ended up getting disability partly for mental health and those issues and he kind of used that against her...’So because you get this money for having me, you have to buy me not just any jeans, but these specific jeans, and sneakers...’ and so in a lot of ways...the kids get power...over their parents because they speak English and their parents don’t...So I find that’s always a kind of an interesting dynamic, which is pretty unique to here in some ways...in any other kind of town, you kind have to somehow ...learn the language or find some way to kind of assimilate and get in, where here you could survive for a very long time without speaking the language...”

The patient population at one RH stakeholder’s adolescent medicine clinic had changed markedly over the past two decades, reflecting newer waves of immigrants from Pakistan, India, and Bangladesh. Here, Jeffrey, Chief of Medicine for an adolescent health clinic, described

some of the challenges facing his first-generation teen patients and the way in which he approached their parents:

“...These are kids where their parents are from this other world. They’re being brought here against their will ‘cause the whole family picks up and moves here, and they are trying to be Americanized when the parents are saying, ‘No, we don’t do that in our culture.’ So things like... ‘No, I don’t want to wear the typical Pakistani garb,’ and mom says, ‘Yes you will, ‘cause you’re Pakistani girl,’ and she’s saying, ‘Yeah, but I’m the only one in my class who dresses like this, I wanna dress like all my other friends.’...Even something as simple as, ‘All my friends go to McDonalds, why do we keep eating this halal meat?’... My paradigm is I’m there for the teenager, which certainly raises some issues with the parents often...sometimes we need to spend a lot of time with families and explaining to them, you can’t raise a Pakistani girl or boy in Brooklyn, unless you’re gonna be living in a ghetto, and if the kid is going to public school, you’re not going to be in a ghetto....But understanding some of that and letting them know that I’m respectful, and although I don’t know about it, I’m willing to learn...but at the same time, they gotta understand that they need to give the kid a break, so to speak...”

Participants also commented that among particular immigrant populations, “conservative” social norms and religious beliefs influenced attitudes towards reproductive health, and specifically, contraception and abortion. Olivia, a mental health provider at a SBHC explained:

“A lot of families have not adopted our culture into their culture... for example the birth control is something new to them, it’s not something they have a lot of knowledge of... your mother probably didn’t take it so you have a lot of myths about them. Reproductive health is not offered in the DR [Dominican Republic] as an example, they don’t get that there... The value on family and religion, they don’t want abortion or they don’t believe in abortion... which is different than another population. And...they [immigrant families] don’t have an education; they didn’t go to college so that’s not emphasized especially for a lot of the girls...”

Christina, a senior executive at a Reproductive Health Services (RHS) organization, discussed the ongoing challenge her organization faced of how to engage the parents and youth of recently arrived immigrant communities around sexual and reproductive health issues in ways that are respectful and appropriate:

“...A question that I would want us to continue to think about is how best to talk about these issues in new communities in the city, and being more culturally attuned...because ...it’s a very different landscape...So that’s an ongoing challenge...And for many people in new communities, like Latino communities or even the Asian, their community focus is

gonna be maybe their churches. They've come here, they've been here maybe a couple of years. Their whole life pivots around their neighborhood, their jobs, and their churches, and yet their kids are going to go to school, grow up, and get something very different, so we need to figure out how to have conversations that don't exclude those parents, recognize their values, and yet help their kids."

SOCIAL AND POLITICAL SUPPORT

Lastly, it was frequently noted that the progressive work being done in NYC with regard to teen sexual and reproductive health would not be possible in most other parts of the country. Primary rationales offered for this wide latitude included a long history of funding and political support for reproductive health, particularly for adolescents, the city's northern liberal "culture" and popular support for sexuality education and the widespread availability of services. Andrea, a city health official, compared her experience working on a teen pregnancy prevention initiative with those of her fellow grantees located in other states and jurisdictions to illustrate the relative security of reproductive health services for teens in New York:

"...These other grantees are in settings where if the teen does something, man, they are really outta luck. Makes me feel very thankful to be in New York, 'cause that access thing is so key and it seems very firm here. You know, the anti-abortion forces keep trying to rally up, and they're not getting anywhere...It's [abortion] gotten to be less of a battle in New York. I mean in the 70's right after Roe versus Wade, I remember as a teenager myself, being like, 'Whoah, battlefronts out there,' and that really has pretty much evaporated..."

As director of a reproductive health training program for the state, Aimee noted considerable differences in attitudes towards sexual and reproductive health in upstate New York versus the city, reflecting widespread political variation within the same region. She explained:

"From some of the work upstate that we're doing, we get anecdotal stories about people just being so afraid and the fear of offering reproductive health services in very conservative communities, and it's almost...there are fantastic leaders throughout New York State that we've found, but it almost could be Texas in some of these places. There was a big victory somewhere upstate because they finally let them give out condoms in the high schools. It was a huge huge thing just a few months ago...we had that battle 20 years ago in New York City..."

MINORS' RIGHTS

As described in Chapter Five, a key legal feature of the adolescent health landscape in NYC is minors' rights to seek confidential reproductive healthcare without parental consent or notification, which has been in effect in New York State for over three decades. Not surprisingly, upholding these rights and working to ensure confidential services within an exceptionally complex healthcare environment were key priorities for both groups of participants. Justifying their focus, interviewees referenced studies demonstrating the “chilling effect” that repealing confidentiality laws would have on teens' willingness to seek services. Despite their staunch promotion of confidential teen services, participants overwhelmingly believed that engaging parents on their teens' sexual and reproductive health was also important. Both RH stakeholders and HCWs generally agreed that the most ideal scenario was when parents knew that services were available, were aware of their child's related healthcare needs, and represented a source of support for their child to make healthy decisions. Although this scenario did occur, participants noted that it was not as frequent as they would like. Below, Sonya, a director for a teen health center that provided integrated medical and mental health services, described the way her clinic has approached the issue of parental involvement:

“...I think confidentiality helps the kids come in to the services, because many kids will not come if they don't think it will be private, but then once we have them here, we talk with them about their relationship with their parents or guardian...For example, a kid may be gay, lesbian, or transgender, or the kids may be having sex, and they say, 'No, no, I cannot tell my parents, they will kill me.' And we say...If you want, you can bring them here and we'll sit down with you guys and help you tell your parents and we'll not let you go if we think you're not safe.' ...I think teenagers do better with their parents love them, communicate with them, and help and support them. Sometimes that's not possible due to the life that many of our families have and many are very stressed themselves. But ideally if the kid can have a wonderful relationship with their parents and get the counsel from them, that kid will do better, just in general. So we strive for that.”

Lisa, a social worker at a SBHC, reiterated that parents' supportive involvement in their child's sexual and reproductive healthcare was helpful, particularly at making teens feel comfortable with decision-making around contraception, but that minors' rights is necessary for those parents who are not or cannot be supportive:

"...It's helpful...when they [parents] are involved. Because I think in my experience, when the parent is on board...there's an increased likelihood that the teenager will stick with the method. I mean, for instance, I know a couple girls who have gotten the IUD, and each girl discussed it with her parent, and the parent was on board, and so I just think it made those girls feel a lot more comfortable with the decision...However, I think that a lot of these kids have parents that just are not open to the idea that their child might be sexually active and are scared about birth control options, so I think when that's the case, it's not helpful for them to be involved..."

Participants frequently described having these conversations with parents and their children, usually well before the onset of sexual activity. Pediatric and family medicine physicians often had developed trusting relationships with the families of their teen patients and had longer-term opportunities to interact with parents than providers at other types of clinic settings. Deborah, who had been a family medicine physician for over 10 years, commented:

"...I find that it's nice in the family medicine realm of things...because I do know both [youth and their parents] and I think the parents really do trust me. So they're like, I don't have to know, I know Deborah will tell me the right advice, you know, leave it to her that kind of thing. And usually that works well..."

Below, Jeffrey shared his approach in discussing the issue of confidentiality with the parents of his adolescent patients:

"So I always teach the residents, it's an interview, it's not me interviewing the adolescent or the family, it's them interviewing me...Probably once every five years, we'll get a parent who says you're not being in the room alone with my son or daughter. And one of the things that often comes up is that there's a history of sexual abuse, things like that ...And we're very respectful of that and we ask the adolescent what they want, and if they say they want their mother in the room, then that's fine...And it's very funny, this just happened to me about a month ago, the girl said, 'I know you're gonna ask me if I drink, use drugs, have sex, and smoke cigarettes and I don't do any of those...' and I said, 'Great, you just made this so much easier for me!' And then she laughed, and the mother laughed, and she said, '...You could have asked her that stuff in front of me; I know she's

a good girl.’ And I said, ‘I’m so happy you guys have a good relationship and you know what’s going on with her because a lot of my patients don’t have that kind of relationship with their moms, so you should be really congratulated...’

While participants in these settings frequently noted the delicate nature of these conversations when parents accompanied their adolescent children to the clinic, many interviewees observed that it also created important opportunities. Alisha, a physician at a pediatric clinic, explained:

“...Every once in a while things come up during the confidential portion of physicals... then it can get a little complicated but...sometimes, in the best case scenario, when parents are in the room, and this does happen occasionally...one of the things that a parent will mention is, I want you to talk to so and so about birth control options. That’s really great, um, because it allows me to very quickly just address it and let them know that we can talk about the options together, but then I’m also going to ask you to step out of the room so I can speak to her alone about them. It doesn’t happen as often as I would like... I would say it’s definitely not the usual case and generally those questions come up once parents are out of the room.”

For HCWs who worked in settings where parental involvement in their teens’ clinic visits was less common, such as in high school SBHCs, decisions about if and when to involve parents in discussions about contraceptive decision-making were more indirect. Nancy, a nurse practitioner at a SBHC, explained:

“I...don’t cut the parents out from the get-go. Like you know, I’ll say, is there anyone in your family that you talk to about that stuff? ‘Cause some girls do, and that is great, ‘cause ok, if you talk to your mom, maybe you want to talk with her about the different methods, maybe she can help you in this decision. I don’t like assuming... ‘cause sometimes I want the parent as my ally in this, if they’re supportive and they’re gonna be helping out in the big picture of pregnancy prevention. But ya know, the reality is that a lot of the time that’s not the case...So, then I will work with the teenager about that. Getting a method that works for them that they can kind of...be discreet.”

Virtually all HCWs agreed that the framework of minors’ rights with regard to reproductive health services was essential; however, some participants, most commonly located in SBHC settings, felt that it could contribute to challenging situations that inadvertently fostered antagonistic relationships between HCWs and parents. Carla, a medical provider at a SBHC, felt

strongly that parents should not be involved in their teens' sexual and reproductive healthcare, describing the conflict that sometimes arises:

"...I've seen parents, okay, coming in here, hoot and howl, scream and yell at their kids, and all I can tell them is, 'I don't know where they got the birth control pills, they could have gotten it right down the street here.' I will not admit or deny, I tell them point blank. And I feel so, so bad for the student. And I want to tell the mother so bad but I can't reveal. I can't. The student's confidence is in the way... My thing is, if this student... is sexually involved and she had enough common sense to come to a clinic and say listen, I need some birth control, I don't wanna get pregnant, I want condoms, you know what? Good for you. And obviously she couldn't go to her mother... Obviously, because look at the behavior you are exhibiting right now... I don't think there should be any parental involvement, no, no, because look what's gonna happen."

Similarly, Emma, a nurse at a SBHC, expressed frustration about what she saw as the naiveté of parents who did not communicate with their children about sex, which resulted in teens being afraid to discuss the issue openly with parents:

"I think it's so unfortunate that a lot of these parents are so naïve, and if they were able to communicate with them they would be much better off. It's sad to me that teenagers don't have the guidance from a mom or an aunt 'cause they can't tell, and just going by what the boyfriend says or what the girlfriend, who's in the same condition as them. Even I see 18 year-olds who are afraid to tell their mother. And I'm like, 'Yeah, you don't think you can talk to her? She's been there done that, she can tell you some good stuff!' But they're afraid. Especially people from the Caribbean - it's like a cultural thing... You know, some parents are throwing away their birth control... I had a girl who got kicked out like that... Or parents who call in because they're upset that their children are being seen here... I want to scream, 'Are you kidding me? Your child is trying to protect themselves!'"

Deborah, a family medicine physician, empathized with the difficult position in which parents are oftentimes placed regarding their teens' sexual and reproductive health:

"...It's hard, because I feel for the parents. I'm a parent myself! I understand and I know that it's... when the kid becomes pregnant, then it is your responsibility, right? But no you can't have any input as to when - and I've definitely had situations where, you know, parents bring their kids in for me to tell them if they're pregnant or not, or if they've had sex or not, or you know, they want to know, and it's a hard place to put parents..."

The above quotes reflect the varied and nuanced ways in which participants operated within the legal framework of minors' rights to reproductive health. Not surprisingly, policy issues that are presented as fairly straightforward in principle are in reality much more complicated in practice.

MAJOR ASRH ACTIVITIES AND RESPONSIBILITIES

With consideration of the broader political, socio-cultural, and legal contexts articulated above, this section briefly describes major ASRH activities and responsibilities undertaken by RH stakeholder organizations, followed by adolescent pregnancy prevention approaches deemed most effective by participants. The most commonly identified ASRH activities among organizations represented included direct patient care and youth development services. Depending on the organization's clinical setting and specialty, reproductive healthcare was delivered within the context of primary care or family planning. Accordingly, the extent, availability, and scope of specific services varied. Assistance with enrolling teens in NYS' confidential reproductive health insurance – the Family Planning Benefit Program - was also mentioned as a key activity by several stakeholders. A few stakeholders noted that the provision of reproductive health education for patients, clinicians, and parents was a core component of their organization as well. For example, Aimee directed a project that trained healthcare providers who served adolescents with the overall goal to integrate reproductive health services into primary care. Stakeholders from the RHS organization developed and implemented curricula for use in schools, after-school programs and community centers, and with adults.

Two RH stakeholders who were employed by the city's health department identified reproductive health data monitoring and surveillance as primary organizational activities. This included the collection and reporting of key indicators, publishing data on citywide trends in sexual activity, contraceptive use, pregnancies, and births, and responding to data-related

requests from elected officials and other interested parties. Lastly, several participants raised the central role of advocacy and policy development at city and state levels within their organizations, which ranged from ensuring the confidentiality of adolescent reproductive health services, supporting the provision of comprehensive sexuality education in schools, and addressing issues around adequate provider reimbursement and billing for contraceptives with the state's Medicaid office.

WHAT WORKS? TEEN PREGNANCY PREVENTION POLICIES, INITIATIVES, AND PROGRAMS

In discussing the scope and types of ASRH activities undertaken citywide, RH stakeholders highlighted a number of programs, initiatives and policies considered to be most effective towards reducing unintended adolescent pregnancies and increasing access to and awareness of reproductive health services. Before describing these findings, however, it is necessary to briefly examine the ways in which participants understood and defined adolescent sexuality, as their interpretations reflected underlying values and judgments. While both RH stakeholders and HCWs stressed the importance of non-exploitive relationships and young people feeling as if they had choices regarding their sexual expression and decision-making in their definitions of “healthy” adolescent sexuality, significant differences also emerged. These divergences underscored priorities and informed approaches undertaken at population and clinic-levels by participants.

RH stakeholders tended to emphasize the need to consider adolescent sexuality as being broader than sexual activity, encompassing identity, attraction, and self-concept. Participants in this group also frequently used language such as control, empowerment, and rights to convey a

particular construction of sexuality rooted in individuality and autonomy. For example, Janelle, a former director for a youth development organization explained:

“Um, I would say, first of all, to be able to recognize that sexuality, sexual urges, the way ones feels about their body, the urges to connect with someone else, or to recognize that one...has a right to even acknowledge that they are sexual beings, ‘cause I think that for a lot of young people, that whole thing is just so frightening for a lot of them...and I think that a choice on and that people have choices as to how they will decide to express their sexuality. I do think that it’s important that young people be aware of, to be healthy, that the health part of it is that their bodies are very special, they have a right and a responsibility to protect themselves and others in the expression of their sexuality. And, the fact that sexuality is not something that’s just about physical expression.”

Theresa underscored the importance of youth feeling in control of the decisions they made, which resulted from a sense of self-confidence and comfort in their sexuality:

“...A teenager who understands their sexuality, are [sic] comfortable with it, and has a sense of control over their sexuality and the decisions they make about it... ‘Cause many times I’ve found that they don’t understand what’s going on with them...they’re just walkin’ in the wind with their peers, they don’t feel comfortable talking or reading about it...”

Sonya, a medical director at an integrated teen health clinic, emphasized the importance of non-exploitative and healthy relationships in her characterization of adolescent sexuality:

“...I think if a teenager makes a decision [to be] in relationships with people that bring the best out of them...That are not putting them down, that are not abusive, that complement and help them grow. Definitely no putting down, no abuse, none of that, and where the teenager’s empowered as to when they want to do what and with whom.”

Relatedly, RH stakeholders frequently highlighted the importance of pleasure in their definitions of adolescent sexuality. Ellen, a former executive for a reproductive health services organization, commented:

“...The point is not to deny adolescent sexuality, but to talk about it in a way that can be very positive, very life enhancing, very pleasurable...Just last night I was showing all the data on first experiences of sex: 42% of young people in one study found that their first experience with sex was very negative. So I think that we have to come a long way to talk about adolescent sexuality positively and that, you know, that talk about pleasure and different varieties of sexual experimentation that can be very positive, and we have yet to

do that. So I think that adolescent sexuality is a very positive life enhancing empowering force that just needs to be guided and not constrained or restricted.”

By contrast, HCWs tended to describe specific attributes that they associated with “responsible” sexual behavior. These included young people being knowledgeable about health risks and engaging in safer sex practices like using condoms, getting tested, and communicating openly with their partner(s). For Carmela, a SBHC medical provider, healthy adolescent sexuality meant a careful consideration of the risks posed by sexual activity and ways to prevent unwanted outcomes:

“It means a kid that thinks about safe sex. Um, may not always be prepared, but at least thinks about it. Thinks about birth control, whether they’re male or female, and also about just the ramifications of sexual activity. You know, I see a lot of kids who just keep coming in for STD testing to see if they got anything but they haven’t changed their behavior, and I keep telling them, I don’t want to test you for all these things, including pregnancy, until it turns positive. Let’s do something to stop this.”

Janina, a health educator at the FMC, noted the importance of teens being well informed and acting upon the information gathered to make healthy decisions:

“I guess it would be having a teen or an adolescent that’s well informed. That knows, that has options, that has resources available...probably someone who’s aware of those resources also. Knowing who they can go to for questions...And having good follow-through. Using the information.”

For some HCWs, being in monogamous relationships, abstinent, and/or delaying sexual activity until completing high school were mentioned, alluding to a moral element of adolescent sexuality. In addition to teens being in consensual relationships where protection was being used, Meredith, a SBHC mental health clinician, highlighted the importance of monogamy:

“...I guess I would define it as an adolescent who was in “a healthy relationship,” a consensual relationship, um, where you know, I guess safety measures were being used regularly um, and with a regular partner. Sort of, you know, I guess a monogamous relationship. Maybe that’s being filtered through the lens of where I’m coming from as an adult. But ideally I think that would be great if kids can do that too.”

Alisha, a pediatrician, emphasized the importance of delaying sexual activity in her definition of healthy adolescent sexuality:

“That they’re abstinent...but aware of their options, and aware of the importance of waiting until...they’re developmentally ready and in a committed relationship and hopefully out of high school before making these types of decisions [to become sexually active], which is always the lecture I give.”

Interestingly, RH stakeholders rarely mentioned safer sex practices in their definitions of sexuality, and HCWs seldom highlighted the pleasurable dimensions of sex. With consideration of the constructions of adolescent sexuality offered by participants, the following section describes overarching approaches deemed to be most effective in addressing teen pregnancy from the perspectives of RH stakeholders and HCWs.

Several participants mentioned the citywide sexuality education mandate enacted in 2011 as an effective population-level strategy to potentially lower pregnancy rates. However, it was acknowledged that considerable latitude was given to individual school principals to determine the grades in which the curriculum would be taught and which school staff would teach it, resulting in potentially uneven impact across the city. Media campaigns such as the Bronx-based “dual protection” campaign, depicted in Figure 6.1 were also identified by several RH stakeholders and HCWs as being effective in spreading awareness about and normalizing pregnancy and STI prevention for both young women and men.



Figure 6.1. Dual Protection Media Campaign from the NYC DOHMH

However, another teen pregnancy media campaign unveiled around the same time as the above campaign evoked a very different reaction from RH stakeholders in particular. In 2013, the Human Resources Administration (HRA), a city agency responsible for managing social service and economic benefit programs, launched their “*Think Being a Teen Parent Won’t Cost You?*” campaign, which promoted a message that was very discordant from that of the health department and its community partners. The ads presented the consequences of teen parenthood in no uncertain terms – failure to graduate high school for children of teen parents, entrenched poverty, and single parent homes – using images of a diverse group of crying toddlers to deliver the messages, as depicted in Figure 6.2 below.



Figure 6.2. Subway posters of the HRA’s “Think Being a Teen Parent Won’t Cost You?” Campaign/Photographer: Author

The campaign sparked an outcry among advocates and former teen parents for its stigmatizing and fear-based tactics. Ellen remarked:

“I think that’s a perfect example of where, you know, you can use data, but if you use fear and all of that to basically try to change individual behavior...I think it’s atrocious and I would surmise even though it’s hard to evaluate a subway campaign, that it does no good except make people feel more guilty about what they’re gonna do anyway...”

There was widespread agreement among RH stakeholders that while providing education about SRH was essential to pregnancy prevention efforts, it needed to be linked with access to clinical services, as either component by itself would be insufficient to meet the needs of young people. Aimee explained:

“I think a lot of people criticize comprehensive sex education; [that] it doesn’t work, there’s no studies that show that it works. You know, if you don’t have access to services along with that education, it’s not gonna work, or it’s not gonna work well. Just by telling people about birth control methods...I think it’s really important and I’m totally supportive of comprehensive sex ed, but if you don’t link it to clinical services and support services, mental health, youth development...”

Participants presented various and often divergent viewpoints on the most appropriate or ideal settings in which to deliver sexual and reproductive health services to youth. Several stakeholders felt strongly that reproductive healthcare was best integrated into a primary care setting in order to comprehensively address health issues, as reflected by Jeffrey:

“...One of my pet peeves is that adolescent medicine...has been viewed as sex, drugs, and rock and roll...and I have made a conscious effort in every program that I’ve set up, wherever I am, to set up programs that are comprehensive health care for teenagers and young adults... We incorporate immunizations and educational goals and objectives and tobacco education and alcohol and drug education and tobacco cessation as part of the same visit as reproductive health, so whether a boy or girl is coming, they’re getting the same message, whether they’re abstinent or not. And that STI screening and for lack of a better term, family planning...is seen as part of primary care.”

Similarly, Diane articulated the relative advantages of housing reproductive healthcare within primary care compared to family planning settings:

“This model works well because you’re not fragmenting the care. Adolescents feel more comfortable asking questions and talking to their providers about reproductive health when it is integrated within general primary care. We did a study looking at continuation rates between teens who received their reproductive health care at our health center compared to a family planning center, and we found that our [primary care setting] continuation rates were higher, both with contraception and using the services.”

Drawbacks to the delivery of reproductive health services within primary care sites in community settings were raised by Christina, who questioned the extent to which these providers

would embrace a positive view of adolescent sexuality. She also expressed concerns about potential inadvertent breaches of confidentiality:

“I have a concern, and this is anecdotal, that with the emphasis on the FQHCs [federally qualified health centers] and their provision of family planning, are they gonna be...they’re a great resource in the communities. They are primary care, they’re growing, and a part of many many neighborhoods in the city. It’s not clear to me that all of them are gonna embrace adolescent sexuality, and whether they’re gonna provide family planning services in a comforting, inviting place for teenagers to come in. I mean, particularly if your Aunt Mary’s there getting her diabetes checked, so I mean really, do you want to be there?”

The benefits of SBHCs were extolled by both RH stakeholders and HCWs as ideal primary care sites for the delivery of reproductive health services due to their convenient location in venues where many youth spend a majority of their time and their interdisciplinary model of medical and mental health care. SBHCs in NYC are licensed by local hospitals, FQHCs, and diagnostic and treatment centers located within school buildings. They are primarily established in areas with high medical need and few healthcare resources, and are operated by an interdisciplinary staff of medical and mental health professionals (NYS Department of Health 2010). While not all SBHCs nationally or within NYS provide comprehensive reproductive healthcare, most NYC SBHCs serving high school grades offered a range of services. Carmela, a nurse practitioner at a SBHC, described the relative advantages of receiving contraceptive services in her clinic setting versus one designated specifically for such care:

“...I think with the school, that is the one stop shop. We’re open all year...and I think that’s incredible access. ‘Cause, you know, I see this a lot, let’s say I have a guy that comes in and his girlfriend wants to get BC [birth control] and I send them to Planned Parenthood, and I say, ‘Go with her, ‘cause it’s a little hard to do this all by yourself. Just sit with her in the waiting room.’ It’s friendly, but it’s not like this...you always have to go through the appointment system and filling out paperwork...they’ll take care of you and it’s all confidential, but it’s not as easy as the SBHC, which is right there...”

Nancy, a medical provider in a SBHC, emphasized the value of onsite mental health services in treating youth more holistically and normalizing the importance of emotional, and mental health:

“We are so lucky to have onsite mental health services...So much of what I do is mental health related...I’m not a mental health provider, but I can identify mental health needs and I can work together with the mental health provider to get a patient to get the services that they need. So, you know, someone who’s had three abortions, like, let’s look at this, what’s up? And that’s to me...this is a red flag, there’s something else going on...Or someone struggling with methods, or a lot of really high risk - someone who’s coming in for the third time with an STI, I’m gonna refer to mental health services if they’ll go...We take a look at the whole big package here...”

Regardless of the setting, participants underscored the importance of services being delivered within an “adolescent friendly” environment, which included assuring confidentiality of reproductive healthcare, no out of pocket costs to patients, and patient-centered and non-judgmental care. Several participants also highlighted the importance of teens receiving personalized and thorough contraceptive counseling to support method selection and adherence. Reflecting a recent citywide emphasis on increasing awareness of and access to LARC, interviewees often stressed the significance of ensuring that these methods were readily available to adolescents. Susan, a city health official, commented:

“...I think it’s really hard for anyone, not just teens, to remember to take something every day, so I think it’s why we’ve really worked hard to raise awareness about the other methods, ‘cause I think the evidence shows a much lower success rate for methods that are user-dependent...There are some people who are amazingly good at taking pills, so great – maybe that’s a good method for them. But most of us humans are not and so I think that’s why it’s so important for teens to be offered all the methods and to have easy access to the methods, not just the ones that are user-dependent but the ones that are longer acting.”

Andrea reiterated the preference for longer acting methods given difficulties with adherence to user-reliant contraception, praising the perceived ease and privacy of these methods for young people:

“I think, you know, the ‘LARC-iest LARC’ we can get going is the best for young people. ...Like all women, the girls need to have the thing that takes the least amount of thinking on a regular basis to make it easier. Anything that they have to do and anything where they have to reveal to other people what they’re doing is gonna make more of a barrier for them, whether it’s their parents or even their friends...So any of the methods that make it problematic from a privacy point of view, I think are difficult.”

However, not all RH stakeholders supported the recent prioritization of LARC methods so unequivocally. While many participants praised efforts to make these highly effective methods of contraception more available to teens, some expressed concerns that, given the potential for being used coercively, their promotion needed more thoughtful consideration and reflection:

“I’m a little bit worried about that now with the whole move to the IUDs and I think we have to be very conscious with wanting to promote IUD use as an important highly effective method, not as the be all and end all...I feel like that’s the newest kid on the block now, the IUD, and it’s just taking over everything. And I think we have to be very careful not to forget the choice argument, that we’re increasing choice, we’re not promoting or pushing one method...It certainly is vitally important and it’s great that all this research has been done and we know that teens can use it now...but I think we need to be mindful.” (Aimee)

Jeffrey took issue with what he saw as the recent trend of “pushing” LARC methods for teens, arguing that his patients wanted less invasive methods with which they could exert more personal control:

“I have a lot of problems with some of the things that I get. You know there’s this push in NYC that everybody should get LARC. And I don’t think that LARC is what we should be pushing. What we should be pushing is adolescents making a decision, if they’re sexually active, what they want to be using, and for the vast majority of my patients, LARC is not what they want. They want the pill, they want the patch, they want that control. They don’t like the idea that something was ‘put into them;’ I’m quoting them, ‘put into them,’ and, yes, they know they can go to a doctor to have it taken out, but they don’t like the idea that you know, it’s in me, and that’s it.”

A number of RH stakeholders also highlighted more holistic attempts to address adolescent sexuality and reproductive health needs, including the onsite provision of integrative or comprehensive health services and education to young people, youth development programs, and service learning activities. According to participants, these approaches differed from more traditional clinic settings because they considered the broader context of youth’s lives in the delivery of healthcare services, while connecting them with other non-clinical resources,

including therapy, art, legal services and employment assistance. Below, Sonya described her clinic's integrative philosophy:

"We try to have a program without barriers...It's really a very holistic way of working with them about their general wellbeing. This is not just about family planning, this is about these teenagers really having access to all the services that they need and helping them stay in school, and helping with their legal issues...helping to enhance their lives so that their sense of self is such that they try to do the right things for themselves...That's what these kids need. Just a one silo [approach], that's not enough for the types of issues and the types of trauma that these kids bring us."

Of the importance of onsite social and health services for adolescents, she continued:

"I think if you work with teenagers...You know, if we do the medical piece, and then...for family planning you have to go to that clinic, for mental health to the other clinic, for nutrition to the other clinic. Then when you get in trouble with the law you have to go...no. For one thing, I think it would be hard to figure out what to do and you'd almost have to take them by the hand. But also they'd be afraid. They don't know those places. So we just think that the more we have onsite...the better for the kids."

Even if not part of their organization's strategy, most RH stakeholders identified youth development and service learning as highly effective ways to strengthen the capacity for youth to lead healthier lives, including their sexual and reproductive health. Such an approach was often contrasted with the crisis-based orientation to adolescent health, wherein a particular problem (e.g., teen pregnancy) was the focus of an intervention, rather than a more holistic orientation to health that hinged upon youth's resiliencies:

"I guess for me, it really is about a model that is looking more on strengths and resiliencies, and really seeing young people where they are...A lot of models are built on, what's the problem? So let's define what's the problem is and then come up with ways to fix the problem. And I think that from a strength-based or resiliency-based approach, I think there is just so much more possibility about being able to first of all, help young people to be able to see themselves as having the power to make a difference in their lives, and a whole lot more creativity is possible..." (Janelle)

Participants highlighted several youth development programs, most notably, the Carrera program model, as being particularly effective at preventing pregnancy. The Carrera program began at the Children's Aid Society in NYC and attempts have been made to replicate its success across

the country. It works with a cohort of children around the age of 10, who, along with their families, receive intensive case management and wraparound services, as well as sports programming, academic achievement, literacy and financial support. Though criticized for being very expensive given the small numbers of youth reached, it has been shown to be highly effective at achieving its goals to delay pregnancy and childbearing among participants. In addition, service-learning was mentioned by several participants as a form of youth development with the potential to effect positive change in the lives of teens. Here, Christina described her organization's work to integrate sexuality education into a service-learning program:

"...Another strategy NYC has pursued is...a service learning model out of DYCD [Department of Youth and Community Development]. And you know, the data show that kids that are involved in service learning having lower rates of pregnancy. Part of it is they're so busy, but the other part is there's an engagement there with the caseworkers and the people and the teens, and so what we're doing is working with the staff that are involved, giving them the skills, the knowledge and the confidence, frankly, to talk about sex with young people. And integrate it into the service learning. I would love to see more of that..."

Theresa's healthcare organization initiated a strengths- and asset-based service learning and educational program for adolescents after realizing that despite provision of onsite reproductive health services, teen patients' risk behaviors did not change substantially. She explained:

"One thing we learned was that despite the fact that we're offering contraception to the teenagers, they were still coming back...and I'd say, 'Well how can I help you because you're...still taking risks, so how can I help you?' So we did focus groups a lot, and they said what they wanted was more mentoring, more engagement with an adult, more community engagement, and so when we were writing this grant, we were looking for a program...that doesn't just focus on teen pregnancy...So they have different learning modules, a lot of community service...They choose a theme, whatever they want, they're really engaged in their communities, and they have classroom time where they talk about their bodies, puberty, they talk about negotiation skills, talk about their parents. They did a parent communication workshop...and we felt it's made a much broader impact than just having the services in the clinic."

Lastly, several stakeholders cited support for parenting teens through initiatives such as the Nurse-Family Partnership, a case management support program for first time mothers, or other support programs, as a youth development model that resulted in improved health and other outcomes for both the mother and child.

CHALLENGES TO COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR TEENS

In discussing the activities and strategies undertaken by stakeholders and their organizations regarding adolescent SRH, a number of significant interrelated challenges were identified. First, several participants remarked on the disjointed and narrow programs available, which often had a singular focus on just one piece of SRH, such as access to contraception or sexuality education. Moreover, some believed that a cohesive overarching framework or strategy within which all of the interconnected pieces fit together was lacking. In many cases, participants tied these issues to the nature of state and federal funding mechanisms that are often categorical and myopic in their scope. Janelle lamented the limited and narrow funding available that resulted in program silos for particular issues and services, which ultimately do not address these issues within the broader context of youths' lives:

“...Funding’s still very categorical....At one point there was talk at the state level about really realizing that you know, all of the different funding that might be available for providing services to young people really does need to kind of be looked at so that the funding would be less categorical and services could be delivered in a more creative way... instead of having people, you know, young people and even adult people go to one place for one thing, one place for another, and yet another place for something else.”

Likewise, Ellen noted the dearth of funding for youth development programs as compared with “crisis” or problem-based approaches, stemming from a more systemic lack of understanding about adolescence as a developmental stage and the social determinants of teen SRH:

“...Funding’s a big issue. So if it’s hard to get funding for youth development programs, which are more comprehensive, you’re gonna get these piece meal things that target contraception in isolation of all the rest of adolescent, um, needs. So...the organizations I think with the funding that’s available to do the work, it’s really important...Unless, you know, there’s this understanding and framework at a really higher policy level, yeah...a lot of money is going to go into abstinence education that could be going into youth development. And the lack of real analysis of the problem, the lack of real understanding of what adolescence is about, I think, and therefore leads to very tunneled vision when it comes to funding and opportunities for developing programs.”

Susan also described difficulties associated with advocating for funding to address the root causes of adolescent childbearing:

“I think one of the conflicts to keep in mind, at the national and local level, is...it’s hard to get funding when you say, ‘Well, really this [early childbearing] doesn’t cause poverty, really it doesn’t do this, it’s something about equity,’ it may be a less compelling area to focus on with funding if you don’t create that sense of urgency, and I think that can sometimes compete with good science.”

Similarly, several stakeholders commented on the limitations of *any* program, youth development or otherwise, to substantially alter the structural and economic inequities that were seen to drive the distribution and occurrence of SRH outcomes such as teen childbearing. Any impactful change, therefore, would require considerable societal investment targeted at the root causes of such inequities. When asked what she thought could be done to effect more systemic change, Aimee commented:

“I don’t know! More taxes, uh, I don’t know! That’s, yeah...it’s a tough sell. People don’t even want people to have universal health care in this country, so. And how do you develop a program to address that? I guess the closest thing would be acknowledging that you can’t do it, totally, but there’s this program...they’re integrating like a little bit, ‘cause they don’t have the money to do it...helping kids early, like in 9th grade, to understand what they need to do to apply for college. So things like that are very helpful if you could latch that onto pregnancy prevention programs. Beyond handing them the pill, the ring or the IUD, to latch it to other issues in their life.”

Another formidable challenge described by participants was the difficulty associated in measuring the impact or effectiveness of the work undertaken by their organizations. In particular, an important theme that emerged was the predominance of “evidence-based”

strategies and approaches, which were viewed as a necessity by some RH stakeholders and a source of frustration by others. Several participants questioned the “politics of research,” which determined both the value of the phenomena studied and explanatory power of the evidence. The resulting accumulation of a narrow bandwidth of evidence served to reinforce the way an issue was viewed and benefitted particular types of interventions. Aimee explained:

“...Believe me, I know how important research is and evidence is, but the politics of research and what gets studied, and also throwing things out because you couldn’t show evidence, especially with young people...like if you talk to young people and you think about your own life. You might not be able to equate something that happened to you a year or two later to that intervention you had with that person in that SBHC until 10 years from now. And you may never be able to study that, but it doesn’t mean it didn’t have an effect.”

Below, Janelle highlighted these challenges with regard to youth development programs and alluded to a lack of political will to combat poverty in substantive ways:

“...For a whole lot of years, funders didn’t wanna hear about the little vignettes and the success stories; ‘Show me proof, show me proof!’...And I could remember trying to get funding and funders wanting to, ‘Well, we’d be willing to fund you if you can prove that an integrative holistic approach to youth development is effective. What happens to young people five years down the road...?’ Sure, you’re gonna find what happens in six months to a year. Can we go five years out?...And now there is far more proof that’s out there. So I can only surmise that there’s still lots of politics in, and in the whole politics of poverty...is there really a war on poverty, and are we really dedicated as a society to help everyone reach their fullest potential? And the answer is no. There’s no real investment in that, so - why fund things if you believe...that it’s expensive and people are going to “waste” those dollars?”

Other participants, such as stakeholders from the city’s health department, regarded data-driven and evidence-based programs to be essential and pragmatic ways to expend limited resources on those interventions thought to have the biggest impact. Below, Andrea reflected on her attempts to work with another youth-serving city agency on a teen pregnancy prevention initiative where there were clear ideological differences concerning program efficacy and impact:

“...This other city agency...has been hard to deal with because we want them to get with the evidence-based programs program [Laughter]. It would have been an investment, but

instead of investing money in a proven, uh, service-learning program...they created their own home grown service learning program....And I can't...that's like me saying, you know, there are all these medications for your blood pressure. I'm not gonna give you those, I've got some stuff I've cooked up in my basement that I think is really good! That just would not be acceptable...So that's like a very science-y way of looking at this stuff, and those folks are not at all in the science field, I think, so it's one of those paradigm things. I mean somebody who we're working with at a high level [there]...She's like, look, what kids need, what all of the evidence, your evidence, shows...is kids need an adult who cares about them. And I'm like, 'Okay, that's true, but you can't make that happen! Here's something you can make happen!' And we know what outcomes we'll get if we do these programs. And then you can do the other things also that might result in having that other relationship thing but...she's very driven on that thing which is a very unmeasurable [sic]..."

Another persistent and significant challenge identified by RH stakeholders was how to effectively engage young men in sexual and reproductive health issues, broadly, and in pregnancy prevention, specifically. In addition to the pervasive view of sexual and reproductive health as relevant only for young women, young men sought health care far less frequently, rendering a holistic approach all the more necessary to engage them on issues relating to their health. Many stakeholders reported organizational activities and programming that reached out to young men in various ways, including the creation of youth advisory boards, tailored materials and messages, and media campaigns. Susan related:

"...This is an issue that comes up all the time...where, you know we have partner meetings and there's 49 women and two men...I think there continue to be challenges around how to really engage young men. I mean, we're very aware when we develop any educational materials that they're applicable to males and females. And we've shared materials with some of the government agencies...that serve primarily young men..."

Several RH stakeholders struggled with how and whether to involve young men in conversations about contraception, regardless of their potential influence on female partners. Christina commented:

"We have had some different campaigns where we've geared our messages more towards young men. I think there's more we can do in including young men in the process, certainly in all of our educational work and everything, they should not be left out. Having said that, I feel strongly that a lot of the contraceptive methods need to be

focused on young women. I mean we gotta find the right balance. We need to do both but what you want to do is empower a young woman to feel that she can take charge.”

Andrea pointed to the lack of a clearly defined role for young men in contraceptive decision-making as well as a paucity of data to inform a stance on what their role should be, which made further exploration in this area difficult:

“I don’t yet know what the data shows about young men, like, so part of me you know, the belligerent null hypothesis part of me is like, why do we want to have young men involved ‘cause this is, like, the young woman’s decision?...But the other part of me says, obviously the girl in a heterosexual relationship is going to be highly influenced by the guy in the relationship, so we’re idiots not to involve the men as well. But what’s their role? I don’t think we as a health department have really come to a conclusion about the role of the young man...There hasn’t been a lot of research done on this. Everything’s been so focused on the girl, so we don’t really know, which is unfortunate.”

ACCESS BARRIERS: PERSPECTIVES FROM RH STAKEHOLDERS AND HCWS

At first glance, access to reproductive health services in NYC, particularly when compared to most other cities in the United States, appears relatively ample. The city is home to a vast healthcare network, which collectively boasts extensive services for reproductive health in a variety of healthcare settings. Additionally, services are provided within the context of the minors’ rights legal framework that allows teens to access this type of care confidentially. Despite this supportive “climate,” RH stakeholders and HCWs identified a number of obstacles or barriers at the patient, clinic and health system levels that are believed to impede the use of such services by teens.

Issues identified at the individual patient-level most commonly included teens’ lack of knowledge about the availability of confidential reproductive health services and discomfort seeking care. Susan explained:

“I think teens still don’t...A lot of teens still don’t know that services are confidential, that they have the right to confidential services, that no one needs to know. I think that remains, and I don’t know this for sure, if it’s shifted; we’ve worked hard to get that message out, but I think...that’s still true.”

Citing the high density of service providers in NYC, Jeffrey pointed to teens' knowledge deficits as the primary barrier to seeking care:

“Um, the only barrier I think is really how much the adolescents know. So I was thrilled with the Teens in NYC app because that addresses the knowledge gap that exists in adolescents. I think that in NYC, again, we have a skewed view of the world. Access isn't an issue, 'cause there are hospitals across the street from each other vying and fighting for the same patients. Travel is not the barrier that it is in West Virginia. Nobody has to drive 120 miles to go to a Planned Parenthood for a termination.”

This sentiment was also reflected by HCWs, who, as a group, by and large, believed that reproductive health services in the Bronx in particular were available and easily accessible to teens. Brianna commented:

“There's no barriers [to accessing family planning services], the only barrier is the teen. They're their own barrier, because everything is so accessible to them. It's confidential care and they know this. It's free, because of the Medicaid, teen health Medicaid, so the bill doesn't go to their parents...It's their lack of education and knowing that it's here for you.”

Other participants referenced some teens' discomfort with seeking services, as illustrated in the below quote from Deborah, a medical provider:

“...[There's also] that whole issue of teenage time where you don't feel comfortable going to your PED [pediatrician], but you don't have an adult doctor set up, you don't want to go to where your parents go. It's a very vulnerable time and makes people neglect things that they should probably go to get but they just don't feel like they have a comfortable setting to do that.”

Fear about parents finding out about their use of services was also mentioned by some participants as a patient-level “barrier” that limited the extent to which some teens sought reproductive healthcare:

“Some teens may have a lack of information...as far as resources, where can they go. I think there's some fear as far as, 'If I go to the doctor are my parents gonna find out?'...And...they may not know that their doctor can give them all this without their parents finding out... I think...that may be some of the difficulty for some teens. I think it's perceived difficulty rather than actual difficulty. Actual for them but not actual on a systems level.” [Ethan, FMC medical provider]

Many RH stakeholders and HCWs also noted provider and clinic-level barriers that limit access to care. While using every clinical opportunity to assess teens for sexual activity and their need for related health services has been recommended by the city's health department and several professional associations, such as the AAP (2014), several stakeholders highlighted ongoing struggles to achieve this goal, as reflected in the quote below by Susan:

"... We found...when we started working in the SBHCs...there are many opportunities to offer teens and provide them with contraception that are missed opportunities. So that if a teen comes in for a sports physical, take a sexual history. Is she having sex? You know there's many times when teens come for other reasons and obviously if they're coming with an asthma attack you're not talking about birth control, but if they're coming for a pregnancy test, you better! And often even that wasn't happening...and there was push back, like, 'I don't have time to do it,' or whatever. So I think there's still those issues around taking every opportunity...I think there's still many times teens walk in for care for another problem and don't get asked or offered reproductive health services."

Several participants also cited some providers' discomfort discussing and addressing teens' sexuality and reproductive health. Theresa provided herself as an example:

"...There's barriers on the providers, they themselves didn't help! Like me, I told you that I didn't know how to talk to them about it, from my own culture, so I had to be educated about it. So, you can imagine having a teenager come to me at that time; I wouldn't have been the best person to give her all the resources because I didn't know enough."

Sonya remarked on the lack of understanding among some providers about teens' legal rights to seek related services and their failure to speak privately to the young person as potential barriers, and which also affect the type of information disclosed:

"...Many providers don't understand the right of teenagers with respect to confidentiality, and also if you're talking with a teenager, it's very important to talk to that teenager by themselves at some point during that visit. Two very, very basic things that can be done that I think will enhance what the teenager will share with the provider. And then the third thing is really...the approach to patients...people assume that if something is going on in the life of that young person, whether it's abuse or that they're having sex, that they will volunteer that information, and my experience is that you need to ask them directly about any kind of behavior if you want them to answer..."

Appointment scheduling, clinic policies around the provision of onsite contraceptive supplies and outdated or restrictive protocols pertaining to reproductive health services were also seen by some participants to limit the accessibility and availability of services. Additionally, participants indicated a lack of consistency across providers and clinic sites in providing contraceptive education, which suggested a continuum of information quality and comprehensiveness that teens receive. Janina, a health educator, explained:

“I think what would make it [our services] better is more consistency as far as the patients that we see...I feel like every teen more or less should have some sort of education about contraception and I’m not sure how often that happens. It could happen with the primary care provider, we don’t really know about it, but I think that consistency is an issue just among the site and throughout multiple sites...I don’t think the care that’s provided is the same for everybody. I don’t think that’s the way we plan it, that’s just the way it works out.”

Participants also identified multiple obstacles at the health systems level, including issues with insurance coverage, financial barriers for provider reimbursement and breaches of confidentiality. Allison related a story about a patient’s experience with a lapse in health insurance to highlight the “ways that people get caught up” in the complexities of the health system:

“I had a patient who had an abortion and was supposed to start on Depo Provera, and she went to get the prescription, and she was supposed to come right up and get her shot. And there was some snafu with her insurance. Anyway, she became pregnant again within two months. And so, you know, I think that there are barriers. Sometimes it’s insurance, sometimes co-pays, sometimes, you know because you don’t want anyone to know, you don’t wanna use your insurance... there are all these things that, kind of, hold things up...”

Lastly, reimbursement for services provided was also mentioned by several RH stakeholders as a challenge, due to the fact that many clinics offered low or no-cost services for teens who often were either uninsured or could not use their parents’ insurance for fear of their confidentiality being breached. Addressing these issues has recently become more exigent due

to the emphasis on LARC methods, which are the most expensive options and often cost-prohibitive for many clinics to stock without a mechanism for reimbursement. Susan commented:

“I think there continue to be financial issues particularly around IUDs and implants in uninsured teens and there continue to be barriers around not being able to use existing insurance. So if the parent has a MMC [Medicaid Managed Care] plan, and the teen needs confidential services, you cannot bill their plan or there’s gonna be an EOB [explanation of benefits] that gets sent home. So there are still real issues around clinics being able to bill even if a teen has [insurance] coverage to protect their confidentiality.”

The issue of confidentiality was underscored by many HCWs as a perceived barrier, rather than an actual one. Deborah’s comments below point to the imperfection of the health system at preserving total confidentiality, and the need to develop better systems to protect teens’ privacy:

“We’ve tried to...deal with the confidentiality issues and making sure that insurances don’t get notified...that somehow...through our crazy bureaucratic process that parents don’t get somehow notified of their teenagers’ sexual decision-making, but that system is not perfect by any means...so I think it’s a very real concern that kids have that their parents are gonna find out ‘cause a lot of times they do! Unfortunately, for getting a bill or something that shouldn’t have necessarily gone to the home but does. I think we need to...work on a better way to deal with that...so when we say it’s confidential, it really is confidential, and that they don’t kinda get bit on the other end of things, ‘cause that’s definitely gonna make them not trust the doctors, not trust the system, and not access the system...”

As a policy director for a RHS organization, Linda was involved in committees organized around the implementation of the Affordable Care Act (ACA) in NYS, and in particular, its implications for reproductive health. Her description below of the impact of healthcare reform on eligibility requirements for Medicaid exemplified the complexity involved in the delivery of this particular set of health services, further exacerbated by its application to teens:

“...There are a million...unintended consequences...misalignment with confidentiality, all kinds of things that are on a daily basis surfacing...For example, one of the things the ACA has done has been to redefine income eligibility...So, because it is based on a tax unit...when someone, i.e., a minor, goes to apply for Medicaid...initially it was...They can’t apply on their own because...the family unit is the tax-filing unit....So we pushed very hard and do have...legislative statutory language that preserves FPBP [Family

Planning Benefit Program] as minors can enroll on their own...However, Medicaid for Pregnant Women, whether it's prenatal care, or for termination services...all of a sudden we're confronted with, oh my god, what's gonna happen to a 17 year-old that prior to this had been able to apply on her own for Medicaid to get a termination, now has to...turn to her mother or father, whoever's the head of household, and say, 'Oh, I need your income verification because I'm getting a termination.' ...What it is taking us...to be able to see what kind of workarounds we can do...because if there is no protection for minors to be able to obtain that Medicaid coverage for terminations...it could really have extremely significant effects on a young person's access to abortion services."

Importantly, several participants strongly articulated that although providing access to free contraceptive services for teens was essential, it was not a panacea. Rather, it needed to be considered within the context of adolescent development, sexuality and broader social forces impacting educational and economic opportunities for youth.

CONCLUSION

This chapter presented study findings pertaining to the overarching political and legal landscape of ASRH, broadly, and teen pregnancy prevention initiatives, specifically, in NYC. A prominent theme that arose from interviewees was the value placed on integrated and comprehensive healthcare settings to deliver reproductive health services to youth. Participants also reflected upon the particularities of carrying out pregnancy prevention efforts in NYC, highlighting the city's unique characteristics that were thought to impact it. Many participants identified challenges and complexities resulting from myopic funding streams and limited funding and the fragmentation of our healthcare system, as well as difficulties in engaging young men in sexual health promotion and pregnancy prevention. Moreover, despite policies and programs that facilitate access to reproductive healthcare in NYC, RH stakeholders and HCWs identified considerable barriers for teens. The next chapter will shift to the clinical level in order to present findings from HCWs on their priorities, values, and approaches with regard to the delivery of reproductive health services to youth.

CHAPTER SEVEN

VALUES, ATTITUDES, AND PRACTICES AMONG HEALTHCARE WORKERS

INTRODUCTION

Studies on the content and delivery of family planning services with adolescent women have primarily been conducted in designated reproductive healthcare settings such as Title X clinics, despite the fact that the majority of youth access such care at primary care practices (Rubin, Davis, and McKee 2013:131). In addition, research exploring healthcare provider practices, attitudes, and beliefs about family planning services for youth almost exclusively focuses on the perspectives of clinical practitioners, and to a lesser extent, of social workers. Accordingly, this study addresses two major gaps in the literature: first, HCWs interviewed worked in one of three types of primary care settings where teens accessed reproductive healthcare; second, HCWs of various roles were interviewed, including clinical support staff, nurses, mental health counselors, and medical staff with various types of training. This research sought to better understand how HCWs of various types and within different clinic specialties approach the provision of adolescent sexual and reproductive healthcare.

Unlike family planning clinics, where the majority of visits are exclusively about a sexual and/or reproductive health issue, primary care clinics have broader health goals and imperatives. In these settings, reproductive health is integrated into other primary care services that the clinics provide. In addition, clinics included in this study served different age populations. For family medicine clinics, the patients served range from newborns to the elderly, while the pediatric

clinic patient population ranged from newborn to 21. School Based Health Clinics (SBHCs) were the only type of clinic in this study that exclusively served adolescents, although the pediatric clinic recently opened “teen clinic hours” one afternoon a week for adolescent patients to visit with a nutritionist, health educator, and/or reproductive health counselor.

For all clinics, an explicit goal described by HCWs was the provision of services to an underserved population. Meredith, a psychologist in a SBHC, explained:

“Well, the goal overall I guess is to take care of these kids holistically and to take care of their medical as well as mental health and just kind of create healthy kids who are living in a very often unhealthy environment in terms of both physically and psychologically, and to increase the chances that they’re gonna be coming to school every day and not missing appointments outside... Just helping a high risk population.”

In addition, several SBHC HCWs noted that although the overall focus is comprehensive, there is an emphasis on reproductive health. HCWs in the FMC and PED settings described similar overall goals as those for SBHCs: the provision of primary, comprehensive, and preventive care to underserved populations. In addition, both FMC and PED serve as training sites for residency programs where they strive to model evidence-based clinical decision-making for residents.

HCWs interviewed comprised a diverse group of individuals with various clinical roles and, subsequently, relationships with the young people they served. It is important to note that while all HCWs are involved in the delivery of reproductive health services to youth, including contraceptive education and/or counseling, medical providers are the only category of HCW that can prescribe and dispense a method. Table 7.1 displays the various HCWs represented in this study and their major clinic roles and responsibilities with regard to teen patients.

Table 7.1. Clinic Activities by Type of Healthcare Worker

Type of HCW	Major Clinic Roles and Responsibilities with Teen Patients
Medical Providers	Comprehensive physicals, acute care, chronic disease management, vaccinations, sick visits, injuries, and reproductive health services
Mental Health Providers	Therapy (short- and long-term), behavioral counseling, pregnancy options counseling, group facilitation on healthy relationships, sex, and contraception

Table 7.1. (Continued)

Type of HCW	Major Clinic Roles and Responsibilities with Teen Patients
Health Educators	One-on-one patient education on a variety of topics, including contraceptive counseling, waiting room presentations, group facilitation on reproductive health, prenatal care, and chronic disease management
Clinical Support Staff	Assist medical providers, prep patients, give vaccines, administer pregnancy and STI tests and provide results, blood work, reproductive health education, coordination of prenatal services, group facilitation

Given the different professional backgrounds and lengths of time in practice among the HCWs interviewed, it is not surprising that the type of education received and extent of experience on the topic of contraceptive counseling varied. Reflecting on the diversity of attitudes and levels of comfort among pediatricians on providing adolescent sexual and reproductive health care, Nancy, a SBHC medical provider, commented:

“...I have to say...there’s a broad, broad variety I think in provider attitudes across the pediatric spectrum. Family medicine, no... like I don’t see it in the same way. But pediatricians? And pediatric nurse practitioners?...There’s really a broad range of attitudes towards reproductive health in that they’re not trained. Pediatricians are not trained in reproductive health so much...you know, you have kids transitioning from their primary care providers that they’ve known their whole life into kind of adolescent stuff.”

Most medical providers reported having received didactic training during their post-graduate clinical programs, but as Alisha, a pediatrician at the PED clinic, noted, this type of information is lost quickly if not part of their routine practice:

“...In medical school we definitely had...to rotate through all the specialties so I spent some time in GYN [gynecology] and just shadowing physicians... so you’re lectured on everything under the sun in medical school but I don’t really think that those types of things [contraceptive counseling] stuck with me so much then... that kind of information is use it or lose it.”

For the majority of health educators, social workers, and clinical support staff, most of their knowledge about sexual and reproductive health services came from professional experience and on-the-job training. Gaining experience and exposure to working with young people around these issues fostered greater levels of comfort with the topics, although HCWs used different

approaches or styles in the provision of services. Given the ever-evolving landscape of adolescent medicine and reproductive health, the need for continuing education, ongoing training, and keeping current with clinical guidelines and best practices was considered important by some HCW.

REPRODUCTIVE HEALTH SERVICES IN THREE PRIMARY CARE MODELS

Before delving into the ways in which HCWs discussed contraception with teen patients, it is important to situate these interactions within the context of reproductive health services (RHS) available at these clinical settings. All sites provided pregnancy, STI, and HIV testing, as well as contraceptive counseling; however, there were considerable differences in the availability of contraceptive methods dispensed onsite, reflecting different clinic policies.²⁴ Table 7.2 provides a snapshot of RHS offered at SBHC, FMC, and PED clinics staffed by HCWs in this study.

All SBHC settings offered emergency contraception and regular hormonal methods. In addition, some sites offered IUD and/or hormonal implant insertions, dependent on the availability of trained providers. At the FMC clinic, condoms, Depo, IUDs and the hormonal implant were available onsite; patients had to obtain the remaining methods by prescription. At the PED clinic, the general protocol was to provide a prescription for all methods to patients, although a small reserve of pills and Depo were often available for patients with “insurance issues”. Depo users without insurance issues must return to the clinic after picking up their medication to receive the injection. Brianna, a pediatric nurse, outlined the process by which decisions are made regarding what methods are available in her clinic compared to a referral for

²⁴ Onsite availability references the ability for medical providers to offer the method to the patient immediately, without requiring them to leave the clinic in order to fill a prescription, a potentially important protocol as some research has shown that having to fill a prescription may present an access barrier for teen patients in particular (DOHMH 2012; Hock-Long, Herceg-Baron, Cassidy, and Whittaker 2003).

services at the OB/GYN clinic upstairs: OCPs and the Depo shot are available at the pediatric clinic because these are methods pediatricians can administer. Any method that required an insertion of some kind was not suitable for pediatricians, as she explained that they did not have the proper room set-up and are not as familiar with the pelvic area. This was the case even for the hormonal implant, which is inserted sub-dermally under the arm, or the NuvaRing, which is inserted into the vagina by the patient. The transdermal patch was also only available at the OB/GYN clinic and thus required a separate appointment.

Table 7.2. Reproductive Health Services Offered at SBHCs, FMC, and PED Clinics

<i>Type of Service</i>	<i>SBHC</i>	<i>FMC</i>	<i>PED</i>
<i>Pregnancy Testing</i>	Onsite	Onsite	Onsite
<i>STI/HIV Testing</i>	Onsite	Onsite	Onsite
<i>Contraceptive Education/Counseling</i>	Onsite	Onsite	Onsite
<i>Pregnancy Options Counseling</i>	Onsite	Onsite	Onsite
<i>Pregnancy Termination</i>	Referral Only	Onsite	Referral Only
<i>Condoms</i>	Onsite	Onsite	Onsite
<i>Emergency Contraception</i>	Onsite	Prescription Only	Prescription Only
<i>Oral Contraceptives</i>	Onsite	Prescription Only	Prescription Only
<i>Patch</i>	Onsite	Prescription Only	Prescription Only
<i>Ring</i>	Onsite	Prescription Only	Prescription Only
<i>Shot</i>	Onsite	Prescription Only	Prescription Only
<i>IUD</i>	Onsite availability dependent on SBHC; otherwise referral	Onsite	Referral Only
<i>Hormonal Implant</i>	Onsite availability dependent on SBHC; otherwise referral	Onsite	Referral Only

FOLLOW-UP SYSTEMS

HCWs described various protocols and systems for following up with teen patients who initiated contraception, as will be described briefly below. The goal of follow-up visit is to facilitate medication adherence and increase the likelihood that patients will return to the clinic as needed for appointments, prescription refills and other supplies. At the PED clinic, HCWs explained that teen patients using the Depo shot were contacted by phone to remind them that their next shot was approaching and to make an appointment within the specified “window

period.” There is no such protocol for patients using other methods. At the FMC, medical providers are very cautious about contacting teen patients due to concerns of a potential breach in confidentiality. Therefore, a decision was made to privilege confidentiality over patient follow-up. Staff have been instructed not to send no-show and appointment reminder letters home nor make phone calls because, though this information does not reveal details about the type of appointment, it has gotten some teens into trouble with their parents, who did not know their children were receiving this form of care. Additionally, it is very difficult to make an appointment at the FMC months in advance (e.g., so a teen can schedule their next Depo shot three months after their office visit for the current shot). Instead, patients must call approximately a month before their next shot to schedule an appointment. However, to facilitate adherence, medical providers write prescriptions with refills so their patients can obtain the Depo medication before their appointment and bring it to the clinic to be administered. Generally, other types of birth control prescriptions (i.e., oral contraceptive pills, the patch, and ring) are given for one year, but one complication to this practice is that NYS Medicaid generally does not honor a prescription for more than three months. In these cases, a new prescription must be provided to the patient. Moreover, Medicaid patients cannot request a refill on a prescription until it runs out. Some medical providers have established a workaround practice to help mitigate these challenges by instructing patients to call the health center and leave a message so the provider can then determine how to renew or refill the prescription. In these cases, providers do ask for confidential phone number to call back; however, this form of communication is not always reliable since their patient population frequently use a pay-as-you-go mobile phone plan that either may become deactivated when they do not pay, or requires changing telephone numbers when the plan expires.

The SBHC sites have, arguably, the setting most conducive to follow-up because their patients attend school in the same building as the health center. A program-wide protocol is in place to recall patients who have a follow-up or missed appointment for any reason, not just the initiation of contraception. The recall process proceeds as follows:

1. Front desk staff at the SBHC create a list of upcoming and missed appointments and send it electronically to the school campus manager;
2. The school campus manager then enters this list into an electronic administrative system, which will prompt an alert when the student scans their ID upon entry to the school the following morning;
3. A school staff person will remind the student that they have an appointment or need to come to the health center.

Unfortunately, there are numerous opportunities for this process to go awry, as described by HCWs. For example, the front desk staff may not have time to make and send the list. If the list does get sent to the campus manager, they may not enter the list into the system. Or the school staff operating the ID scanner at the entrance may not inform the student that they are requested at the health center. A student losing their ID is another issue, as they will not be notified upon school entry. The multitude of ways in which clinics choose to engage teen patients outside of the healthcare setting reflect various priorities, challenges of working within complex systems, and the provision of services within the context of confidential reproductive healthcare.

PATIENT DEMOGRAPHIC MIX AND CHARACTERIZATIONS OF ADOLESCENT PATIENTS

HCWs served a diverse range of patients typically reflective of the surrounding neighborhood demographics of their clinic. The majority of teen patients were classified as

youth of color, predominantly Black and/or Latino, with a sizable population of recently emigrated or first-generation patients from Latin America (in particular the Dominican Republic), the Caribbean, Southeast Asia, and West Africa. Teen patients were perceived to come primarily from working class and low-income families that received some type of supplemental benefit, such as food stamps or social security disability, and often presented at the clinic with considerable medical and/or dental neglect. The insurance status of their patient populations were frequently unknown by HCWs, particularly at SBHCs. Of those who did know, the consensus was that the majority of teen patients were uninsured or belonged to their parents' MMC plan.

HCWs most commonly described their adolescent patient populations as “high-risk,” referencing high rates of unprotected sex, sexually transmitted infections and multiple sex partners. In addition, mental health staff referenced the high prevalence of trauma and chronic diseases as contributing to the overall “high-risk” health status of these patients. Meredith explained:

“...It’s a highly traumatized population...a lot of, you know, histories of neglect, emotional abuse, physical abuse, sexual abuse, and so it’s high need...you know, kids with really poor attachment issues where... kids without main parental steady figures in their lives, and kids with a lot of illnesses, more than you necessarily see in other areas... whether it’s diabetes, asthma...high-risk in a lot of respects.”

HCWs also tended to characterize their adolescent patients as lacking in knowledge of sexuality, reproductive anatomy, and STI and pregnancy prevention. Carla, a SBHC nurse practitioner, described the typical way reproductive health concerns are raised by teen patients at her clinic:

Carla: “...They will tell the patient services rep, ‘I need to speak with Ms. Carla privately,’ and that will kind of alert [them] that it’s probably a sexual and reproductive health issue.”

Hannah: “Does that happen frequently?”

Carla: “Every day. Every single day...and most of the time it’s because they want a quick pregnancy test because they’ve had sex the day before...this is not just the young ladies,

this is also the young boys, they'll come in and want to be tested for 'everything.' We have to find out if there's a test for everything [laughter]! That test doesn't exist... You'd be surprised, the education that's really needed, because they are so, so uninformed..."

When asked about the main reasons teen patients come to her clinic, Sandra, a clinic support staff member at the FMC responded:

"Number one, unplanned pregnancy. They come due to I guess the education on their level is not given to them about protection, about ways of protecting yourself, because we have all the resources but they don't use 'em."

Brianna, a pediatric nurse, considered the role of education in the spread of sexually transmitted infections among teens in the Bronx, suggesting that an awareness of their high prevalence would result in behavior change among her patient population:

"The main thing is STDs... You have to be able to know what's out there and be smart about it...and they're not educated to know...I'll say, 'Do you know that the south Bronx has the highest rate of STDs than anywhere else in the country? Do you know that?' No, they don't know that, because if you do, you wouldn't be so frivolous and loose...you'd be much more careful about yourself."

Cassie, a prenatal counselor at the FMC who facilitated support groups for pregnant teens, attributed a lack of consistent contraceptive use among her clients prior to becoming pregnant to naiveté and being misinformed about the reproductive cycle. She explained:

"It's a naïve part. It's more of the education that they didn't really look into...they don't understand that it can only take one time...but in their mind, like, 'No he pulled out!' I'm like well that's not...there's a small percent...there's a lot of stuff they didn't know."

Perhaps not surprisingly, teens' perceived ignorant, risky, and irresponsible behavior caused frustration among some HCWs. During a discussion about the necessity of dispensing supplies onsite because of the challenges teens face in visiting a pharmacy, Tracy, a SBHC medical provider, relayed an anecdote about one of her patients who she had been unable to see for follow-up to receive treatment for chlamydia:

"Two months ago, I have a girl...she has chlamydia, she's 18, she won't come to get treatment and I called in a Rx and she won't go pick it up – what else could I do? You

have chlamydia for god sake! Ya know, it's not like you're pregnant, you have to get rid of this chlamydia...in the beginning, like two months ago I was kinda like... you know you don't have any symptoms, it just came up, that's really good, it's not an emergency just come in as soon as possible within the week. Well now, as she's not coming in, I'm like, you could be infertile, you could have PID, you could die...your vagina can fall off ya know almost...and she's still like, 'I'll try to come tomorrow' and doesn't come. I've got like 35 emails... 'I'm in Honduras, my sister's in the hospital, uhh I woke up late...' I mean every excuse in the book. She has an Ipad. I'm mean she's not even poor! I'm like, go to the pharmacy and pick it up! 'Oh but my Medicaid...' Just pay for it! I don't know why...very intelligent girl, seems savvy, I mean...she has an Ipad and you dress nice, you have \$30 if you don't have your Medicaid, but it's not worth spending \$30 on the pill?"

This narrative is important both because it reveals a perception by some HCWs that their patients do not value or place priority on their health, and hints at underlying attitudes about responsibility and deservingness. Despite these predominantly negative characterizations, several HCWs also reflected on how resilient and resourceful their teen patients were. Carmela, a nurse practitioner at a SBHC, commented:

"...They're a very resilient group of young people, particularly the ones who've had a fair amount of exposure to violence, family violence or Bronx violence...it amazes me how they recover from that...Someone who's been abused in foster care...and yet they have an insight and a desire to just get through it and deal with it...I see this all the time; they are more on the ball than the parent...and it's like the child taking care of the parent as opposed to the parent taking care of the child... and you really get a sense that even at 16 they'd be better off if they just were on their own because the parent's just making it worse. And I just it amazes me how they're able to go to school. Some of them do extremely well at school, and yet there's such chaos around the rest of their life."

GENDER SCRIPTS, TEEN RELATIONSHIPS, AND "CULTURE"

Another significant theme that emerged in HCWs characterizations of their adolescent patients was the way in which gender and adolescent relationship dynamics were portrayed. In describing heterosexual relationships and issues they address with their patients, HCWs often imbued their explanations with particular values and moral lessons about appropriate sexual behavior and gendered stereotypes of young women and men. For example, Emma, a SBHC nurse, reflected on how she spoke with her son and male patients about sex and responsibility:

“Like I told my 30 year old, remember everybody you sleep with and these people that you think are fast, and easy, these could be your baby’s mama. And I use that term...and that’s what they end up being. So if you think she’s fast and cheap, is that who you want to raise your baby? And I have had those conversations with the guys [in the clinic]... when they come in: ‘Boy if she gave me something, that’s it!’ Why is it all her fault? Why did you put it in if you knew she’s had multiple partners? If you knew she’s easy then why did you do it? And now you’re gonna blame her?”

Carla relayed the below anecdote to demonstrate the way she encourages young women to use condoms with their partners. In these conversations, she emphasized that they should always be prepared and depend on themselves, not on their partner(s):

“I had a client this week, she came in...for cystitis...she was 20 years old, already had a 2 year-old son from the baby’s daddy...and this guy she’s been seeing for a year, and she looked at me like, ‘Use a condom? Well I’m only seeing him!’ I told her, point blank, ‘You are only seeing him. Is he only seeing you?’ ...I say, you know what? He may be the nicest guy in the world and sometimes things happen that is not his fault and he may not have had any malicious intent against you, ok, and he may not even want to tell you... because it was a nothing situation...but the fact is that it did happen. He may have had one too many to drink, hanging out with the boys, and...not all women are as nice, as sweet as you, some are a little loose...and all you need is that one time if he’s not using a condom with you, he didn’t use a condom with this loose incident, and what happens? Then you’re HIV positive...And that’s how you gotta put it in the real terms for them.”

Gendered “cautionary tales” such as the ones described above were often used by HCWs to impress upon their teen patients the importance of wearing condoms and to raise their self-assessments of risk. Moreover, the female and male archetypes portrayed in these narratives – young women who are either naïve or promiscuous, and young men who cannot control their sexual impulses and are unfaithful – served to reify stereotypical gendered expectations.

HCWs frequently pointed to the gender asymmetries and roles in the broader society to explain why their adolescent female patients struggle with using contraception consistently and communicating about sex with intimate partners. Janina explained:

“I think there are challenges for them using any contraceptive in general...I like to say that some of it is just lack of education but I don’t know...maybe lack of empowerment ...just having the ability to say this is what I need you to do in order for me to feel safe... I feel like a lot of our teens don’t have that, so I think that’s a major barrier...”

Emma held similar beliefs about the reasons her female patients did not use contraception or discontinued methods, citing the perceived over-emphasis placed on what partners think:

“They just don’t wanna...they can’t seem to demand it, you know, you don’t want the pregnancy but you don’t wanna go against what your partners says...or my partner feels the IUD. And they check it here; it’s not out of place, your partner does not feel it, you know. It’s like, so caring about what the partner says. Your partner wouldn’t even know what’s going on if you didn’t mention it, you know....so I think self-esteem...it’s all like, to me...we need some empowerment for these females.”

Additionally, although the topics of sexual pleasure and desire were rarely raised by HCWs about teen relationships, several mentioned that their female patients often found sex unpleasant and many did not have an expectation that it could or should be pleasurable. Meredith explained:

“You know, the girls are trying to please...their male partners...and...there’s a large number of girls who don’t really want to be sexually active but are because they feel like...I’ve heard many times, like, you know he’s a man and if not he’s gonna do it elsewhere, um, he has needs...so girls saying that they don’t find sex pleasurable, that it’s actually uncomfortable...”

Allison, a medical provider at the FMC, expounded on the reasons why her teen patients struggled to communicate about pleasure and intimacy with their partners:

“It’s so complicated. There’s not much communication, there’s a lot of pressure, a lot of expectations. People don’t know their bodies. They don’t know what they like...they don’t even know that sex is supposed to feel good! It’s so much about you know, doing it to get it over with, doing it ‘cause that’s what it’s often been...men asking for stuff... and that’s what the guy wants, so they do it...it’s pretty quick, they don’t even know to ask to get pleasure for themselves...”

Perceived frivolity with regard to social expectations about intimate sexual encounters among the youth served was also noted, often attributed to generational and cultural differences between HCWs and their patients. Emma commented:

“It’s deep... it’s a cultural thing...the whole cultural influence on the young people today...the girls are now acting like the guys, so sex is not something that you do when you’re in love, it’s something that you just do. It’s like hanging out...so you’re taking that whole male perspective of sex...it’s just too easy right now.”

Relatedly, several HCWs felt that some young men attempted to demonstrate masculinity through impregnating a female partner. Carla offered her perspective on the role that becoming pregnant or getting someone else pregnant may fulfill among her patients:

“...Remember the lady is impressionable, she’s looking for the love she may not be getting at home either...so for somebody to tell you, I don’t want to use a condom, I want you to have my baby...that is like a bestowed honor...You gotta look at it from their point of view. Alright? It’s no longer about I wanna marry you and here’s an engagement ring...it’s I want you to have my baby. Well this is like, oh my goodness we’re going to the Four Seasons tonight...It’s a completely completely different world.”

Reflecting similar attitudes about social norms and expectations, other HCWs questioned the accountability of men in the broader communities of which their teen patients were a part, citing a perceived acceptance of infidelity and lack of responsibility regarding fatherhood. Some interviewees attributed these issues to few positive male role models and absent fathers at home, citing the need for more male HCWs to initiate conversations and develop gender-specific initiatives around sexual and reproductive health.

Lastly, participants frequently provided rationales for teen patient behavior that stemmed from a “cultural” explanatory viewpoint, particularly for Latina patients. Describing relationship dynamics among her patients, Carmela offered:

“You have the Latino machismo that gets involved in some of this as well, ‘cause we have a fair amount of Latinas and Latinos, so that’s part of it also. That’s that whole relationship dynamic although I don’t think it’s as strong as it was, but it’s still there...like, he’ll take care of me, or I’ll take care of her...”

Culture was also seen to influence attitudes towards contraception and pregnancy. Tracy noted:

“Sometimes, especially in the Spanish population, the partner doesn’t want them to be on anything...Because I think sometimes the partner either wants them to be pregnant or the partner is concerned like, old wives tails: it’s gonna get you fat, it’s not good for you, my mother didn’t take anything...”

Similarly, HCWs often attributed patients' concerns about fertility to culture. In discussing where fears about infertility come from, Michelle, a physician, provided an explanation derived from her experiences with Latina patients:

“I don't know if it's just a cultural thing, [being] worried about fertility. 'Cause a lot of them...seemed to be worried about being pregnant, especially Latino girls are very worried about whether they can get pregnant...And just speaking with...adults who are from their same ethnic background...in the DR that's how it is, everyone their age is having babies and so they're thinking, you know, that there's something wrong...I've had teenagers...who wanted to have fertility testing. I was like, 'Uh uh, no doctor's gonna do fertility testing on you 'cause you've been trying for 3 months.' We had a student who, she was trying to have a baby and she was concerned because her period was late and she wasn't pregnant...and she was 15, 16, and I was like, oh god...Then she had a positive pregnancy test in June. It finally happened.”

The “cultural” value placed on fertility and motherhood by some groups, again, predominantly among Latinos, was echoed repeatedly by HCWs as an explanation for higher rates of pregnancy. Meredith noted:

“I think it's more so with Hispanic girls...their understanding of womanhood is mothering from very young ages because that's what their mothers did and their mothers before them...So that's kind of an archetype for them, the female caretaker...”

DELIVERING SEXUAL AND REPRODUCTIVE HEALTHCARE

HCWs identified a number of foundational values and strategies that supported their delivery of sexual and reproductive health services to teen patients. While many were not necessarily unique to the delivery of sexual and reproductive healthcare, they reflected aspects of their work that were deemed particularly important and valuable to working with teen patients on these issues. A primary aspect of HCWs' abilities to develop effective and trusting relationships with teen patients was the need to build rapport, which was accomplished in different ways. HCWs frequently described the importance of letting patient interests and concerns drive the conversation and creating a safe space for the disclosure of potentially difficult or sensitive information, as described by Nancy, below:

“...it’s really patient driven...and depending on what’s going on in their life, I think setting up kind of a safe conversation is my main goal. And then figuring out where the teen wants to go with that. So it could be about gender roles, it could be about domestic violence, it could be about relationships that she’s not comfortable or he’s not comfortable with. It could be about figuring out their sexuality, where they fit on the spectrum of homosexuality, heterosexuality... helping them talk about their feelings about all this very confusing stuff. And also kind of giving information, but mostly making sure that they know this is a safe place.”

Sandra, a clinical support staff member at the FMC, noted the importance of developing this bond with patients, as they often return to her for subsequent issues and visits. The quote below illustrated this point, specifically regarding her involvement in the delivery of abortion services provided at the clinic as compared with her colleagues who objected to assist these patients:

“...I’ve actually sat there with the teens having their procedure done and talking to them and calming them down...my colleagues will say, ‘Oh due to religious beliefs I can’t be in that room...’...But then you’re not supposed to be judgmental. You’re here to provide a service. Like, I build a relationship with the patient when they come in... ‘How are you, are you feeling better?’...after that they come to look for me...”

For some HCWs, an important aspect of developing rapport with teen patients was being “authentic” in their interactions. Nancy explained:

“...Teenagers, more than any other patient population, I feel, can sniff out fakeness a mile away so if you try to be anything that you’re not, you totally lose credibility and they will turn you off like that. So you have to be who you are... you know, I’m a white woman with three kids who grew up in Pennsylvania. I didn’t live the realities of the teenagers here and I don’t pretend that...but it doesn’t mean that I can’t do a good job empathizing...”

Sandra commented that because she comes from the same neighborhood as her patients, it lent her considerable credibility and allowed her to interact with them in ways that other HCWs could not:

“...Like most of the patients come...I went to school with, my children go to school with them, I still live in the same area, I still come to visit...And then they see that because I’m a nurse...if a nurse and a doctor listens to my kind of music, and drives my kind of car, they’re like... they get where I’m coming from.”

One of the main goals espoused by HCWs was the need to empower their teen patients to depend on themselves and recognize the control they have in their own health. For example, Carla described how she tried to shift her patients' mindset about consistent condom use through condom demonstrations:

"...I even have a little penis that I call Peter. And I show the young ladies and the young men...I use the non-lubricated condoms and show them how to put a condom on. So if you empower them so they feel comfortable, so they're not depending on you, you can depend on yourself, ok...and once you give them a sense of empowerment and 'I can do this for myself,' they're like, 'I can take control and I can have some power in this situation.'"

Emma emphasized the need for her female patients to be in control of their bodies and not be unduly influenced by their male partners when making decisions about using contraception, as she believed they often did not remain in the relationship if a pregnancy occurred:

"...My answers might not be, I don't know, totally professional. I speak more to the females and I tell them how important it is [to use protection]; it doesn't matter what he says, it matters what you want and it's your body...so that's me judging...most relationships that end up in pregnancy do not last, you know, they can say whatever they wanna say. When you have this baby, you're usually on your own...so... you should do what you wanna do. And I say most guys don't even know you're using anything...and it's none of their business, so you just do what you need to do for yourself."

The above quote is reflective of the ways in which HCWs framed contraceptive decision-making among their female patients within the language of autonomy and independence, imbuing their clinical interactions with particular values and ideologies about sexuality.

Another strategy utilized by HCWs was to clarify perceived inconsistencies between patient behavior and stated intention. Janina used this approach with teen patients in her one-on-one sessions about partner communication and inconsistent contraceptive use:

"Sometimes, there is the issue of the partner that doesn't want to use condoms and stuff like that, so that conversation is tough, for anyone, but especially for a teen...[so] just trying to figure out what's the problem. What's preventing you from having that conversation? And just kind of creating that ambivalence that, ok, you're ready to have sex but you're not ready to have this conversation kind of thing?"

Occasionally, HCWs described the use of pregnancy tests to accomplish this cognitive dissonance with patients who were hesitant to use a regular contraceptive method. Emma explained:

“I usually speak to them about uh...what ifs. What if you were to get pregnant? Then how important is it to not get pregnant and how will it affect your future plans if you do get pregnant? And if it’s something that you don’t want, then what can you do to prevent that, because doing this...this is not safe. So, and sometimes I don’t tell them what the results are and they say, ‘Miss please tell me!’ And I’ll say, ‘No, I want you to think about it.’ I know it’s negative at the time, but just think about it... ‘What would you do if? Well leave that up to when you see the provider, write it down. What if?’”

Lastly, interviewees frequently saw their role as helping young people see the “big picture,” which included guiding teens through the larger implications of their behaviors and decisions. This kind of assistance was seen as essential with youth, as they were overwhelmingly perceived to be unable to connect cause and effect or plan ahead (see Chapter Nine for a more detailed discussion). For example, Carla emphasized the importance of getting female patients to use contraception consistently, as sexual encounters with teens tended to occur spontaneously:

“...Remember, a lot of times with adolescents, sexual encounters are not planned... we’re not, OK, this Saturday, we’re gonna go to the hotel motel Holiday Inn. It doesn’t happen like that. Therefore...they’re already in a situation where it’s like, ‘Whew! I’m on the pill, I’m good.’ So that’s what you have to do...They’re not thinking ahead, they’re thinking right now. They don’t plan ahead, only for the day. They’re thinking right for this hour, they can’t even think 15 minutes ahead of time, and that’s what our job is to help them think ahead a little bit.”

This “big picture” approach also frequently involved exploring the potential consequences of particular decisions that were not perceived to be considered by young people. Meredith explained:

“I think I’ve learned that ultimately, these adolescents are...they’re gonna do what they feel is right for them, and I think it’s my job to provide them like the full picture of all the options and choices out there to help them think about things that they wouldn’t naturally

tend to gravitate towards, like consequences, more of the big picture, thinking about what it means to have a child...” (SBHC mental health clinician)

Decisions about using contraception, becoming pregnant, or having a child as a young person evoked particular values, opinions, and attitudes from HCWs, of which many were well aware. Thus, some participants mentioned the importance of striving to remain impartial and set aside personal feelings about these issues. Nancy described the need to be reflective about her approach and to use opportunities to “check-in” with other clinic staff when she felt herself becoming judgmental:

“...I have to say, like it’s about being super nonjudgmental...and it also depends on am I really tired and cranky and this is my 40th kid that I’m talking to about birth control... and this is where the staff around like is really helpful. I’ll go into the LPN room to do whatever and she knows by the tone of my voice where I’m at...and she’ll just look at me, she’s like, ‘Mother?’ And I’m like, yeah, I’m in the mother mode, yeah, the mother thing, you’re right, you’re right... so, I think I can do a pretty good job now, mostly cause I can recognize in myself when I’m starting to become naggy...when I’m out of my super nonjudgmental mode, and bottom line is, it doesn’t work... like, why start?”

While withholding personal judgment was considered important, interviewees often acknowledged how difficult this can be in practice. For example, within SBHC settings, mental health providers offered options counseling to pregnant patients who desired it. In addition to providing education and resources, options counseling afforded an opportunity for patients to think through the available choices – continuing a pregnancy, getting a termination, and adoption – with clinic staff. Mental health providers frequently stressed the importance of leaving their biases at the door and presenting each option equally, but at the same time, acknowledged underlying values about the appropriateness of teen parenthood. Meredith explained:

“... We can all struggle when you’re doing this job to keep your stuff out of it. So I think that’s something that I’m used to working on. But with options counseling, working with the pregnant girls, that’s the hardest. It’s not necessarily about the birth control or a lot of other choices that people make, but for this age group, options counseling is the one that for me personally is very hard and also kind of keeping yourself in check to make sure that your opinions are nowhere in sight, which I’m sure is not 100% accomplished

but...I give all of the options, um, and I give options of why it would be great to be a mom and I'll do the pros and cons of that... but do I say it's cool? Probably not."

Lisa, a social worker at an SBHC, related a story about a teen patient whom she saw for part of her pregnancy. Although this patient faced particular challenges during her pregnancy relating to support from her boyfriend, she had returned to the clinic several times since giving birth and has had a very positive outlook on the experience. When asked if that was difficult for her to reconcile, Lisa responded:

"For me, yeah... But then again...I don't know...I always try to...not be pushing one way or the other... you know what I mean? But I think there are certain things I say that probably give off the impression that you know, it's like...I can't wrap my head around the fact that right now if you had a baby, that your life would be great. I said to this girl the other day...I don't think it's selfish to think about yourself...And I don't think it's selfish for you to think, is this really the right time for me to have a child, would I be able to give my child everything I think they need?...So I do feel a little bit wary of like, saying certain things that might make the person feel like I'm pushing them in that direction..."

On the other hand, some HCWs made comments that reflected perhaps an unconscious bias towards a particular pregnancy outcome. As a clinical support staff member, Sandra's official role in pregnancy options counseling was to administer pregnancy tests and assist the medical provider with terminations should the patient want one; however, Sandra also described the ways in which she went "above and beyond" to assist teen patients who received a positive pregnancy test:

"...I'll sit in the room with them and give them 5-10 minutes, whatever, however long they need. I say listen this is an option, you have 2 options, or 3 if you wanna adopt, but the only person who can live with the decision is yourself...I be like, 'If you do have to terminate, and it's your decision, you might be setting yourself...if you wanna set goals for yourself....' Sometimes I go on online and I Google schools that you can go to that have GED, a LYFE program [Department of Education childcare program in particular high schools], but that's me, I go above and beyond..."

In this case, Sandra's attempts to locate parenting teen resources for patients who are considering abortion may be interpreted by some patients as judgment about this option.

In discussions with HCWs about their perceived roles and strategies employed with teen patients regarding sexual and reproductive health, interviewees frequently referenced their own families and/or personal experiences. For example, some HCWs discussed their relationships with their children, noting the importance of open communication and having trusted adults in their lives. Cassie explained:

“If we can get these teens to really understand that we are there for them, and they shouldn’t be ashamed or afraid to want to talk about it if they don’t have no one at home...but the education piece starts at home...that’s how I feel... Cause like I told you, I have a 15 year old...but she is able to come to me. But that’s very rare cause you don’t find too many...so she’s able to come to me, and if she can’t come to me, she have her doctor she can talk to, she have all the nurses she knows since she’s little...knowing that they’re not gonna cross the boundaries and tell me...they leave it to her.”

Emma had been a teen parent herself, and often shared her story with patients to highlight the importance of using protection to prevent pregnancy. As a 15 year-old from a “Christian background and a church-going family,” she tried to obtain protection for she and her boyfriend at the time, who refused to purchase condoms. Emma described feeling isolated and intimidated, with nobody to ask for advice, as she feared that her doctor would tell her parents she was sexually active. Ultimately, Emma became pregnant and had her son, and while she considers him a “wanted child,” she believed that becoming a parent at 16 completely changed the course of her life. She stressed how difficult it was to raise a child to her female patients, who, in her opinion, sometimes “glamorized” having a baby. As the lack of available confidential reproductive health services was a pivotal part of her experience, the message Emma attempted to impart to her patients was to take advantage of what the clinic afforded them:

“I say this to them: you have everything here. Before it was hard to get these things. You couldn’t go to a doctor to get confidential care; you couldn’t get the birth controls...or even the EC you couldn’t get. You know, there’s adults right now who can’t afford the \$50 pill. Take advantage of what you have here and make better decisions!”

DISCUSSIONS ABOUT CONTRACEPTION

The previous sections in this chapter served to provide a broader context for the conversations HCWs have with teen patients about contraception. As articulated above, while all HCWs interviewed engage in some discussion with patients about birth control, their role(s) in these interactions varies, as does the content of these discussions. Broadly, areas of overlap included an assessment of patient knowledge, previous contraceptive experience, and an overview of available methods; however, these conversations are tailored to the patient in front of them and informed by HCWs' experiences about what is important to cover during adolescent contraceptive counseling visits. Because patients may see several HCWs over the course of a contraceptive counseling visit, there are opportunities to receive both reinforcing and contrasting information about related topics.

A contraceptive counseling session in the three service delivery models described in this study is largely initiated in one of two ways: 1) HCWs may proactively discuss the need for contraception upon assessing the patient for sexual activity and/or administering a pregnancy or STI test; or, 2) the patient comes to the clinic interested in starting a method. In the case of clinical support staff, their time with patients is fairly limited and these conversations tend to happen while patients are waiting to see the medical provider or another HCW. Generally, clinical support staff provided education and resources about contraception, and relayed information back to the medical provider as needed.

Similarly, health educators and mental health providers counseled and provided education about contraception. Mental health providers also worked with patients on related issues pertaining to inconsistent method use, relationship problems and family conflict. Both of these HCW roles were able to spend more time with patients as compared with clinical support

staff and medical providers, and thus were able to delve more deeply into patients' needs and concerns. Several HCWs also facilitated conversations about contraception in group settings. In addition to the aforementioned services, medical providers dispensed or prescribed the selected method(s). They also obtained patients' menstrual and general health histories in order to identify any relevant medical contraindications to particular methods prior to selection.



Figure 7.1. Teen health pamphlets available at a SBHC. Photo credit: Author

Given the above information, it is perhaps not surprising that a prominent theme that emerged with regard to discussions about contraception was the lack of uniformity or consistency in the ways in which contraceptive methods were described, the order in which they were presented to patients, and the extent to which related domains of influence were addressed. Indeed, some HCWs reiterated the fact that the counseling style, approach, and topics covered were up to an individuals' discretion. Most frequently, HCWs presented methods using a “smorgasbord” approach, which anthropologist Pamela Erickson (1996) has described as a model of family planning care in which “...clients are educated about the efficacy, side effects, risks, and benefits of all available contraceptive methods,” after which a

method is selected based on patient needs and for which there are no medical contraindications (68). However, these conversations do not occur in a vacuum, and HCWs imbued these sessions with particular values and opinions that consequently shaped their direction. The below responses by medical providers about the delivery of contraceptive counseling typified the smorgasbord approach explained above. Michelle elicited what patients already knew about available methods, assessed their comfort with each option, and directed them towards one that would “work best” for their lifestyle:

“I always want to gauge what they know before telling them stuff...they might just know the basics, like, it’s a shot, and you get it every 12 weeks...Which is good, but you know it’s like, I have to do the pros and cons, the side effects, which they might not know...I’ll say what we have and then ask is there any one that you’re considering...? And then I kind of...’Do you mind getting shots, ‘cause you know if you don’t like getting shots, then Depo is out’... or ‘Are you comfortable inserting things into your vagina?’ I ask that to see if the Nuvaring will be okay. And then if they’re a good pill taker. If they seem to be interested in long-acting, of course then I talk about the IUD, and go into the procedure...Most of the time they ask me... ‘What...do you think I should take?’ And I say, ‘I don’t care, it’s whatever...fits for your life.”

Lifestyle, in this context, connoted a number of ideas and values, including the perceived level of responsibility of the patient and comfort with others knowing about one’s sexually active “status.”

Moreover, it was important for some HCWs to help their patients identify the ways in which particular methods may be incorporated into that lifestyle. Nancy commented:

“Like if you have a parent who knows when you get your period all the time, let’s think about methods where you’re gonna get a regular period. If you are wearing a skimpy bikini all summer long, where ya gonna hide a patch? You know, so just thinking about how it fits in to their particular life.”

In addition to assessing patients’ knowledge and comfort with particular methods, some providers also noted the importance of knowing whether the patient and her social network may have had previous experience or familiarity with specific methods. Ethan, a family medicine physician at the FMC, explained:

“...If you know, a 16 year old girl is sitting in front me, [and] she says, ‘I want to know about birth control,’ I...ask first off, ‘What do they know?...And then she’ll tell me whatever

she knows. And then I'll say, 'Have you used anything before?' What have her friends used? And I like getting a context of what they know already and picking up on any misinformation that she might have gotten or things she's worried or concerned about."

Carmela also attempted to elicit information from her patients' social networks, as well as their attitudes and comfort with particular methods:

"I first say, 'Tell me, if you could pick a method, if you've heard about it from your friends or seen it on TV, read it in a magazine, what would it be?' ... Because I think that way I can tell if they've had any old wives tales: Well I saw this thing about Yaz and it gets rid of the hair on my upper lip and I wanna use that, or my mother told me she had this IUD and she almost died...so it's sort of helps me figure out where they're at..."

The order in which HCWs present contraceptive methods has been the subject of much recent attention in clinical and public health research and recommendations. Specifically, a growing number of practitioners and organizations have argued that options should be presented to patients in order of clinical effectiveness. The primacy given to clinical efficacy reflects a recent turn in the family planning field to use a "tiered" counseling approach and has been supported by influential clinical and public health researchers, as it is believed to increase uptake of the most effective methods (Peipert et al. 2011; MMWR 2014). In this model, the long-acting reversible contraceptive methods, also known as "top tier" methods (IUDs and hormonal implants) are described first, followed by "middle tier" methods (Depo, patch, ring, and pills), and finally barrier methods (cervical cap, diaphragm, and condoms), with the providers' goal being for women to choose the most clinically effective method to prevent pregnancy. In the spring of 2014, the tiered counseling model was highlighted as a best practice for the provision of family planning services in the CDC's Quality Family Planning Report, published in the Monthly Morbidity and Mortality Report (MMWR 2014).

As described earlier, HCWs in this study by and large presented methods to their patients based on what they had heard about and/or previously tried. Some participants also highlighted the most popular methods used by patients at their clinic. When asked if she discussed contraceptive methods in

any specific order, Deborah responded:

“Yeah, I don’t think I do... it also depends on kind of what they tell me and what they used or what issues they might have had with different things. Like if they’ve already told me that something is totally out, even if I feel like it might be a one of the better methods, I might not talk about that first. But I usually do tend to...mention the ones that I’ve found that most people like and prefer, so I’ll tend to mention the IUD first, one of the first ones, and oral birth control because those are kind of the most common I feel like among patients here.”

Still other HCWs noted the importance of tailoring the contraceptive education to the frequency with which that patient is engaging in sexual intercourse. Allison explained:

“I would start with what they’re interested in and depending on their situation...if they’re having sex, you know, once a month, I might, with someone who lives far away and has to fly in, I might not suggest kind of a long-acting contraceptive...depends on what their situation is... most kids even having sex once a month...Now if the kid’s around the corner, I would still think about long-acting, but it goes along a lot with what their situation is.”

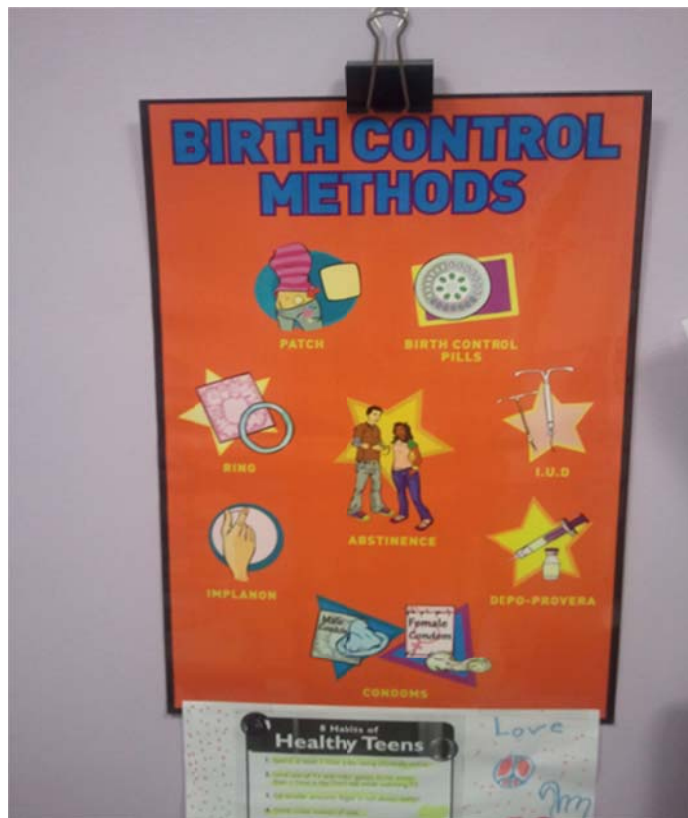
Less commonly, HCWs presented the methods in order of efficacy. Alisha described the ways her contraceptive counseling style has evolved to incorporate the tiered approach with her teen patients:

“Well, I mean I think in general...it’s most comfortable for me to talk about the forms of birth control that I have the most experience with, so, you know, talking about condom use is very easy, talking about contraception...like OCPs...is relatively easy because I have a couple that I prescribe regularly. Talking about Depo is comfortable because I give that enough...But then, you know, a couple of years ago...it felt a little uneasy to talk about using the patch, um, because there was a lot of controversy about the side effects, and causing the blood clots...It’s not as much of an issue now because we don’t have many patients on the patch. And I would say that definitely my comfort level just having a conversation about IUDs, and feeling more comfortable the more that all of these major organizations are really endorsing IUDs in teens, so...whereas before I would probably spend most of my time talking about methods that I was most comfortable with and now I’m trying to take an approach of, ‘these are the most effective methods versus least effective.’”

Another important finding that emerged from interviews with HCWs was the extent to which condom use and dual method use (hormonal or LARC methods *and* condoms) were emphasized in counseling sessions. While sometimes presented as distinct or competing interests or priorities in policy and funding landscapes, from HCWs’ perspectives, STI and pregnancy prevention went hand-in-hand. Excluding abstinence, condoms are the only contraceptive option currently available that prevents STIs.

They are also the most popular method of pregnancy prevention among teens, nationally (Martinez, Copen, and Abma 2011). HCWs frequently noted the high prevalence of STIs, in particular chlamydia, among their teen patients. The fact that their patients were seen as “high-risk” for contracting and transmitting STIs influenced how condom and dual protection messages were incorporated into conversations about additional pregnancy prevention. For example, Allison commented:

“So I always talk about condoms. I’ve done a lot of HIV work, and I know how many of my patients with HIV don’t tell their sexual partners that they’re HIV positive...and it’s more than half... so, I do talk about that. The first thing I talk about is condoms and that no matter what else you get, you still gotta use condoms.”



**Figure 7.2. Visual aid of various birth control methods at a clinic.
Photo credit: Author**

Sandra emphasized the importance of “double” protection within the context of pervasive infidelity in her conversations with teen patients:

“...It’s okay to tell your boyfriend, spouse, whoever, put on a condom...because not only does it protect you, it also protects them. Because with these kids coming with STDs, it’s like, ‘Oh but I’ve been faithful!’ But then the other one’s saying vice versa, ‘I’m always faithful,’ and then

they making each other feel bad, and it goes back and forth. So I just tell them, 'Listen, there's no right or wrong, but it's double protection.'"

The extent to which HCWs encouraged and/or counseled teen patients who consistently used condoms to also use a hormonal or LARC method varied. Some HCWs highlighted the difficulty to convince condom users to adopt a second, more effective method of pregnancy prevention. Michelle described her approach as follows:

"I try and say, you know, 'Do you want a hormonal method to use? Because always using both of them is the best thing to do to prevent pregnancy,' so you know I do ask...but I kinda gauge it based on the patient. I bring it up and if they seem a little interested, then you know I'll either talk about it some more or give them some information, but a lot of times [the condom-only users] they're just like, I don't want the hormones in my body."

Alternatively, other HCWs tended to focus more on non-barrier methods of pregnancy prevention, assuming that all teens are aware that using condoms is necessary for the prevention of STIs and HIV.

Carmela explained how this is addressed in her counseling sessions:

"...I ask them if they would like to use a method or if they've thought about using a method besides condoms because people I think understand they need to use condoms. Whether they actually do or not is another story..."

ADDRESSING THE INFLUENCERS OF CONTRACEPTIVE UPTAKE IN THE CLINIC

Over the course of a contraceptive counseling visit, HCWs may tease out several phenomena considered both dependent and independent of the individual, which they believed influenced contraceptive uptake and use. The purpose of these elicitations was to both help their patients select the "right" method and provide guidance to decrease the likelihood of method discontinuation. However, decisions about what topics to address and how to do so were left to HCWs' discretion, which resulted in widely varied coverage of salient domains of influence.

A major perceived influence of contraceptive uptake and use among HCWs was the level and biomedical accuracy of patient knowledge. Counseling and group sessions often presented an

opportunity to correct misinformation, which was seen as a major barrier to the adoption and use of hormonal and LARC methods. By identifying what a patient already knew about the available options, many HCWs picked up on so-called “myths” that are thought to be quite pervasive among their patient populations. In addition, interviewees perceived that their teen patients in general struggled with medication adherence and did not tolerate side effects well. Lastly, HCWs frequently reported the importance of providing opportunities to alleviate concerns that patients may have about contraception, such as comfort with the method’s modality (e.g., inserting the contraceptive ring into the vagina).

Overwhelmingly, HCWs emphasized the uniqueness of contraceptive experiences to teen patients, which was intended to challenge or contradict the information they received from family members, boyfriends, and peers. This is particularly relevant when discussing the impact of hormones on future fertility. Allison observed a perceived preoccupation among her teen population with their fertility and the ways in which these concerns may inform reproductive decision-making:

“... A lot of kids worry about that [their fertility]...I think some kids get pregnant the first time just to make sure that they can get pregnant. I’ve seen that, where they like, ‘Well, I just wanted to make sure.’...And then they have an abortion, or they have the kid even though they aren’t really...they didn’t sort of plan for it that way.”

Cassie heard various concerns about fertility and contraception negatively impacting one’s health that were voiced frequently by young women in the educational groups she facilitated:

“...They have these myths about birth control like they’re not gonna get pregnant later on in life, it’s not good for your body, you can become sterile...And they also get these ideas from home. The moms will tell them, they don’t want them to have sex or get pregnant but they still get this message where if you take birth control now you’re not gonna get pregnant later on or you’re gonna have problems. We talk about it during group, so the kids know the facts that it’s not true.”

Relatedly, HCWs noted that female family members’ reproductive experiences also factored heavily into contraceptive decision-making. For example, if someone in their family had difficulty

becoming pregnant, or they themselves had medical issues that may make it difficult to conceive, patients may be hesitant to try a hormonal method of contraception. Carmela explained:

“I think it [fear about contraception causing infertility] also plays on things that they hear...you know like their aunt talks about all the trouble she had getting pregnant, her mom had trouble getting pregnant for whatever reason, and maybe that runs in the family. We have a lot of girls who are overweight, they have polycystic ovaries, they have irregular periods, they’re worried about that and I tell them, ‘Look, the cure for that is not to keep trying to get pregnant. The birth control pill will actually give you a regular cycle. Hopefully you lose a little weight, you know your cycles will come back.’ But I think that that’s always a big concern...”

HCWs frequently described the challenges in persuading their teen patients that hormones in contraception were not dangerous to their health and would not interfere with their ability to become pregnant in the future. Some providers attempted to explain endogenous and exogenous hormones in layperson terminology -- that females have naturally occurring levels of the hormones in contraceptive methods in their body – though it was generally not considered a successful strategy. Other HCWs used probabilities to demonstrate the likelihood of becoming pregnant if not using any method of protection to counteract some patients’ fears about infertility:

“...A lot of girls will come in afraid to take something ‘cause they think they’ll never get pregnant if they take something... Or they’ll say to me, ‘You know, I’ve been having unprotected sex for 2 years and I don’t think I can get pregnant.’ And I explain to them, you’ve just been very lucky and that, you know, unless they have some sort of weird history of a lot of STDs or irregular periods and things like that...it’s gonna happen. And I give them the, ‘Line up 100 girls. None of them are using birth control. 80 of them will be pregnant by the end of the year.’” (Carmela)

That older female family members of teen patients often held and shared misgivings about the safety of contraception and concerns about it causing infertility should be considered within the political and historical contexts of family planning initiatives targeted towards communities of color. As described in Chapter Five, examples abound of state-sanctioned and unofficial forms

of reproductive coercion that may impact individual, family, and community attitudes and perspectives about the safety of contraception and its impact on fertility.

Another domain thought to influence teen contraceptive use according to HCWs was the perspective of the male partner(s), although concerns or discussions about the role of male partners in contraceptive decision-making was discussed less routinely, and often not at all unless initiated by the patient. If partners were discussed within the context of contraceptive counseling visits, most often it occurred with regard to condom negotiation. When teen patients raised issues or concerns about partners' discomfort with their use of contraception, HCWs often described attempts to steer the conversation back to their readiness and/or desire to become pregnant:

“I tell them, what would be best for you? Sometimes they bring it to my attention, ‘Oh but my boyfriend...’ And I said, ‘Is your boyfriend gonna get stretch marks?’ ‘Cause nowadays, the kids are all about their appearance because how social media puts it...so, I’m like, ‘Do you want stretch marks?’” (Sandra, FMC Clinic Support Staff)

Nancy echoed a similar sentiment, redirecting female patients towards their ability to make an autonomous decision about choosing to contracept or not:

“I certainly have scenarios where girls don’t want the partners to know what they’re using, particularly with Depo or even an IUD sometimes...or whatever the method is...so kind of helping support them that this really is their health decision. That just ‘cause he wants a baby...are you really ready to be a mother at this moment of your life?”

Reasons given for why these conversations were not consistently incorporated into contraceptive counseling visits included the perception that teens do not base such decisions around their partners, since their relationships are often short-term, and the topic not having been integrated into their practice.

As mentioned earlier in this chapter and in Chapter Six, HCWs also acknowledged the potential role parents may play in adolescent contraceptive uptake and adherence. However,

despite citing teen patients' concerns about their parent(s) finding their contraceptive method or noticing changes in their menstrual cycle due to its use, discussions about parents in counseling sessions were inconsistently initiated. Most frequently, HCWs reiterated the confidential nature of reproductive health visits to their teen patients. For those who were unable to or could not discuss contraception with a parent, HCWs helped them identify methods that could be hidden.

HCWs often referred to parents who monitored their teen patients' menstrual cycle with monikers such as "pad police" and "pad counters," both referencing a parent who counted the number of menstrual pads in supply at home to ensure their teenager was having a period, and thus was not pregnant. Therefore, methods that resulted in amenorrhea or fewer periods may be noticed by these parents and arouse suspicion. Given these considerations, medical providers often offered the types of questions they asked their female patients in order to help them select the "best" method, as reflected in the below quote by Tracy:

"So the one thing I always ask them, when they decide to go on BC [birth control], does your parent know that you're sexually active? If that's no, which most of the time it is, ok, does your parent need to see your period? Because if your parent needs to see your period or you need to see your period or whatever, then there's certain methods we don't use. And then if that's the case, well will they find the pill? Can they see the patch on you? Then the ring may be the best method, unless a lot of them don't like to touch their vaginas... so sometimes...they're good with any one thing and sometimes everything is an issue."

Perhaps not surprisingly, the reason most frequently given by HCWs about not delving more in-depth or more routinely into the above spheres of influence on contraceptive uptake was a shortage of time. All HCWs had a productivity standard to meet for the number of patients seen and visits conducted each day. In addition to scheduled appointments, clinics accommodated walk-in visits to varying degrees, which added to the already full schedule of patients, and particular times of day were especially busy for some clinics. Most importantly, the level of depth required to meaningfully engage and elicit valuable information from teen patients was often extensive. When asked if she pro-actively

discussed the influence of parents or partners with her sexually active teen patients, Alisha explained:

“I don’t really ask about partners. I guess I should...and yeah, if a parent is there and in the room when the conversation is initiated, that’s great...often times this is a long conversation, so if I’m crunched for time I don’t even get into...I don’t even go there...”

Similarly, Michelle noted the limitations to how she was able to engage her patients in discussions about healthy relationships and parental communication about sexual and reproductive health:

“I mean the discussion should probably happen more, but I really only tend to discuss that in regards to the method [selection]...it’s something that in general is neglected...I feel like I kind of mention that in passing...It’s definitely an important topic...healthy relationships and condoms...I feel like I’m gypping my patients a little bit not being able to delve more into those issues...but yeah I don’t have time for it.”

Topics that received more sporadic attention during contraceptive counseling visits included an exploration of patients’ educational goals, future plans, the impact of particular methods on sexual pleasure, and attitudes towards pregnancy. In addition to time constraints, a possible explanation for rarely discussing attitudes about pregnancy is that HCWs generally believed that the vast majority of teens they served did not want to become pregnant. Moreover, if teens were seeking contraceptive services, it may be presumed that their motivation to avoid pregnancy was high. These issues will be addressed further in Chapter Nine.

METHOD SWITCHING AND DISCONTINUATION

As is reflected in the literature on contraceptive use among adolescent and adult women, method switching and discontinuation were common phenomena described by HCWs in this study. In particular, participants broadly observed that their teen patients often stopped and started a method, which was attributed to relationships ending, a parent finding the method and throwing it out, forgetfulness, “laziness,” the chaotic lives their patients often lived, and difficulty getting young people to adhere to medication in general. Most HCWs regarded method switching to be normal and acceptable, although several expressed confusion about why

inconsistent use occurred in the context of widespread contraceptive access.

A commonly held perception about method switching was that it tended to align with patients' relationship status. Carla explained:

"...A lot of times it's the relationship they're in...for example, if they're seeing a guy for 6 months, for them that's like an eternity. Once that relationship breaks up, they don't wanna use any birth control... and they don't wanna be bothered with the method then...until a new guy comes along. Then they want something."

Additionally, several HCWs believed that inconsistent method use was a function of their patients' stage of development, as adolescence was widely regarded as a period during which planning ahead is difficult (see Chapter Nine for a more detailed discussion). In addition, resistance to being on medication was perceived to be related to contraceptive discontinuation.

When asked if it was common for her patients to stop and start several methods, Tracy responded:

"Absolutely, and flip flopping all the time. I had one particular girl, for 2 years, every time I saw her she flipped her method. She thought it was like a toy...I think it's still being young...their reluctance to be on a method....I think a lot of people don't wanna be on medicine, don't want to take something every day...I don't wanna be on a pill...I just wanna have sex and have fun and not worry about that piece of it."

Lisa described her thoughts on why her patients may find it difficult to use contraception consistently:

"... We just see so much [inconsistent contraceptive use] and it's hard for me to understand it too...which is why I think the IUDs are so great, right? Because it just entails them to get the procedure and then they're set. Um, I mean it's very rare that I've worked with a girl who is consistent with taking a birth control pill every single day...I know girls that are consistent with Depo...but even then, I just think sometimes a lot of these girls... there's so much going on in their lives and...they get stressed and overwhelmed and they're not thinking about, you know, oh yeah I have to take my pill today, oh yeah it's time for my Depo shot."

Lisa's explanation for why method switching occurs also incorporated features of particular methods that require more or less regular involvement by the user, a point to which I will return shortly. Less commonly, HCWs expressed frustration about patients' inconsistent or

discontinuous contraceptive use, particularly with the long-acting, and more expensive, methods, as illustrated by the below quote. Sandra's comments also suggest that part of the frustration stemmed from patients being adequately "warned" about side effects prior to method selection.

"That's a very rapid change here because they don't even give it an opportunity to work, and then that's wasting funds and wasting the providers' time as well. Because it takes a while to put a Mirena... 'Oh I'm cramping!' But you just had a kid! Which one is worse pain, delivery? Or just this little cramping for a little while?... Now if you've had a month or two with it and you still have the same complaints, then ok, we'll think about another method... Especially [the hormonal implant]; that causes a lot of irregularities, but you were given the pros and cons. Now you have a scar there... give it time to work before removing it.... there's some girls within a 6 month period they've tried everything."

Contraceptive discontinuation was seen as a larger problem with a less clear explanation. Several participants speculated that some teens used contraception sporadically or stopped using it to "test" whether or not that could become pregnant, which relates back to an earlier finding regarding pervasive concerns about fertility. Particularly because supports were available to help patients adhere to their selected method, some HCWs expressed confusion about why some teens who did not articulate a desire for pregnancy suddenly stopped using contraception. Carmela commented:

"...Non-compliance in coming back, I do see a lot of that. And I don't know why because I give them an appointment to come back in a week or two just to come tell me how they're doing. I tell them, you know, this is the luxury that you have in school; you can come in here every single day if you need somebody to remind you to take your pill. You can come in here every single day if you have a question, you know, whatever I can do to help you to remember to make sure you come back before a holiday to get your refills. And yet still... they will just stop."

HCW ATTITUDES ABOUT CONTRACEPTIVE METHODS AND THEIR APPROPRIATENESS FOR TEENS

Recent studies by Dehlendorf and colleagues (2010a, 2011) have shown that provider characteristics such as age, specialty, and practice type most strongly predict recommendation of specific contraceptive methods, suggesting that patients may receive different information depending

upon their provider. As is evident from the above sections, interviews with HCWs revealed the adoption of various counseling approaches and emphasis on different topics during family planning sessions with teens. Although analysis of these data by age and specialty did not reveal significant differences, variation did occur when comparing the three practice types. Specifically, the types of methods readily available onsite at PED and FMC tended to align with the methods HCWs reported as being the most widely used at their clinic and the most appropriate for their teen patients. For example, pills and the Depo shot were the most popular hormonal methods at the PED clinic and were also the only options teens could obtain without a referral to another clinic. This finding is perhaps not surprising, as HCWs tended to recommend the methods most commonly chosen by teens at their clinic and those with which they had the most familiarity. Similarly, the IUD was a popular method at the FMC. Interestingly, Deborah, a physician at the FMC, noted the role of residency training in IUD insertion at her practice as one possible contributor to its recommendation by certain providers:

“...I think there’s definitely certain providers, and sometimes I feel bad with some of the residents, where I do feel like they are kind of pushing it [the IUD] because they want to do them²⁵ ...and that’s a different agenda, clearly...”

Despite the introduction of several new FDA-approved methods over the past several decades, HCWs at SBHC and PED sites noted that the pill, followed by Depo-Provera, remained the most widely used hormonal method prescribed to teens, with the IUD and pills being the most popular methods at the FMC. HCWs displayed mixed reactions to the ubiquity of the pill for their teen patients. Michelle gave a qualified response about her patients choosing OCPs:

“...There are some kids that are really good pill takers. I tell them, whatever works for you. If

²⁵ After IUDs declined in popularity following side effects and complications associated with the Dalkon Shield (a particular type of IUD) in the 1970’s, subsequent generations of medical providers were not trained to insert this method. With renewed interest in IUDs in the 2000s following professional association endorsements (ACOG 2007, 2011) and the development of several new types of IUDs, provider training has become an essential component of increasing use of this method. Specific challenges to training providers include a limited pool of existing trained providers, provider bias about the safety and appropriateness of IUDs, and issues with stocking this method given its high upfront cost.

you think you're gonna remember to take a pill every day at the same time every day, then go for it, but if you think not, then go with another method."

Overall, HCW attitudes about available methods and their appropriateness for their patients appeared to influence how and what is discussed in counseling sessions. Below, Deborah shared her thoughts on what methods may work best for her patients, highlighting those with fewer perceived side effects:

"Um, I'm a big IUD fan...I think they're so ideal because you know, similar to Depo, you don't have to think about it, but usually...not as many side effects...And like, to me, it's kind of easier; if you don't like it, we can pull it out. It's done!...The thing with pills is that you have to take every day. Although it's nice to start with them to see how they deal with them, they usually do have some side effects, and teenagers appear to be more sensitive to those hormones. And to take something every day...I don't even take something every day so I just think that's a set-up in a lot of ways...and I like the ring. A lot of my patients don't like it...but I think it's good too...I don't push anything...but if they ask me for what I think, in my opinion, those are the ones I would recommend."

Meredith expressed skepticism about the ability for her patients to use the pill and suggested more long-acting options:

"...What I've seen...is the regular, like, the pill, is problematic for a lot of the girls...Because of regular usage and being responsible enough to take it...I don't even know that it's a judgment. It's just not necessarily the best method so I try to get them to think about other methods like IUDs for the ones who are really sort of regularly sexually active. Or the NuvaRing, something like that...there are a subset of kids who are responsible enough to take a daily pill and feel comfortable with that but I think the majority of students in this population are not."

For this HCW, the "best" method was one that did not require daily attention or effort, and was thus the most clinically effective at preventing pregnancy. Similarly, Lisa shared her trepidation about pills being suitable for her population and her personal preference for longer acting methods:

"I think if it's a responsible teen that's very mature, and you know, level-headed and proactive, I don't think there's anything wrong with birth control pills...but with the population I work with, that's more likely not going to happen. So I would say I would be a stronger advocate for something like Depo or the IUD because it doesn't require them to be on top of it, you know?"

While some studies have shown that teens are far more likely to inconsistently use OCPs than adult women, others have found modest differences between these groups, at 13% versus 9%, respectively (Kost, Singh, Vaughn, Trussell, and Bankole 2008; Whitaker et al. 2008; Trussell and Wynn 2008; Kost et al. 2008). Importantly, both Meredith and Lisa made a point of stating that OCPs may not be best for *their* patients, suggesting that particular individual, community and environmental characteristics may hinder their ability to use this method effectively, but with which, presumably, other teen populations would not struggle.

Depo-Provera was a polarizing method among the HCWs interviewed. For some, this option was considered the easiest and most tolerable for patients, while others held significant reservations about its use, particularly for prolonged periods of time. Brianna felt strongly that Depo was “best” for teens:

‘...They’re not habitual people. They don’t remember stuff, to take a pill every day? And so the Depo is great. The IUD...most of them are so promiscuous that that can cause infection. We don’t want that to create any further problems, so the safest one is the Depo.’

When asked how she presented the methods in a counseling session, Brianna explained:

“I always go first with the Depo, because I know the teenagers...The IUD is not gonna work, the IUD is hormonal, of course, but there’s a lot of side effects, there’s a lot of bleeding, maybe cramping, and they’re not gonna take to kindly to it, and they’re gonna want it out, and after that they’re not gonna want any...so we try not to scare them away. I say the Depo is the least invasive one, it’s a little pinch, you forget about it for 3 months...They like simple...safe.”

By contrast, several medical providers expressed concerns about Depo due to intolerable side effects (e.g., spotting, weight gain) and the potential impact on bone density in the future.

Though they did prescribe it occasionally, it was not their preferred method. Allison explained:

“...Well the shot...I’m concerned about osteoporosis in their future. You really can’t take it for that long...it’s a very short-term choice from my point of view. I like it because it lasts, but um, you know people really don’t like the irregular bleeding, you could gain weight with it, I find people come in late all the time for the next shot...You know it’s nice

for those 3 months, but then they miss the next shot and it just...I dunno. It works for some people and I'm certainly willing to use it, but I don't think it's the greatest choice."

Deborah's misgivings about Depo resulted from what patients had told her and the fact that once the injection was given, it could not be "undone":

"Depo is one that people have a lot of side effects from, so you know, it's enticing to a lot of people 'cause it's like, 'Oh it's three months, I don't have to think about it,' and da da da, but a lot of people wish they didn't do it. And it's one of those things where once you put it in, it's there. So I do kind of give people a pretty serious warning with that one so they're aware of their risks of having kind of intolerable side effects. 'Cause mostly people will come in so distressed about bleeding, or not getting their period, or gaining tons of weight, that I want people to know that it can be very distressing and to really be mindful of that."

Upon reflecting on how contraceptive method decisions are negotiated within clinical encounters, most medical providers described their exchanges with patients as part of an ongoing dialogue that emphasized flexibility and finding a method that fits the patient's lifestyle rather than feeling attached to a method with which they were dissatisfied. Carla explained:

"...I tell them, listen, nothing is engraved in stone...if this doesn't work this time, we got other ones we can try till you get something that's gonna work."

Similarly, Carmela emphasized the patient's right to stop any method:

"I tell them, just because they take something today doesn't mean they have to be on it forever. That if you hate this method, we'll fix it."

In some cases, it may take several visits before a patient decided to select a method or maintained use of one with which they're satisfied. Nancy explained how she approached this process:

"I feel like I've gotten more educated about this and worked on this better with my teenagers, like, this is an ongoing conversation, and if something doesn't work, so what? Let's go on to the next thing. This is a relationship, we're gonna work at this, and you and I have to like be in really good contact about this till we figure out the method that's right for you, so here's the menu, let's pick something on the menu. If it works, great, if it's not working, come on in and tell me about that cause like let's try something else. 'Cause not everything works the first time...So like really kind of reassuring them..."

Less commonly, medical providers described a style that more closely approximated shared decision-making between the physician and patient. Deborah reflected on her shifting approach with regard to counseling patients to use a hormonal or LARC method as opposed to a “natural” method such as withdrawal:

“...I used to kind of preach, ‘You have to be on something!’...People will tell me they’re using the withdrawal method, and before I’d be like, ‘Oh you can’t do that, that’s horrible!’ But if they’ve been using it for the past eight years and haven’t gotten pregnant, ok! That’s pretty good odds... I think I’ve become more comfortable now with kind of hearing people’s success with whatever method they’re using and knowing that our methods are not the best. They do bring side effects...so I...used to find I’d push these other things on them and then they’d get all these other horrible side effects. So it’s like...if you’re willing to take that...increased risk of getting pregnant, but not having the side effects that you get from these other things, that’s your choice! As long as you feel informed about it and you know the risk you’re taking, that’s your choice. I feel more comfortable with that, that kind of co-sharing the decision with the patient...where...I would have felt like a failure before if they had gotten pregnant.”

This orientation, however, was rarely used with younger and more inexperienced teenagers because youth were seen as needing more guidance and structure than adult women with a more extensive track record of not becoming pregnant.

Lastly, HCWs highlighted the importance of both managing patient expectations about common side effects and, if a patient experienced them, negotiating initial continued use of a method. Below, Lisa reviewed how she discussed common side effects with her patients:

“...I think that just talking about what are your concerns, you know...what are you looking for, so we talk about that. Just informing them, you know, I know some of them also worry, they get a lot of spotting, so they worry about stuff like that, so just informing them about side effects, possible side effects, that just because you’ve heard this might happen it doesn’t mean it’s gonna happen. If it does happen, you can always go back to the doctor and get it tweaked.”

Nancy described the guidance she provided to patients interested in the Depo shot and her attempts to manage irregular bleeding some teens experienced as a result:

“Depo, I have to say...we try really really hard before that first shot to really get it into their heads, like, you’re gonna have unpredictable, wacky bleeding. It’s gonna happen, it’s really normal, it’s gonna happen. If you can get through 6 months then, pretty much you might be in the clear. It’ll stop. And maybe you’re gonna be that 10% that’s not

gonna bleed after the first shot, but likely you'll be bleeding. But still, girls will come in...They don't want the second shot because, 'Yo miss, I was having my period the whole time!' So I try...I give calendars to the girls after that first shot so we can really quantify it because sometimes it feels like you're really bleeding all the time but you're not."

Likewise, Carla provided a similar scenario of a patient experiencing side effects from Depo and how she addressed their concerns:

"The only issue I've had with the Depo is they don't get their menses, and they um, 'Oh my mother monitors my period.' [I tell them] 'This is what we discussed remember?' 'Oh yes yes I remember what you told me.' They have no problems, ok? I say if it really really really becomes an issue, and your mother's really on your back about it, you can always switch to oral contraceptives..."

Note that in both of the above scenarios, neither provider told their patient to stop the method after the first shot and try something else. While switching was generally regarded as acceptable, HCWs can and do exert considerable control over patients' decisions about when to stop using methods that are less patient-controlled.

CONCLUSION

This chapter presented findings from HCWs on the ways in which reproductive healthcare is delivered in three types of primary care settings. More specifically, it sought to elucidate how HCWs conceive of their role with regard to ASRH and the promotion of contraceptive use by teen patients. HCWs often painted their teen patients in narrow and reductionist terms, and in some cases, reified traditional gender roles and stereotypes regarding sexual behaviors and expectations among women and men. Given the dearth of available literature on the content and effectiveness of counseling strategies employed, it is perhaps not surprising to discover the subjectivity evident in the numerous approaches and topics broached by HCWs. Interviews with participants also revealed particular values and ideologies about ASRH that shaped clinical practices, such as recommendations for or against particular methods.

With consideration of these findings, the next chapter will present themes on sexual and reproductive decision-making from the perspectives of female youth.

CHAPTER EIGHT

THE SOCIAL CONTEXT OF FEMALE YOUTHS' SEXUAL AND REPRODUCTIVE LIVES

INTRODUCTION

Interviews with female youth sought to better understand how reproductive decision-making, broadly, and contraceptive choices, specifically, are negotiated. Additionally, this research sought to contextualize behaviors and practices within the broader familial, intimate and interpersonal spaces inhabited by young people. As described in Chapter Four, teens were interviewed at primary care clinics within a hospital network in the Bronx.

FAMILY, HOUSEHOLD, AND NEIGHBORHOOD SETTINGS

A demographic analysis of the 12 zip codes where participants resided at the time of the interview indicates that, compared to NYC as a whole, these zones have at least twice the percent of female-headed households. In five of the zones, the annual household income is less than half of what New Yorkers earn on average, with an additional three zones making at least one-third less than the average income. The prevalence of female-headed households and major disparities in household income clearly illustrate the feminization of poverty in these areas, with 30% or more of individuals residing in eight zones living below the federal poverty line as compared with 15% for NYC. Additionally, seven of the 12 zones have more than a quarter of residents 25 year-olds and older who have not graduated from high school, compared with 15% for the city overall. Lastly, the unemployment rate among 25 year-olds and older is twice as high or higher in eight of the zones as compared with NYC. Collectively, these data demonstrate considerable

inequities in income and education for most areas in which female participants resided compared to the city overall.

Interviews with teens gathered information about family life, paid and unpaid employment (both their parent/s and their own), and their contributions to the household in order to better understand family dynamics and stressors. Of the total sample (n=26), 15 teens lived with one parent, who in all but one instance was their mother. Five participants lived with their mom and a stepparent, with an additional five who reported living with relatives other than their parents, such as a grandparent or aunt. One teen lived with both parents. Not surprisingly, participants described varying levels of closeness with their immediate and extended family, though virtually all teens reported having a close relationship with at least one family member. As the primary caregiver for the vast majority of teens interviewed, this person was often their mother, though certainly not in every case. As will be described in more detail below regarding communication about sex, these participants frequently characterized the connection with their mother as open, honest and supportive, with several teens likening their relationship with their mom to a friend due to the level of closeness. Seventeen-year old Vanessa commented:

“...I feel like sometimes I forget that she’s my mom ‘cause we don’t ever argue about anything. I don’t have any issues with my mom, I’m just going through a phase where I’m really grouchy and I don’t like to be bothered...We do everything together...we cook together - she’s teaching me how to make Dominican food - we clean the house together. I spend most of my days together with her since we live together.”

Zoe, a 17 year-old, described the reason she thinks her mom gives she and her siblings “more freedom” than her friends:

“I’d say my mom is more like a friend to me. I think she does that because when she was younger she didn’t have like freedom and everything. She’d always be on punishment, so she likes to give freedom so we don’t have to go out. You find when you have freedom that you don’t go crazy.”

Conversely, several teens described more difficult relationships, characterized by frequent arguments, a lack of trust and less freedom. Leah, an 18 year-old, is the youngest of five siblings, and described feeling stifled living under her mother's roof:

“On my mom’s side I’m the baby...she doesn’t spoil me but she just babies me. I can’t go anywhere, I can’t go outside, can’t get a job, can’t go to college. She wants me to stay under her wing forever. All her [other] kids are grown. I understand where she’s coming from, but when it gets to the point where I can’t do anything...She thinks that every time I wanna go somewhere - her excuse for everything is, ‘cause she watches a lot of homicide shows, and she thinks that every time I go outside, such and such will happen to me. That’s why she doesn’t let me go anywhere.”

As mentioned earlier, the majority of teens interviewed (n=25) did not live with their biological fathers, and many did not see them frequently or at all. This was most often due to geographic distance, the nature of their parents' relationship, or their father's lack of involvement in their lives. Daniela's relationship with her father embodied elements of all of the above. Born in the U.S., she lived in NYC with her mother and sisters until moving with one of her sisters to the Dominican Republic (DR) where her father currently lives. Daniela spent several years during middle school in the DR and returned to the Bronx in high school, but continued to visit the DR periodically. She explained that her family had been having some difficulty recently due to her father's drinking problems, which resulted in her mother leaving him in the DR during their last trip. When asked if they were planning for him to come to New York at some point, Daniela responded:

“Supposedly he will, but he’s calling me and telling me to help him out, send him the ticket, and the problem is, I never lived with him. I only really started living with him when my mom brought him here, but our relationship hasn’t been very well. He’s kind of a person that he likes to insult me and stuff. So I don’t really see him like a father ‘cause of the way he acts with me. It’s like my mom is my mom and my father at the same time.”

Beatriz's parents split up when she was eight years old, but they continued to have an on-again off-again relationship for years afterwards. Currently, both of her parents are remarried and

living in NYC, but because they are not on speaking terms, her father has not spoken with Beatriz or her siblings at all in the past several years. When I asked whether the situation was difficult for her, she commented:

“Doesn’t make it hard for me but for the two little ones [her younger siblings]. I know what it is now. I got used to it. They the ones getting hurt and that’s what they don’t see. I think my mom see it but she don’t accept it. And my father really don’t see it, and he’s got two little ones and one coming. And I think that’s gonna affect them growing up...they need to think about what they’re doing. Like me and my [older] sister, we don’t care, we’re like whatever, it’s just the same thing over and over and we don’t care anymore.”

Reflecting upon their parents’ relationship when they were together, teens often described them as difficult, tumultuous and occasionally violent. Veronica, 17 years old, lives with her brothers and their wives, while her mother lives in the DR and her father lives in NYC. Of her mother and father’s relationship, she explained:

“They won’t get along. They always argue, and they had like stuff that happened in the past, so it affected them, and then my brothers didn’t like him either. So before when we all lived together, my brothers kicked him out. They kicked him out.”

Laura, 16, lives with her sister and her husband, brother, nephew and her three year-old son.

Laura’s mother passed away three years ago, before she learned that her daughter was pregnant.

Her parents had separated years ago, after what Laura explained was a lot of mistreatment of her mother by her father. When I asked about her relationship with her father, Laura responded:

“We did know him for a while, but he had left and came back and then when mom got sick, he just...we tried...we just kicked him out of our lives. We want nothing to do with him. When we told him to go to court to get custody of us so we wouldn’t go to foster home, he said no, ‘cause I had told him my mom was dying, and she didn’t want to tell him ‘cause you know they didn’t have that connection...My mom already had another partner at that time so we had told him to go and give my aunt custody [of us]. That’s all he had to do was to give her the custody, sign a paper, that’s it. He said no, I’m not gonna go...’cause he had a lot of problems with the law, he’s been getting arrested for drinking, jumping over the trains, so he said he wasn’t gonna go, so after that we just got him out of our lives and we don’t want nothing from him.”

Despite her father's unwillingness to sign paperwork to transfer custody, Laura and her siblings were able to avoid going into a foster home and live with their aunt:

"...When I got home, my aunt told me, 'Oh, the lawyers came, they say that now that you don't have a mother or a father it's time for you to go to a foster home, 'cause you don't have nobody. So I'm like, 'But you're my aunt, I could stay with you!' But we aren't legal from here, we don't have no papers, so that's when my aunt decided to file for custody and she had said that it shouldn't matter, my mom's last wish was to keep us with her. And my aunt was shaking; she was scared she would be deported. I don't know how she did it but she went to family court. She lost her job because of it, just fighting for us. She was always there for us...And I know my mom, for some reason, she did it."

The quality and extent of relationships with stepparents and partners of their mother and father also varied among the teens interviewed. Some participants reported a high level of closeness and support while others describing difficult situations where they tried to spend as little time with them as possible. Josefina, 19 years old, characterized her relationships with her step-mom and a former partner of her mom's (her younger sister's biological father) positively. She explained:

"...My mom and my step-mom get along, we all get along. 'Cause basically my mom left my dad so then by the time my dad had met my step-mom, they were already over it, so my dad and my mom and my step mom got together and they have a good connection.... My little sister's father...lives in Connecticut now with his family, so he usually comes to visit us and stuff. He raised me and my brother and then they had my sister, and now he moved away. I kinda miss when he's gone. Like he's been there my whole life."

On the other hand, some teens reported negative relationships with stepparents that were a source of conflict and stress. Fabiana, 15, has been living with her mom, brother, sisters and step-dad for about seven years. Although she described close relationships with her mom and siblings, her relationship with her step-dad had become increasingly difficult over the years:

"I have a good relationship with my mom, not with my step-dad at all...Me and my brother have a really good relationship, and my two younger sisters are in love with me, so I get most of the love from them too...At first me and him [step-dad] used to get along nice, and then he started to show his true colors. He started to treat me like I was no one. He didn't accept me being my mom's daughter from another father, so he treated me badly. So after that, I kind of like, you know, when I see him in the house I go the other

way 'cause I know he's gonna start something. I'm better off keeping my distance from him then me and him arguing and my mom telling me to stop."

Due to the large number of teens whose parents were not born in the U.S. or who themselves immigrated (n=18), many participants described personal and family member's experiences moving from, and sometimes returning to, another country, and being separated from siblings, parents and extended family for lengths of time. As a result of the great physical distances that these teens lived from their immediate family members, it was also not uncommon for participants to live with extended family. For example, Isabel, 18, had moved from the DR with her mother when she was about seven years old. Since her mother still lives in the DR and her father is currently incarcerated, she has been living with her cousin, her cousin's boyfriend and their three small children for the past few months. Several years ago, Sofia, 19, joined her mother and siblings in NYC from Colombia, where she had been living with a cousin while her mother worked to bring her to the U.S. At first, the transition was difficult for Sofia:

"...When I came here my life was kinda hard, 'cause I don't have like...I had a bad attitude. When I was [in] Colombia I could do whatever I wanted, but when I came here my mom put a stop to that. She didn't want me to go out too much...so she controls me a lot. And my sister was getting jealous because I had the attention since I was the baby. But as the days passed, now [I] have a good relationship with my brother and my sister."

Ximena, 16, was born in NYC, but after her parents split up when she was an infant, she was sent to live with a great aunt in the DR. She lived there until she was four, when she moved back to the U.S. to live with her mother and stepfather. Ximena's relationship with her mother has been conflicted, resulting in periods of time where she lived in a shelter and with her grandmother, who currently has custody of her. In comparing her experiences living with her mother and grandmother, Ximena noted:

"It's very different than like the home life I had with my mother...it's very like, my mom would sleep all the time, I never really got any mother-daughter time ever. And with my

grandmother it's like, with the short time I've been with her, she's been squeezing in so much, like, bonding time that it's almost being made up for in a way."

EMPLOYMENT AND EDUCATION

Thirteen teens in the sample were aware of at least one parent, stepparent, or family member within their household who was employed outside the home, while eight reported no outside employment.²⁶ There was a wide range in types of employment held, including but not limited to construction, the service industry, the public sector and healthcare support. Teens frequently commented on the difficult nature of their parents' work and challenges associated with finding higher paying positions. For example, Vanessa, 17, noted:

"She [mom] works at a home attendant, so she works with old people. She goes to their homes and cooks and cleans for them. That job does not make any money in my opinion. She did a course to be a bus driver assistant – helps the kids get on and off the bus – but she cannot find a job in that field."

Sixteen-year-old Ana explained:

"Mom is on disability so she can't work now. Dad works in a hotel at night. He comes home at 6:40 am and sleeps during the day before going back to work."

Participants also described the hardships faced by unemployed parents who were looking but unable to find a job:

"[Mom is]...not working right now. And she's really desperate and um she's looking for a job, she don't find nothing. My brother's the only one who's working, who has a job. I don't remember where he works. But it's a store." (Valeria, 17 year-old)

Not surprisingly, formal employment was less common for teens in the sample, with six out of 20 reporting a paid job or internship outside of school. Some participants expressed a desire and interest in finding a job, but were unable to do so, or did not hear back after submitting an application. Carolina, a 17-year-old whose mother is unemployed, explained her family's situation with regard to employment:

²⁶ Five teens were unsure as to the status of their parent/s' or other family members' employment.

“Anything that has to do with social security, my ma don’t want me to work. ‘Cause we not working and we receive public assistance and welfare, so they told my mom that if one of us [the children] were to [work], they’d take away the help that they give to support me. If I worked, they only taking me out. And my mom needs the money for all of us. So I’m like, OK, I’m not gonna argue with her.”

In spite of this, Carolina has found ways to earn some money so she has to depend less on her parents’ limited financial support:

“Before I used to tutor but now my sister is tutoring the girl...so what I do is I clean this lady’s house and she pay me. I used to do her laundry too, so I will find way to get a little something, ‘cause like I said, I don’t wanna take away my mom’s saving neither, she’s probably saving it for rent or something.”

Daniela recently left her high school and joined a GED program. During the interview, she described the importance of her earning money and gaining some independence from her family:

“...Right now the things are not good and stuff. Yeah I’m in school, I’m looking for a job and stuff like that, to see if I go to night school while working the mornings. Because in this country that’s what you have to do. If you don’t aspire yourself to something, then who’s going to help you out? ‘Cause my mom has her own problems and I don’t want my life to be with my mom and that my mom gives me everything...”

The vast majority (25 out of 26) of teens contributed to the household in numerous and often considerable ways, most commonly including cleaning, doing laundry, cooking, taking care of younger siblings, cousins, nephews, and nieces as well as buying groceries and other supplies.

Beatriz, 17, described how she helps out around the house:

“I clean all day, I take care of my two little brothers, and when my family needs me to babysit their kids, I do that too. Sometimes they don’t even ask me!”

With the exception of one interviewee, all young women in the study attended public high schools located in the Bronx.²⁷ Interviewees reported varying levels of satisfaction with their educational experiences thus far, with the most frequent comments pertaining to the quality of instruction and their peers. Since the 1960’s, New York City experimented with the creation

²⁷ The only outlier was a teen who had recently left her high school and was in the process of enrolling in a GED program.

of small schools to combat abysmal graduation rates, student performance disparities, and high rates of violence (NY Immigrant Coalition and Advocates for Children 2006). The overarching theory behind this strategy was that if large schools were broken up and replaced with several small schools, each with their own administrative oversight, students would receive more individualized instruction, safety would improve, and graduation rates would increase. The so-called “small schools movement” has resulted in the creation of numerous schools within a single building that, in addition to fulfilling the NYS and City Department of Education requirements, are often focused on particular themes (e.g., languages, the arts, mathematics) (Robbins and Meyer 2013). Many of the public high schools in the Bronx, including those attended by the teens interviewed for this study, were impacted by these organizational and pedagogical policies. Although the effects of this movement are too extensive to describe here, it is important to situate participants’ experiences within the educational environment in which they regularly interacted.

After recently moving to the Bronx to live with her grandmother, Ximena, 16, ended up at her high school by process of elimination. Because it was so late in the year, there were few school enrollment vacancies, so she chose from what was still available. When asked about her thoughts of the school, Ximena commented:

“I don’t like it, it’s so broken up; there’s no kind of unity at all. There’s so many different schools. It’s not like a normal school where there’s a basketball team that everyone cheers for. No, it’s like, everything is broken up ‘cause they thought there was a whole bunch of gang violence, so to make it better they had to break it apart. But now it’s just horrible, even the teachers are constantly saying there’s no way this is a good solution. And it really sucks because [the schools] have the fanciest names ever...I go to a [business-focused] school. You know how horrible I am at math? It’s all these fancy names and they don’t have any special classes at all, it’s just basic. Just to sound cool.”

While not asked directly during interviews, participants often spontaneously described issues and concerns related to violence and safety within their schools, such as the hostility of their peers

and the need to “keep to themselves” to avoid getting into trouble. Valeria, 17, explained:

“...The students here at school...mmmmm. They argue for no reason, they wanna fight with you for no reason, if you look [at] a girl, they feel that you’re looking at that person with dirty looks or something like that. You need to walk and look like...not far. You can’t look at people. I don’t like this school, it’s weird.”

Seventeen-year-old Kamilla described her school as one “for kids that are trying to get help,” noting its “bad” reputation and the way she approached her classmates:

“It’s a lot of deans in my school. That’s how bad the school is, that you have to have a dean at every door...waiting for a child to come in the hallway...A lot of things happen. A fight could break out, kid could get hurt. You got lockers in the hallway, somebody could smash somebody’s head in the locker. That’s death right there. I don’t pay that no mind ‘cause I don’t have problems with people. I don’t make problems. Like I tell people, I got in school to get in and get out, and that’s my life.”

In 1998, the New York Police Department (NYPD) gained oversight of and responsibility for school safety, resulting in a proliferation of NYPD personnel in NYC public schools (NYCLU 2007). The policing of schools in the city has increasingly come under scrutiny from numerous groups, including by the New York Civil Liberties Union (NYCLU). In a recent report by NYCLU, the authors pointed out that because police personnel “are not directly subject to the supervisory authority of school administrators, and because they often have not been adequately trained to work in educational settings,” these staff often enforce rules and wield authority that go well beyond the “narrow mission of securing the safety of the students and teachers” (NYCLU 2007:4). Examples of inappropriate treatment found included: intrusive searches, arrest for minor non-criminal violations of school rules, abusive and derogatory comments, unauthorized confiscation of personal supplies, physical abuse, and sexual attention (NYCLU 2007:4).

With the exception of one participant, teens interviewed for this study attended schools that required students to have their belongings scanned by metal detectors and to provide their

school ID to a security guard; a process that often resulted in students being late to their first period class. Justine, a 17 year-old senior, commented on the security measures taken at her school:

“I don’t like that school. They have metal detectors. I don’t like that, you can’t bring no phone, nothing, you gotta take off, like, these boots [pointing to her winter boots] if you comin’ through...everything, like you a criminal.”



Figure 8.1. Electronic device storage van parked outside of a high school in NYC.²⁸
Photo credit: Author

While at the SBHC where the majority of teen interviews were conducted, I witnessed an exchange between a school security guard and a student who had been waiting at the clinic door to be let in for her appointment.

This morning, I was sitting in the nurse’s room when a school cop came busting through the clinic door following a female student who was “mouthing off” to her. The cop followed her into the clinic and began aggressively yelling at the student: “You don’t talk to me like I’m a child. You don’t tell me to shut up. I disrespected you? I disrespected you?!” The confrontation apparently arose because the student wanted to get into the clinic to see her provider and the door was closed as clinic staff were at lunch. The school cop told her to go back upstairs. The student then became upset and “talked back” to the cop, after which the confrontation ensued. After the situation quieted down,

²⁸ Cell phones and other electronic devices are prohibited in the city’s public schools, but in practice the ban only affects those students attending schools with metal detectors. Companies charge students \$1 per day to leave their cell phones with them during school hours.

a clinic staff person commented to me, "That's what we go through every day. If it's not one thing it's the other." The interaction and the HCW's comment makes clear the fact that providers in school clinics are situated within some challenging and oftentimes divergent ideologies, approaches, and politics. School cops (and the school more generally) have one agenda (safety, discipline), while the clinic has another (ensuring the health and wellbeing of their patients). Field Notes, December 10th, 2013

This exchange underscored the challenging juxtaposition of a clinic inside a school building; given their divergent missions and loyalties, clinic staff and school personnel may perceive of and respond to youth quite differently.

Several teens also shared experiences that underscored the social and economic marginalization of their own neighborhoods. Josefina, a 19 year-old participant, grew up in the Bronx and has lived there her whole life with her mother, brother, sister, and for a period of time, her stepfather. They moved frequently, at one point living in shelter housing for several months due to a fire in their apartment building. Currently, she lives "in the projects." Of her current situation, Josefina commented:

"...People seem scary there. And it's like, I work at the movies, so I have to come home late and that's really...I have to be aware. And usually there's cops around as they're hot-spotting the spot most of the time. And usually I bump into drunk people and stuff like that. Hopefully we move soon, I'm dying to move. [I] don't feel safe there at night at all."

Kamilla, 17, also grew up in the Bronx with her mother and siblings. She described herself as a former "street kid," often getting into trouble and occasionally getting arrested. Several years ago, Kamilla was involved in a violent altercation with an older woman that she considers a pivotal moment in her life. She explained:

"I didn't even know her. We was doing laundry and she just started with me. I'm like, 'Miss, you're like 30 something years old. You're starting with a 15 year old?' She threw bleach on me and it got in my eyes, which is why I can't see [well] now. She almost killed me. So I...this is bad...I put her in a coma and I broke her ribs...I think they said I broke her jaw and her nose. So, I almost did life for almost killing her. But she coulda done life for almost killing me 'cause that's bleach. It went in my mouth, my nose, my eyes, I coulda damn near went blind! And that just changed my life. I think, well, I wanna be 'this' when I get older. But if I'm out here doing this or that, I will never get there. I used

to think the streets would get me there. But the streets will never get you anywhere but either dead or in jail. So I thought better of myself.”

DISCUSSIONS WITH PARENTS ABOUT SEX

In this study, teens exhibited a wide range of experience and comfort talking with their parents about sex and related topics. Among the teens interviewed, 77% (n=20) reported having had prior conversations about sex with a parent or stepparent. Many participants described these conversations as more general in nature, relating to broad discussions about menstruation and reproduction. There was also wide variation reported by teens regarding when these conversations took place. Zoe, 17, explained that her mother started to discuss sex with her and her brother at a young age:

“I guess it was my mom decided to talk to me and my brother about it so if anyone would touch us inappropriately we would know if it was wrong or not...”

Vanessa, 17, remembers her mother trying to talk about it with her when she was in middle school:

“It was very vivid. I didn’t want to get into the conversation so I’m like, ‘Yeah Mami, I know about it, I don’t care.’ I think I was 11...I ignored her, or I tried to. I ran away!”

In high school, Vanessa’s mom tried to bring up the issue of relationships again, which resulted in a more personal discussion about premarital sex:

“We did have a conversation about boys, but it was so awkward. She asked me if I would ever sex with my boyfriend. And at the time, I was a virgin, but I told her yes. She looked at me like, ‘No, that’s something you should save until marriage!’ I’m like, ‘Well at least I’ve been dating my boyfriend for a maximum amount of years. I’m not like these other high school girls who just do it on a whim.’ She’s like, ‘No, that’s so wrong.’ I’m like, ‘I don’t think it’s wrong...’ She’s like, ‘If you come up pregnant, you better not come to me.’ I’m like, ‘Of course not.’ She asked very randomly; we were watching TV in her room and she was like, ‘Would you ever have sex with your boyfriend?’ And I said yeah! I was so focused on the movie I didn’t even think about it.”

Fifteen-year-old Jazmin explained that by the time her mom started having conversations with her about sex, she had already heard quite a bit about the subject from her siblings; however, discussions have been more frequent now that she had a boyfriend:

“Yeah... we had the birds and the bees talk plenty of times, and like now that I got a hickey it’s like... even more out in the open... It was like, too late when she told me, ‘cause my brothers and sisters are already like, ‘Yup so let me tell you what I did with this girl. So when you do this, better that I’m telling you.’ So it’s like, okay! So I knew more than she thought I did. She started talking to me about it when I was like 14, but like my brothers and sisters beat her by so many years, so it’s like, I already know.”

Although rare, a small number of teens interviewed indicated that they told their mother when they began, or were planning to, have sexual intercourse for the first time. Samantha, 17 years old, had been dating her boyfriend for over two years at the time of the interview. She reported a close relationship with her mom, and explained that they had previously discussed sex as part of a general conversation. In addition, she spoke with her mom about starting on birth control prior to becoming sexually active to help regulate her period. Before she and her boyfriend decided to have sex, she discussed this decision with her mom:

“It was kind of weird, but at first it [the decision to use contraception] was for my period, and then I was like, ‘Ma, I’m thinking about being active,’ and she was like, ‘Ok. I just want you to be protected in case anything and use a condom too.’ So I said yeah, ok, fine.”

More commonly, teens reported having conversations with a parent about their sexual behavior after the onset of sexual activity. Josefina, 19 years old, started having sex with her boyfriend of three years when she was 17. Due to the close relation she had with her mother, Josefina let her know shortly afterwards, which resulted in her coming to the school clinic to obtain contraception:

“I actually told her [my mom] once I started having sex. I was like, ‘I lost my virginity!’ And she was like, ‘Go to the doctor and get birth control!’ And I was like, ‘What is that?’ And she was like, ‘Oh, so you don’t get pregnant!’ And then I came to the clinic and the doctor gave me birth control.”

For some participants, telling a parent that they were sexually active was not a question of if but when. Fabiana, 15, was waiting for the “right moment” to tell her mother that she had started having sex with her boyfriend and was using oral contraceptive pills:

“Right now I don’t wanna tell her ‘cause I don’t wanna put so much...you know, pounds on her, and let her stress about the situation. I’m better off waiting until I know that she can handle it. And I know...she wouldn’t take it in a bad way...I know the time is coming for me to tell her but I wanna wait for the right moment and I want her and me to be alone so...I’ll be able to talk to her without anyone around and tell her why I did it...”

Among the total sample (n=26), 17 participants indicated that at least one of their parents - most commonly their mother - knew that they were sexually active. In most cases, the disclosure of sexual activity status was the result of a parent discovering information or finding contraception. Beatriz, 17, had been seeing her boyfriend for several months at the time of the interview. Her mother discovered that she was having sex when an explanation of benefits letter²⁹ was sent home from their health insurance company with a description of sexual health services rendered. Beatriz explained:

“I was like how did [the letter get sent]...? I don’t get it. And my mom asked me that same day, that night, ‘Did you have sex?’ She asked me so many times. I lied a lot. But that same night I told her, yeah I did. I had sex. I said I have something to tell you; I was laughing, and I was like, yeah. She was like why didn’t you tell me? She had one day upset, and then she was ok. She said it was gonna happen anyways.”

This conversation resulted in a subsequent discussion about birth control, about which her mother was very supportive. Beatriz continued:

“I wanted to get on birth control but I didn’t want to till I told my mom [that I was sexually active]. So she told me, you need to get on birth control if you’re living in my house. I’m like, ‘Of course I’m gonna get on birth control. I was thinking about it,’ and she was like, ‘Alright.’”

²⁹ Explanation of benefits (EOB) are provided to insurance beneficiaries as a form of consumer protection to ensure against over-charging and inaccurate billing, provide information about denied claims and appeals, and include details of the clinic visit. As EOBs are mailed to the patient’s address following a clinic visit, they can result in a potential breach of confidentiality for adolescents seeking reproductive healthcare under their parent or guardian’s health insurance plan.

Ana's mother found out about her daughter's sexual activity status through a neighbor:

"I was close with my neighbor, right? And then there was once I had a [pregnancy] scare and I told her about it, 'cause me and my neighbor, we were really close. So I think my neighbor told her mom, who told my mom...and after she promised she wasn't gonna tell, but she told her. And then my mom asked me and I told that I wasn't [a virgin]. Our relationship got better after I told her though... 'cause now like she basically knows everything so I can just...like if I have any questions or anything, I can just come to her."

Alejandra's mother found her birth control pills and confronted her. She explained:

"I hid my stuff, like my birth control and my condoms, and then she found out that I was taking them and then she told me like, 'Oh are you having sex?' and I'm like, 'Yeah,' and that's when stuff happened...I was scared at first and then I was like, I have to end up telling her anyways. So I said listen, I'm doing this and this and this and this. And she was disappointed. She even left the room 'cause she was afraid she was gonna hit me. But like, then later on she just wanted me, after me telling her this, she wanted me to tell her the truth all the time, and if I have any questions to just tell her and ask her..."

The anecdotes above reflect that although the experience of their parent discovering their sexual activity status was nerve-racking for some teens, it often resulted in more open dialogue about their sexuality and health.

For some participants, parents became aware that they were sexually active when they became pregnant. Among the teens interviewed, six reported a previous pregnancy, of which three told their parents. Nicole, 18, lived with her grandmother, aunt and cousins in Manhattan. Her mother lived in California with her siblings, and her father was incarcerated. Nicole moved back and forth from New York to California several times over the past few years, at one point living with her long-term boyfriend. She and her mother had had earlier discussions about sex, during which she told Nicole to be careful and to tell her when she was thinking about becoming sexually active. Nicole explained:

"She found out that I was sexually active...I moved out here [to New York] with my boyfriend and I had um, got pregnant, and I had to get an abortion, so after that that's when I went to her and she was like, 'Well you know you can get this or you can get that.' So then we made the decision together on which BC [birth control] I would go on."

Similarly, Justine, 17, had not discussed her sexual behavior with her mother until she became pregnant:

“I had got pregnant by [my boyfriend] and I had told her, and I was like 3 months into it, and she just took me to a place and just got it [an abortion] done. And then after that she just made me go on it [contraception].”

As the stories above illustrate, teens tended to discuss contraception with a parent after it was already known that they were sexually active. The majority of teens indicated that if parents did preemptively raise the issue of protection, it related to condoms, and not hormonal or long-acting reversible methods. Alejandra, 15, explained:

“[With] my mom, the most we talked about was like condoms, but we don’t talk about birth control.”

Thirteen teens reported that at least one parent knew they were using a hormonal or LARC method of contraception, a finding to which I will return later in this chapter.

For some teens, being able to approach a parent about issues relating to sexuality and sexual health was considered undesirable and challenging. While Sofia, 19, felt that she had a good relationship with her mom, she did not discuss her sexual life with her because she was concerned about how it would affect their relationship. Sofia explained:

“I don’t talk like that with my mom...she’ll be like, ‘I know you have sex,’ and I keep walking ‘cause she saw me like the baby. She’s like, ‘You’re my baby.’ When my sister was 19, she told my mom, yeah I have [sexual] relationships, everybody do – you did it. So when my sister started like that my mom was like, ‘Oh my god, she’s my baby and she’s had these relationships. So, after that their relationship changed. And I don’t want that, so I just keep walking...”

When Valeria’s parents found out she had become sexually active, they expressed disappointment and anger at her decision. Subsequently, her father brought her to a clinic while living in the DR to get on the Depo shot, which she currently uses. In the year prior to the interview, she also discovered that she had a strain of HPV that causes genital warts, which has

caused her considerable stress. During the interview, she lamented the fact that growing up she had little communication with her mother about sex and protection:

“Every time I used to ask my mom about sex, STDs, and stuff like that, she got red. She was like I don’t know, I don’t know. So if I know all the stuff that I know right now, it’s because of me, you know? Because I’m learning little stuff here in school. ‘Cause my mom doesn’t tell me nothing. The only thing that she say to me is, ‘Don’t have sex, don’t have sex.’ That’s not the way that you need to talk with your daughter. When I have my kids, when they like 10, I will talk about everything with my kids...you know, everything? And I have a son - if I have a daughter too, I will give to my kids like a bag of condoms...I’m gonna try to be the best mother that I can be.”

Carolina, 17, described a difficult relationship with her mother, who did not believe in sex before marriage or using birth control. Ever since puberty, she heard the same message over and over again:

“My mom, she told me if you ever get pregnant, you’re leaving [the house]. Don’t come to me, don’t depend on me, don’t talk to me.”

When Carolina was 16, she became pregnant and sought a termination. At her request, the school clinic’s social worker subsequently brokered a visit for Carolina, her mom and step-dad to discuss what had happened. She explained:

“...My stepfather told her [my mother] what happened. And she got mad at me, she’s like, ‘Why couldn’t you talk to me?’ I’m like, ‘Mom, the communication was never there at first... Why should I tell you my problems?’”

During the counseling session, her mother’s disapproval of contraception was reiterated, so although Carolina would like to be honest with her, she did not feel that she could:

“Right now she thinks I’m not [on birth control], but really I am. I’m just hiding it for her not to see... When my mom gets angry, she gets frustrated. There have been times when she has hit me, and for no reason, so I’m like, I’m not gonna take the risk. I’m like, ‘Mom what would your rather me do? Tell you the truth or lie?’ Knowing that I don’t want to lie to you. I don’t want that.”

At the time of her mother’s death, Laura had been pregnant and was planning to continue the pregnancy. Laura’s involvement with her 17 year-old boyfriend, Hector, had been a major

point of contention between she and her mother, a topic about which we spoke at length during the interview and for which she expressed regret and sadness. According to Laura, she was initially unaware of what sex was or that she could become pregnant at 13, as she had not received information about reproduction or protection from anyone when she became sexually active. Moreover, her mother was not willing to discuss these issues with her. For example, after she started having sex, she went online to look up information about HIV and other STIs:

“...I would ask my mom about it [STIs] and she would just hit me on the head and be like, just don’t talk about it.”

Initially, she kept her relationship with Hector a secret from her mother. When she finally did reveal that she was involved with someone, her mother demanded that she end the relationship and restricted her activities after school. Instead of breaking up, Laura found ways to see Hector without her mother knowing. Because they did not want to be seen together in the neighborhood by her mother or other family members, they most often stayed in at Hector’s apartment across the street. Hector did not live with his family, as he had moved to NYC from Mexico to work full-time in order to send remittances home. Laura explained the potential impact the secretive nature of their relationship had on her becoming pregnant:

“I think if my mom woulda been more [understanding], we woulda gone to the movies, we woulda gone out more, instead of just staying in his house doing bad stuff that we weren’t supposed to do. And I think that’s the reason what got me pregnant... it was the trust that my mom didn’t give me.”

At one point, Laura and her boyfriend tried to have a discussion with her mother about their relationship, which only alienated them further:

“... When we tried to talk to my mom once, my mom yelled. One time he called my mom; he sent me a message and said he was gonna call her, and I was shaking I was so nervous. And this was when she had the cancer, so she was in pain...She picked up the phone and says, ‘Who is this?’ and then she tells him, ‘Leave my daughter alone or I’ll call the police and they’ll deport you, ‘cause you know you’re not from here, and you’re older than her, how you going out with a minor?’ And then my mom yells at me and she

smacks me, she's like, 'What is wrong with you? He's older than you, don't you understand?' And I just remember telling my mom, 'I hate you, I hate you,' and then ran to my bed and crying."

These narratives highlight the varying levels of difficulty some young people faced in being able to communicate honestly and openly with a parent(s) about intimate relationships, sexual activity and protection, which often impacted their lives in profound ways.

DISCUSSIONS ABOUT SEX WITH OTHERS

Clearly, parents are only one group with whom teens may discuss sexuality, intimate relationships, and sexual behaviors. Participants also noted other individuals and settings where they engaged in and reflected on these topics - most notably, friends and siblings, school, the Internet and popular media, clinics, and their sexual partners. In general, teens described a range of comfort discussing their personal sexual experiences and issues with friends and siblings, but most indicated learning more general information and receiving advice from these individuals.

Kamilla, 17, explained:

"Like, my friends, they actually like, they gave me warnings before anything happened. Like, girl if you do this, you do this, this could happen. If you do this, this most definitely is gonna happen."

Daniela, 19, received information from her friends about sex that included encouraging her to become pregnant, which she contrasted with what she discussed with her sister:

"They used to tell me, 'Oh, you could do this, it's fine for you to have sex...or have a kid...'...I used to think about it, but then I used to speak to my sister about it and she'd just tell me, 'No, this is not this, and that...' and she'd explain to me in that way."

Jazmin, 15, first learned about sex from older siblings, which served to both normalize sexuality and provide an open line of communication when she became sexually active:

"I have friends that's much older than me, like my siblings, and yeah so it's like, 'So this and this happen, and this and this,' and I was like, 'Um, oh...' 'And when you have sex this and this happens and you have to do this and this' and it's like, 'Okay!' When I was

younger it was like awkward...and when you get older it's like - it's whatever now. My brothers talk freely about everything.”

There was tremendous variation reported by participants regarding discussions about sex and protection that took place in school. Some teens remembered receiving information in health classes about sexual development and reproduction, STIs and pregnancy. For example, Sofia did not recall receiving any health education prior to immigrating to the U.S. from Colombia, but had since learned about these topics in the two high schools she has attended in NYC:

“When I first learned about that, it was in my school. They were talking about how to protect ourselves to not be pregnant and all that. I heard it in the other school. They were teaching a lot about that, birth control, development, and then when I came to this school, I heard it there too.”

Alejandra, 15, took a health class within the year prior to our interview, but the extent and quality of information provided was inadequate from her perspective:

“I took health like in the middle of the year, but we didn't really talk about like - we talked about this [sex and protection] but it wasn't really on the topic or anything. We would always like fool around and stuff...so we wasn't really talking about this but like all the stuff we talked about in health I already knew 'cause I had gotten that information from the doctor [at the clinic].”

Daniela felt that information about sexuality and sexual health was lacking at her high school, and was only provided if the student requested it:

“...Actually in the schools and stuff they barely talk about that; unless the counselor tells you or you ask her about it, they won't tell you.”

The variation found among study participants with regard to receipt of sexuality education in schools is consistent with the lack of uniformity and vague standards found not just in NYC but in many states and jurisdictions across the country. In 2011, then-mayor Bloomberg put forth a mandate to require NYC schools to include sexuality education as part of comprehensive health education students receive in middle and high school (NYC DOE 2015b).

While the NYC DOE recommended specific comprehensive sexuality education curricula, principals are not required to choose it. Moreover, they are given considerable discretion as to the implementation of selected curriculum, including which Department of Education employees will teach the content and in what grades it will be introduced.

Though less commonly reported than peers, other settings with which participants engaged that contributed to their knowledge and understanding of sex and protection were the Internet and popular media. Most often, teens conducted Internet searches to find out answers to specific questions, such as what vaginal intercourse is, how to protect oneself from STIs and HIV, and other related topics. For participants who used the Internet for these purposes, it was part of a broader pattern of seeking information online about health more generally. Zoe, 17, explained:

“Most of the things [I’ve learned] have been from reading pretty much. I read a lot of pamphlets and I’m always on Google trying to figure something out, ‘cause I always think I’m sick or something. So I’m always Googling things.”

When participants mentioned popular media coverage of intimate relationships, sex and pregnancy, it was mostly dismissed as being unrealistic; however, some teens described the value of certain media in helping them clarify their own behaviors and decisions. As described earlier, Carolina became pregnant at 16 after using condoms and emergency contraception inconsistently. After her termination, she wrestled with the decision about whether she should use a more “regular” form of contraception, the outcome of which was partly influenced by a television show she had been watching for several years:

“Since my freshman year, I’ve been watching a show called, The Secret Life of the American Teenager. They talk so much about birth control, and that show is... um, there was this girl, she kind of went through what I went through, but the thing is she had the baby but she lost it when she was gonna give birth. So it was so touching to me, I’m like oh my goodness I could have gone through this and she went back to birth control [after

the miscarriage], and I'm like oh, wow. This October I finished watching the final season. That show actually kind of helped me decide what to do [about birth control]."

Teens also frequently noted the role of healthcare workers in the provision of information and resources about sexual and reproductive health issues. Most often, however, these discussions took place after the participant had become sexually active and was seeking services for contraception and/or pregnancy and STI testing.

Lastly, female youth frequently reported having had discussions about sex and protection with sexual partners and/or boyfriends (discussions about contraception are presented later in this chapter). In particular, some participants disclosed the number of previous sexual partners and discussed whether or not they had been tested for STIs or HIV. However, the extent of disclosure varied depending on the individual and the partners' level of commitment. The majority of participants reported having been tested for the most prevalent STIs among teens (chlamydia and gonorrhea) and HIV, and often, with routine frequency.

Alternatively, some teens were unaware of their partner's STI and HIV status. Carolina had recently started 'hooking up' with a good friend, whom she referred to as a "friend with benefits." She got tested regularly for STIs and HIV and was using the contraceptive patch, but she and her friend were not using condoms. When I asked whether she knew if he got tested, she replied:

"I don't know, he don't talk to me about that, but I think he do. In that way he's like me, he wants to know, like, when everything is updated, if he has to update his vaccines he'll go, so I'm convinced he does [get tested]."

Justine, 17, had been with her boyfriend for about five years. Like Carolina, she came to the clinic for regular STI and HIV testing, which always came back negative for any infections. To her knowledge, her boyfriend had never been tested, which she attributed to the difficulty of "getting guys to go to the doctor."

Several participants reported getting tested with their partner or showing each other the test results prior to and/or after becoming intimate. Josefina, 19, was tested at her school's health center and accompanied her boyfriend to a clinic, the results of which made her feel more ready to have sex:

"I came to do STD tests and he also did...I went with him to get his tests and I got checked here and that's when we started talking about it, and I was like, 'I think I'm ready.' And he's like, 'Are you sure?' And I'm like, 'Yeah!' [Laughter]"

Among the total sample, six teens reported ever having an STI. Most commonly, the infection was chlamydia, which aligned with national and city-level data on its prevalence among youth.

Participants rarely indicated only engaging with one individual or setting on the subject of sexuality, sexual health and reproduction. With consideration of the multiple sources identified from which female youth received and sought out information, some of which was contradictory, these findings suggest that interviewees continually assessed the validity of information against their personal experiences and new knowledge or evidence they obtained.

INTIMATE RELATIONSHIPS

At the inception of this project, it was not my intention to sample such a high proportion of teens with intimate partners; however, the majority of participants seeking services from the clinics at which they were recruited (n=23) indicated currently being in a relationship. The remaining three teens in the study were not currently in a relationship, but were sexually active. All female interviewees in relationships were the same age or younger than their current male partners, with an average age difference of 1.26 years and a range of zero to four years. Relationships ranged in length from two months to five years, and there was widespread variation in teens' expectations about their futures with these partners and the level of significance they held in their lives.

Teens noted multiple positive aspects of their current relationships; most commonly support, love, and comfort. Alyssa, 17, met her boyfriend at school, and at the time of the interview had been dating him for three months. She explained that for her, the level of support he provided was one of the most important aspects of their relationship:

“...My boyfriend is so supportive, and he’s so nice. I like supportive people. Like, relationships I think - like your boyfriend or your girlfriend - is supposed to be like your backbone, so if you’re having issues with your parents, they’re supposed be there.”

Participants frequently reiterated the importance of support in their romantic relationships.

Fabiana, 15, had been with her boyfriend for several months. They met at her former school in New Jersey before she moved with her mother, stepfather, and siblings to the Bronx. At the age of 13, Fabiana was raped at a party while visiting family in the DR. She survived the traumatic experience, but was understandably wary and mistrustful of sex, intimate relationships, and boys as a result. From Fabiana’s perspective, her boyfriend’s support was instrumental in helping her regain trust and self-confidence:

“...He knows everything I’ve been through in the past, and like my family issues, and my relationship issues, and I have like really bad trust issues, even with my family, and he makes me confident that I actually have someone there, so when I’m down and I need someone to talk to ‘cause I can’t go to my mom about some things...he’s there, and he understands it...”

Laura’s relationship with her boyfriend of four years had been tumultuous, but withstood disapproval from her family, the death of Laura’s mother, the birth of their son, and several break-ups. To her, the fact that they had endured so much together further solidified their bond.

She explained:

“I feel ‘cause of all that we’ve been through, we noticed that we can’t be without each other. For some reason we end up still being together...he’s always like, if anything I need, he’s always there for me. He supports me mentally and for money and all that, he’s always there for me and my son.”

For many, this support from their partner gave them a sense of comfort and familiarity.

Veronica, 17, commented:

“I don’t know - he’s, like, special to me. He’s different...he makes me feel different, like I’m happy with him. It’s not like – when I’m with other guys it’s like, I don’t want you. I feel comfortable with him.”

Participants also noted the importance of feeling loved and appreciated by their significant other(s), which was demonstrated in various ways. Kamilla, who had been with her boyfriend for about six months, explained:

“...Anything I ask for, I get. I’m so spoiled. Like, every day, I wake up and if I’m not with him I wake up with a text, or a call. When I’m with him, I wake up to breakfast and every day I get a new teddy bear, I love you...and when we wake up he’s like, I’m glad I have you. I told my mom, it’s like – I felt this way with my baby’s father, but it didn’t really feel as good.”

While the benefits of supportive partners were highlighted, participants also described stressors and harmful experiences in current and/or former relationships, including frequent arguments, controlling behavior, cheating, physical and emotional violence, and disrespect. Alejandra met her first boyfriend in eighth grade, after which they attended different schools. Unable to see each other regularly, and faced with constant arguing and the pressures of school, they broke up after about one year together:

“...It was just like, we would have our arguments and stuff but then he’d be like, ‘Oh, every relationship has arguments and stuff,’ but we would constantly have arguments and it was like to the point where I was just tired...the reason why I broke up with him was that we barely had a relationship. It was like over the phone type thing. It was like long distance. It was really hard to see each other, like the luckiest time I could see him was on a Sunday or whatever and that’s about it, and then I have to go back to school and stuff. So it was really hard and I felt like sad and tired and stressed out with swimming and school and then on top of that the relationship so then I just broke up with him.”

Josefina had been dating her boyfriend for over two years at the time of the interview. Although she described him as loyal, attentive and thoughtful, she also gave several examples of ways in which he attempted to control her behavior:

“...He has issues about the way I dress, especially in the summer. And he was my first relationship so especially in the beginning, I didn’t know how it would turn out, and when we first started going out, he was like, ‘You can’t wear any shorts,’ and I’m like, ‘Why? I’ve been wearing shorts all my life in the summer! It’s like 90 degrees outside, it’s not like I’m showing my butt or anything.’ And he’s like, ‘Oh you’re trying to get the attention of other guys.’”

Josefina also described how her boyfriend tried to limit her interactions with friends, particularly those who are male. As a result, she now felt alienated and out of touch with herself:

“Like I had two friends, and he was like, ‘Oh, they’re gonna [be a] bad influence [on] you,’ and I’m like, ‘Hey I’m 19! I’m not gonna let anybody influence me and if I do do anything it’ll be my fault ‘cause I wanted to do what I wanted to do’ ...And I kind of stopped talking to my friends, so now I pretty much just talk to him. So I feel like I just - I need to go out and meet new people and stuff. He’s also like, ‘Oh, you can’t have any guy friends,’ and I notice that it’s not only him, it’s also the media too. Like I see it on Instagram. ‘Cause I have Instagram and they’re usually posting up like, ‘Oh if you have a girlfriend, she better not hit on any guy...’ So it’s like, now any guy tries to talk to me, I’m like get away from me! [Laughter]”

Unfaithfulness was mentioned by several participants as a feature of current and/or past relationships. For example, Sofia discovered that her boyfriend of almost a year had been cheating on her when she tested positive for chlamydia. In addition, he had failed to mention that he had a child in the DR, where he had been living for several months. She explained:

“...He went to DR and when he come here, he told me that he had a baby. And I was like, ‘What? Are you serious?’ He told me that he had a baby, like a one year-old. But he didn’t tell me nothing about this [before]. And now you told me this? And after that, when I came here [to the clinic] they told me I had an infection and I was like, ‘Yo, you cheated on me!’ And he was like, ‘Nah...’ And I said, ‘Yes you did! Because I had an infection.’ And he was like, ‘Oh, so you told me that you had an infection because of me. Or I went to the DR and you stayed here [implying she cheated on him]. I’m like, ‘No, because I’m not like you...’ And then we broke up.”

Lucia, 16, met her boyfriend in her neighborhood during middle school. They had been together for over three years, during which she discovered that she had chlamydia. With her boyfriend being her first and only sex partner, she accused him of cheating on her, which he did not deny. Of the aftermath stemming from this revelation, Lucia explained:

“...After that we spent like five months like not talking at all. I deleted him from everything. I even moved with my mom. We moved to another place. And then...I heard rumors that he wanted to talk to me and things he’s saying. He’s calling my mom over and over, so my mom screamed at him to stay away. Then a week later he called and I picked up the phone...and since then...”

While Lucia agreed to give him another chance, she no longer trusts him and suspects that he is still cheating or will cheat again. When I asked why she decided to give him another chance, she replied:

“I’m used to him...you know, he was my first one, and I don’t imagine myself with other people...It’s not gonna last forever, but for now I’ll just stand still there.”

Another feature of intimate relationships described by some participants was physical and emotional violence. Carolina, 17, had recently gotten out of a volatile relationship with Daniel, with whom she had been dating on and off for about a year and a half. She described their relationship as initially “very healthy” with few arguments or conflicts:

“My family raised me with, ‘Don’t just go out with a guy that you’ve met for a week. Get to know him...’ So I know him for six months and no relationship yet, now I’m like, ok, I see how he is, I like who he is, and I really see myself in a healthy relationship with him.”

After about eight months, the arguments began. Carolina said he began to act aggressively and in a controlling manner, trying to stop her from hanging out with friends and demanding to see her phone to review text messages and phone calls. She ended the relationship briefly, but decided to give him a second chance after Daniel pleaded with her to take him back and attempted to demonstrate his reformed ways by reenrolling in school (he had previously dropped out). However, once back together, he continued to exhibit the same pattern of behavior. In one particularly violent episode, Daniel punched a mirror that shattered on the floor during an argument and pushed Carolina, who fell on top of the glass shards. Around this same time, Carolina discovered she was pregnant and sought a termination, choosing not to tell Daniel about

it for fear of repercussions. Once again, she ended the relationship, but Daniel showed up at her house one evening irate over hearing that she had been on a date with another guy:

“...He came to my house with a glass bottle and I’m like, ‘Are you gonna throw this?’ And he missed. Well, I don’t know if he wanted to throw it at me, but it hit the wall. I’m like, ‘I realized that there are better people than you and I just don’t want this relationship anymore.’ And he started crying, started begging and I’m like, ‘I’m sorry. You had your chance and you ruined it for yourself.’ So that night he broke my phone and my mom walked outside and was like, just get your phone, go inside, and I’ll deal with him. And she was pregnant at the time, so um, my mom kicked him out. She got rid of him, and I was crying ‘cause I felt like I was gonna get hurt, I was gonna get hit. It was more a fear. And he would just not stop bothering me. I’m like this is over between me and you. And now I’m glad that he’s not bothering me.”

Ximena, 16, shared a similar narrative of control and intimidation by her ex-boyfriend Philip, who was nine years older than her when they dated for a few months in the previous year. They met at a group interview for open positions at a local event space, and although he was initially hesitant to pursue her due to their age difference, they were both interested and decided to go on a date. She described their relationship as intense, almost immediately:

“[After the interview where they met] we went to a party that night, and then to a park afterwards. And I should have known after that first night that he was crazy, ‘cause he was telling me, ‘Oh, you’re so different,’ and ‘I’ve only known you for this short time but I’m feeling so strongly for you,’ and all this. And I thought it was so cute. After one week, it was like, oh my god, he’s so jealous, possessive and crazy! He’s so Puerto Rican, oh my god that’s so cute. I liked it, I felt loved. I was like oh my god someone’s afraid to lose me! That’s so cute or whatever.”

Similar to Carolina’s experience, this jealousy and possessiveness manifested in attempts to limit Ximena’s interactions with friends, particularly males, going through her phone and Facebook account, and requiring constant validation of her devotion to him:

“...The issue was mostly verbal, like he kept making me feel bad. Like he’d say, ‘I care about you so much and this is how you treat me?’ And I’d be like, ‘How do I treat you?’ We’d be walking down the street and he’d be angry with me because a guy would be checking me out and he’d think I was looking back at him. And he would grab my hand and squeeze it so fuckin’ hard and I’d be like, ‘What the fuck are you doing?’ He’s fuckin’ psychotic. He’d get mad at me that I wasn’t holding his hand tight enough.”

After several more weeks of escalating and continuous arguments, Philip pushed her, and Ximena decided to end it. This proved to be more challenging than she had anticipated, however, as Philip did not accept her decision at first:

“He would show up where he knew I would hang out and I got kind of scared, so in a way I kind of just accepted it. He’d show up and I’d be like, ‘Oh, I guess we’re together.’ And he’d get mad that I would want to go to my friend’s house, and he’d be like, ‘No, you’re not going. I said you’re not going.’ And I’d be like, ‘Well, they’re expecting me,’ and then he’d let me go. He knew if I didn’t show up there would be an issue. So I’d go over there and the entire time I’m there he’s texting me like, ‘Oh, I hope you’re having fun with your friends.’ And then he’d call and yell at me. It was really making me sad, I felt like I was being overpowered.”

Eventually, despite repeated threats and constant phone calls during which Ximena reiterated that they were no longer together, Philip backed off. Looking back on this relationship, she reflected:

“...That’s the worst relationship I ever had because it started off so fast, like he swore he loved me and all this stuff. And that’s a very powerful word. A scary word. And he assumes that because he said that word, that must be the truth. And he moved fast, so fast. We had sex a lot. That was the only time we weren’t arguing. It wasn’t even a relationship, because honestly it was almost like, I was just there, and the only thing I’m benefiting from here is this [the sex]. This is horrible. I felt like a fuckin’ slut...”

This theme of emotional abuse and disrespect was also profoundly evident in Leah’s on-and-off again relationship with her ex-boyfriend James of approximately two years. A fellow student in the campus where Leah attended school, she said that they frequently got into trouble together:

“I made him wait a whole year [to have sex]. And then the second year, every time we did that, I got in trouble for it. Like I would be late for school, and he’d get me in trouble and apologize. And every time I got in trouble my dad would find out.”

Eventually, Leah grew mistrustful of James, who was frequently seen hanging out with another girl who would sometimes text Leah from James’ phone and pretend to be him. At his request,

Leah would send James intimate photos of herself, a decision that would later cause significant repercussions for both she and James. Leah explained:

“I only did all that just to make him happy...and he would say that he would do better, he would change, but I would never see that. And I only stuck with him because like, at the time, I didn’t see myself with anybody else.”

After they initially broke up, Leah and James did not speak for several months. Then, James began reaching out, often trying to convince her to get back together with him when she began a new relationship with someone else. They briefly reunited, but when she put a stop to it, he would threaten to post or share pictures she had sent. His school’s administration eventually caught wind of the fact that one of their students was in possession of and sharing illicit photos of Leah and other girls, and called Leah’s parents to let them know. At this time, Leah also discovered that James had secretly recorded them having sex, and had shown pictures and videos of her to other girls with whom he was involved. As an 18 year-old, James was ultimately charged and served time in jail. Since he’d been released, Leah had run into him occasionally. She explained one recent incident that encapsulated the fear and intimidation she still felt towards James:

“I seen him [James] in the morning. I was coming off the bus and crossing the street. Me and him made eye contact and he just kept looking at me. I don’t know how to explain it. You know like when you think you’re not gonna see a person again and then you do and they just watch you like...and I didn’t wanna go anywhere near him. I didn’t want to move. And I have nightmares sometimes where he kidnaps me. And after what happened, I have a fear of him.”

SEXUAL EXPERIENCES AND ATTITUDES TOWARDS SEX

As described in Chapter Four, criteria for participation in this study included previous or current experience with vaginal intercourse at the time of the interview. Eleven of the 26 teen participants had consensual vaginal intercourse for the first time between the ages of 13 and 14;

ten between the ages of 15 and 16; and five between the ages of 17 and 18³⁰. Because research on contraceptive use tends to be divorced from studies on sexuality and pleasure, and thus fails to contextualize decisions within sexual histories, expectations, and motivations, interviews with teen participants also elicited information about their sexual experiences and desires.

Participants expressed various circumstances and experiences related to their decision to engage in vaginal intercourse for the first time.³¹ Most commonly, the young women with whom I spoke articulated that they were curious or interested, felt “ready,” and/or had a desire to “get it over with.” Alyssa was 15 when she decided to have sex for the first time with the young man who lived across the street from her. She described her emotions leading up to the experience as a combination of nervousness, particularly about the potential for pain, and interest:

“So, okay. The first time I had sexual intercourse, you know, the pop ‘ya cherry thing, I was scared about that. That I was gonna bleed. Then I didn’t do it...I kinda did it but I didn’t do it, and then I bled and I was like, no, I’m not doing this. Then I was like, ok, let’s just do it because like, I already lost it so I might as well...I was nervous, and...not excited, but interested. Yeah, I was interested.”

Lucia, 16, had known her current boyfriend since she was 11. At the time of the interview, they had been together for about four years. As she explained, part of the motivation for deciding to have sex was curiosity about what it would be like:

“I don’t know, the curiosity...to see how everybody say, ‘Oh that’s so good!’ Ok, but when I finished, I was like, well... Wow. Ow. [laughter]”

Like other interviewees, Josefina expressed a combination of emotions about becoming sexually active. She was curious about the experience of being intimate with someone, and felt ready to

³⁰ Consensual sexual intercourse was specified because two participants indicated that their first sexual experience was rape.

³¹ Sexual activity encompasses a wide range of behaviors and meanings, including, but not limited to, anal, oral, and vaginal sex. Due to the limited nature of one-time interviews and the study’s overarching topics of contraceptive behaviors and attitudes about pregnancy, participants were directed to discuss sexual activity as it pertains to vaginal intercourse. These findings are not intended to represent the entirety of sexual behaviors experienced by the teens interviewed.

find out what it was like, but wanted to make sure it happened when she was in a relationship.

Josefina explained:

“I, um, I don’t know...I just wanted to know how it felt and then I was just like...I was always on myself, I was like I have to be ready, I can’t let the opportunity go to waste; I’ve been waiting 18 years, I’ve been single for 18 years, I can’t just...and then, um, I just decided to do it. Just to do it...I was looking for a relationship, like, I wanted to be with somebody in order to lose my virginity. And I guess my boyfriend had the chance!”

Looking back on that first experience, participants described a range of reactions and observations about its significance for them. For a few teens, it evoked positive memories:

“Our relationship is still strong, but [having sex] kind of made it stronger, and it kinda made us more...it created more communication between us and now I feel more safe with him than I was before.” (Fabiana, 15 years old)

For many, the experience of having sex was not what they had anticipated. In particular, while most teens were aware that vaginal intercourse may initially be painful and bleeding may occur, a few participants were still surprised. Isabel, 18, had sex for the first time with an ex-boyfriend she dated for two years. Of their first sexual encounter, she commented:

“I stopped having sex after that. Yeah, this is not gonna work out...because of the experience. I have had sex since then, but it took me a while to get over that [the pain].”

Kamilla, 17, described a similar reaction:

“I’m gonna be honest, I was nervous [about having sex for the first time], and I didn’t expect it like that...I didn’t expect that it was gonna be, like, how can I put it? I didn’t expect it to be the way the outcome was. Like, you know, with everything bleeding after...”

Vanessa, 17, contrasted the intimacy and romance of her experience with what is typically portrayed in films and television:

Vanessa: “I didn’t expect it to hurt as much as it did...I thought it would be like the movies! It wasn’t like that at all.

Hannah: “So how would you describe it?”

Vanessa: “Me wanting to hit him, ‘cause in the movies it’s completely different. It starts the scene with, ‘Oh my god, I love you so much!’ and it finishes with, ‘This was great!’ and it wasn’t like that at all.

For a significant minority of young women interviewed, their first experience of vaginal intercourse was described as unpleasant, upsetting, or even regrettable. Leah had sex for the first time at the age of 15 with a boy she liked, but with whom she was not in a relationship. When I asked her to describe the experience, she reflected:

“I was upset. When it was happening the first time, I was upset because - alright it’s my first time. If I feel a way about it, if I make a slight noise, he would tell me to shush. I’m like who are you telling to shush? You’re not the one that’s in pain here. You shush. Then he’s like, ‘Don’t cry, you’re a big girl.’ I’m like, ‘Dude, shut up.’...It was painful at first, but after a while it didn’t hurt anymore, and then I started enjoying it. And right after that he stopped.”

In hindsight, several participants wished they had chosen to have sex with a different person.

For example, Sofia’s first encounter did not match the expectations she had set for the experience:

“Well, the first time that I had sex, he was not that kinda type that like...I was expecting. It was something that happened but at the same time I was like, ‘Why am I doing this? But I don’t wanna do it with this person, you know?’ ‘Cause it was with my friend, but uh, we was drinking and everything like that, but it went to that thing and then I was like, ‘Oh my god, why did I do this?’ ‘Cause I was always, always thinking that my first time has to be perfect, it has to be this, this, this, and that don’t happen like that. Looking back the next day it wasn’t what I wanted to have happen.”

Seventeen-year-old Veronica indicated that her first time was a mistake. When asked why, she replied:

“Because it wasn’t really the right guy, it just happened. I was just dumb, stupid. Like, while it was happening, he treated me like shit. I was just like, ‘Ok get off of me.’ So I felt like, ‘What the hell?’”

Other participants observed that they should have waited longer before having sex, and some regretted the experience. Of her first time, Ana, 16, explained:

“It wasn’t really a good experience. I was kind of young, I was really young [13], and I didn’t really think at that time. So if I could go back, I wouldn’t do it.”

Interviewees' comments conveyed significant variation about the value placed on one's virginity. As alluded to by several of the quotes above, it was regarded by some as special and in need of protection until the right circumstance, emotion (e.g., love, trust), and/or individual appears. For others, it was viewed as something to "get over with," though these perspectives may shift over time. In this quote, Leah articulated her evolving view, given the benefit of experience:

"When I think about it, how girls talk about it like your thing [virginity] is very precious, you're supposed to treasure it. They make a big deal out of it. At the time, let me be honest, I'm not really thinking about that. So I just did it to get it over with. I didn't do it without thinking about it, but now that I look at it, I'd rather do it with someone that I really care about rather than someone I like... 'cause I'm with someone right now who treats me better than anyone that I've been with, and I'd rather have given it to him than anybody."

Several participants gave explanations for why being "too attached" to your first sexual partner may not be desirable. For example, Beatriz had seen her older sister go through a tumultuous relationship with her first love, which ended with neither of them speaking to each other. This observation informed her decision about the circumstances she wanted for her "first time":

"I knew him for like for four years, and it happened last year during the summer, like two days before my birthday. And we knew each other, we never thought we were gonna like each other, but I didn't want a relationship. He didn't, I didn't. Why? Because I didn't want to fall in love, I didn't fall in love when I did it. I don't know if people be like, that's weird 'cause everybody that do it, they do fall in love. And...I thought I was gonna get hurt if I did. 'Cause people always talking about it like, I was so hurt! Like my sister, like I saw what she went through and I was like, I'm not falling in love...no, that is not cute. I saw what she went through. And I think those little pictures are in my head about her and her boyfriend...They used to fight a lot. And they treated each other like shit. Like that's not cute at all. She was with him for two years....So when she left to [go to] Puerto Rico they don't know nothing about each other no more. I don't want that to happen, just no."

While not necessarily mutually exclusive, "losing it" may also be considered a prerequisite to becoming an adult and an obligatory feature of relationships for young women. Perhaps not surprisingly, few of the teens interviewed explicitly indicated that their own sexual desires

motivated their decisions about when to become sexually active, although reasons offered such as “interest” or “curiosity” may hint at such desires for some participants. The following section explores meanings and levels of comfort that participants associated with sex and its relative importance beyond their initial sexual experience and/or partner.

Sexual intimacy and engagement were considered very important to a minority of young women interviewed. Veronica, 17, explains why she considers it an important part of her current relationship:

“Like, we get...I don’t know. We fall for each other even more, and it’s just makes us closer.”

Josefina, 19, also regarded sexual intimacy to be a significant feature of her current relationship, although she and her boyfriend’s recent arguments have made her less interested:

“[I would say that sex] is very important to both of us...the fact that we argue so much makes me lose interest. But then on the other hand, he’s like, ‘Aw, please. Come on,’ and I’m like, ‘No, just leave me alone.’ ...Like we used to have sex a lot, but not anymore. We stopped.”

For the majority of participants, the sexual component of their relationship was perceived as less critical than other characteristics and dynamics. Teens also frequently described their sexual encounters as fairly sporadic in nature. Both of these findings were more prominent among the younger women in the sample (i.e., 15 and 16 year-olds), although they were also conveyed by older teens. Naomi, 15, had been with her boyfriend for eight months at the time of the interview. She did not feel that having sex made she and her boyfriend more intimate because, as she explained, they were close prior to introducing sex into their relationship. Jazmin, 15, explained that while sex was not a very important aspect of her life now, and in fact did not need to be a feature of her current relationship, she expected that it may become more important with age:

“Now I don’t think so. Like I heard when you get older, it’s like more important than it is when you’re younger, so it’s like...I don’t think about it as much. Maybe when I’m older I’ll think about it more than I do now.”

Older teens, who appeared more comfortable reflecting on their sexual experiences and their impact on relationships, often articulated the value of sex in relation to other more important aspects of their connection with their partner(s); namely, companionship and emotional intimacy. Zoe, 17, explained:

“...I mean it’s not a big part because, um, I don’t know, I don’t really feel like it’s needed in a relationship. I think we’re more friends first than anything, so if I’m just like, if we’re hanging out and we’re just like watching a movie or something, I feel like that’s a bigger part of it than sex. Because if you can’t be connected on other levels, then it’s not really, like, a relationship.”

Vanessa, 17, was in a long-distance relationship with her boyfriend, who attended college outside of the city. They waited about one year before having sex for the first time, but once the threshold was crossed, it did not become routine:

“...It just...it felt natural doing it when we did, but after that it was just like, oh if you wanted to, we could it doesn’t really matter. We could just watch TV.”

Nicole, 18, described a transition within her current relationship regarding the importance she and her boyfriend placed on sexual activity:

“... We don’t really think about it as much as we used to. So it doesn’t really affect our relationship. We go around it sometimes. We either, like we’ll go out or we’ll do different activities or play cards or something. We feel like it’s not always about that.”

Many participants compared earlier sexual experiences to those within their current partnerships, noting differences in their levels of comfort and desire. As mentioned earlier, Fabiana’s first experience with sexual intercourse was not consensual. She had been with her current boyfriend for several months, and while she continued to struggle with issues around intimacy and trust, her depiction of their relationship underscores the importance of their sexual encounters feeling mutually desirable and without coercion:

“...It’s good ‘cause you know, like...it’s not like I’m forced to do anything. It’s like if I wanna do it, alright, then we’ll do what we can. If I don’t, then he understands. He doesn’t force me. He actually gives me space, he doesn’t like, lead me into it. Like I have to let him know that, you know, this is what I want to do; are you okay with it? Can we do it? That’s how it works. If one of us is not okay with it, then we let each other know. And we kinda work things out to lead to something that we both wanna do.”

Alejandra, 15, had been in an earlier relationship where she felt there was an overemphasis on sex that made her uncomfortable:

“...Whenever we did see each other, we always had sex and it was kinda weird, ‘cause I felt weird ‘cause all we did was watch a movie, kiss and then have sex, and I would leave. It wasn’t really...it was just a routine, and I felt used and I told him that and he was like...he felt bad because I felt used.”

By contrast, Alejandra’s current relationship was, from her perspective, more balanced:

“...I like the sex here and stuff like that, and I don’t feel used in this relationship. Like I told him about the used part and stuff like that and he’s like, I wouldn’t do that. If you want to just hang out, we’ll just hang out. Like that’s what I wanted from my other relationship. I wanted to hang out and go on a date and stuff.”

As discussed earlier in this chapter, teens described a range of comfort regarding communication about sexuality, sexual behaviors and their health to parents. For some young women, relationships with a parent, most often fathers, were profoundly affected when it was discovered that they were sexually active. Valeria, 17, had been living with her father in the DR before moving to the U.S. in high school, and currently only saw him about once a year. Early on in the interview, she mentioned that she was not speaking to her brother or father because they were angry with her. Later, Valeria explained that this was due to her becoming sexually active:

“When he [father] found out that I wasn’t a virgin no more...oh my god, my god...he was mad at me...Somebody, I think it was my aunt, told him I wasn’t a virgin. I don’t talk to her no more.”

When I asked how that news impacted their relationship, she replied:

“He stopped talking to me. He was so mad at me. He was disappointed, ‘cause, um, he trusts me, you know he used to let me go to other places and trust me, and he felt like I disappointed him ‘cause I have sex and stuff like that.”

Leah, 18, did not have a particularly close relationship with her father, who was technically separated from her mother, but still came to stay with them at the house frequently. She described him as “a very grumpy person,” whose mood often affected everyone around him negatively. Although once very protective of her, Leah explained that their dynamic had shifted recently:

“...At one point I used to be like his baby. I was the apple of his eye. He’d do anything for me. He still would, but we don’t have that connection anymore because he found out that I’m not a virgin anymore.”

Similar to other stories heard from interviewees, this information was disclosed to her parents by someone else; in this case her partner’s sister to her brother’s girlfriend. Once Leah was confronted with this news, she decided to be upfront and confirm that it was true. The reaction Leah received from explaining her behavior to her father was harsh and unexpected:

“[My dad] beat my ass. He called me a whore. He just went off ‘cause I was like his baby. So he didn’t expect that. But I was completely honest with him. I thought that by me being honest he would go easy on me, but he didn’t... ‘Cause I guess, like, it was more serious, ‘cause the person I had had that with [had sex with] lived right around the corner from me. So he’s like, ‘So who’s this boy right around the corner?’ I understand that he got offended by that, so I told him. Instead of lying I was being honest... Then he called me a whore and I didn’t like that. That’s something I can’t forget. ‘Cause that was like my first time. After that, like our whole relationship changed. I have respect for him because I have to, but I don’t look at him the same anymore.”

CONDOM USE AND EFFECTS ON SEXUAL PLEASURE

Before delving into how participants obtained information about hormonal and LARC methods of contraception, it is important to briefly present relevant findings on condom use. Not surprisingly, virtually all female youth were aware of and familiar with male condoms, the most

popularly used method of birth control among teenagers in the United States (Martinez et al. 2011). While most teens indicated that they did not discuss contraception with their partners prior to engaging in sexual intercourse for the first time, many reported using condoms. When asked how it was “decided” whether to use condoms, interviewees frequently gave puzzled looks and shrugs, implying that explicit conversations prior to sexual intercourse about protection seldom occurred, and instead, unspoken expectations from one or both parties determined the decision. Regarding her first experience with a former partner, Ana explained: *“Things just kind of happened, but we used condoms.”* This notion of things just “happening” was reiterated by several participants in relation to decisions about whether and when to use condoms. Alternatively, other participants expressly articulated the need for their partner(s) to wear a condom before engaging in intercourse, as illustrated by this quote from Isabel, 18 years old:

“I was like, ‘What are you gonna use?’ And he was like, ‘A condom, hello...’ And then yeah, that was it.”

Among the 26 teens interviewed, three participants had never used hormonal or LARC methods, relying on condoms for pregnancy prevention. Two young women, Jazmin and Naomi, were 15, while the third, Adriana, was 17. Jazmin had been in a “friends with benefits” relationship with her friend’s older brother on-and-off for over a year, during which time they used condoms. However, recently Jazmin became involved in a relationship with a young man with whom she had not had sex at the time of the interview. She was open to the possibility of initiating a hormonal or LARC method at some point in the future, but was as yet undecided about particular methods she might consider. When asked what would prompt her to start using a method other than condoms, she replied:

“Just ‘cause you never know. It’s like, you never know. The condom can accidentally break and the next thing you know you’re pregnant...”

Naomi, also 15, had been in a relationship with her boyfriend for about eight months at the time of the interview. She explained that they did not use condoms all the time, and recently had a discussion about whether or not they wanted to have a baby together. Once they collectively made that decision, Naomi and her boyfriend researched available options and ultimately settled on the *Mirena* IUD because it would likely result in Naomi no longer having a period. At the time of the interview, she had made an appointment for the IUD insertion procedure.

Lastly, Adriana, 17, had been using condoms fairly inconsistently with her sexual partners until she tested positive for chlamydia, after which she insisted that her partners use condoms. Adriana held deep reservations about using hormonal or LARC methods in the future, as she felt that the hormones in them were unsafe. Thus, she did not plan to initiate one of these methods in the foreseeable future.

While the available literature is replete with studies examining attitudes towards condom use and effects of condoms on male sexual functioning and pleasure, fewer researchers have explored the effect of condoms on female sexual pleasure, particularly among adolescent populations (Higgins and Hirsch 2008). In this study, a significant minority of female youth highlighted the impact of condom use on their sexual arousal and pleasure, which, although not the focus of this research, points to the importance of better supporting female pleasure in sexual and reproductive health education and services. For several participants, the use of male condoms caused their vaginas to become swollen, itchy, and irritated. Justine rarely used condoms with her long-term boyfriend Marcus because of how her body reacted to them. She explained:

“... Condoms irritate me. You know how they adjust to certain people’s bodies in certain ways? It bothers me down there. It’s itchy and I don’t like that feeling.”

Similarly, Lucia stopped using condoms with her boyfriend due to vaginal swelling they caused:

“I didn't want to use them at all. My thing gets swollen and then I have to like...Ow! It starts itching.”

For other teens, using condoms impeded their ability to become aroused. Below, Ximena, 16, described her attempts to use condoms with her male partners and its effect on her level of arousal:

“...At first, like the first two times, three times, maybe, we tried using condoms. I don't like condoms because I don't feel everything. I think they smell really really bad, like, I feel like, I smell it and it's like...Ugh, I don't even want you any more. I feel like I'm being fucked by a dildo. I don't like it. I don't like it! It's not human to me, you know, so...And it's uncomfortable. I'm so afraid it's gonna break. And I'd rather do it completely raw than to have the chance that it would break and I would get scared. Like they would always break, within the first five minutes... 'Cause I was really really dry, so rubber plus dry equals cracking. And also because of the rubber, 'cause it smelled real bad to me. And it [the condom] would go away and automatically it's like a waterfall.”

Likewise, several participants described the differences in feeling, pleasure, and intimacy when they did not use condoms with their partners. Fabiana, 15, had been using condoms with her boyfriend until she recently started taking birth control pills. In discussing the experience with and without condoms, she observed:

“It's different because like, I don't know. It's kind of weird telling you this, but like...but with the condom it doesn't feel the same. It doesn't have the same feeling, and without it, it kinda feels more intimate, it feels more like it's actually happening...It's really uncomfortable, he told me that it's really uncomfortable too, 'cause there are moments that it comes off, there's moments where it doesn't wanna go in...like it's a whole mess, so...”

INFORMATION SEEKING AND SOURCES OF INFORMATION ABOUT

CONTRACEPTION

In order to better understand how female youth make decisions about and negotiate hormonal or LARC method use, it is important to identify how and where they acquired information about various methods. In addition, an examination of how teens sort and interpret

the validity of this information, which often comprises an amalgam of biomedical evidence about safety, efficacy, risk, and first-, second-, and third-hand experiences with contraception, is critical to understand the value placed on particular forms of knowledge.

Teen participants in this study gathered information about available contraceptive methods from numerous sources, including friends and siblings, family members, healthcare workers, and the Internet to help inform their decisions. Not surprisingly, all teens interviewed indicated that they obtained information about contraception from clinic healthcare workers; 13 from friends, siblings, or cousins; 11 from parents or other adults in the family; nine from searches on the internet; and eight from middle or high-school health education classes. For the latter source, the majority of teens who referenced it noted that they primarily learned about abstinence and condoms, not other methods of pregnancy prevention.

Many teens identified social workers and healthcare workers in the clinics that they visited for reproductive health care as important sources of information about contraception. This finding is consistent with standard procedures for obtaining contraception, as young women must go to a clinical setting in order to be prescribed a hormonal or LARC method. As described earlier in this chapter, teens often visited the clinic once they were already interested in starting on a method, although some participants also indicated that healthcare workers initiated conversations about contraception before they were ready to choose an option. Information provided by clinic healthcare workers to interviewees most commonly included a description of what contraceptive methods were available and the mechanism(s) by which they prevented pregnancy. Beatriz, 17, was initially unaware of methods other than birth control pills, which she did not want to use for fear of her mother finding them. When she visited the clinic, she discovered that other options existed:

“I was afraid that she was gonna find out. I thought there was only one way you could use birth control – the pills. Like people talk about the pills all the time. And I was like, damn I can’t use that ‘cause it’s like pills pills pills! And she’ll find it. And I came here [to the health center] and they told me there’s a lot of stuff, and I was like ‘Oh ok, I wanna do this!’”

Isabel, 18, was initially hesitant about going on birth control because she was concerned about gaining weight. She learned about the different options available through clinic healthcare workers and gathered information about which ones were more likely to be associated with that particular side effect:

“I’ve heard about all of them [the methods]. The pills, patch, Depo, that little, whatever [gestures to indicate the vaginal ring], and the T [IUD]...I learned about all of them at the clinic. They actually brought it out there [showed her samples of the methods]. They had it [a birth control options poster] before on the wall.”

Additionally, clinic staff was available to answer questions raised. Ana, 16, had been thinking about getting contraception for some time, and came to the school clinic several times to speak with providers about it:

“I came downstairs ‘cause, um, I wasn’t really sure that I should have done it or not [gotten on birth control]. I came like a few times and asked the doctor, and then I finally got convinced to do it.”

During Carolina’s experience getting an abortion, she relied upon the support of the school clinic’s social worker, and eventually the medical provider, to offer information and help her decide about using contraception:

“...When I came down here [to the school clinic] to talk to the doctor, she gave me information but also my social worker. She was like, ‘cause she knew about the abortion, and the doctor didn’t know, so she was like, you don’t have to worry about going through that again. So she helped me get on birth control.”

While most teen participants reported positive experiences with HCWs when they sought care for their sexual and reproductive health, several interviewees relayed stories that conveyed

judgment from providers about using services at their age. For example, Daniela, 19, received her first Depo shot from a nurse who questioned her decision to be sexually active:

“The nurse told me, ‘Oh, you’re very young, why are you gonna put it [use the shot]?’ I said because it’s important for me, so she was like, ‘Okay, you think you’re pregnant? You’re having sex and things like that?’ And I said, ‘Yes, I’m having sex and that’s the reason why I’m putting it,’ and she was like, “Okay...so you’re having sex already and you’re only 17 or 18?” Something like that...I spoke to my doctor about it and she was like, ‘There are people like that, these kinds of people, they think that, they have kids and they think they’re doing the wrong thing and because they don’t speak to their child, they will hear, ‘Mom, I’m pregnant.’”

In addition to the information gathered from medical providers, participants commented on aspects of the clinic’s environment that made them uncomfortable and therefore less likely to seek services. Ximena, 16, had made several appointments at a family planning clinic, but was unable to keep them. In addition to the clinic hours not being conducive to her schedule, her brief phone call with the front desk clerk ensured that she would not return:

“...I don’t like it there at all. ‘Hi, can I make an appointment?’ ‘What’s your name?’ ‘Ximena.’ ‘How old are you? [said sternly] Hmm, 15? You said you’re 15?’...People say that unless you’re – if you’re embarrassed to say things like that, you shouldn’t be having sex. I understand that makes sense, but it was really about the atmosphere. I didn’t feel comfortable.”

In addition to feeling uncomfortable, long wait times for appointments were also described by several teens. Lucia, 16, was accustomed to receiving her Depo shot at her school’s clinic, but as it was closed during the summer, she needed to go to a community clinic to have her next dose before leaving New York for the summer:

“...Over the summer, before going to DR, it was time for the next shot of Depo. So I was like, ‘Oh my god I need to get Depo, oh my god,’ and I just had to go to another place and get the freakin’ Depo...It was like waiting too much and a lot of people and I’m like, oh no. This is...I felt uncomfortable. People was looking at me like, you so young. It was like, not for...[people my age]. On one side it was only for pregnant women and child and then the other side was for ladies...”

Similarly, Alyssa, 17, described feeling awkward attending clinics in her neighborhood. Even though her family knew she was using contraception, the notion that she would receive that service in such a familiar setting was uncomfortable:

“I don’t feel comfortable in certain places, in certain areas. Like by my house, I don’t feel comfortable in the clinic there. Because I know people, and I don’t feel comfortable with them giving me a [Depo] shot. I like here [at the school clinic] because, they know me, of course, but they don’t know my family. And I mean, even though my family knows, I don’t like...it’s just uncomfortable. It’s like my aunt giving me a shot in my butt...”

Teens recruited at school-based health centers (SBHCs) overwhelmingly reported seeking information from healthcare workers there due to the convenient location of this setting, belief in the validity of the information being provided, and ability to be seen quickly and confidentially. Of her SBHC provider, Alejandra commented:

“Yeah, like whenever I have questions or whatever, or I’m really concerned about something I just ask the doctor and she just tells me.”

Samantha, 17, had been seeing her SBHC medical provider since middle school:

“...I’m very comfortable talking to her, I’ve been with her since 6th grade. I hardly come now, but I’m starting to come more since starting birth control.”

The fact that participants could be seen by their provider during the school day without having to travel to an appointment or miss a full day of school was mentioned frequently by teens who visited their SBHC. Fabiana, 15, explained:

“...In here, instead of having to leave school and have to go to the doctor’s appointment, you can just come downstairs, make an appointment, and then make sure that your teachers know that you’re gonna be down there so you can make up the work that you’re missing, and then go upstairs when you’re done and that’s it. It’s much easier than missing school and going to the doctor’s appointment.”

Several teen participants also noted aspects of the SBHC environment that they deemed positively; namely, the calm atmosphere, shorter wait times than “outside” clinics and non-

judgmental staff. Laura, 16, had been going to her school's clinic for the past three years. When I asked how it compared to other clinics that she had been to, Laura replied:

"I like coming here more than going to my regular clinic. I feel more comfortable here...it's like, more quiet, not a lot of people are here, and it's quicker, and it's not like outside where it could take hours."

Zoe, 17, emphasized the importance of feeling comfortable when receiving these healthcare services, which the SBHC fulfilled by attending to her needs without judgment. She explained:

"When I go places I just look for comfort, so that's what they did. They made me feel comfortable enough to talk to them...Like they, it didn't seem like they were judgmental or anything, they understood what was going on and they wanted to help out and stuff like that."

Ximena, 16, also valued the non-judgmental tone of the clinic, but as her comments demonstrate, she was unaware that these services existed when she was planning to initiate contraception:

"...They [the SBHC staff] make me feel so comfortable. They're not like, they're not looking at me like, 'You're on birth control?' ...I didn't even know that they existed 'cause I walked past here every single day through the metal detectors. I noticed the door, but I didn't know they were there. And I like that in a way 'cause it's like, 'Oh it's confidential,' but at the same time, I'm like man, I woulda been on this [contraception] since September if I had known. It's not really advertised in my school. I knew there was a clinic, but not the services."

Information gathered from parents about contraception also featured prominently for some participants. Similar to general discussions about sexuality and health, teens tended to reference their mothers' knowledge, experiences and perspectives, rather than their fathers'.

When Beatriz first started hearing about contraception from friends, she was initially turned off.

She became more interested in high school and wanted to find out more information:

"Like birth control...I didn't know what the hell was that! I had no idea. People were like birth control this and this...I was like, 'What?' I looked it up on the Internet and I was like, 'What the hell is this?' And then I asked my mom and she explained it to me."

A particularly important facet of information about contraception that some teens learned from their mothers was their personal experiences with various methods. While Fabiana's

mother did not yet know that she was having sex with her boyfriend and using contraception to prevent pregnancy, they had an intimate and candid discussion of her mother's use of the IUD recently. Fabiana explained:

"It was so funny because I had asked her a weird question. I said, 'Are you still having sex with my stepdad?' And she goes, 'That's none of your business.' I was like, 'But I mean, like, y'all still together and you still sleep in the same bed, I'm just wondering.' And I'm like, 'What if you get pregnant again?' And she's like, 'I'm not gonna get pregnant,' and I asked, 'How do you know?' And she said, 'I'm on birth control.' I'm like, 'Which one?' She told me the IUD. I was like, 'The one that goes up?' And she goes yeah. And I said, 'So you don't get your period?' And she said no. I'm like, 'No wonder 'cause you know we have a big box of pads, so like, it's full! I'm like why is my mom not using them? And then I got curious, I was like, is she pregnant? And then that's how we got into it. She told me how it was when she first got it: a lot of pain and a lot of cramps, but she feels like it's safe. So my stepdad doesn't know she's on it 'cause he wants more kids. So she's like, you know, I gotta do this myself. So she did it and then, you know, she feels confident with it, but she feels like there are moments when she gets bad cramps or whatever, and it feels weird not getting your period."

Many teens also reported receiving information from friends and siblings. In particular, their experiences with various forms of contraception, whether positive or negative, carried substantial weight for some participants. Vanessa, 17, spoke with an older and more sexually experienced friend to get information about contraception:

"...My friend is older than me and she's had sex quite a few times and she knows a lot about herself. So I depend on her to get information with her experience."

Kamilla, 17, started using Depo after the birth of her child. In helping her make the decision, she described the importance of hearing about contraception from "somebody that really knows about it":

"My friend, she's 18. She's got three kids. She's like girl, I'm telling you now, you wanna jump on this birth control. I'm like, 'Why?' She's like, 'Because! It stopped me from having my kid, it stopped me from being pregnant again. You know I'm struggling with three already!'"

Fabiana, 15, confided in friends who had tried the methods she was considering to help her make the decision:

“I went to a friend, because of one of my friends is on the IUD...so I said, ‘What should I do? I don’t know, like should I do this one?’ She told me, ‘I have the IUD, and to be honest when I had it at first, I had really really bad cramps and all I did was sleep ‘cause the pain was so strong.’ And I told her, ‘Were you on the pills before?’ And she said, ‘No, I went straight to the IUD.’ And one of my other friends, she’s on the pills, and she told me that she didn’t get it from here [the school clinic], but she got it from her doctor. And she got it made just for her. So it kinda works better on her ‘cause those are made just for her and if anything she knows that it’s for her. And I told her, ‘Do you think I should be on the pills or the IUD?’ She told me, ‘If you feel like the IUD is better for you, then go ahead, but I can’t help you out ‘cause that’s your decision, and if you feel like the pill is better for you, then you know, you decide.’”

Sisters and cousins were also often referenced by teens as sources of information, as they provided opportunities to learn about their experiences with various methods. Daniela, 19, had two sisters who have been on the IUD and Depo. She explained:

“ Um, well my sisters... One had the IUD for 10 years, the other one put on the five years ...They’re already used to it and stuff like that. She told me at first, she wanted to take it off because it hurts a lot. It bothers her. But then she had already four or five years with it. ‘Cause she has two kids, so she decided to put it on...I use the shot [Depo] while my sister was using the shot and she came up pregnant, so she was like, ‘I don’t guarantee you to put it on if I came out pregnant with it.’ My [other] sister also tried the IUD but she took it off because she said it hurted so much, so she said let me just take it off.”

Alternatively, positive experiences with a method could also prompt someone to initiate it, as was the experience of Isabel with the hormonal implant:

“...My cousin, she was the one that actually encouraged me. ‘Cause I was scared at first, I thought you would get fat and stuff like that. She has the implant, so I asked her, like, how does it feel to have that, and she told me and then she said, ‘You don’t get your period,’...so I was like, ‘Ok, I’m going with that one!’”

As noted earlier in this chapter, there was significant variation among teens interviewed regarding the extent to which they received sexuality education in schools, and particularly information about contraception. This inconsistency speaks to reports from some participants that discussions about birth control did not occur in their classes, while others indicated that

these topics were covered. Nicole, 18, remembers receiving information in a health class once a week that covered several topics, including contraception:

“...They would come in every Friday and they would tell us about it. So it would be health and drugs, and then we’ll have a discussion about everything.”

Carolina, 17, remembered a health program from her freshman year, where students from a nearby university came to discuss sex, contraception and healthy relationships. She returned to the information provided in these sessions after her abortion to help her decide about starting on birth control:

“Well, in freshman year...some student came in and told us about it. It was a health program, every Friday they would come and teach us about different...not just birth control, but like healthy relationships, and that’s where...when I tell myself, after I went through [the abortion], I started thinking about it. All of this happened sophomore year and I’m like, wow. Let me...I went through the books again and I’m like, okay. And I’m like, I’m sorry I’m not gonna give my mom what she wants. I’m gonna go on birth control...”

Less frequently but still mentioned by several participants was using the Internet to search for information about contraception and to have questions answered. Ximena, 16, relied on information she gathered online because she knew that “things constantly evolve.” Before starting on a method, she explained:

“I researched everything, even though I knew a bunch of stuff, like I still researched it ‘cause I know things constantly evolve and it’s not the same information as - you know what I mean?”

Similarly, Valeria, 17, uses the Internet, and specifically Google, to find out answers to specific questions about different methods:

“I look on the Internet, you know, ‘cause to know what’s up...I go to Google, and if I wanna know something, I just write a question.”

Alejandra, 15, used condoms and birth control pills to prevent pregnancy and STIs. She heard that condoms sometimes break and researched how to prevent this from happening online:

“I have never experienced...something bad happening or whatever, but people that I know, like, the condom will pop or something, so I was kind of scared about that when I heard it...and I like searched up information about condoms like that and how to prevent them from breaking...It said like to put, like, to get lube and put it inside the condom and outside the condom so it doesn't break.”

In almost all cases, participants described gathering and evaluating information from several sources, rather than obtaining everything from one individual or “setting,” to help them reach a particular decision. For example, Alyssa, 17, referenced learning about the Depo shot from a teacher, a friend, both of her parents, and the clinic before selecting it:

“So, I heard about the shot two years ago when I was in 9th grade. Um, by my teacher, ‘cause it was an all girls school, so she said, ‘Oh, I’m going to take these girls to the clinic do you want to come?’ And my friend got the shot, and I said, ‘Oh...’ So she was like, ‘Oh I don’t get my period,’ you know she’s telling me stuff, and I’m like, ‘I’m not believing this girl, whatever.’ Then I asked my dad, I asked my mom, and I was like, maybe I should. Then I told my teacher, maybe I wanna get a shot. And she said, ‘Ok, that’s fine.’ I went to clinic with her, and I started going every three months to get it.”

What is particularly clear about the above anecdote is that the legitimacy of the Depo shot as a safe, reliable contraceptive method increased for Alyssa as she continued to find out more information and check it against what she already knew.

When asked about which sources they identified could be considered the most valuable or trustworthy, most participants chose clinic healthcare workers, followed by parents, and friends or siblings who have personal experience about contraception from which to draw. Sofia, 19, succinctly stated:

“I trust more the doctors. Yeah. Or the people who had the experience.”

Jazmin, 15, reiterated this second point:

“[I trust] my siblings and my friends who went through it already.”

Zoe, 17, referenced her mother and clinic healthcare workers:

“[I trust] my mom because she used to work in one of these clinics here. So...I would go to her about things like that [contraception] first, and then I’ll come see [at the clinic]...”

Particularly regarding the Internet, which was almost never cited as the most trustworthy source, participants viewed the information gathered with a healthy dose of skepticism and contrasted it with other sources. About finding information online, Samantha, 17, explained:

“Sometimes like I’m curious, I’m like, ‘What is this?’ And then, ‘Ooh what did I...?’ Then I’ll talk to my mom and she’ll tell me, ‘cause she’s been on birth control before...’ cause there’s a lot of stuff out there, like, ‘Hey, you might grow an extra lip!’ What!?”

Similarly, Daniela, 19, referenced cross-checking information learned online against what she heard from people she trusted:

“I just do a search when I have nothing to do in my house. I’ll just get on my computer and look for information. But after that, I also ask people that know. ‘Is this right? Is this not?’”

Recommendations about methods from trusted sources influenced contraceptive decision-making for the majority of teens, with medical providers’ and family members’ input identified as the most valuable, respectively.

USING CONTRACEPTION

Table 8.1 displays information about participants’ previous and current contraceptive use, as well as the approximate length of time between reported first consensual sexual intercourse and uptake of a hormonal or LARC method. Among the 23 teens who had ever used a hormonal or LARC method, four had selected a method prior to the onset of sexual activity. For two of these participants, the reason for contraceptive uptake was the need for menstrual regulation; for the other two young women, the decision was made in preparation for becoming sexually active.

For the 19 remaining teens³² who had selected a hormonal or LARC method for the primary purpose of pregnancy prevention *after* becoming sexually active, three did so between zero and six months after first vaginal intercourse; six between six and 12 months; seven between 12 and 24 months; and three at or after 36 months. The median time between first vaginal intercourse and selection of a hormonal or LARC method for these 19 teens was 12 to 24 months.

Table 8.1. Contraceptive Use Histories of Participants

Name (pseudonym)	Age	Reproductive History	Approximate Time Between First Sex and Hormonal/LARC Method Use	All Methods Ever Tried in Chronological Order	Current* Hormonal or LARC Method Used
Alejandra	15	Never Pregnant	0-6 months	Condoms, OCP	OCP
Brittany	15	Never Pregnant	6-12 months	Condoms, Pill, Patch, Ring	Ring
Fabiana	15	Never Pregnant	Selected prior to onset of sexual activity	Condoms, OCP	OCP
Jazmin	15	Never Pregnant	Has never used hormonal/LARC method	Condoms	Condoms Only
Naomi	15	Never Pregnant	Has never used hormonal/LARC method	Condoms	Condoms Only
Ana	16	Never Pregnant	12-24 months	Condoms, Patch, Depo	Depo
Laura	16	Birth	12-24 months	Condoms, Depo, OCP, Patch, Paragard IUD, Mirena IUD	Mirena IUD
Lucia	16	Never Pregnant	0-6 months	Condoms, OCP, Depo, Ring	None
Ximena	16	Never Pregnant	12-24 months	IUD, Depo	Depo
Adriana	17	Never Pregnant	Has never used hormonal/LARC method	Condoms	Condoms Only
Alyssa	17	Never Pregnant	Selected prior to onset of sexual activity	Condoms, Depo	Depo
Beatriz	17	Never Pregnant	6-12 months	Condoms, Patch, Implant	Implant
Carolina	17	Termination	12-24 months	Condoms, Patch	Patch
Justine	17	Termination	36 months	Condoms, Depo	None
Kamilla	17	Birth	12-24 months	Condoms, Depo	Depo
Samantha	17	Never Pregnant	Selected prior to onset of sexual activity	Condoms, OCP	OCP

³² This figure excludes the four teens who chose a hormonal or LARC method prior to the onset of sexual activity and for menstrual regulation.

Table 8.1. (Continued)

Name (pseudonym)	Age	Reproductive History	Approximate Time Between First Sex and Hormonal/LARC Method Use	All Methods Ever Tried in Chronological Order	Current* Hormonal or LARC Method Used
Valeria	17	Never Pregnant	6-12 months	Condoms, OCP, Depo	Depo
Vanessa	17	Never Pregnant	Selected prior to onset of sexual activity	Condoms, Patch, OCP	OCP
Veronica	17	Never Pregnant	6-12 months	Condoms, OCP	OCP
Zoe	17	Never Pregnant	6-12 months	Condoms, OCP	Condoms Only
Isabel	18	Never Pregnant	36 months	Condoms, OCP, Implant	OCP
Leah	18	Never Pregnant	12-24 months ³³	Condoms, Patch	Patch
Nicole	18	Termination	36 months	Condoms, OCP	OCP
Daniela	19	Never Pregnant	6-12 months	Condoms, Depo	None
Josefina	19	Never Pregnant	0-6 months	Condoms, OCP	OCP
Sofia	19	Termination	12-24 months	Condoms, OCP	Condoms Only

INITIATION OF CONTRACEPTION

Among teens participating in this study, several prominent reasons were given for the timing of initiating hormonal or LARC methods (see Table 8.2). For 23 interviewees, decisions were made after becoming sexually active. While these reasons are not necessarily mutually exclusive, they represent the primary rationale offered by participants during the interview. The impetus for starting one of these methods most commonly included a desire for more effective pregnancy prevention than condoms and/or to stop using condoms with an intimate partner (n=11).

Table 8.2. Reason for Initiating a Hormonal/LARC Method

Category	Number of Respondents
More pregnancy protection/to stop using condoms	11
Previous pregnancy or pregnancy “scare”	6
Parent finding out about sexual activity	4
Non-contraceptive benefit	4
No response	1

³³ Leah reported using the patch inconsistently; sometimes it was considered her primary form of pregnancy prevention, whereas other times it was used to regulate her menstrual cycle and manipulate when her period would come. Despite this complexity, she has been included in the category for 12-24 month contraceptive uptake after sexual initiation for analytic purposes.

Fabiana, 15, described the importance of delaying pregnancy and the peace of mind that she felt knowing she was “safe”:

“...My mom got pregnant at a young age with my brother...17, 16, something like that. And I don't want to repeat history, 'cause before when she was younger, they didn't have birth control pills or none of this, so it was hard for her to grow up and have a baby at such a young age and have to start high school all over again...I don't want to have what she had, so I'm trying to keep myself and trying to, like, if anything happens, I know that I'm safe and I don't have to worry about like, 'Oh, I should take a pregnancy test now, my god, this and that,' [and] have the responsibility of thinking that something happened, when I know I'm safe with the birth control pills.”

For some participants, feeling better protected against pregnancy also intersected with a desire to not use condoms with an intimate partner. Ximena, 16, found sex with condoms particularly painful and uncomfortable, and was interested being able to do so with her boyfriend without fear of becoming pregnant:

“...When I meet Adam, the first time we were trying to, like, we were able to [have sex], he's like fuck, I can't find these condoms! And I'm like, 'Oh god. That word.' And he's like, 'No I have to, I'm so afraid [of you getting pregnant]. Really really, like, you know?' The first time we actually had sex, he finally found the condoms, and it was so horrible, it was like this fuckin'...he's just like, up in there, and I'm like...trying to hold my breath so I don't smell it, pretending it's not there, that kinda thing, like the frickin' elephant in the room, and after five minutes of this shit, I was like I can't take this, it hurt in a bad way...it felt like burning...and I was like, I don't wanna burn. And he's like, 'Ok, I think you need to get on birth control 'cause this is not working.' And I'm like, 'Yeah.'”

The second most frequent response from participants regarding their decision to initiate a more effective form of contraception was experiencing a previous pregnancy or a pregnancy “scare.” Nicole, 18, had gotten pregnant the previous year with her current boyfriend. On her decision to start using oral contraceptive pills, she explained:

“I didn't want the same thing [pregnancy] to happen again, and I just thought it was more of a responsible thing...for both of us.”

Other interviewees described situations where they thought they might have been pregnant as the primary reason for contraceptive initiation. Isabel, 18, used emergency contraception (EC) after a sexual encounter where she became concerned that the condom had failed. She explained:

“...I had a little accident when the condom slipped out, so I was like, yeah, I’m not taking the chance.”

Likewise, Zoe also felt concerned that she could become pregnant after a condom slip, which prompted her to start using birth control pills.

“There was one time I had Plan B...I think the condom came off, and I didn’t like the feeling of being unsure, like, if I’m gonna be pregnant or something like that, so...to avoid that again, I just decided to, um, me and my friends decided to just go to the clinic and get birth control together.”

It is important to contextualize the decision about when and whether to initiate a hormonal or LARC method of contraception with how young women assessed their own risk of pregnancy. In addition to the role of accurate information about anatomy and reproduction on one’s personal assessment of their fertility, these beliefs can be highly subjective, situational and informed by previous experiences. In general, the majority of teens felt confident that they could become pregnant if they were not using some form of protection. Samantha, 17, described her thoughts on the subject:

“I know I could get pregnant. Everyone in my family has had no problem, the only reason why my aunt has a problem is because when she was smaller she wasn’t really careful about who she was having sex with, and she ended up having some type of disease that’s around the vagina and prevents you from having a kid because if the child comes out, it gets sick.”

Similarly, Josefina had a high personal assessment of pregnancy risk, as illustrated by this anecdote about her and her boyfriend initially deciding to stop using condoms after she initiated oral contraception:

“... We decided to stop using it [condoms] ‘cause I’m on birth control. And then, like, we tried it the first time. He came inside of me, and then I was just like, ‘Oh my god I think

I'm pregnant.' And he's like, 'You're on the birth control, you're gonna be fine!' And I'm like, 'No I'm pregnant!' So I wasn't even asleep or anything till like the four weeks or whatever so I could get a pregnancy test. That happened maybe four times and I was like, 'You know what? That's it, you're using condoms 'cause I'm not gonna risk it.'"

However, five participants expressed concerns and even doubts about the likelihood that they could become pregnant. Reasons for lower personal assessment of pregnancy risk were varied, including repeated acts of unprotected sex where a pregnancy did not occur; a family history of infertility; and the potential for a previous termination or hormonal contraceptive use to have made them sterile. Daniela, 19, had recently returned from the DR, where she had been staying with her boyfriend. She described feeling unsure that she could become pregnant due to the number of times she and her boyfriend had had unprotected sex over the past month:

"...I wanted to speak with my doctor [today] because I've been, yeah, having sex with him [my boyfriend] and stuff like that, without protection, and I've seen that I haven't gotten pregnant. 'Cause it's weird when you're having sex with someone mostly every day...and I wanted to see just to check that I don't have a problem."

In addition, several women in Daniela's family had experienced difficulty becoming pregnant, which she thought may also impact her fertility:

"...I have family that has those kinds of problems and stuff, and like they say it could also happen to us [she and her sisters]."

Similarly, Ximena, 16, was having unprotected sex with her boyfriend for several months and had not gotten pregnant. She explained:

"We tried condoms two times and then the third time were like, fuck this. He literally grabbed the thing, threw it out the window...ever since then, for like three months straight, like every other day, usually every day...we'd have sex like twice, and never had a pregnancy scare. Weird. He would always pull out. I don't know what it was."

For some interviewees, having frequent unprotected sex without becoming pregnant seemed to challenge or contradict the absolute certainty of social and clinical messages that are often repeated to young people about pregnancy: it only takes one time. While true, conception must

also take place under a particular set of circumstances that are only met during certain times of a woman's menstrual cycle. Carolina, 17, explained her interpretation of this information and how she applied it to her sexual encounters:

"...My eighth grade science teacher told me, 'Oh, you could get pregnant the first time you have sex,' and then the thing that a lot of people don't tell us is that, um, yes, the sperm stays up there, but the thing is that the minute we get our period and the eggs drop, and the sperm is there, that's when we get pregnant. Everybody thinks like, 'Oh, there's a lot of eggs there and the sperm could just go in any time, but it's only when your period's about to come and it drops and that's where people didn't mention it. 'Cause most of my friends, they first thought that. I'm like, 'No, look at it this way...' So I explained to them, and I started realizing that it was right because after my period, I would not use condoms, and I didn't get pregnant that week, so they were wrong. And that was after my period, only for a week, and then the week after, we used protection, like just in case. And then I started having more knowledge. So I'm like, okay. In a way it was like an experiment for me...just to see for myself."

Another concern raised by some interviewees was that previous exposure to hormones in contraception or a termination procedure had made them infertile. Justine, 17, had recently stopped using the Depo shot, which she had taken for over a year and a half immediately following her termination. When asked why she was concerned that she would not be able to become pregnant in the future, she explained:

"I dunno, because I be watching TV and I be seein' how like the famous people be having low sperm cell counts or they don't have enough eggs and I be wondering, like, how can I find out that? Or then I was thinking in my head, like, the birth control probably messed me up that I can't have any kids."

Like Justine, Nicole started using hormonal contraception immediately following a termination. She articulated fears that the procedure may have made her unable to have children in the future:

"I'm afraid now because after I had got the abortion, I went through a lot of different things where as I got a cyst...After that, it was like directly after, then I started getting infections and I had to constantly go in and out the hospital...one was a yeast infection from taking antibiotics from everything and on top of that I had got a really really bad infection to where they had to give me a needle on my butt cheek...yeah, to this day I'm worried that maybe with the abortion that will mess me up..."

The third most frequent sets of responses regarding the decision to initiate hormonal or LARC methods included a parent's discovery that a participant was having sex and the non-contraceptive benefits associated with using such methods. In Valeria's case, her father had her put on the Depo shot while she was living in the DR with him:

"...My dad, at that moment he was thinking that I was a virgin, but when he find out that I wasn't a virgin no more he started giving me the shot."

Several teens reported that it was not pregnancy prevention but rather the non-contraceptive benefits conferred as the primary driver of their decision to initiate hormonal or LARC methods.

Alyssa, 17, initially started on the Depo shot to help her period go away:

"...At first, I wasn't sexually active when I went on birth control. So, then I asked my dad, and I said, 'Um, I think I'm gonna go on birth control.' He said, 'Why?' And I said, 'Because I play a lot of sports, and like, I don't want my period anymore.' And...he's like, 'Fine.' So I tried it, and I was like, 'Yes, this is awesome.' Then I just kept going, like, I like this, I'm gonna keep doing this. And then I became sexually active. Then it's more, like, useful, of course."

Similarly, Vanessa, 17, started on birth control pills for help regulating her period:

"What actually made me decide to start using birth control was...it actually wasn't him [my boyfriend] at all. It was because I had a very irregular period, and I thought being on birth control would make it more definite."

FACTORS THAT SHAPE HORMONAL OR LARC METHOD SELECTION

For female youth who chose to initiate hormonal or LARC methods, a multitude of intersecting factors contributed to their selection and continuation among the available choices. The importance placed on these considerations varied for each participant, and even among individuals over time, but they represent the most salient themes identified during interviews. As elucidated by the young women in this study, method uptake and use were ultimately the result of an often complex decisional process whereby costs, benefits, and subjective constructions of risks were continually defined and assessed.

MENSTRUATION

Because some hormonal/LARC methods alter women's menstrual cycles to make them more or less frequent, the significance and value assigned to menstruation (or lack thereof) by interviewees was important to understand. In particular, having an irregular period with frequent spotting is more commonly experienced among Depo, Mirena IUD, and hormonal implant users for the first three to six months of use, subsequently resulting in amenorrhea³⁴ for many women. Among the youth represented in this study, 13 indicated that it was necessary for them to have a "regular" monthly period, whereas the other 13 preferred for menstruation to be infrequent if not absent while using contraception.

When asked why it was important to get a monthly period, several participants described the role of menstruation in cleansing the body. Zoe, a current condom user, explained:

"I feel like – it's like, not...I guess it's a cleanse or something. Like it's normal, you're releasing an egg, like, it's what's supposed to happen I guess."

Similarly, Vanessa, an oral contraceptive user, felt it was important to have a monthly period, and actually started using birth control in an attempt to make her irregular period more consistent:

"I feel that it's...it's a way that females get all the nasty stuff out of their body. I feel that we should celebrate having our period. Everybody gets all cranky about getting it...I get excited when, like, hopefully it will come, so I'll feel better about myself once it's over...because when I get my period, it doesn't hit me as hard as every other female, I don't have crazy cramps, I don't get cranky, I just bleed."

Another reason many interviewees cited for why a regular monthly period is important to them is what it signifies: that they are not pregnant. This sentiment was reiterated by a variety of participants, including those using a hormonal method, condom only users and those not

³⁴ Amenorrhea refers to the absence of menstruation.

currently using a barrier or hormonal method. Justine, who recently discontinued use of Depo and was not currently using a method, succinctly explained:

“If I get my period, I know I’m not pregnant, if I’m not on no type of birth control.”

Alejandra, a dual user of birth control pills and condoms, articulated the anxiety not getting her period would cause, despite using contraception:

“...I’d get scared. That’s when I’d get scared, like when I don’t get my period, or I’m like, whoah, what’s going on? So I think it’s mandatory to have my period...”

Carolina, a patch user, described the importance of selecting a method that results in a regular period, noting the difference in her peace of mind when she was not using any form of birth control versus now:

“I think it’s something good to get your period, ‘cause it gives like...I feel like it’s like, oh, you’re not pregnant, so don’t worry. ‘Cause there have been a lot of times when I had sex without a condom, and um, his sperm was there, so I was worried, I’m like, oh my period might come, but I don’t know this week or next week. So I was panicking, and I would take plan B, but it would take a while. My period came the following week. And I’m like, so now, I know when my period’s gonna come. So that’s why I’d rather be on the patch.”

Conversely, a few participants were drawn to particular methods because of the likelihood that they would eliminate their period. Naomi had scheduled an appointment at the clinic to have a Mirena IUD inserted the following week. Of her rationale for selecting that method, she explained:

“Mirena had a lot more things that I woulda wanted. I like that it takes away my period, it works immediately...”

The importance of monthly menstruation described by some participants in this study is supported by cross-cultural anthropological literature on the meaning of menstruation, which illustrates its association with the “natural” world, femininity, cleanliness and purity (Buckley and Gottlieb 1988; Renne and van de Walle 2001). For other participants, however, a decrease

in or absence of menstruation was desirable, as it reduced painful symptoms associated with their period and allowed for greater control and manipulation of an event that perceived as inconvenient for sports, sexual encounters, and other activities.

EFFECTS OF METHODS ON MENSTRUATION

Participants reported both positive and negative effects of various methods on their menstrual cycle. On the positive side, some young women experienced more regular, less painful, or shorter periods. Fabiana, an oral contraceptive user, contrasted how her period felt before and after initiating the pills:

“I used to get my period like really, really heavy and now that I’m on it, it’s like I barely...it’s barely there. I get a little bit but not a lot. It’s like between. I like that change because I used to have to change my pad every hour, every two hours, and I used to get really really heavy cramps and it was bad. I’d get headaches; I’d sleep all day. If I wasn’t sleeping I was eating. I was a mess, so with the pill it’s like, I know it’s coming, I get, like, the cramps, but they aren’t as strong as they were before.”

Others enjoyed the fact that they could use their contraceptive method to manipulate when their period came. Josefina occasionally took her birth control pills continuously rather than taking a week off in between packs to bleed:

“...For the summer, I can like, stop my period. I go and start a new pack right away. I did that last summer, it was fun. We went to the water park, so I did that so I could enjoy it.”

Similarly, Leah, occasional patch user, used her method to help regulate her period and control when she had them:

“If I had an event coming up and I wouldn’t want my period on that day, I would use it...It’s not really something that I do continuously. Whenever I feel like using it, I just use it.”

More commonly, participants described the negative effects of particular contraceptive methods on their menstrual cycle, with spotting, irregular and heavy bleeding among the most frequently reported. With a few exceptions, Depo and hormonal implant users experienced the

majority of negative effects. Alyssa, a Depo user, described her menstrual pattern while using the shot:

“...It’s hard because...I get it for like a month. A whole month to have your period. It is depressing. So stressful. Then you have to take it [the shot] again after two months, so you don’t get your period for two months...And the thing about it is it’s annoying because there’s sometimes spotting, and then sometimes full, then sometimes spotting.”

Ana, also a Depo user, was prescribed oral contraceptive pills at her last clinic visit to help minimize the spotting and irregular bleeding associated with the shot. She explained:

“Yeah, I’m using the pills also because the Depo, um, I had my period for like a month, so she had to give me the pills so it could stop...I got my period from October to like November, and I got it again this week.”

Isabel experienced similar issues while using the hormonal implant for three months:

“I was not getting off my period. I had my period for like two months straight of the three months that I had it. All the time, it would not stop. So then I was like, ‘Yeah, I want to take this off.’ She [the provider] said, ‘But give it some time.’ Then I lasted another full month, so I said, ‘Yeah, I can’t do it. Take it out.’ So when went back and she took it out.”

Although not all women experience similar effects on their menstrual cycle when using hormonal or LARC contraception, it is clinically recommended to provide patients with sufficient information about what effects may occur in order to allay surprise or concern. Some teens recollected being told by their provider that their menstrual patterns may change, while others did not recall receiving this information.

COMFORT WITH METHOD MODALITY

The method’s modality (e.g., injection, insertion, adhesive) and associated features played a large role in what options were ruled out or considered by participants in conjunction with other factors that influenced their decision. Overwhelmingly, the hormonal implant was the method with which teens reported being the least familiar. With few exceptions, those interviewees who had heard of the hormonal implant were uncomfortable with it and expressed

confusion about how a small plastic tube inserted into their arm would prevent them from getting pregnant. Fabiana, 15, explained:

“There’s another one, I don’t know which one it is ‘cause barely anyone uses it. I forget what it was...but there’s one that you put inside your arm, and I don’t know how that works, but I don’t trust it ‘cause why is it gonna be inside your arm? I don’t know how it works, but yeah, that I don’t trust that much.”

Similarly, Lucia, a former pill, vaginal ring, and Depo user, commented:

“The implant? Nope! No! Why!?! Under my skin? No!”

Alternatively, the one current user of the hormonal implant highlighted its “hidden” feature as an advantage that contributed to her selection of the method:

“...I heard about the implant ‘cause my friend has it, and she was like, ‘It’s cute,’ meaning, like, it’s cool. And I’m like, I wanna get into that! I think that’s perfect for me. No one’s gonna see it and then if you wanna touch it, you can touch it. I touch it every night. Yeah, I be like [touches her arm where the implant is located]. I wanna see that it’s there, right there.”

The IUD was considerably more widely recognized by participants, but like the hormonal implant, the majority of teens were not interested in using it, due in part to fear about the procedure and discomfort with something being inserted vaginally. Samantha, a pill user, explained:

“I didn’t like the one that goes inside me, ‘cause I was a virgin, so you can’t do that to me!”

Virtually all participants had heard of the Depo shot, and nine had ever used it. For teens who were fearful of needles, the Depo shot was an option that was almost always ruled out.

Nicole, a current pill user, described her rationale for excluding this option when she was deciding between the oral contraceptive pill and Depo shot after her termination:

“They gave me a choice to either pick which one I wanted, and they asked me a question to make sure I really understood what they are and what my choice would be. So I felt the pill would be better for me, even though sometimes you forget, but you can always

quickly take it. Um, I didn't want any needles or anything 'cause I was already going through enough with being pregnant and going through needles..."

Conversely, others were looking for a longer-term method that would not require them to come back to the clinic frequently. After having tried the IUD, which expelled from her uterus after several weeks, one participant settled on the Depo shot due to the need to return just every three months.

Seventeen teen participants were familiar with or had heard of the vaginal ring; however, very few expressed interest since it required being inserted into and removed from the vagina every month, as reflected by Ximena's remarks:

"What do I look like? That looks like so much work, inside my...like what? I would mess up. I would mess up. It would get lost in there. I don't know what would happen, but that's not a good idea."

While less explicit in her rationale, Isabel found the idea of vaginal ring uncomfortable:

"No, I feel like that's...no. I'm not interested [in the ring]. Nothing drives my mind to do that."

Almost all interviewees had heard of the transdermal patch. While seven teens had tried it, most discontinued the method. Among users and non-users alike, there was widespread agreement about perceived disadvantages of the patch. Most notably, that it was visible to others, came off when wet, and looked "gross" after being on your body for a week. Beatriz first started with the patch, but switched when the summer came due to her discomfort with others being able to see it and know that she was sexually active. Similarly, Alejandra was concerned about others being able to see the patch, along with its ability to withstand being in water:

"...The skin one, the patch, I was thinking about doing that, but then again, doesn't it come off when you swim and stuff like that? And then don't they see it? Don't they see the patch when you swim? So I was feeling uncomfortable about that one."

Other interviewees disliked the appearance of the patch. Zoe explained:

“...My friend used it and I didn’t like how it looked on her skin. It just looked gross, like it was dirty around the edges...”

Reflecting the diversity of opinion on method preferences among interviewees, a few young women preferred the patch due to its perceived ease of use and advantage of its adhesive modality:

“[The patch] is the only one I’ve used. And I wouldn’t use any other one. ‘Cause this is more safer than the other ones. It’s easier, you just stick it on anywhere. It’s so simple. Take it off the next week, then put on another one, and then another one. It’s like a Band-Aid, a big Band-Aid.” (Leah, 18 years old)

All interviewees were familiar with oral contraceptive pills, with thirteen young women reporting previously or currently using them. For some, hormonal methods of contraception were ubiquitous with pills. While other issues with oral contraception were noted and will be described later in this chapter, the method’s modality was by and large perceived positively by participants. Pill users often noted the ease of use and their ability to remember to take them every day. Alejandra explained:

“I just felt like this one [the pill] is more better for me, because, like, I can take it every morning, and I can remember and stuff.”

Interestingly, the fact that the pill needed to be taken every day, considered a significant disadvantage by many HCWs and reproductive health stakeholders in this study, was occasionally seen as an asset by teens. In particular, it connoted an element of control for some, with the repetitive act of swallowing a pill serving as a potent reminder that they were protecting themselves from getting pregnant. Fabiana perceived the daily routine required to take birth control pills effectively as safer than a more “hidden” method where its efficacy was less evident:

“I was worried ‘cause I didn’t know what type of birth control I could take, I was like, I don’t know if I should take this one or that one, so she gave me a paper and it has the different types of methods, and like the percentage of how the effect will be. So there was

the shot, and the shot was every three months, but in order for me to know that it's working I'd rather be on the pills 'cause with the pills, I know that if I take it now, I know that I'm gonna be safe later and I don't know how the shots work every few months. And with the pill I feel more safe 'cause I'm taking them and I know that they're actually working."

Nicole also described the visual and routine aspects of taking birth control pills to be positive attributes, as you can easily see if you missed a pill and your period comes at expected intervals:

"What I like about it is that you'll know if anything's wrong like, you'll know if you're pregnant or anything because if you at least skip three days or even if you take the two that you miss, or you know how if you miss one day and you're able to take the two...If you don't get your period right away, then you'll know something's wrong, so that's one thing that I do like about it."

However, not all participants felt positively about the daily routine required by pill use.

Several teens anticipated that they would have difficulty remembering to take it every day, which made this method a less ideal choice. For example, Daniela explained:

"I'm of a person where, the problems in the house and stuff like that are annoying...if I know that I have to do something, if I don't write it up and stuff like that, and that day I don't look at the notebook, I know I'm going to forget. 'Cause there are times that I write it but then the next day I'll forget about it, and then I'll see the notebook and I'll be like, damn I had to do this and that...I thought about it because I don't want something like the pills that you have to take every day. And then I know I'm not gonna take it. 'Cause my doctor give it to me and I have it but I forget to take it. So I was like, you know what? No. There's no need for me to ask for it if I know I'm not going to take it."

In reality, participants weighed various methods' attributes simultaneously with previous experiences, expectations about sex in their relationship(s), their comfort with the modality and how a particular option would fit into their life. The quote below from Alyssa exemplified this fluid process:

"So as you see, internship and all that extra stuff, I have to do everything by myself with the other birth control methods except for the NuvaRing...Condoms, ok, they're nice, but if I know a boy is clean, and we got to the doctor together, and I'm clean, we should be able to not use condoms. So I would like that...One. Two, the pill, I can't be consistent with that, because - I can't be consistent. The patch? I don't want it on my skin two weeks or whatever the amount is because it looks dirty, I don't like that. And I don't know, I don't want anything inserted. It gives me...when I got checked for chlamydia, I was

freaking out, I was like, ‘No, I can’t look at my stuff!’ The doctor’s like, ‘You have to,’ but then I’m like, ‘If I’m gonna get birth control, and then have to stick [referring to inserting her fingers into her vagina to check IUD strings or insert/remove the ring]...No, no. So I was like, ‘No, I’m just gonna get the shot. It’s easy, I could remember, and that’s it.’”

OTHER WOMEN’S EXPERIENCES USING CONTRACEPTION

Additionally, other women’s experiences on hormonal or LARC methods also informed teen decision-making in this study. In particular, hearing about the negative experiences of others appeared to have a powerful effect, even if the participant did not know the person directly. The most commonly described scenarios that teens recounted related to weight gain, safety, and effectiveness.

Weight gain due to using the Depo shot was a prominent concern voiced by many participants, who often recounted stories about friends’ and relatives’ experiences to justify their apprehension. For example, Isabel noted:

“I’m terrified of, not needles but, my friend got it, right? And she was skinny. Now she’s like a blimp, so yeah I’m not doing that.”

Similarly, Carolina had heard from others who had used birth control, including her mother, that they had gained weight:

“...People that went on birth control, they were like, ‘Oh, you’re gonna gain a ton of weight. And I was like, ‘Oh my goodness, I don’t want to gain weight!’...And my mom, she said the same thing once...She said she gained a ton of weight. And I’m like, really that could be true? So that was one of my concerns.”

Another set of issues raised by interviewees concerned other women’s experiences with method safety and the effectiveness of contraception. Sometimes participants knew the person they were referencing, while other times it was more vaguely phrased, as in, “I heard” or “people say.” For Valeria, a story about one her classmate’s experiences while using the IUD made her less

inclined to trust its efficacy, illustrating the power of rumor in shaping contraceptive decisions for some young women:

“Um, some girls they use the IUD. They think that they’re not gonna get pregnant and they do, ‘cause sometimes that doesn’t work. ‘Cause I know a girl that used to use that and she was having sex and she got pregnant. Someone at the school. That was weird!”

Before Carolina started using the patch, she was unsure whether contraception would actually prevent her from becoming pregnant. She explained:

“...There have been people who are like, ‘You could get pregnant even with the birth control,’ and I’m like, ‘Isn’t that supposed to prevent you from being pregnant?’ So it was doubts again, I had doubts. And that was another of my concerns, that doubt...”

Likewise, Fabiana was not interested in trying the patch or the IUD due to stories she’d heard about both:

“I heard about the patch, but the patch doesn’t work’ cause my friend’s mom had it, and it didn’t work on her at all, ‘cause she got pregnant with my friend. Then there was the IUD, and I heard...it’s not that I heard a lot of things about it, it’s just that I don’t feel comfortable with it...My friend told me that her mom had it and she was having sex and the guy moved it, and then that’s how she had her. So it was a whole disaster ‘cause she didn’t expect it at all. I guess it is a good method but for me? I can’t do that.”

Nicole referenced a television show where the protagonist was using an IUD but it had been expelled without her knowing to illustrate her mistrust of the method’s effectiveness:

“I’ve seen...I watch TV about it and stuff, and on one show, I think her IUD had fell out and she didn’t know what to do about it so, I was like, I don’t want that to happen to me. You think it’s working and then it’s not, it’s gone. And then something happens.”

While it was common for teens in this study to underestimate the clinical effectiveness of hormonal or LARC methods, participants tended to vocalize the most doubt about the efficacy of the IUD, which is actually the most clinically effective reversible method after the hormonal implant. The perception that some methods do not work well, or that hormonal or LARC methods are not as effective as they actually are (predominantly based on anecdotes of pregnancy while using these methods), represents an interesting example of the ways in which

population- and individual-level risk are constructed and communicated. HCWs and RH stakeholders frequently dismissed stories such as those described above as myths or urban legends, with the recommendation given to provide accurate biomedical evidence to correct this misinformation. However, although rare, pregnancies do occur while using hormonal/LARC methods. From a clinical standpoint, one in 100 women will become pregnant while using the IUD (Hatcher et al. 2011; Guttmacher 2014); however, if someone knows or hears about that person who became pregnant, their individual perception of risk may be heightened.

It is also important to point out that while teens often heard negative stories from peers and others about hormonal contraception, it did not always impede their adoption of a method. Kamilla, a Depo user, filtered out the information she received based on the perceived quality of the advice:

“Sometimes people give me bad thoughts, like, I don’t know why you’re getting on birth control ‘cause you’re gonna wind up pregnant anyway...I pay it no mind. Like, I heard you but I can’t hear you. It’s going in one ear and going out the other ear. If I think that it’s not good advice, I’m not gonna listen to you.”

Similarly, Laura’s sister and others expressed concerns about her use of the Mirena IUD because she no longer had a period, which they believed would cause problems when Laura wanted to have more children in the future. While somewhat conflicted about the validity of this information, she continued to use the IUD:

“Everybody tells me, ‘Oh it’s not good not to have your period, ‘cause you know it’s bad, ‘cause you know, they would always tell me that it’s really bad ‘cause I couldn’t have babies and this and that, and I’ve seen it on TV, that you know, holding the menstruation that later on I will have problems not having kids or I won’t have kids at all. Sometimes it makes me scared. Sometimes I don’t believe it and sometimes I do.”

Beatriz, a hormonal implant user, completely dismissed the concerns her friends articulated about using birth control:

“My friends don’t use birth control at all. Like, they don’t want that ‘cause they think it’s gonna affect them in the future. And I’m like, ‘Oh my god, y’all are so dramatic and you need to check yourself, ‘cause you never know. You could get pregnant like this and you’re mad young to have a baby. You don’t have a job, you don’t have nothing.’ So I decided to get on the birth control and they were like, ‘Don’t do it that’s not good!’ And I’m like, ‘No, I’m getting on birth control. It’s my body, it’s me, it’s not y’all.’”

OPINIONS AND INFLUENCE OF PARENTS ON METHOD CHOICE(S)

As described earlier in this chapter, a substantial number of participants reported having conversations with parents, and in particular mothers, about sexual activity and protection. A smaller proportion of participants sought advice about what method to use when they became interested in initiating contraception. After Josefina told her mother she had started having sex, she went to the clinic to discuss available options with her doctor. Before making a final decision, she went home to discuss further with her mother:

“I had asked my mom if I should take the shot or the pill. Oh, and I told her about the IUD. She was like, ‘Don’t take the IUD or the shot.’ She says ‘cause the shot made her gain weight. And she told me to take the pills, and so that’s what I did.”

Beatriz explained the conversation she and her mother had regarding available methods before eventually choosing the hormonal implant:

“...I was talking to her [my mom] about BC and she said, ‘You should go on the shot, but at the same time you should not, because I was on the shot,’ and also my aunt got fat. So I said, ‘I’m not getting that.’ And then the IUD, she said, ‘Oh, that’s inside you, it has a little stick, you know, when you wanna take it out. And then she was like, ‘What if he’s fingering you and he takes it out?’ And I was like, ‘Oh my god, you’re really thinking about that.’ And then I didn’t ‘cause then I thought about it too and I was like, true, what if something like that happened or what about if we’re doing it and he’s hurting me down there because I have it? So then I’m like, I’m not getting the IUD. And then the little circle - the ring - she was like, ‘You should not get on that one.’ And I’m like, ‘Why?’ Like I thought it was a ring, but no, it’s a big thing. And I’m like, wow, no. When I saw it, I was like, ‘No way, I’m not getting that.’”

Other participants based their decisions, in part, around what methods their mothers had used.

When Lucia stopped using the birth control pill due to frequent yeast infections, she decided to try the Depo shot, since it was more effective and her mom had used it:

“The Depo, it was, you know, my mom used the Depo so I’m like, okay, let’s try the Depo. My mom uses it, why can’t I use it?”

Alternatively, some teens whose parents were not aware that their daughter was sexually active and/or did not support their use of contraception chose not to discuss birth control methods with their mothers. For these participants, method selection was influenced by their mothers insofar as they required secure places to hide it. For example, after Carolina’s mother discovered her box of birth control patches and they had an argument, she started throwing away the boxes and keeping the individual patches in her wallet. She explained:

“She found the box of patches once and got really angry with me. So she’s like, ‘What are you doing?’ And I had to lie ‘cause I wasn’t gonna deal with her anger so I said, ‘Oh, I was doing my friend a favor. She wanted birth control and she don’t got health insurance at this point so I kept them for her.’ So she threw them out...I was like, ‘You could throw them out, I’m not on it.’ She [the medical provider] gave me three boxes before but now it’s one box. She’s like, ‘Take a box at a time,’ so I’m like, ‘Ok.’ So I hide it. My mom - she finds everything! I’m like, I don’t know how I’m gonna do it now, so all I do is I throw away the box and put the patches in my wallet. My mom’s not gonna look for it there. She just thinks I have card and money in there.”

Although Vanessa started using birth control pills to help regulate her period, she was not comfortable telling her mother she was using them. Therefore, she hid the pills in her school bag along with other medications and vitamins:

“...My reasoning to take it [pills] is for my period and I don’t like telling my mom about it ‘cause I literally have to sit down and explain to her, and I don’t want to have that conversation. [The pills] are in my bag. There’s a pouch where I keep my make-up and pads, and I put it in there. She looks around everything and she does find stuff. I always have an excuse for everything ‘cause...it has a whole bunch of pills in it...and I tell her it’s for my hair, my skin, my nails...’cause I do have those pills.”

OPINIONS AND INFLUENCE OF MALE PARTNER(S) ON METHOD USE

Among the teens who were using a hormonal or LARC method and reported currently being in an intimate relationship, virtually all indicated that their partner was aware that they were using “something.” Additionally, the majority of teens suggested that their partner was

supportive of their use of contraception. For some participants, the “approval” or agreement of their boyfriend was obtained before initiating a method. Ana described the conversation she had with her boyfriend prior to starting the Depo shot:

“... We don’t want kids now so I believe that if you get pregnant it’s because you really wanted to, because there’s so many different methods for you not to. So I told him I wanted to try to shot and he agreed with me.”

Similarly, Josefina told her boyfriend she was interested in using birth control pills:

“He was okay with it. He was like, it’s better. And then he started to get information from his friends, and then I got on it. He agreed.”

Samantha’s boyfriend supported her use of the birth control pill, even setting a daily alarm on his phone to remind her to take it:

“...I told him, like, ‘I’m just gonna do the pills,’ and he was like, ‘Fine, I agree,’ and such and such, ‘cause we’re not okay with having a kid right now so...Me and him have the same alarm [to remember to take BC] at 10:00. So every time my alarm goes off, his does too and he’s like, ‘Did you take your pills?’

In addition to sharing interest in and seeking approval for use of contraception, a number of participants also discussed available options with their partner, often at length, before choosing a method, although the extent to which their opinion mattered varied. At the time of the interview, Sofia was using condoms, but had made an appointment to have an IUD inserted the following week. Prior to making this decision, she discussed it with her boyfriend:

“...He’s like, ‘You feel comfortable? You sure do you want that? They put that little thing inside...’ I’m like, ‘Yeah.’ He’s like, ‘Why you don’t try the pill?’ I’m like, ‘Because with the pills I feel dizzy and I don’t like the needles with the shot.’ He’s like, ‘It’s fine, well you use [your] birth control and I use my birth control, we’re gonna be safe.’”

Likewise, Naomi had scheduled an appointment to have an IUD inserted after she and her boyfriend researched available methods:

“...He read up more about it, more than I did. He asked people and brought information to me.”

Ximena was familiar with all of the contraceptive methods available due to her previous experience working in a mobile health clinic. She and her boyfriend made the decision for her to use an IUD together:

“I was like, ‘Ok, what do you think is a good idea? I know what I think, what do you think?’ He’s like, ‘Um, you know, something that you don’t have to think about all the time is the best thing.’ ‘Cause you know, pills for example, like with my medication, I can’t remember to take it. I choose not to remember to take it. I was just like, I don’t wanna worry about it either. He’s like, ‘Either Depo, the frickin’ tube, the hormonal tube, or IUD,’ and I was like, ‘I kinda want IUD ‘cause it lasts a long time...’”

Fabiana’s boyfriend was initially concerned that she would miss pills, but after discussing it, they decided that it was a safer and more “responsible” option than others she was considering:

“...Like, at first he told me that he wasn’t really sure about the pill ‘cause he told me like, ‘What if you miss a lot of days?’ I told him that that’s what the responsibility is, you’re supposed to remember so you’ll know it’ll work for you. So I told him about the IUD; I was thinking about getting it but at the same time he told me not to, ‘cause...he knows I’m gonna be flipping out about everything that happens with it. He’s better off me being on the pills where he knows I’m taking it and I know I’m taking it and even if I miss a day, I could always go back and take the pill that I missed. So I feel more responsible with the pills than me being on something that I wouldn’t know what’s going on.”

Four participants who were in a relationship indicated that their partners did not initially or currently support their use of contraception. For example, Justine had recently stopped using the Depo shot and was undecided about whether she would fill the prescription for oral contraceptive pills her doctor had given her. While she and her long-term boyfriend, Marcus, were in agreement that they did not want to have children right now, they did not have extensive conversations about it:

“...Like every time I get on the birth control, he knows, but we don’t sit down and talk, like, we know we don’t want to have no babies right now.”

Justine did not think Marcus wanted her to continue using birth control, a question she posed to him directly during the interview, as she opted for Marcus to join us. When asked whether she thought he would support her starting the birth control pills, she replied:

“Let me ask him. ‘Listen! [Motions towards Marcus, who was sitting diagonally from Justine listening to music with headphones] Do you support me using birth control?”

After mumbling something that sounded like, *‘I don’t know how I feel,’* Justine responded:

“‘No, you remember. You told me that you wanted me off the birth control, that it was the same thing...that it don’t clean the body, all that backed up blood and stuff.’”

Beatriz’s boyfriend was worried that her using the hormonal implant would impact her ability to have children in the future. She explained:

“He didn’t want me to get on birth control at all. He’s like, ‘Then it will affect you in the future. Then we can’t have kids,’ and I was like, ‘I don’t know why you’re thinking about kids right now, ‘cause I’m not thinking about kids, stop thinking about kids, we’re not having kids!’ Oh my god. And he’s like, ‘You never know, it might affect you in the future,’ and I’m like, ‘Oh my god that’s not gonna affect me. They told me about everything...now I’m more informed about this stuff.’...I’m like...it’s me not you. Who’s gonna carry that baby for nine months? Me right? I don’t want that, I don’t wanna have no babies. I’m 17, I’m young still.”

When Daniela and her boyfriend had been together in the DR, they had not been using any form of protection, but when she came back to the States, she told her doctor that she was interested in trying the hormonal implant. At first, her boyfriend was hesitant about Daniela starting on a birth control method because they had discussed having a child together while in the DR, but ultimately they agreed that it was not the right moment for them to start a family:

“I told him that I was gonna put this one on [the hormonal implant]. He told me, ‘Ohh,’ stuff like that, and, ‘What, you don’t wanna have a kid with me?’ I’m like, it’s not that but it’s not the right moment and stuff, it’s like we still young and stuff like that. We need to just first look up to the future, school, and then when we’re really ready for it, that’s when we’ll have it....So I told him, it’s not the right moment, and so he’s like, ‘Yes I agree with you, we could wait.’”

An unexpected finding that arose over the course of these discussions about partners’ support of contraception was that a small number of teens indicated that past and current boyfriends wanted them to become pregnant or would be happy with that outcome should it

arise. For example, when I asked Beatriz why she thought her boyfriend wanted to have a baby with her right now, she explained:

“...He’s like, I wanna get you pregnant, and I’m like, no you cannot get me pregnant! Like I wanna know...why do you wanna have a baby so badly? Like you have a baby then y’all don’t take care of the baby...I’m like, you need to relax. I go to school right now and you don’t have a job. I’m not gonna have a baby when I’m still living with my mom, you’re still living with your mom, and no, that’s not gonna work. That’s not how I want to have a baby...But he’s like, ‘In 3 years?’ And I’m like, ‘Yes, 3 years. 3 years!’ And he was like, ‘You know how some people are like, oh, I shoulda gotten you pregnant before you got on birth control?’ I’m like, ‘I woulda killed the baby!’ And he’s like, ‘No, you wouldn’t!’ And I wouldn’t, but no, thank god I got on the birth control.”

Beatriz’s explanation for her partner’s desire to have a child with her suggested that doing so would solidify a bond between them and demonstrate a high level of commitment to each other, but also hints at potential issues of control. While unable to ascertain the value of having children for young men in this research, a limited number of studies have explored this issue. One recent study found that male partners’ desires for pregnancy may influence female partners’ contraceptive use (Schwartz, Brindis, Ralph, and Biggs 2011).

ASSESSING RISK

In considering the various intrapersonal, interpersonal and social factors described earlier in this chapter that may shape contraceptive choices, many teens weigh perceived benefits against costs in order to make decisions. Part of this calculus also involved an assessment of the risk particular methods posed relative to their advantages. It is important to highlight that both risks and benefits are situated within a broader context of one’s history and experience, personally defined, and nested within larger social structures and processes. As such, they do not necessarily align with biomedical risks and benefits assigned to various methods. For example, as described in chapters one and three, an increasing trend towards promoting contraceptive methods based on efficacy has been observed in both the literature and by influential

professional associations and government agencies. From this vantage point, clinical efficacy is the primary consideration in method selection. Moreover, there is an assumption made that distinctions between the typical use effectiveness of the oral contraceptive pill, at 91%, and that of the hormonal implant, at over 99%, are meaningful to women choosing between the various methods.

However, interviews with young women in this study overwhelmingly revealed that the clinical efficacy of hormonal/LARC methods is only a small part of the decision, with many other considerations taking priority over it for most participants. Zoe, a former pill and now condom only user, described her thought process regarding the risks and benefits particular methods posed:

“Um, I didn’t wanna do the Depo Provera um, because...I heard it makes you gain weight and I didn’t like the fact that you might not have your period for, like, the whole time you’re on it. So you might spot but you might not get your actual period. And it’s like, three months is a long time. Um, everything else just seemed like a little more risky, so I chose to take the pill...like, I know the side effects for some of them might be the same, but like, when you’re on the pill you have your period, and it like lightens up the cramps and things like that, um, it’s effective if you take it every day at the same time, um, I don’t know...I guess it would fit more into what I’m comfortable with.”

For Zoe, side effects, and in particular, significant changes to her menstrual cycle superseded other considerations about method selection. Before Josefina decided to start using birth control pills, she had ruled out particular methods – namely, the IUD and Depo shot – after discussing them with her mom, whose opinion she valued highly. When asked if there were any other methods she would consider, she mentioned and quickly excluded the hormonal implant:

“That one looks interesting, but I didn’t wanna risk it, so I got the pills ‘cause I feel like I’m more sure and I’m good at reminding myself to take it all the time...”

Alejandra, a current pill and condom user, described the importance of her choice being uncomplicated and safe. When asked how she decided on using the pill, she replied:

“I heard like really bad stuff about the other ones, like the one that goes up your vagina...like my sister’s friend, she has that, and like, she’s pregnant or something... and it’s like all the way up there and, like, they can’t find it in her thing so there’s a possibility that she needs surgery. Like, I don’t like need that. I have pills, like...I don’t do all that stuff.”

While the risk of complications due to IUD use is rare, in this case, Alejandra learned information that made her unwilling to consider it, despite its high efficacy to prevent pregnancy.

Alternatively, Sofia had experienced a previous ectopic pregnancy³⁵ while not using contraception. Additionally, she had tried birth control pills, but stopped using them because they made her feel lightheaded and nauseous. Her decision to consider the IUD was partly the result of these earlier experiences:

“I was, like, reading about the other options, like the ring and the patch...they’re gonna make you feel the same thing [as the pills], and I don’t wanna go through a shot because I don’t like that. And I think there’s another one, they put it in your arm, and I don’t like that one...I don’t like that feeling, so I think that the IUD is more better for me and I gonna feel more comfortable.”

It was very common for teens to report experiencing side effects associated with hormonal contraception, most notably headaches, dizziness, weight gain, bloating, and moodiness, which sometimes led to their discontinuation. These side effects will be discussed in greater detail later in this chapter. However, for others, side effects were balanced against the benefits of being on contraception conferred. For example, Alyssa had been using the Depo shot for over two years. She described having experienced a number of side effects, including headaches, weight gain, irregular and lengthy menstrual bleeding and mood swings. Despite these outcomes, she was committed to staying on the Depo shot for the foreseeable future. When asked what the pluses were to continuing on the shot, Alyssa explained:

“Well, it’s birth control, so I can have unprotected sex with a clean person and yeah...and then I won’t get pregnant. Well, there’s a 98% chance I won’t get pregnant.”

³⁵ An ectopic pregnancy occurs when a fertilized egg implants outside of the uterus (Mayo Clinic 2015).

Um, I don't know...Some people are really really skinny and they gain a little weight. So I'm kinda happy, it's kinda hard to maintain, but yeah, I like that...There's a lot of reasons, I guess you could say."

Valeria did not like getting the shot, as she was afraid of needles, but this fear was outweighed by the importance of protecting herself from getting pregnant:

"I'm scared of the shot, I cry, you know, every time, 'cause I'm so scared of it, but it's good 'cause I need to protect myself... Um, I like to use the shot because I have seen some teenagers that they got pregnant. They don't have no house, they living with the rules of their parents, they need to drop school for them to get a job to buy stuff for the baby. My cousin is 17 and she was working in McDonalds, and she buy all the stuff for the baby, and her boyfriend, he didn't buy nothing for the baby...I don't wanna be her. That's why I use my condoms and I protect myself and that's why I always come here."

Likewise, other participants voiced the importance of preventing pregnancy at this point in their lives, which made the disadvantages more tolerable.

OTHER PREGNANCY RISK REDUCTION STRATEGIES

In understanding the full picture of pregnancy prevention strategies employed by teens, it is important to point out that other risk reduction techniques were frequently mentioned by participants either in addition to or instead of condoms and contraception. Withdrawal, or the "pullout method", was the most common. In Leah's last relationship, she and her boyfriend were not using condoms and she had not yet started on the patch. To help minimize the risk of becoming pregnant, they practiced withdrawal, in addition to occasional use of EC:

"He didn't like to wear condoms, that was one of the issues. He said the condom takes the feeling out of everything...He wouldn't do that [ejaculate] inside of me, he would always, like, go somewhere else. So I had no worries about that. 'Cause he didn't want me to have that [become pregnant]. He'd always tell me to go to the nurse if I wanted to be safe or be sure."

While Laura was not fully aware that she could become pregnant at 13, she and her boyfriend also practiced withdrawal in the absence of other methods:

"We would use the pull out, pull out thing. I never thought I was gonna...[get pregnant], 'cause that's what he would do."

A number of participants also reported using EC when they were unsure whether they had used their regular method of contraception correctly, a condom had slipped, or no method was used.

Josefina described a common scenario that resulted in her taking EC:

“...There was one time where I forgot my pill, so then I was like, I’m not...I’m just gonna pop the Plan B ‘cause I can’t risk it.”

Finally, a few teens reported using both a hormonal/LARC method and condoms. This prevalence of this approach to both pregnancy and STI prevention is lower in the United States relative to Western European countries, and in 2009, the percent of public high school teens in NYC reporting dual use was approximately 8.5% (Higgins and Cooper 2012; NYC DOHMH 2011). Recently, a campaign on the importance of dual protection was launched in the south Bronx by the NYC DOHMH with teens as the intended audience, reflecting the city’s emphasis on both forms of protection to combat concurrently high rates of unintended pregnancy and STIs among youth. Among the teens in this study, dual method use was rare, but not absent. Vanessa described her rationale for using both condoms and birth control pills with her boyfriend:

“I like condoms. ‘Cause pregnancy isn’t the only bad thing you should be looking out for. I’ll feel better if he has one on.”

Similarly, Samantha noted that she and her boyfriend continued to use condoms after she started using pills:

“I always stop it, like, do you have condoms? Even though I’m on birth control I still use a condom ‘cause it’s like double protection...And I made him get checked too. And I made him show it [the STI test results] to me. And I made him show my mother too.”

METHOD SWITCHING

Table 8.3 shows the number of interviewees who reported having ever tried the methods listed in order of frequency. The majority of teens, 23, reported ever using condoms, with birth control pills being the most popular hormonal/LARC method, tried by 12 participants. The next

most frequently used method was the injectable shot, followed by the patch, with nine and six teens reporting ever use, respectively. The vaginal ring, hormonal implant, and IUD were each ever used by two participants, representing the least widely used methods.

Table 8.3. Number of Participants Who Reported Ever Use of Contraception by Method³⁶

Contraceptive Method	Number of Participants Who Reported Ever Using the Method
Condoms	23
Pills	12
Injectable Shot	9
Patch	6
Ring	2
Hormonal Implant	2
IUD	2

Hormonal/LARC method switching among the teens interviewed for this study was relatively common. While 14 participants had only used one of these methods at the time of the interview, nine had tried two to three other methods. Among this latter group, differences in method switching among younger (15 to 17 year-olds) and older (18 to 19 year-olds) teen participants were negligible; one teen was 15 years old; four were 16; three were 17; and one was 18.

While overall relatively proportionate, there were some differences between the approximate time between first sex and use of hormonal/LARC methods among method switching versus non-method switching participants (see Table 8.4). Most notably, there was a larger proportion of method switching participants who initiated hormonal or LARC methods in the first six to 12 months after sexual debut versus non-method switching participants. Additionally, a greater proportion of non-method switching participants selected contraception prior to the onset of sexual activity versus method switching participants; however, due to the small number of participants in each subgroup, these findings should be interpreted with caution.

³⁶ Due to method switching, method totals will exceed the total number of participants in the sample.

Table 8.4. Approximate Time Between First Sex and Hormonal/LARC Use Among Method Switching Participants

Approximate Time Between First Sex and Hormonal or LARC Use	Number of Non-Method Switching Participants	Number of Method Switching Participants
0-6 months	2	1
6-12 months	3	3
12-24 months	4	3
36 months	2	1
Selected prior to onset of sexual activity	3	1

The most common reasons provided for switching from one hormonal/LARC method to another were side effects, dissatisfaction with the method, and concerns about the method's safety. Coinciding with results presented earlier in this chapter, the most common side effects experienced that resulted in switching methods were weight gain and irregular bleeding. At the time of the interview, Laura, 16, had tried five hormonal/LARC methods in the almost three years since her son was born. She started with the Depo shot, but stopped using it after approximately six months due to weight gain:

“So I remember...after giving birth, there was, like...a lot of things [reading material] on birth control. I had nothing else to do but read, and I didn't know none of this, so I was getting interested in it...and then I was telling my sister about it and I decided to get on the shot...I had it for like almost a half a year, and I didn't like it. ‘Cause I was gaining a lot of weight, and I just decided to get off it.”

Isabel, 18, had used oral contraceptive pills before switching to the hormonal implant because she was interested in having a less frequent period.

“First I was doing the pills, and I decided I didn't want to do that, like, it's not that I didn't like anything about it, it's just that because told me that you can't get your period [when using the hormonal implant].”

She switched to the hormonal implant after one month of pill use, but found that instead of making her period lighter, the implant caused her to bleed constantly. After having the implant removed, Isabel went back to the birth control pills, which she was using at the time of the interview.

After discontinuing the Depo shot, Laura briefly tried birth control pills and the patch before having an IUD inserted. Like Isabel, Laura also experienced changes to her menstrual cycle; namely, a heavier period and “horrible cramps.” Although otherwise satisfied with this method, Laura decided to switch to the Mirena IUD when a friend told her that using it made her periods go away. At the time of the interview, she had been using this IUD for over a year. While her periods have largely disappeared, she expressed dissatisfaction with the Mirena IUD due to cramping:

“I don’t like it as much [as the copper IUD] ‘cause...I like it but it gives you a lot of cramps, like it goes from here to here [gestures from her stomach to below her pelvic region] and it hurts. You’re getting your period but you’re not.”

Dissatisfaction not related to side effects was also a common reason to switch methods. For example, some participants disliked or were confused by how to take the birth control pill properly. Brittany, 15 years old, started on the pill before switching to the patch and then the vaginal ring. Of her decision to start with the pill, she explains:

“Because I thought that was the easy one. But then, after I went through the whole cycle, it really wasn’t ‘cause you have to remember the same time that you did it yesterday and take it like that.”

Similarly, Laura started using oral contraceptive pills after she discontinued the Depo shot. She tried the pills for about two weeks before deciding that it was too difficult for her to remember to take them consistently:

“I came here [to the health center] to get the pills. And I didn’t like it, ‘cause you know, I would take them wrong. I didn’t even know. ‘Cause the lady [clinician at the school clinic] explained it to me but I didn’t understand how she explained it to me. I thought she said just take one every day, doesn’t matter what hour. So I would take one at 1:00, at 2:00, and then I realized that you have to take them at the same time. So then I didn’t like it, so I decided to give that up.”

Several participants also stopped using the patch because it did not stay on properly or it left marks on their skin that they did not like. Vanessa explained her rationale for switching from the patch:

“I didn’t like it ‘cause when I take showers it will come off and then it’s not sticky anymore and I can’t put it back on my skin. So I’m like, this is dumb.”

Brittany started using the patch because she “thought that would be easier than the pill,” but found that it left marks on her skin, so she stopped shortly afterwards. Likewise, Laura used the patch briefly between the birth control pills and the copper IUD, but stopped using it due to the marks it left on her skin and concerns that it was not an effective method. She explained:

“I didn’t like it ‘cause, like, it would leave you a sticky mark right there once you take it off and I’m like, ‘Oh, no.’ And I was scared ‘cause people said it’s not 100%, it’s like 50%, so I’m like, I’m not getting that. So I took it off and decided not to use that.”

HORMONAL/LARC METHOD DISCONTINUATION

The previous section described reasons for and circumstances surrounding teens’ decisions to discontinue one hormonal/LARC method and switch to another. In addition, five participants discontinued use of a highly effective form of contraception and had not initiated a new method at the time of the interview. The reasons to discontinue a method were largely the same as those articulated above – experiences with side effects and menstrual irregularity; however, some additional nuances warrant further investigation. Table 8.5 shows participants who discontinued a method, the reason provided, and whether they indicated any interest in starting a different method at the time of the interview. The table is followed by brief vignettes about each participant’s contraceptive use trajectory and salient factors that shaped their decisions to ultimately discontinue use.

Table 8.5. Reasons Given for Method Discontinuation and Interest in Other Methods Among Non-Hormonal/LARC Using Participants

Participant (pseudonym)	Age	Reason for Hormonal/LARC Method Discontinuation	Interest in Starting a Different Hormonal/LARC Method
Lucia	16	Desires Pregnancy	No
Justine	17	Menstrual Irregularity	Unsure
Zoe	17	Side Effects	No
Daniela	19	Side Effects	Yes
Sofia	19	Side Effects	Yes

LUCIA

Lucia’s contraceptive use trajectory spans several years while in a long-term relationship with her boyfriend. They had tried using condoms once or twice but did not continue to use them because they caused irritation and itchiness for Lucia. She initiated her first hormonal method (oral contraceptive pills) shortly after they began having sex, but stopped using them because they caused frequent yeast infections. After that, she decided to try the Depo shot, which she maintained for about nine months, discontinuing it due to amenorrhea, concerns that she would not be able to get pregnant right away after discontinuing, and a desire to become pregnant. Afterwards, Lucia briefly tried the vaginal ring “out of curiosity,” but ultimately decided to stop using all forms of contraception several months before the interview in an attempt to conceive with her boyfriend. In Lucia’s case, a constellation of factors shaped her uptake and discontinuation of methods, including experiences with side effects, concerns about her fertility and shifting attitudes towards pregnancy.

JUSTINE

Like Lucia, Justine was in a long-term relationship. She and her boyfriend used condoms sporadically, if at all, for the same reasons articulated above. At 16, Justine became pregnant and started the Depo shot after the termination. After having been on the shot for over a year, she decided to stop using it because she was dissatisfied with the changes caused to her

menstrual cycle (amenorrhea) and concerned that the hormones in the shot would interfere with her ability to become pregnant in the future. During the interview, for which Justine's boyfriend was also present (at her request), her medical provider came into the room to obtain some follow-up information from Justine. Below are my field notes from the exchange:

Completed an interview with 17 year-old at the pediatric clinic today. The participant was still finishing up her visit when I approached her, so I ended up sitting in the interview room speaking to her boyfriend for a while before she was able to join us. We were about halfway through the interview when her doctor came in and pointedly asked what the interview was about. I told her it was for a study on teen health, to which she replied, 'Oh, good,' and with a stern look, continued, 'These two need to be using birth control.' She then motioned for the interviewee to come see her. When they left the room, the participant's boyfriend and I said nothing for a moment before he noted how awkward and uncomfortable the exchange was. Field Notes, November 19, 2013

When Justine returned from meeting with her provider, she explained that the doctor had given her a prescription for birth control pills. I asked her if she had come to the clinic that day wanting to start on a new birth control method, to which she replied:

"No, she just suggested it...because I don't like that shot...I woulda never even...Because my plan was not to get that birth control anymore...But she came to me with it. I don't want to do it but - I'll do it. She told me to start today as soon as I go get them."

Although Justine did indicate that she would pick up the birth control pills from the pharmacy, she also expressed hesitation about starting on another hormonal method. Her boyfriend's concern about the safety of using birth control mentioned earlier in this chapter also may have contributed to her ambivalence about this decision.

ZOE

Zoe, a self-described consistent condom user, was in a long-term relationship at the time of the interview. She had started using birth control pills after becoming sexually active, but had stopped the previous month due to side effects relating to sexual arousal. Zoe explained:

"Um, I told the doctor that, like, sex, if I'm aroused, it doesn't really show, it's like – she said it has something to do with the hormones in the pill or something like that. So like, I

wouldn't say dry, but...I stopped the pill and then I noticed, and then I went back on and then I noticed the same thing, so I was like, it must be the pill."

While Zoe indicated that she would like to have an additional "back-up" to the condom, she was hesitant about going back to a hormonal/LARC method due to the issues with sexual arousal, the importance of having a regular monthly period, and the need to find an option about which she felt comfortable.

DANIELA

Daniela tried the Depo shot several years prior in a previous relationship in which she and her boyfriend were also using condoms. She discontinued the shot after the first three months due to weight gain and heavy bleeding, which contributed to feelings of depression:

"...I put it on but the problem is it was making me gain more weight. I was at the time losing weight and I wasn't...if there was other stuff it will help me out better... 'cause I'm not going to make the work of going to the gym, being on a diet or whatever, while the shot is going to make me gain the weight...I was also getting my period very heavy and getting it more...So I just got into a depression with that and I decided I'm not gonna put it on no more."

In the fall of 2012, Daniela became involved with her current boyfriend while she was staying in the DR. While there, they did not use condoms, and for a period of time, considered potentially having a baby together:

"...In the moment, I don't wanna lie, 'cause in the moment and stuff like that, he wanted me to get pregnant, and I also wanted to. And maybe that's why we wasn't using condoms and stuff like that because we [were] both thinking about...But then when it was time for me to come back [to New York], then I got here, I just started thinking and getting everything into my mind, and seeing what my sisters are going through with the kids they already have. It makes me think and say no, it's not something that I want. I'm already in school; let me just finish school, and when it's already time that I know I could have a child, then I'll have it."

Once she returned home, she decided to make an appointment with her doctor to find out if there were any physical or biological issues that may make it difficult for her to conceive and ask her about the hormonal implant. Daniela's contraceptive use history underscores the concurrent

influence of intimate partners, personal assessment of pregnancy risk and ambivalence towards pregnancy on decisional processes about reproduction.

SOFIA

Lastly, Sofia was currently using condoms with her boyfriend, Luis, with whom she had broken up and gotten back together once over the past two years. During their split, she became involved with Diego and decided to try birth control pills because he did not like to use condoms. Sofia only used the pills for a month because she felt dizzy every time she took them. Of her decision to start using pills, Sofia explained:

“Because I was saying, ok, the pills is more easy, more comfortable, I just have to drink it, like, every day at the same time. But then I feel like dizzy and everything like that and I’m like oh, this is not gonna be good for me, so I stopped.”

After that, she and Diego continued to sporadically use condoms, until she eventually became pregnant. Because the pregnancy was ectopic, a miscarriage was induced. According to Sofia, the experience made her re-evaluate the importance of preventing a pregnancy:

“...After that I was thinking, I’m too young. I don’t want to have babies. I want to finish my high school. So after that we started using condoms.”

Later, Sofia discovered that Diego had been cheating and had transmitted chlamydia to her, so they broke up. Months later, she got back together with Luis. While they were more consistent in their condom use, Sofia’s earlier experience with a previous pregnancy had elevated the importance of being protected. She explained:

“I wanted something that’s just to protect myself ‘cause I don’t wanna pass through that and get pregnant.”

At the time of our interview, she had made an appointment to have an IUD inserted. Again, Sofia described her rationale for method selection:

“Because I was like reading the other options, like the ring and the pills, they’re gonna make you feel the same thing. And I don’t wanna go through a shot because I don’t like

that. And I think there's another one, they put it in your arm, and I don't like that one...I don't like that feeling, so I think that the IUD is more better for me and I gonna feel more comfortable."

In addition to reiterating some of the same themes found in other teens' narratives, Sofia's story highlights the fact that attitudes about particular contraceptive methods may shift over time as experience accumulates and new perspectives materialize. The first time Sofia selected a method, the pill seemed like the right choice and the one with which she was the most comfortable. However, after experiencing the side effects associated with the birth control pill and a subsequent pregnancy, the IUD emerged as the "best" option.

CONCLUSION

This chapter presented findings from female youth about the broader social and familial contexts within which sexual and reproductive decisions took place. While the study design did not allow for a more ethnographic examination of teens' lives, the structural vulnerability within which many participants lived was alluded to in their descriptions of neighborhoods and schools, family hardships, and relationship trauma. Despite these experiences, interviews with female youth underscored the often significant responsibilities these young women manage and provided insight into the motivations and rationales for sexual and reproductive health decisions. Many female youth in this study employed a complex cost-to-benefit analysis in their contraceptive selection process that was informed by the level of communication with parents, relationships dynamics, new experiences and information gathered, personal comfort with the method, and perceived risks posed by available options, including menstrual cycle disruptions, possible complications, and effects on future fertility. The following chapter examines perspectives about reproduction from RH stakeholders, HCWs, and female youth, including an

examination of the perceived causes and outcomes of teen childbearing and diverse conceptualizations of planning and intention with regard to pregnancy.

CHAPTER NINE

PERSPECTIVES ON REPRODUCTION

This chapter addresses female youth, health care worker, and reproductive health stakeholder perspectives on reproduction. In particular, it explores how HCWs and RH stakeholders conceived of the psychosocial, family, cultural and socio-economic causes and consequences of pregnancy and childbearing during adolescence, as well as the socio-cultural values underpinning these explanations. While many participants acknowledged the complexity of adolescent reproduction, offering nuanced viewpoints and distinctions about its meaning, virtually everyone considered it to be undesirable and indicative of a broader “problem.” The chapter also examines the diverse meanings and values assigned to planned and intended pregnancies by all three groups of interviewees.

PERSPECTIVES ON THE CAUSES OF ADOLESCENT PREGNANCY AND CHILDBEARING

In order to better understand the ways in which goals and strategies to promote greater use of hormonal/LARC contraception among teens are approached, HCWs and RH stakeholders were asked to reflect and provide their opinions on the causes and effects of pregnancy and childbearing during the adolescent years. The distal causes identified by participants will be discussed by level of perceived “causation”: individual; family; community; and broader societal forces. However, it is important to point out that although these levels of influence have been separated out for the purposes of analysis and reporting, HCWs and RH stakeholders

overwhelmingly articulated multiple intersecting causes and factors they believed contributed to the occurrence of pregnancy during adolescence.

THE INDIVIDUAL LEVEL

One of the most salient ways in which both HCWs and RH stakeholders explained the causes of pregnancy and childbearing during adolescence was through the lens of development. Virtually all participants conceptualized the years between approximately ten and 21 as a discrete biological, cognitive, and behavioral period of development, and its relationship to sexual behaviors, decisions, and outcomes was evoked frequently during interviews. In particular, participants frequently referenced the still developing “adolescent brain” to explain why pregnancies occurred among this population. For example, Janelle noted the influence of brain development on adolescents’ limited ability to plan ahead regarding the prevention of unintended pregnancies:

“... You know, when working with adolescents and talking about, well what are your hopes? What are your dreams? And then it appears that their decision-making around contraception and relationships or whatever don’t seem to be in sync, um, or you know, if I get pregnant I’ll deal with it. Um, some of it is really, what is currently a better understanding of neurologically with the adolescent brain, which isn’t really fully developed. I think that has added additional information as far, sometimes, as the difficulty in young people having the ability to be projecting out ten years from now or five years from now or whatever.” [Former Director, Youth Development Organization]

Within this framework, the developmental stage of adolescence was characterized by key features and descriptions among participants, including an inability for adolescents to think abstractly or consider the consequences of their actions, and a propensity for impulsivity. Carmela pondered the continued “problem” of pregnancy during adolescence over the past three decades, despite better methods to prevent it and greater confidentiality of services:

“There has to be a bigger reason because it’s been a problem certainly since I’ve been in practice which is 30 years... certainly there’s more ability to not get pregnant now. There’s confidentiality, there’s all kinds of reasons why it shouldn’t still be a problem but

it is. And I think a lot of it is just adolescent young adult psychology that you just live in the moment; you don't think about it...I just read something recently about how adolescent brains are wired different. They can't put a cause and effect together. And you see that in a lot of decisions they make. They sort of don't realize that, yes, I have to fill out this paper by this date or they're not gonna get into this program, but they don't fill it out. And it's like, what's the problem? It's just the way their brains are wired.” [SBHC medical provider]

Allison evoked developmental and biological rationales to explain why teens are often inconsistent users of protection to prevent pregnancies and STIs:

“...It's a big responsibility. It's all their responsibility...They have to take it, they have to be in charge of it, um, and...planning ahead, is not teenagers' best, uh, attribute. And I think their brain isn't developed in that way yet, there's a lot of connections that aren't made yet and it's just not how they're thinking...” [FMC medical provider]

Nancy noted the difficulty in assessing younger female adolescents' attitudes towards pregnancy, as she felt they were often not able to think abstractly:

“A lot of the young girls, they're not there. They're so concrete. Super concrete, so it's really about adolescent development and how they're able...can they think abstractly?” [SBHC medical provider]

Christina noted the role of invincibility, seen by many interviewees as an innate characteristic of adolescence:

“Some of that is...that invincibility where it's, 'Oh, that can never happen to me.' I don't know why so many young women believe they can never get pregnant, but they do.” [Senior Executive, RHS Organization]

Several HCWs also noted the developmental predilection for teens to behave impulsively and without consideration of the consequences of their actions. Alisha, a pediatrician, evoked this reasoning to explain why pregnancies occur among this age group despite, in her perspective, access to education and plentiful resources about prevention:

“I think developmentally teens just have a tendency to not really think through the consequences of their decisions. This day and age, condoms are just so widely available that it seems like there should be no reason for teens to get pregnant, especially when across the board the schools are doing such a great job with health education...”

Not surprisingly, RH stakeholders and HCWs frequently contrasted behaviors, decisional processes, and outcomes among adults and youth, often associated with particular connotations about responsibility and judgment. Andrea, a city health official, believed that adolescents simply had “more” of the characteristics that make it challenging for adult women to regularly use contraception, which affirmed her support for long-acting reversible methods for this population:

“So, you know, I think that what teens are...they have many of the characteristics or behaviors that adults do, but just more of them, if you know what I mean. It’s not like it’s so completely different than grown ups, like teens are so much worse about taking a daily pill. Everybody’s bad at that. So they’re just gonna be worse.”

Carla equated sexual activity with being an adult, thereby requiring teens who chose to engage in adult behaviors to act in concordantly “responsible” (i.e., adult) ways. About the importance of consistent contraceptive use, she commented:

“They [teens] have to understand that they have to use it consistently. If...you’re an adolescent and you wanna do adult things, you gotta take the adult responsibilities that go along with it, ok?...You can’t be an adult one minute and then revert back to a child. It’s either you’re in the game or you’re not.” [SBHC medical provider]

Adolescence was also characterized as a time of exploration and instability, particularly as youth may experience fluctuation in their intimate relationships and undergo physical changes that result in discomfort with their bodies, which was seen to influence sexual behaviors and decisions. Below, Ethan, a FMC medical provider, noted that the experiential and exploratory aspects of teen relationships may place them at greater risk for pregnancy:

“...One thing that may be different among teens...is...teens being more in flux with relationships and exploring and, um, being perhaps more risky with their behavior because they are exploring and they are learning at the same time about their sexuality and their bodies. I think sometimes that might result in situations that they haven’t anticipated and sometimes that’s pregnancy.”

Another prominent individual-level reason participants offered about the causes of pregnancy and childbearing during adolescence was teens' conscious desires to have a baby, which often fed into widespread perception that such teens are looking to fill a void due to a lack of love and support in their lives. Janina, a health educator at the FMC, explained:

"...I think some teens might feel alienated. They might want that baby, might want something to call their own. They're not getting the attention or the education that they need from their parents. Their parents might be working two, three jobs and they're not really getting that. So I think...that plays a role too."

Nancy described the connections she saw between mental health and cognitive decision-making among some of the teen patients she served, linking behaviors to their structural vulnerability:

"I find that there is a real subset of girls who, subconsciously, and I believe consciously, really want to get pregnant. Girls who want desperately to have something and someone to love and love them unconditionally and...the desire for pregnancy is really because their life sucks. Sucks. And I'm amazed that they get out of bed and come to school. And to have a baby would be something that they could do well perhaps. People notice pregnant women, people are nice to pregnant women...This baby, you know, as much as they can understand this, this baby's gonna love them and maybe in ways that they've never been loved before...It's real. It's a real thing."

A lack of other goals was also cited as contributing to the distribution and occurrence of pregnancy during adolescence. Michelle, a SBHC pediatrician, observed differences regarding goal-setting and a desire to delay parenting among teen patients who did not become pregnant or sought terminations versus those who became pregnant and chose to continue the pregnancy:

"...A lot of the ones who most recently I've referred for terminations, they've been like, 'Look, I'm graduating, I'm going to college. I'm moving out and doing something to better myself, so I can't deal with it.' Where I feel like...some of the ones who decide to keep [the pregnancy] are just, you know...they don't have a good grasp of doing anything with their future...I don't know if they just have this abstract, 'I wanna be a basketball player when I grow up.' And I'm like, 'Okay. Being Kobe Bryant is like one in a million, what's your back up plan?'"

Similarly, Tracy, a SBHC medical provider, described the associations she perceived between academic achievement and future employment goals, risk-taking behaviors, and adolescent

childbearing among her patient population:

“...For the most part, the ones that are college bound, you know, really into their studies, maybe they’re on a scholarship, they’re definitely not getting pregnant. They’re doing everything they can. For the ones that, I wanna say, poorer students, that there’s a lot of truancy, they don’t come to school, they’re in summer school. They just don’t care so much about their studies. Those are the ones that I see are having more of the unprotected sex, getting pregnant. And it’s kinda like stopping them from continuing but...it’s almost a self-fulfilling prophecy because I don’t think they would continue [with their education] anyway. They’re really not interested in going to work and going to school. They’re really interested in hanging out, having a baby, raising their baby. That’s what they want...Maybe the ones that have unprotected sex, or get pregnant, they think, ‘Well I’m not gonna go to college anyway. I’m gonna work at McDonalds for five dollars an hour. I might as well just get Medicaid and WIC and just raise my baby...”

Meredith, a SBHC mental health clinician contrasted expectations about teens’ futures by their social class:

“Also, you know, motherhood being sort of like a foreseeable role as opposed to maybe a kid coming from a different socioeconomic background understanding that maybe college and becoming a professional of some sort is the goal. But motherhood, which is obviously an important role in life as well for a lot of people, is one of the only options.”

The above quotes reflected a largely unquestioned assumption that attending college and having a career ought to be the primary goals for every young person. Although worthy and laudable ambitions, they elide the formidable obstacles many low-income youth face in achieving them, and in more subtle ways, dismiss other goals, such as motherhood, as failures. The comment below from Carla highlighted the differential value placed on particular life “accomplishments”:

“...They don’t see themselves doing anything. This may be the only accomplishment in their life that they’re gonna have, and it’s having this baby...They don’t see themselves getting out of high school, going to college, having anything to accomplish.”

Lastly, many participants observed a sense of hopelessness coinciding with limited social and economic opportunities among teens who become mothers. Nancy explained:

“I think probably the biggest cause of teen pregnancy in my patient population is lack of any hope in the future, in any other kind of a future. Number one by far...If a young woman feels like there’s really nothing else for her, then pregnancy doesn’t look so bad.”

Olivia, a mental health provider at a SBHC, described this lack of hope among some of her female patients:

“You know, sometimes I feel like a lot of the kids don’t have a lot of hope. They don’t feel that things can change or they’ll be different. Or that there’s another way out or another life they can have.”

Andrea reasoned that social and economic marginality fostered a sense that one does not control their future:

“...People who are sort of ignored, kind of stepped on, they don’t have a sense of that or their own future. ‘Ah, ya know, shit happens to me. Today it’s that, I don’t know...my brother fell out of the window ‘cause there’s no window guard, tomorrow maybe it’s that I get pregnant.’ So there’s this sense of, like, I don’t really control my destiny, and I don’t have a role to play. Very opposite from what a middle class kid grows up with.”

The extent to which participants linked these “individual-level” explanations to broader social, political and economic processes and structures varied, with RH stakeholders being more likely than HCWs to make connections. In the below quote, Allison situated teens’ use of contraception within a wider web of relationships, including those with parents and partners, with particular attention paid to power dynamics in the latter that influence their use of condoms:

“I think remembering to take it [the pill] every day, hiding it somewhere so someone doesn’t know, and then figuring out where to take it every day at the same time every day...Or, you know, or let’s say they’re on the Mirena [IUD] and they’re not getting their period, kind of faking they’re getting their period for their mother. There’s a lot that goes in if they don’t have open communication at home. A lot of this stems back to...you know, the open, having that kind of relationship. Both with your family and with the guy... I think condoms are very difficult because it really means taking a stand and, um...it goes back to the identity. Really being strong in who you are and what you want, and being willing to stand up for that. I think that’s very difficult.”

Several participants also described the intersection of adolescent sexuality and associated behaviors and outcomes with structural factors such as poverty and lack of opportunities for disadvantaged youth. For example, Christina commented that her current understanding of adolescent sexuality is more inclusive of the social contexts within which it develops:

“I think it’s healthy for young people to explore, to ask questions, curiosity, I think understanding the implications of all of that, and good decision-making...and so what you wanna do is provide the kind of information and a safe space, if you will, to ask those questions. And I would have answered that question a couple of years ago and ended it there. Now I am much more aware that adolescent sexuality needs to be understood and grounded in an understanding of what’s going on in their communities. So the level of bullying, violence, drugs, homophobia, immigration phobia, and power dynamics play out, and while we love to think adolescents are innocent and it’s all about like, do you like me, I like you, all of that stuff impacts their decision-making, their understanding of the world, their sense of themselves.”

THE FAMILY AND COMMUNITY LEVEL

The influence of teens’ families and communities on pregnancy and childbearing during adolescence was also discussed widely by both HCWs and RH stakeholders, although more frequently by the former group. In particular, family dynamics and parental conflict were cited as important contributors. Lisa, a social worker at a SBHC, described a family history that many of her teen patients who became pregnant shared:

“...Just from my experience, I have also seen these girls that have - there’s parental absenteeism, they don’t have their fathers in their lives, and that’s something that really pains them, and angers them.”

For Brianna, a nurse, the pregnant teen patients she saw tended to come from chaotic homes, which was perceived to contribute to a desire to have a baby:

“I think most of them...they come from homes with parents who are, you know, always drunk, always high, and most of these teenagers want something to love, something to care for, and this is what happens. They have a baby, the baby becomes that...”

A history of adolescent childbearing in a young woman’s family was also widely cited as a powerful influence on their becoming a teen parent. Interestingly, this explanation was almost exclusively offered by HCWs. Below, Ethan, a medical provider at the FMC, clarified the role of family history on teen childbearing:

“I think there’s also some normative social things that influence that as far as like, my mom was 16, my grandmother was 14 when they had theirs, and so that’s just what they know.”

Theresa, a medical director for a network of FQHCs, explicated further on the role of the family, highlighting the importance of expectations, communication and support:

“I have found that it starts with the family. You’d be surprised. Some families have low expectations and there’s a generation where the mother had a teen pregnancy and the child is saying, ‘I don’t want be like my mother’ but she ends up having a pregnancy. Communication within the family - the family has to play a very strong role, and I found in many of the families, that role is not there. The expectations, the communication, the guidance, I mean, many of the kids who had a pregnancy say, ‘Nobody talked to me about it. I couldn’t talk to my mom about it, there was no one to ask about it.’”

Alisha widened the circle from maternal lineage to siblings and other relatives, constructing a patient’s family history of early childbearing as a “risk factor” for their becoming pregnant:

“I think that if you have other siblings or relatives that are the products of teen pregnancies or who you’ve seen pregnant as a teen, it’s more likely to [happen]. It’s a risk factor as well.”

THE COMMUNITY LEVEL AND IMPACT OF “CULTURE”

When discussions with RH stakeholders and HCWs extended further away from the individual level to more distal influences on early childbearing, the norms, expectations and values of teens’ “communities” arose frequently. Communities were differentially envisioned among participants and included peers, neighborhoods, and “cultures” or ethnicities. For example, several participants perceived a dearth of adults and peers to serve as “appropriate” role models. Olivia commented:

“There’s not a lot of role models here. A lot of the kids don’t have role models at home. A lot of their parents work a lot, so I sometimes feel like they don’t have parents that can be influential, more encouraging. They also don’t have a lot of peers that go to college or have other goals...”

Jeffrey offered a personal perspective on the normative influences of “particular” communities on reproductive health outcomes for teens:

“Well we know that if parents were young parents when they gave birth to their kids, they set up a system that may or may not lead to future teen pregnancy, we know that. We know that the peer influences you know, have a huge influence on that. I was the product

of very young parents, and you know, the idea that my mom gave birth to me at 17, back in the 1950's, you know, shocks me today. But at the same time, my mom had graduated from high school when she was 15 and a half. My dad graduated from high school, he was 17; they both had jobs. The world was a very different place, but I'm still amazed that that happened. And my parents were pretty cool. And we spent a lot of time talking about that. But why didn't I become a dad when I was 13 or 14? Because they took me out to Long Island and took me away from the influences that might have led me down that path. I don't think they did it intentionally for that particular reason but they did it because they thought it was a better place to get an education and a better place to raise a family. So with the peer influences on top of the, for lack of a better term, parental culture or lack of influence on kids, all go together...you know?"

Susan, a city health official, also noted the influence of the family and neighborhood environment on shaping teens' expectations and goals, adding the additional complexity of how they may manifest within a deeply inequitable society:

"...If you're in a family where...your mom was a teen mom or you had other disadvantage where you yourself don't see adults in your neighborhood who are going to college, you know...in a society with so much disparity and inequity, there are many factors that go into the decision-making and weighing that in an equitable society, um, you wouldn't necessarily see. And it's, to me, one of the reasons why we see such high rates [of teen pregnancy] here compared to other developed countries in the world."

In conversations with interviewees, a key theme to emerge with regard to the distal causes of teen childbearing was the community or group "culture." As described in Chapter Seven, invocations of culture were most frequently directed at Latino or "Hispanic" groups by participants to explain particular behaviors and outcomes. Olivia, who saw a largely Latino patient population at her SBHC, reflected on the role of "culture" in terms of the value placed on motherhood and its association with being a woman, as well as the neighborhood's "culture" that reinforced early childbearing:

"There's cultural reasons - that they wanna be moms, they wanna have their own families. Like they might not know about other opportunities or other roles that women can have. In their family, their grandmother or their mom stayed at home and took care of the family...Again...if they don't see anything else they can attain or accomplish, then you end up doing what everyone else does in the neighborhood. Either because you want to belong or because you feel like there's nothing else."

Ethan had worked previously in a largely Mexican-American Catholic community in south Texas, where teen pregnancies and childbearing were common and abortion was not acceptable for most young women. Moreover, intergenerational family support ensured that parenting teens could continue to go to school should they desire it. By contrast, his teen patients in the Bronx who became pregnant faced different social realities and often had limited family support:

“Here when I ask, ‘Well how are you gonna go to school?’ ‘I don’t know, my mom’s also pregnant,’ or, ‘My mom’s in jail,’ or, ‘We live in a one-bedroom house and my whatever stepdad is abusive,’ and there’s just all these other issues here where it doesn’t fit in as well. Whereas there [in Texas] it was like, everyone’s already done this. There’s so many ways that I can go around this.”

While not explicitly articulated by participants, the comments above reflected consideration of individual, family and community issues that related to structural violence, vulnerability, and material constraints experienced by teens. Alternatively several HCWs evoked a “culture as a barrier” rationalization for early childbearing, as reflected in this quote from Carmela:

“It all comes down to expectation and the culture that they live in, where the mother had me when she was 14 and maybe it wasn’t the best thing in the world, but if it happens it happens. She’ll understand. Or it’s sort of...like intellectually you know something but when you’re surrounded by it and it’s just not something that is a problem - everybody deals with it - it’s not seen as a problem. It’s something that they live with, and it’s part of the culture, of the neighborhoods. It’s also the ethnic groups. You know, in certain ethnic groups it’s just not as much of an issue. It’s not even seen as a problem, and I think that, you know, we know that it’s a problem because of this, that, and that, but it’s not a problem for them. And I think it’s about actually changing the culture, so people realize you have a lot of options and you have to act on them.”

SOCIAL FORCES AND THE BROADER SOCIETY

Finally, interviewees referenced broader social forces, such as gender dynamics, pervasive sexism, stigma around sexuality in our society and socio-economic inequality, in their attempts to explain the underlying causes of pregnancy and childbearing during adolescence.

With regard to gender dynamics, participants most commonly referred to gender scripts that

limited young women's abilities to negotiate contraception and the timing of pregnancies.

Allison shared her perspectives on relationships she often saw among her patients:

"...I really think so much happens because of sexism in our patriarchal society. So that women aren't really making a choice to have a baby. There's so much that goes into, who's it with and why they choose to use birth control or not, why they choose to insist on a condom. Why they're with the guy they're with, what their self-esteem is...And you know, it's just a real cycle. The moms maybe didn't have the best relationships, and although their moms are trying to do better by their kids, they, you know, they just don't have the example often...They don't expect them [men] to be faithful to you...It's just not expected and then unfortunately that seems to get passed on...Now my expectations are different. Maybe they're not better, but I do see women trapped a lot and being left, and hurt, and undermined and treated like shit. And I think unfortunately most young women who get pregnant are not gonna end up with that guy."

RH stakeholders often noted the role of stigma and discomfort with sexuality among young women as contributing forces to teen pregnancy and childbearing in multiple ways. For example, Susan observed the cultural taboos around sexual desire and double standards that exist for women and men:

"...I think it's really complicated...I mean it's everything from...teens feeling like it's not normal to feel sexual feelings and not wanting to admit it, and if you get birth control, it shows you want sex and if you just let it happen then, um, it's more socially acceptable for females. And otherwise it looks like you're asking for it in this taboo way...Then there's the piece about people just being uncomfortable about their sexuality, and our society gives such mixed messages about sexuality..."

These taboos about sexuality were then perceived to translate into discomfort discussing feelings, desires, and health needs with families, communities and schools, and limited the willingness of some young people to access related services. Aimee, director of a reproductive health training program, explained:

"...the culture of this country does not support that taking care of yourself sexually at any age...is a really great thing to do and is really responsible behavior. There's so much stigma attached to it that that's a battle...to push through that with their own families, with their own communities, with their own schools. They're taught that it's bad even though they're having the sexual feelings and are probably gonna act on them...We're not providing a welcoming environment for teens to...use birth control and really explore their feelings about when they're ready to become parents and what that means to them."

Additionally, some participants, predominately RH stakeholders, believed that persistent and growing inequities in educational opportunity, employment and income between groups in U.S. society also contributed to teen childbearing. Ellen spoke about the unequal distribution of resources and opportunities for young people as its primary underlying causes:

“...If you give opportunities for there to be many more options, um, then many, many, probably most teens would choose that, and delay parenting...So you know, I just think resources are important and all of that, but it’s the opportunities, it’s the future, it’s building competencies to have a future...”

In addition, Janelle observed how inequities in the distribution of and access to opportunity and resources consequently fed into a culture of “immediate gratification”, which itself was a reaction to teen experiences of marginalization and deprivation:

“I think it’s difficult at times, for us as professionals and adults...this issue of kind of immediate gratification is sometimes there. There’s just something that, you know, an adolescent saying, this is something that I want, and no I don’t wanna wait until I’m old and I’m 25...I want it now. And sometimes it’s about the relationship that they are in, and that relationship, good or bad, may be one of the first or the only times where they are really truly feeling recognized, special, and alla that. And they don’t want that to go away...and you know, that’s very compelling and very hard to, I don’t know, to almost dispel that. And I think that particularly for young people that live their lives in such conflict and in such turmoil, and in such sense of them feeling that they are doing without what it is that they see the majority population with...I can’t have this, I can’t have that, and you’re telling me that I’m too young...That’s very, very hard to kind of talk against.”

Following from the inequalities described above, several interviewees observed a lack of access to social, health and educational resources among predominantly youth of color and low-income teens. Sonya characterized the issue of teen pregnancy and childbearing in political and economic terms, noting the role of insurance access, healthcare reform and access to comprehensive sexuality education in their occurrence and distribution:

“I think that...a teen pregnancy, is really, I see it as a social, political, and economic context, and what I mean by that is...if you look at teenagers and young adults as a group, they are the least insured, they have the least access to health care, including all races and classes, that age group. Within that there’s tremendous disparity. African Americans, before health care reform, were 40% more likely to be uninsured within that

age group, and Latinos 300% more likely. Without insurance you don't get care, you don't have access. And also maybe sometimes the school they are going to do not necessarily have the type of teaching about comprehensive sexuality education and understanding your body, and then they don't have the access to those services... So to me, those issues, it's really not about the person. That issue has nothing to do with being Black or Latino... When you look at Latina and white adolescents, they have basically the same rate of sexual activity, but very different outcomes, and the outcomes are social, economic, and politically derived.”

Likewise, Theresa described the role of adequate sexuality education and access to confidential family planning services for youth, noting differences between earlier approaches to adolescent pregnancy prevention and those that exist today:

“So, before all these programs, kids didn't have access to the right information about - some of them didn't know how they got pregnant... So the education about sex and the consequences, what you can do to prevent stuff, well, they didn't have that information, then if they had that information now, purchasing contraception, condoms, you know? [It used to be that] you couldn't just walk into a clinic and get care. Till you had the law that minors could seek reproductive health services, and then it was fought by many... When they went somewhere, they would call their parents or they'd be turned away. So the larger health care infrastructure didn't have the political will... the environment was just not supportive at all levels [to prevent teen pregnancy and childbearing].”

HCWs also discussed broader social, economic and educational contours of teen childbearing; however, their characterizations of the issues were often markedly different from those of the RH stakeholders. For example, rather than offering explanations about why such inequities exist and are perpetuated, HCWs tended to focus on the “symptoms” or manifestations resulting from such disparities. Sandra described the sexual violence, coercion and victimization experienced by some of her clinic's teen patients, but ultimately placed the onus or responsibility on the young woman to find better ways of “getting attention” than through having a child:

“...Most of our situation with the kids who come here [to the clinic], either they're raped, their lifestyles... they're prostitutes at young ages. I've bumped into girls like it's a form of lifestyle. Some do it [have a child] for money; some do it for the attention if they're not getting attention at home. But I'm like, 'There's other ways of getting attention. A child could give you attention but it's just gonna bring you more stress. 'Cause if you can't provide for yourself, how you gonna provide for your child? And how will your child look upon you? You want better for your child, but you gotta better yourself.'”

In addition, several HCWs made comments regarding the perceived “economic” value of having a baby in the household among some of the families and teens they served. For example, some participants noted the role of public assistance in shaping reproductive decision-making. Carla argued that until our society stopped “rewarding” teen parenthood, it would continue:

“As long as you have a society that rewards those things - when you’re a teen mom, you can get WIC, you can get food stamps, you can get Section 8, you get all those things. It rewards it. So are you gonna replace all those things?”

Sandra had her first child at the age of 21 and was raising her alone. In considering the involvement of parents on the occurrence of teen childbearing, she contrasted her priorities as a parent with the perceived misaligned values of some of the parents of her teen patients:

“...If you’re a single parent like myself, you gonna go crazy because you trying to...find the time in your busy schedule to make sure you at least sit with your child at the end of the night, to see, is there anything new I should know about? But some parents just don’t care. Some parents just want their kids to be just like them. They don’t wanna see their children do better than them. ‘Cause I’ve seen that here also, like, um, a few parents, having their child surprise them that they were pregnant as a teen. Well, the parent encouraged it. I guess ‘cause they didn’t have a kid at home, um, welfare’s running out, so since you’re knocked up, you stay in my house and you become the breadwinner.”

These characterizations of low-income adolescent patients and their families as manipulative and abusive of the welfare system are not new and in fact exemplify the archetype of the “welfare queen” that dominated popular constructions of parenthood among poor, single, and overwhelmingly, women of color, in policy rhetoric throughout the 1980’s and 1990’s (Roberts 1997; Bridges 2011).

On the whole, RH stakeholders and HCWs identified numerous intersecting causes, both proximal and distal, that contributed to the occurrence of pregnancy and childbearing during adolescence. However, there were notable differences in how these groups explained them, with HCWs focusing more on individual and community “risk” factors and RH stakeholders addressing the structural, social, and political features. While some of the HCWs tended to

evoke explanations that essentially placed responsibility on the individual, for others it was clear that they may have lacked the framework or language to articulate what was, in essence, structural violence.

OUTCOMES OF EARLY CHILDBEARING

Given the considerable policy, programmatic and scholarly attention on the subject of teen childbearing, it seems reasonable to conclude that such efforts are undertaken because the outcomes are unequivocally deleterious for teens and their children. Much has been written about the negative consequences of adolescent childbearing. This section presents findings from interviews with HCWs and RH stakeholders on these perceived outcomes (positive and negative), highlighting areas where considerable divergence occurred among participants.

BIOLOGICAL

Both HCWs and RH stakeholders reflected upon the physical and/or biological impacts of childbearing during adolescence, with many citing issues such as low birth weight, premature birth, and complications during labor and delivery for the adolescent. Ethan explained:

“I think we know and I believe and accept that teen mothers - there’s the health risks, there’s the risk of preterm labor, there’s the risks about fetal anomalies, slightly higher in teens.”

However, several interviewees questioned the extent to which these negative outcomes were due to young maternal age or existing poor health status, disadvantage, and less access to care, in particular for older teens. Additionally, some participants believed that having a child as an older teen, generally defined as 16 and older, was actually the “best” time, from a biological standpoint, as Nancy argued:

“This is all anecdotal, but there’s part of me that’s like, I am amazed they have a child and a month later it doesn't even look like they’ve had a kid. Teenagers in many ways physically are...in older teens, I feel like they’re very adept at having children. So physically is it a big problem physically for an 18 year old to have a child? No! A 16

year-old? Probably not there either...Look how many cultures around the world where young women do have children in their late adolescence, and teenagers as a general rule, they're very healthy. I don't know statistically but I gotta think it's healthier for an 18 year-old to have a kid than a 40 year-old [laughter]."

Tracy reiterated this point, reflecting on the ability for her teen patients who have become mothers to fare well during delivery and postpartum:

"I mean, I think in many ways – I don't tell them this – females are probably better off having children younger...As far as physical effects on the body, I don't think there's much of a risk there. I think that a lot of them that I've seen have no problems delivering, breastfeeding and that sort of stuff..."

The sizable literature on the biological effects of childbearing during adolescence is replete with studies that both support and dismiss the notion that teen mothers and their children experience deleterious biological effects that can be attributable to their young maternal age (Kramer and Lancaster 2010; Sisson 2012; Geronimus 2003). At least some of the inconsistencies in research findings appear to be the result of using inappropriate comparison groups and lumping younger and older adolescents together in analysis (Kramer and Lancaster 2010; Sisson 2012). When these factors are considered, a general trend among available studies (although not conclusive) is that early adolescents (below the age of 14) face substantially greater risks of poor pregnancy outcomes than late adolescents (Kramer and Lancaster 2010). Further, cross-cultural data illustrate that older teens whose age at menarche and developmental maturity are within normal ranges do not experience greater negative outcomes associated with pregnancy and childbearing than women who delay childbearing until their 20's (Kramer and Lancaster 2010:623).

SOCIAL AND EMOTIONAL

While there was significant divergence among participants regarding the biological risks posed by teen childbearing, virtually all HCWs and RH stakeholders believed that the social and

emotional consequences of being a teen parent in U.S. society were extensive. Janelle commented on the limitations imposed on teen parents to recognize and achieve other goals:

“...The phrase that comes to my head is dreams unrecognized...it’s not even about lack of fulfillment of dreams, it’s the lack of recognition of the right to dream. Um, that almost becomes a real shut down at that point, and I’m not even sure that most young people are even aware of that cross roads.”

Additionally, participants described the challenges teen parents face juggling multiple responsibilities associated with parenthood, school, and having a social life:

“...Even the ones that have the support at home, they still have a child they have to look after. They’ll say it’s very hard. I have to do my homework, I have to clean up. My mother helps me, but I cannot stay with my friends on the weekend, I have my baby. So the social consequences of that, you know?” [Theresa]

Along with the negative social aspects of teen childbearing identified by HCWs and RH stakeholders, participants also shared positive social outcomes that their teen patients or young women they knew had experienced. For example, several HCWs noted the strengthened bond that can develop between mothers and daughters. Bettina, a health educator at the FMC, commented:

“...I’ve seen it [where] the mother would come to the sessions with her, mother would come to the appointment with her, mother was at the delivery. Very supportive. And I think it also makes the teenager...less guilty, less stressed, and less stress on them about you know, oh my god, I have to hide this, my parents are going to hate me for this. It opens up another non-conditional love towards the child and the baby instead of the resentment of, ya know, I shouldn’t have this child, I don’t have anybody...”

HCWs also mentioned personal growth of the young woman as a potential positive outcome of teen parenthood. Carmela reflected on her parenting teen patients’ ability to adapt and learn from the experience:

“...These kids are very resilient and they have the ability to deal with it. They go over their choices, and they make a decision that this is never gonna happen again, or I’m gonna be in control of what happens, and then they move forward...And ultimately, most do have a positive in terms of growth.”

In some cases, interviewees shared examples from their own families, as demonstrated by the below quote from Janina, a health educator at the FMC:

“I’ve had cousins that have had kids at a young age that went on to - took that as a wake up call and got their act together, and went to school, went to college, did what they had to do, got their education, put their kids through school. So it can happen...I’ve seen that happen in my personal life.”

While HCWs often acknowledged the ways in which becoming a teen parent may enrich some of their patients’ lives and be a source of motivation for positive growth, these instances were often considered the exception, not the rule. Moreover, they were overshadowed by the social, economic, and educational hardships associated with teen childbearing.

EDUCATIONAL AND ECONOMIC

Overwhelmingly, HCWs and RH stakeholders demonstrated the greatest amount of alignment and concordance in their responses with regard to the potential educational and economic outcomes of childbearing for teens and their children, which virtually all participants saw as inextricably linked. Diane, medical director of a teen health clinic, commented:

“The issue is that, we know that teen pregnancy puts most teens at an economic and educational disadvantage. If someone’s pregnant in high school or junior high, it puts them at a disadvantage in life.”

Not only was teen childbearing perceived to set youth on a life course of disadvantage, but some interviewees also spoke about the ripple effects on the children of teen parents:

“...If a teen is say, 16, and she doesn’t finish high school, the likelihood of her child finishing high school is also less.” (Ethan, FMC medical provider)

A major concern voiced by both groups of interviewees was that teens who have children while in high school will not be able to graduate. Many participants believed that completing one’s education was a crucial strategy towards upward social mobility for low-income teens. For Carmela, teen parenthood was seen to render that goal impossible to achieve:

“I think one of the biggest thing is just lack of educational attainment, being able to finish your education and to go on to higher education, which is the ticket that people need to get... You need a high school diploma or more than that. And without that ability to move past that, and then all the other barriers that come into place with early parenting, it’s just - it’s impossible.”

Further, even if a teen parent completed high school, participants frequently commented on their difficulty attaining higher education. Alisha shared a story about one patient for whom she saw lost intellectual potential as a consequence of her becoming a mother as a teenager:

“I have one teen who is my patient...and she’s an extremely bright girl. I remember right after the baby was born, you know, we talked about her goal of definitely completing high school and she had a plan and she was planning to go to college. Her mother is very involved, she has the great support. But now the baby is nine, 10 months old, and she’s in a GED program and I think applying to Job Corps. But definitely has the intellectual potential to be really successful, but you know, your priorities kind of shift and it’s just harder. So yeah...I’ve had teens that maybe could have potentially been very successful in a major university but you have a baby and you know, now you’re at [a local community college].”

Virtually all participants also mentioned economic hardship and financial struggles as consequences of teen childbearing, as well as perceived unwanted corollaries such as single parenthood and reliance on public assistance. Allison explained:

“...It’s very difficult raising a child, financially. And if they have a child, partners, most of the time, partners are not there to help. So they become single moms, teenage, no job, depending on the system, hard to take care of the child because there’s no one else supporting them.”

Similar to educational attainment, many interviewees understood the effects of economic instability to be passed down to subsequent generations, mirroring teen parent(s) and their children in a vicious cycle of poverty. Janina explained:

“...The literature shows that there are many [risks] for that teen and for that child. Parents that are teens when they have their kids are more likely to live in poverty. Those kids are more likely to live in poverty than someone else, so there’s a lot...at stake.”

THE RELATIONSHIP BETWEEN TEEN CHILDBEARING AND POVERTY

RH Stakeholders and HCWs presented varied, detailed, and nuanced perspectives about the role of poverty in teen childbearing. Although a strong relationship between poverty and teen parenthood has been widely recognized for several decades, substantiated by the disproportionate number of low-income teens who become pregnant and have children in the U.S. (Geronimus 2003; Sisson 2012), research examining how practitioners and policymakers make sense of this relationship is virtually non-existent. Moreover, recent studies (Kearney and Levine 2012; Sisson 2012; Geronimus 2003; Arai 2003) suggest that the *direction* of this association warrants further examination (see Chapter Three for a more detailed discussion).

As described earlier in this chapter, many participants believed that teens living in poverty were more likely to become pregnant and, subsequently parents, due to the concomitant effects of poor education, fewer educational and employment opportunities, fewer resources and a greater sense of hopelessness than their more affluent counterparts. Theresa provided a particularly poignant explanation from her organization's work with low-income youth of the ways in which living in poverty can limit one's potential and the options available to them:

"...Poverty robs you of your soul. Because it doesn't give you the opportunities to explore yourself as a human being...like when I ask the child, 'What did you eat this morning?' 'I didn't eat anything doctor.' 'Why?' 'Because I missed breakfast.' And I'm scared to ask the next question because they will tell me that all they ate that day is the school food...and with the economic recession...I hear these stories every day and I'm just horrified at the level of poverty. Three families living in a three-bedroom apartment...It robs them of their ability to think, to explore their full potential...Like one told me, she never gets to school before the second period. She's always late, and I asked her why...So she says, 'My mother gets up at 3:00 AM and she's a maid in Manhattan. She cleans in a hotel.' So she's 12 or 13, and she has to look after the other three kids. So she gets up at 5:00 to get all of them ready...The day care that that one goes to is on the other side of where they live, and she has to take that one on a bus, drop her...and then come all the way to school. So by the time she gets to school, the second period is already over. So the school is trying to decide what to do with her because this was a mandatory class...and she had been failing it...So, this is how poverty affects them...They make these

choices. They have to decide, do I take my sister to the babysitter or do I come to school? For her it was a no-brainer. The sister comes first.”

Andrea, a city health official who worked in the Bronx, similarly highlighted the lack of opportunity, differential societal investment in poor youth, and the uniquely American myth of meritocracy as compared with other industrialized nations to explain the distribution and occurrence of adolescent childbearing:

“I think...that it is, um, ‘unbenign neglect,’ which is that our society doesn’t really give a crap about young poor people. And how do we know that? They don’t graduate from high school. We have a whole system where they don’t graduate from high school. They don’t go to college, they don’t have good job opportunities. We don’t pay attention to the social situations they’re in...So we’re not going to go out of our way to make things better for certain segments of the population. And that seems to be, like, an American trait to me. We don’t have a sensibility that apparently they have in other countries about taking care of each other, we’re in this together, ya know. This is like, every man and woman for themselves....You gotta go out there and get what you want, and the converse of you can get what you want is, whatever you get, that’s what you deserve.”

As described earlier, teen pregnancy was seen by several participants to perpetuate the “cycle of poverty” in the lives of their patients and their families. Diane shared the information she imparts on medical students and residents about the generational context of teen childbearing:

“It’s a cycle of poverty, so what I used to tell, when I was teaching fellows and residents, is that, ‘No parent wants their teenager to be a pregnant teen, except for certain cultures where the norm is you have a baby when you’re 16.’ But no parent, regardless - if the parent is African-American, living in poverty in the south Bronx, and she had a child when she was 15 years-old, and her daughter gets pregnant at 15, that is not a good thing! And that parent is trying to give that message to that kid all the time. ‘It’s not a good thing,’ and that’s the message that the kid will hear when she gets pregnant. So the messaging is there, but it’s not working.”

Logic underlying the premise that adolescent childbearing perpetuates a cycle of poverty presumes that poor individuals and families would be able to “lift themselves” out of poverty and into the middle class if not for becoming pregnant as a teen, a viewpoint that is increasingly questioned in the literature (Furstenberg 2007; Luker 1996; Geronimus 2003) and by some

participants in this study. Challenging the conventional association between teen childbearing and poverty, Linda, policy director for a RHS organization, explained:

“I think that the traditional view was, and is still definitely out there way beyond NYC, you know, is, A, gotta stop these kids from, these poor kids, and depending upon what geographic area then there’s the racial implication, these poor black kids, because it has the welfare linkage to it, having all these babies ‘cause it’s a drain on the public, blah blah blah...I think if you look at it, and you say, that it is not...it’s not teen pregnancy that causes poverty, which is the longstanding belief. In fact, poverty contributes to why communities and then sets of folks make decisions about their lives. So that if... great disparities exist and if in fact people are marginalized and do not have equal access to education, to employment, health care, whatever it is, the choices that they make might be different than the choices you and I make, but they are often times a logical choice in response to their class and race and gender position.”

Several RH stakeholders described shifts within their respective organizations regarding how they approached and understood adolescent childbearing and prevention efforts. Susan outlined the process undertaken during her leadership to thoroughly examine the relationship between teen parenthood and a host of deleterious outcomes, which ultimately led to reframing the issue:

“One thing we’ve worked very hard at changing...is um the language. The national language around teen pregnancy was very alarmist and sometimes it continues to be. If teens have babies, the nightmares begin and they’re gonna be poor and they’re gonna abuse their children, and they’re gonna... and we had frankly used some of that same data ‘cause there’s research that shows that...And we started thinking, is this really correct? And we started talking to some researchers who were not impressed with the evidence that teen pregnancy has a causative effect on all of these negative outcomes, it’s associated but not causative, and we convened...a self-study, to read the literature. We brought in an economist, we brought in other experts who’ve looked at this issue, and concluded that teen pregnancy is more a symptom of inequity, of poverty, of lack of resources, and lack of seeing other opportunities in your life...and so we worked very hard at changing the framework and how it was articulated...We used to say teen pregnancy leads to all these things. Now we say, teens need the information, resources, and skills to make healthy decisions about their sexual and reproductive health...”

Ellen argued that the “problem” is not teen parenthood but rather the profound social and economic inequities that contribute to its occurrence and the lack of resources once a young woman has a child:

“It’s a question of economics and you know... income, racism, and economic disparities. That’s, to me, that’s what creates the problem. The problem is not teen pregnancy. I mean... there used to be many more high schools for pregnant teens and parenting teens. Without them it becomes much more difficult to continue your education. So it’s not being a teen mother or father; it’s really what happens to you afterwards and you get caught in a downward spiral and it has to do with what’s available to you.”

Other perspectives on teen childbearing and poverty shared by participants were reminiscent of the “culture of poverty” thesis originally put forth in the 1960’s (Lewis 1961).

Jeffrey attempted to explain the relationship by using an anecdote he shared frequently:

“What is it about not having money in my pocket that causes me to go have sex? I always tell this story of a [patient]... she was sexually active, and we were talking about contraception, but I got this funny feeling from her... and I don’t know why this came into my head, but I said, ‘I have a question. When you have sex do you enjoy it?’ And she said, ‘Not really.’ ... So then I said, ‘Can I ask you a question that’s gonna sound a little funny?’ She said, ‘Yeah,’ and I said, ‘So why do you do it?’ And I swear to you, she said to me, ‘There’s nothing else to do.’ And I was dumbfounded. I’ve told that story probably a 1,000 times... So you have sex because you’re bored? So I don’t know if that has to do with poverty. When my kids are bored they get their Ipads out, they’re in a whole different world, you know?... Does that have something to do with it? I don’t know. Or is it because poverty has led to these general living conditions where other kids are having sex and other kids are getting high and smoking and drinking alcohol, so since I’m hanging out with other poor kids... I don’t know!”

For many participants, explanations regarding the relationship between teen childbearing and poverty walked a line between articulating macro-level structures and referencing differential values and expectations at the individual and community levels. When asked what may be contributing to the circumstances her teen patients find themselves in, Brianna, a nurse, pointed to a lack of education, poverty, and poor role modeling from parents:

“It’s education and it’s coming from the parents... and it’s poverty... it’s what they’re exposed to and what they have access to... what’s around them. I don’t know if you’ve walked around this area, there’s a lot of drug use around this area... and um... poverty doesn’t allow them to have the finer things in life, and learn to appreciate the finer things in life... because they don’t have it. So what’s nice for them is what they see around... and it’s not a lot. So I feel it’s poverty that’s holding most of them back.”

Michelle spoke at length about the interconnected disadvantages many of her teen patients faced towards achieving upward social and economic mobility. While acknowledging the importance of delaying childbearing, she questioned the extent to which this alone would stop the “cycle of poverty” for her patients’ families due to a multitude of intersecting obstacles, both within and outside of the individual. The quote below highlights the ways in which these interconnected levels of influence were woven together in a single participant narrative:

“It’s just...the overall lack of opportunity is such a shame. You know, they’re living in a high poverty area; their education is more likely to be worse. They’re less likely to have good role models and people who are doing various things...The parents are less likely...to be involved in their education, so they’re not going to be in the PTA, hounding teachers...And you know, they’re not gonna be aware of the various educational opportunities, the various colleges...they’re almost expected to go to community college...And I mean...the graduation rate at this school is horrible. Lots of kids drop out and end up going to get a GED...the education system’s failing them, their families are failing them, and they just don’t know what’s available...Then there’s just priorities; they [the families of her patients] don’t prioritize education...And the expectations of the educators are low on them...It wasn’t until I started working with this population...that I learned all the names of the community colleges...I never would have grown up imagining that, cheering people into that...And they’re not encouraged to leave their neighborhood, so all they know is the ten block radius and everyone speaks Spanish there and everyone gets by...One of our school aides, he’s like, half-Dominican I think, and he’s just like, ‘Yeah, that’s why a lot of them, you see them doing barber’s hair and cab drivers because it’s like, they make great money, it’s like under the table. They just have to have to pay the rent for the chair, and they make more money here than they do in DR, so they feel like they’re living the life.’ So they don’t think about going - some of them doing think about going higher.”

While various permutations of the relationship between teen childbearing and poverty were described by participants, a unifying theme underlying most explanations was the characterization of poor individuals, families and communities as devoid of resources, hopes, or resiliencies. A counterpoint to this perspective was offered by Janelle, who shared a profound account during our interview about portrayals of teen parents from impoverished communities and her own experience growing up “poor”:

“There are lots of young people who with the right supports are very good parents. It’s something that they can be congratulated and applauded for, despite being in communities that are so impoverished. Yet there hasn’t been the recognition of their incredible strength and resiliency and the ability to overcome...it’s really about dreams, desire, hopes...Having grown up in a public housing project...I had no idea I was poor...I was fortunate in that...I was always in the top class, and the only person of color, period, for all of those grades in my class. So, there was always this odd thing about all of the kids in my class. The majority...came from Stuyvesant Town and Peter Cooper Village, and so I kinda knew about, well, ‘those people.’ That they had more money...And across the street from the projects there used to be a live poultry market. And that’s where we got our eggs and our chicken and stuff once a week or so...And I can remember...that we went on a field trip to the live poultry market...And what stuck out there was, it was ridiculous that we were going some place that I went all the time. And that was the first time that I heard the word poor. And I remember coming home and saying, ‘Are we poor?’...And I remember kind of talking about, ‘Yes, some people have more money than other people, so what makes people poor is how they feel.’...And I remember when I was in middle school, my mother came to school during open school week, and my homeroom teacher told her that I was doing very well ‘for our kind,’ and that perhaps instead of thinking about going to college, that maybe I should, um, go to a high school that had a practical nursing course [so] that I would be able to provide some income to lift my family out of poverty...And so I mean, when I grew up that was more in your face kinda thing, but I mean this goes on all the time as far as assumptions that people make of people that are growing up in financial poverty. And financial poverty doesn’t mean that those communities are devoid of culture and tradition and resiliencies and strength. So...it’s really not just about childbearing, it’s about whole communities being labeled as being devoid of any hope, of people doing any better than the generations before them.”

Janelle’s comments reflect the ways in which the problematic of poverty can be used as a mechanism of power to categorize and delegitimize the experiences and values of financially poor individuals and communities, casting them as devoid of hope and value.

IS IT A PROBLEM? IT DEPENDS...

As is evident from previous sections of this chapter, HCWs and RH stakeholders gave a wide range of responses about whether or not, and under what circumstances, teen childbearing was considered a “problem” to be prevented. In general, most participants believed that adolescent childbearing was a predominantly negative outcome of sexual activity, though it was rare that someone felt that way in *all* cases. As will be discussed in further detail later in this

chapter, attitudes towards teen childbearing were often shaped by the ‘intendedness’ or ‘wantedness’ of a pregnancy or birth, the existence of adequate support for parenting teens, and the value placed on the ability for teens to make autonomous decisions about their reproductive lives. When asked whether becoming a teen parent could be a positive experience, Meredith, a SBHC mental health clinician, responded:

“I mean, I guess? With ‘teen’ being anyone under 19? 21? Um, I won’t say it never happens, but as a general rule, I don’t think so. And that’s a huge judgment, but...”

While the majority of participants characterized childbearing as largely harmful and undesirable for teens, a minority of HCWs questioned the validity of conventional wisdom or their personal preference about delaying parenthood until a certain age, arguing that it may not be a relevant or desirable goal for all families. Speaking about her teen patients, Nancy commented:

“A lot of girls had mothers who had them when they were very young, so there is a subset of patients, who, if they can get to 18 without getting pregnant, that is a big deal. So who am I to say, ‘Wait till you’re 25,’ or whatever? The fact that you’re pregnant when you’re one month from graduation? You’re making it. You’ve graduated...so that’s very real too. It’s just kind of like incremental steps at progress...and who’s measuring the progress? Whose idea of progress is this?”

Similarly, Tracy noted that her partiality towards delaying parenthood may not be the preference of her teen patients or their families:

“...My choice to not, say myself, get pregnant or my children get pregnant at 14 may not be their choice. That may be okay, ya know? Their culture may be, if you’re 18 you’re like already out of it. Ya know, I mean this is accepted and this is okay... Who’s for me to say you shouldn’t have a baby at 15?”

Many HCWs and RH stakeholders also reiterated that associated outcomes are not always negative, and are dependent on individual circumstances and context. Deborah explained:

“...I can’t say categorically that teen pregnancies are bad thing. I think it depends on the situation, and what’s going on with them, and how mature they are, and how aware they are of the consequences. And...some are great, I mean they’ve thought of all the different

things they need to do and they have everything set up so that they can kind of fluidly go from having the kid to still going into school and there are schools that take care of the kids, so there are lots of options available to them...It's harder more for teenagers, but I've certainly seen 20 year-olds who have the same problem...I mean 'cause there's lots of 20 year olds who don't have their high school diploma...So I think it's a more about the situation than a specific age."

Several participants offered personal experiences to underscore their perspective regarding the uniqueness and multitude of experiences associated with teen parenthood, some of which may be positive. Ellen remarked:

"...I mean, I have a stepdaughter who was an adolescent mother. She now has three kids in the family... What a fabulous family, and they're all incredibly wonderful human beings who give back to their community in an enormous amount of ways. And the three kids are all very successful. So yeah, there's nothing wrong with being a teen parent in certain circumstances."

Similarly, Carla shared that her daughter was a teen parent who went on to become a judge:

"It's up to individuals. It's really individual. I have a daughter now who had her baby when she was 17. She's a judge now...So it's not always a lose-lose situation. Some people need to push, 'Oohh, there's this baby now,' I have, as they say, to get on my grind and do so and so. And for others it's like, okay, that's it for me."

As alluded to throughout this chapter, the majority of the participants believed educational and social support mediated many of the deleterious effects of teen parenthood. According to Nancy, the social support variable was the most influential in determining the outcome of a particular individual's situation:

"I think it's so much more dependent on the social supports around the teenager than anything else. That's kind of the key...There's families that are very supportive, there's other families that are really...it's a disaster. And you can kind of see it coming down the pike...It can go a lot of different ways, but...there's other stories that um, that work out, you know. I'm just thinking of specific girls. They're amazing mothers. It's like, you are an amazing mother, and you're an 18-year old mother with a 2 year old."

Carla also relayed a story about a teen patient who recently gave birth to underscore the importance of supporting teens who make the decision to have a baby:

“I had a young lady [patient] in May; she was 14...[and] she had a baby...Beautiful. She’s still with the baby’s father, I believe he’s 17. She lives up here in the Bronx, he’s in Brooklyn, and um, she’s finished junior high school...She’s moving forward with her plans, and even when the social worker and I spoke with her after the pregnancy test, she was not the least bit upset about it...And I asked her, ‘At 14?’ And...her retort was that, she had spoken to some other friends, family members... and they told her it was not gonna be easy, but if this is what you wanna do, then you’re gonna have to do whatever you’re gonna do...if this is what she chooses to do, okay, then she is gonna, in her own way, make the best of it...So I’m saying, you do have cases, even though the odds seem so insurmountable, but if this is what in their mind and heart they wanna do, then you have to provide the best for them.”

Several HCWs and RH stakeholders also raised the importance of respecting a teen’s autonomy to make a range of reproductive decisions, including the decision to have a child.

While Ethan expressed doubts that his patients would be able to overcome the challenges connected with teen parenthood, he supported the rights of individuals to make the choice to be a parent or not, regardless of age:

“There are teens that have pregnancies and continue them and do well with them and do on to go to college and get jobs...and are successful in life, so, it’s not completely impossible, but I think it’s difficult and more than likely for somebody who’s a teen in the Bronx, and most of the social circumstances that we see them in, it’s not gonna be likely that they’re gonna be one of those successful teen pregnancies that will continue and go on to do great things. Not impossible, but not as likely. And I do think we have to think about it and counsel our patients on the most likely possibilities, rather than fantasies... But, I do think it’s a choice...I’ve seen some teens, sometimes they can be 16 going on 10 and sometimes they can be 16 going on 26.”

Jeffrey expressed concerns about what he perceived to be a particular agenda by the city’s public health agency to dictate when and under what circumstances young people should have children, noting the need to be mindful of adolescents’ reproductive autonomy:

“...I have this problem with the adults, usually Department of Health, making these decisions that this is what we’re gonna focus in on and we’re gonna bring those [pregnancy/birth] rates down...There are adolescents who say, ‘I’m going to have a baby’ and they’re gonna be unmarried, and from their cultural background [it’s acceptable] ...And I feel like the great white father sometimes, imposing my values...just because we have MDs or DOs after our name and just because we have the support of the Department of Health, saying, ‘Thou shalt not get pregnant until I say so.’... Sometimes I feel like somebody’s gotta say that, and I know that it sounds like I’m in

favor of teen pregnancy, but I'm in favor of people deciding when to have their children."

CHARACTERIZATIONS OF TEEN PREGNANCIES

As described earlier, national and NYC-specific surveillance data on the timing and 'wantedness' of pregnancy indicate that the vast majority of adolescents did not want to become pregnant at the time when they did. Participants in this study, not surprisingly, reiterated this perspective; however, this did not always translate into consistent efforts by teens to prevent it.

Cassie, a prenatal counselor, commented:

"A lot of them said they wasn't planning, it's just something that sort of happened. At least that's what they tell me, hopefully that's true. Someone coming in and saying this is what I wanted is very rare. The teens, I seriously don't believe that was their mission."

Emma, a SBHC nurse, described the perceived incongruity between a desire to avoid pregnancy and using protection consistently:

"Most of the girls that I hear, they're not trying to get pregnant. They're afraid of their parents, they have school, future plans, that'll interfere with...so, you know. But I find too many of them are like, let's wait and see what happens."

As articulated earlier in this chapter, many HCWs identified a small subset of their teen patients who consciously desired pregnancy. As is evident in the quote below, these patients were often characterized as being from families where teen parenthood was "normalized":

"...Every once in a while you will have a teen that wants a baby... Often times they've had siblings who had teen pregnancies and who in their eyes are fine and you know, have kids, or parents who were in that setting and, 'Look at me, I'm fine!' ...I had two teens who actually had mood disorders and were very promiscuous and were just set on having children and both got pregnant at the same time and just thought it was the cutest and best thing that could have happened. So in settings like that, I just...it's tough."

Sandra questioned the motivations of teen patients who desired pregnancy, and wondered if they should routinely be referred to a social worker to explore potential issues of neglect or abuse:

"Some come in very often thinking that they're pregnant, but desire it. And I would sit there and ask them, 'Do you want to have a baby? Are you trying? Are you planning?' ... With these teens, I don't really recommend them...if the teen wants to come up

pregnant, that should be a social, like, should they go to a social worker. I mean, maybe it's something else, like, they want the attention, they're not getting it at home, or maybe somebody's doing something to them inappropriately and that person is getting upset 'cause they're not coming up pregnant."

The quotes above suggest that unplanned pregnancies among teens may be more acceptable to HCWs than those that are planned. The values and opinions described by some HCWs may also, in part, explain why some interviewees felt that their teen patients were not always truthful about their pregnancy desires and goals. They also reflect an incongruity between HCWs' counseling messages and relatively recent citywide public health discourses on the prevention of *unintended* pregnancies, which emphasize the importance of planning, and thus the inference that "intended" or planned teen pregnancies are acceptable. These findings are described below.

DEFINING AND PRIORITIZING PREGNANCY PLANNING AND INTENTION

As described in Chapter Three, the primacy given to pregnancy intention and planning has become ubiquitous in public health discourse on reproduction in the United States. For most RH stakeholders and HCWs, un/intended was synonymous with un/planned. Susan defined unintended pregnancy as follows:

"It's really based on survey data...teens who say that they, at the time of their pregnancy, they did not want to be pregnant at that time, and so to me in a very concrete way it means I wasn't planning to get pregnant, I wasn't trying to get pregnant, and it could be everything from I wanted to be pregnant but not right now, which is more of a mistimed pregnancy, or it could be I did not want to be pregnant now or in the near future, or I never wanted to be pregnant...So I think it's basically anyone who did not plan their pregnancy."

For some adult interviewees, pregnancy intention was viewed as a concrete and dichotomous cognitive construct whereby associated behaviors, such as consistent contraceptive use and an articulated position on whether to avoid pregnancy, were aligned. Sonya explained:

"An intention would be, you've thought about it, it's something that you want at this particular moment and you want to pursue it, versus...the kid having unprotected sex but who doesn't want birth control. To me, that's more adolescent ambivalence and not

being sure what to do. Or, 'I don't want a child but if I get pregnant I'll be fine with that.' To me that's not an intention. That's very different."

For other participants, it was conceptualized as a spectrum that ranged from active to more passive forms of intention. The quote below from Aimee illustrated this considerably more complex perspective:

"...Some teens do intend to become pregnant. They want to become pregnant, and sometimes it's very active like, 'I wanna have a baby, I'm doing everything I can to have a baby,' and sometimes it's like, 'I wouldn't mind...'...At one place I worked, we would do pregnancy counseling as the test was running...And we'd ask, 'So, what would it be like for you if we told you that the pregnancy test was positive today?' And one woman in particular is standing out in my mind. She said, 'I wouldn't mind.' And to me that was so striking. That something so vital would have an answer like that. Like, I wouldn't mind wearing a purple shirt instead of a blue one...So I think there are a lot of subtle psychological processes that go into having sex and not using birth control that we don't truly understand, like what's intention and what's not intention."

While virtually all participants acknowledged the role of ambivalence in shaping reproductive behaviors and outcomes, it was often not clear what caused it. For example, Olivia observed:

"Sometimes I feel they might plan it in their minds, but...they might not take it into action. They may want to be pregnant but they might not tell you...A lot of that is not said is the thing. They just don't tell you what it is that they are really thinking or they want. So there's this back and forth or ambivalence, and you wonder, well does she want to get pregnant?"

HCWs shared various examples of how they attempted to elicit explanations from teen patients about their perceived ambivalence towards pregnancy. Alisha explained:

"Every once in a while, I'll have an ambivalence patient or a girl who thinks that she can't get pregnant and for some reason is having some anxiety about that. Maybe because there have been a couple of condom breaks and she hasn't gotten pregnant. So I'll try to reality check them. 'Well, are you ready to have a baby yet?' Try to assess what their future goals are, and if it is a goal oriented teen who has ambitious plans...will just try to use that as a motivation to make better decisions and, you know, 'Do you think that it would be difficult to achieve your goals if you were to have a child?' And I should be honest I'm probably not as open-ended...I wouldn't put that in question form, I would try to give them information about it being more difficult to achieve high goals, and it will affect your earning potential."

Participants also described posing questions and presenting information that clearly indicated their preference for the patient to delay becoming pregnant. Brianna described a recent interaction with a teen patient who had a son and was considering trying to get pregnant again:

“...I said, ‘You have a baby. You’re 17, you have a 2 year old at 17, just imagine dealing with another baby to take care of by yourself.’ She says, ‘Well I take care of my little sister too anyway.’ I said, ‘Okay, so imagine you’re taking care of three children not two, you know, how’s that gonna work? When do you get time to see your friends? What about school? What about spending time with your boyfriend?’ ‘Well he’s always with me.’ I said, ‘Well, he won’t always be with you when you have three children. He’s gonna wanna have some time...you’re a teenager, how about being a teenager? How about just going out with your friends, going to the movies, just living like you should?’ Really, the boy’s not gonna stick around with you with two babies plus your little sister. No...that’s not the life for a teenager. There’s a life to live.”

For several RH stakeholders, the application of the intention construct to their work in adolescent pregnancy prevention was a relatively recent development, signifying an acknowledgment that a proportion of teen pregnancies are “intended,” and thus planned and wanted. Susan described how this interpretation is translated into messages about the types of pregnancies that should and should not be prevented:

“There are a small percent of teens, about 10%, who say they wanted to be pregnant, and the last thing we need to do is demonize these teens and make them feel terrible that we’re preventing all pregnancies. And even though we think it’s best to wait until you’re somewhat older to have the baby...I think teens who make a decision, as long as they’ve got all the information to make an informed decision, and all the facts, and not some distorted information, but true information about the risks and benefits, and they make a decision with no duress or misinformation, I think we need to support teens who decide to continue their pregnancies, which is why I don’t want to just say reduce teen pregnancy. We...want to help those teens stay in school, have opportunities, not drop out, and plan their next pregnancy. Delay future – subsequent – pregnancies, so that they can have time to achieve other goals in their lives and hopefully see that they have other opportunities in their lives.”

While this method of classifying pregnancies is indeed a significant reframing of adolescent pregnancy prevention messages, it still allows for the vast majority of teen pregnancies (90%) to be operationally defined as “unintended,” and thus, justified policies and programs aimed at their prevention. It also presumed that intention is a meaningful and salient concept for teens, a point

that will be reexamined shortly.

Regardless of the terminology used (e.g., un/intended, un/planned, un/wanted), there was widespread agreement between both RH stakeholders and HCWs that *planned* pregnancies are the goal for all women. Susan explained why it is preferable for all pregnancies to be planned:

“You know, often, if you don’t plan it, you don’t know you’re pregnant in your first trimester, you’re less likely to take folic acid...if you have a chronic health problem, [you’re] less likely to have those under control. You’re less likely to have gotten prenatal care and while prenatal care doesn’t necessarily prevent a lot of complications, you may have an STI and not know it. You may have a UTI, so you’re more likely to make healthy decisions about your pregnancy and about the baby if you are continuing your pregnancy and so we really want pregnancies to be planned whenever you decide to be pregnant.”

Similarly, Christina noted the importance of impressing the value of planning with regard to pregnancies upon young women:

“The other piece of it that I think is critical is the whole question of whether it’s an unintended pregnancy and whether it’s purposeful. Most young women will say it was a surprise pregnancy but if it happens it’s god’s ‘whatever.’ We want to be able to say, yeah, if you’re ready for it, make that decision. If you’re not ready for it, plan to not be a parent... You want to affirm young people and you wanna say, you’re not ready? That’s great! Because you’re gonna go on and have a really good future and then you can have kids when you’re ready.”

Moreover, many RH stakeholders perceived that the locus of control for planning a pregnancy, given the ability to access information and resources, was the individual:

“... Giving people... the information and the access to be able to make decisions about what type of contraception they wanna use, when they wanna use it, when they wanna have a child, if they never wanna have a child, whatever it is, is key...” [Linda, Policy Director, RHS Organization]

UTILITY OF APPLYING THE INTENTION CONSTRUCT TO TEEN PREGNANCIES

Despite the pervasive application of the pregnancy intention construct to classify teen pregnancies and births in recent literature and among many RH stakeholders, there was little consensus by participants about its salience or applicability as either a population health indicator or a counseling tool to elicit motivation to avoid pregnancy, particularly for teen and

impoverished women. For several RH stakeholders, assessing pregnancy intention was often considered useful to begin a dialogue with a young person about their attitude towards pregnancy and point out a perceived disjuncture between stated desires and behaviors. Reflecting on her decades-long career working with young people, Janelle explained:

“...As far as planning or intention, yes I think it’s useful. You know, if you can only ask one question, the question should be, ‘Do you plan to be pregnant in the next year?’ so I think that singular question, if you’re doing screening or whatever... So yes I think it does have some usefulness, in at least starting a dialogue... You know, you ask that question and they’re like, of course not! So then of course you’re following it with, ‘Okay, I’m curious as to why you’re here and why you’re sexually active...and what might you be thinking of doing since your plan is not to be pregnant in the next year or whatever...’”

Susan discussed the relevance of building teens’ capacities to make purposeful and planned decisions about pregnancy as part of a transferrable skillset that can be used with a multitude of other health issues and decisions:

“...I think that’s sort of the overall context of women’s health - planning and hoping that teens get skills so that not just with pregnancy, but in life, that it’s a life skill around feeling like you have some control over your life and that you can make decisions... Those are skills around feeling like you have choices and you can make decisions...and that you have that agency about yourself... It’s not just about sex, there’s lots of decisions teens are confronted with, whether to take drugs, whether to smoke...and so we like to think about the work...as developing transferrable skills as well.”

Other participants questioned the extent to which notions of planned and intended pregnancies were relevant or useful for adolescents. For example, Ellen found that the individualized construction of pregnancy intention was rendered more problematic when applied to teens due to their developmental stage and cognitive ability:

“I mean what does intention mean? What does it mean for an adolescent? I mean, when the brain itself is not at the maximum ability to be able to plan and intend, it’s just...physically, it’s probably a meaningless concept... ‘Cause physically it may not be a concept that certain adolescents can really...you know? Intention is socially determined. You can’t deal with this as an individual problem, and for adolescents, it’s a very complicated problem because it’s further exacerbated just by adolescent development.”

Moreover, Diane articulated that planning and intention may be interpreted differently by adolescents than the way they are intended by HCWs and other service providers:

“Intention and planning are not at all meaningful concepts for adolescents because they take it in a negative way...that means then you’re trying to get pregnant. It’s always, ‘No, no, no, why would you say that?’ ...And I think it’s really hard for them to say that someone’s not being judgmental in a discussion about it... ‘Cause they’re sort of embarrassed. Unless they’re doing it obviously on purpose. I had a kid in foster care the other day, who had been trying ‘like mad’ to get pregnant, from the case worker’s words, and she wasn’t pregnant. And I went into the room and said, ‘Great news you’re not pregnant!’ She was devastated!”

Meredith did not believe that her patients would apply the concept of un/intended to pregnancies that she would categorize that way, underscoring the socio-cultural lens through which individuals may view an unexpected pregnancy after it occurred:

“I see a lot of the girls who, you know, might have what we would call an unintended pregnancy. Yeah, it’s sort of obvious that they weren’t planning it or it was the first time they were sexually active and they got pregnant not realizing that they could have gotten pregnant. But then their interpretation of it after is filtered through this maybe religious or cultural understanding of it, such as, nothing comes as an accident, it was meant to be, there’s only one choice and that’s having the child, so things like that...”

Along those same lines, several participants did not regard the concept of pregnancy intendedness to be universally understood or applicable for a multitude of reasons. Notably, for some interviewees, the structural vulnerability in which many of their teen patients lived rendered the concept of planning less feasible and appropriate, even if they were cognitively able to do so. Sonya commented:

“I think...some have the capacity to [intend to become pregnant]. You know, we say that teenagers, usually by the age of 14, can reason as adults...many adults are not reliable users of contraception and they don’t use condoms and they have unprotected sex and the same issues that teenagers have. So to me, it’s similar, but to me the difference is...they are in poverty, and because they have so many stresses and because they do not necessarily have nurturing loving environments and a social network to support them...So, it’s very complex, but I don’t think adults do much better in many ways. Sometimes the doctors here, they say, ‘Oh no, I want to have a child and I want to have it at this time because it’s the right time in my career,’ so to me that’s intentional, that’s planned. They go off whatever method they were on. But the majority of people...”

especially when they are poor and stressed, I'm not sure they are necessarily planning in the same way."

Linda considered the relevance of the pregnancy planning and intention constructs within the personal context of she and her peers, remarking on their limitations to illuminate women's varied reproductive experiences:

"I would say that...a significant portion of, even my peer group, and I'm in my 60's... a significant portion of those had what we are traditionally defining as unintended pregnancies. They wanted children, they didn't want it then, some opted to terminate... many did not because they said, you know what? It's not the perfect time but I want...this child. So, I think that there's something flawed inherently in this question of intended and unintended. Again, when you go to the heart of sexuality, when you go to the heart of what it actually means to use effective contraception, to negotiate relationships, whatever, it's surprising that there's not more "unintended" in certain ways."

Ambivalence about being pregnant was also mentioned as a partial explanation for the prevalence of pregnancies classified as "unintended," as it often manifested in using contraception inconsistently. Janelle observed:

"...I do know that there are lots of young people, um, with their goals of what it is that they want to be or they want to do, and still make choices that are perhaps not in keeping with that as far as how we see them as adults... Um, and I think the whole ambivalence factor of you know, people seeing, 'Oh, this so and so wants to go to medical school and they're doing well in school and all that,' and not understanding the real pull of, um, the importance of relationships, um, sense of self, connection to others, um, perhaps not conscious questions about, 'Am I really fertile? Could I have a baby or could I get pregnant if I really wanted to?' And that kind of curiosity, maybe not even on a conscious level or whatever, could kind of impact the choices that young people make..."

Deborah felt that the issues women experienced with regard to planning their pregnancies were an extension of a broader social problem related to difficulties with long-term planning more broadly. The integration of *life planning* into family planning services was seen as a way to help young women recognize the interconnectedness of their life goals, including whether and when to have children, although in practice this was rarely incorporated into counseling. She commented:

“...I think long term planning for almost everybody is a difficult problem in our country, right? I think everybody wants these short-term gratifications for everything, so to think that our teenagers are going to be any different is a far stretch. For me, I think that the key for family planning for teenagers is life planning better...When kids and teenagers have goals and aspirations and things that they want to achieve in life, that lets them think, well, to get this goal...these are the things that need to be in place, and having a kid is going to make this goal really difficult for me. So, I think that when you look at the more larger picture of, like, life planning, ultimately you’re gonna have family planning there, because you’re gonna have part of that plan, your life plan.”

FEMALE YOUTH PERSPECTIVES ON FERTILITY TIMING

For the 24 female youth participants who did not already have children at the time of the interview, virtually all wanted to be a mother at some point in the future. While the number of desired children ranged from one to four, the importance of and priority placed on family was reiterated by a majority of participants. For example, Kamilla, 17, had one son, and wanted at least three more children. She came from a large supportive family, with eleven aunts and uncles on her maternal grandmother’s side. During the interview, Kamilla spoke about the benefits such a large network of kin provides:

“I want an even number of boys and girls and then tubes cut - gone! Or I might just keep it ‘cause you never know...life is life, you only live once! Why not? Have somebody out there living for you!...I have a lot of uncles, aunties, cousins. Trust me. I have a lot of family...So just in case when I’m not here and my kids need a lot of protection, and I’m probably outta state somewhere, kids are still out here and they need protection. Call your uncles! Best leave my uncles...they’ll be there in a jiffy. ‘Uh-uh, you ain’t about to hurt my niece and nephew.’ My son has four to five kids his age and multiple cousins ‘cause my uncles is out here makin’ babies like there’s no tomorrow. Tons of family to reach out to and support you.”

Fertility timing preferences among teen participants ranged widely: from 18 years of age to early 30’s. For many young women, their preferred timing of pregnancy coincided with the completion of particular milestones or goals, such as high school graduation, higher education home ownership, or job stability. However, as the next section will demonstrate, the meanings and values ascribed to “planning” a pregnancy were diverse and multifaceted.

Among youth in this study, 16 indicated that a female family member in their or their

parents' generation became a parent as a teen. These participants often described the continuous messages they received about delaying parenthood, particularly as they entered their teen years.

Jazmin, 15, explained:

"...My family comes from a long line of young pregnancies, like my great-grandmother had her first child at 14, my grandmother had my aunt at 14, my aunt had her first child at 14. Yeah...My aunt seems to bring it up with me and my cousin the most 'cause, like, we're dating and stuff and my mom found the hickey on my neck. 'So are you having sex?' 'Yeah no...' Even though I am though. I probably wouldn't be on earth right now if she found out...' Cause now they wanna change that cycle. They don't want the 14 and pregnant thing to keep going on in my family."

Carolina, 17, also presumed that her mothers' experiences as a teen parent affected how she approached the issue of pregnancy and parenthood with she and her sisters:

"I feel like she don't want us to repeat her mistakes. She don't want us to live off...I honestly feel like she wasn't ready either 'cause now it's just hard for both my mom and dad to take responsibility of...I see them, they're struggling to get, like, food supplies for everyone, and clothes, and I'm like, mom you guys weren't right. And we argue too so if they really thought about this and made up their mind, I don't think...things woulda been better for both of you. So I understand my mother but she's letting it off in a bad way with threatening and yelling..."

Brittany, 15, explained that her grandmother, mother, and sister had had children when they were 16, and saw those experiences as influential in her decision to contracept:

"I wanna be the one that doesn't have a baby at 16. The one that goes to college, that finishes everything she has to do, and then moves on."

PLANNING, READINESS, TRYING, AND EVERYTHING IN BETWEEN

Discussions about the desires, preferred circumstances and timing of pregnancy among female youth participants revealed a range of complex definitions and explanations that were often incongruous with those offered by adults in this study. When asked what having a "planned" or "unplanned" pregnancy looks like, and whether future pregnancy planning was important to them, teens provided responses that were informed by social expectations about becoming pregnant, personal experiences and future goals. For many participants, planning was

seen as a deliberate act. Alternatively, a lack of planning was associated with being unaware that one was pregnant, not receiving prenatal care, or knowing the biological sex of the baby before it was born. Vanessa, 17, provided her explanation of the difference between planned and unplanned pregnancies:

“[A planned pregnancy] is when you go to a sperm bank and then you see that you want a white man with your baby... Unplanned is pregnancy is where you have unprotected sex and it just happens. Or it is protected and something happens with the condom and that just happens. It’s just the way it is to have a baby.”

While Vanessa’s particular example of planning was unique in the study sample, the purposeful and strategic characteristics it exemplified were not. Ximena, 16, offered a similar comparison:

“Planned pregnancy is like, you see those people who are like, ‘Oh, we’re trying to get pregnant!’ Buying baby clothes and shit and you’re not even pregnant yet! That’s a planned pregnancy. Unplanned is like, ‘Oh my god I’m pregnant! I think I might be pregnant.’ That kinda thing, and it’s like you’re expecting either a really bad or really good impression from the guy...”

Both Vanessa and Ximena’s responses allude to differential fertility norms and expectations for particular groups. Like these two participants, Carolina, 17, described concrete steps that would need to be taken in order for a pregnancy to be considered “planned”:

“It’s when you discuss, you sit down and you talk about it, and you both agree, you talk about the responsibility that...or what you’re responsible and what I’m responsible for. Talking about the baby, of the materials too ‘cause that’s a lot of work, and the clothes, and a nursing room, so there’s gonna be a lot to talk about it before that happens. That’s a planned pregnancy. An unplanned pregnancy is having sex and not being sure if you’re pregnant and not sure if the guy comes in you and not knowing that you’re pregnant when you are. So, um, I feel like, me, for example, I didn’t know I was pregnant until my stepfather mentioned it. So yeah, that’s an unplanned pregnancy. It was not planned.”

Another participant highlighted the perceived differences between planned and unplanned pregnancies as relating to foresight and active versus passive pursuit of conception. Justine commented:

“Like that means, unplanned is just that you pop up pregnant, and planned is like you take your time. You know which month and stuff you want to get pregnant.”

Similarly, Leah, 18, defined an unplanned pregnancy as follows:

“Like they wasn’t thinking about the, um, risks that they might have taken. It was just a quick thing, they wasn’t thinking, they just wanted to get it over with. They didn’t think about what happens in the future, nine months later, and that’s when they have regrets.”

Of the two teen participants in the study who had children, Kamilla considered her pregnancy to be unplanned, while Laura considered hers both planned *and* unplanned. She explained:

“‘Cause like mine was unplanned but at the same time it was planned. ‘Cause we planned it, like, ‘Oh, we have a baby, your parents are gonna accept me and we don’t have to worry about hiding it from nobody,’ but at the same time it was unplanned cause we were unsure to have a baby and we were like...I always tell people it was planned, but then it wasn’t planned. ‘Cause we were talking about it...”

As the above quotes illustrate, how planning or not planning a pregnancy was interpreted and understood by youth participants varied. Regarding planned pregnancies, teens identified numerous advantages, such as being prepared and having enough money saved, and disadvantages, such as the absence of surprise and disappointment when your plan does not come to fruition. Fabiana, 15, described her preference for a “planned” pregnancy, and what that meant for her:

“I think I want to have a planned. ‘Cause you know, when it’s unexpectedly, you don’t know what to do and there’s so much responsibility. When you actually want it and you try to have it, then you know, okay, we’re pregnant, I’m pregnant, we gotta do this, we gotta do that...But when it comes unplanned, you’re really rushing into everything and you gotta make sure that you do everything on time...I wanna live in my own apartment with whomever I’m with at that time. And I wanna make sure that he’s okay with it, I’m okay with it, and we actually wanna have this...I wanna make sure that we’re both okay with it and we’re responsible enough and have a good job to support it, not just have it just to have it. But that the baby’s gonna be okay and that we gonna have everything the baby needs. So I wanna make sure that when I have it, I have a good job, a nice place for the baby to actually live in, and to actually be set and not worry about him just leaving me in the middle of the pregnancy, just make sure that he’s there.”

For many participants, it was not important that a pregnancy was “planned” based on their definition of the concept. In the below quote, Ximena, 16, offered her preference for a pregnancy to “just happen”:

“I want an unplanned pregnancy at 25. I want it to just happen...It’s like, I want to have money in the bank but I like that idea of a surprise, like, ‘Hey babe guess what?’ You know? Not like, ‘Hey, did you check today?’ ...It’s not as exciting. All the little milestones, like finding out. I look forward to that! I look forward to being like, I can’t believe I’m saying this, but I’m kind of concerned that I haven’t gotten my period.”

Beatriz, 17, described wanting an element of surprise and for some of the control about when to become pregnant to be taken out of her hands:

“I think this is how I wanna have it. I want it to be, like, if it happens, it happens. Not like, ‘Oh my god, let’s make the baby right now.’...I don’t want that. I want it to be a surprise, like, ‘Oh my god I’m pregnant. Woo!’ But not now...[laughter].”

For Isabel, 18, having a baby seemed too overwhelming to actively “plan”:

“It’s not that I don’t want to have a kid, but it’s just that I have so many things that I’m aiming for, so it’s just not there...[so it would have to happen] unexpectedly.”

For others, planning was not valued if they became pregnant at a time that was acceptable to them. Brittany explained:

“Like if I’m around the age when I want to have a baby, it doesn’t matter that it was planned.”

In addition, terms that were often used interchangeably in reproductive health discourse and literature, such as planning, intention, trying and “being ready,” carried important differences and meanings for youth. Naomi, 15, distinguished between planning and trying in her response as to what kind of pregnancy she saw herself having in the future. While indicating that she did not want to “plan” for a pregnancy, Naomi explained:

“[I’d like] a surprise... ’cause you already know that you’re trying to be pregnant. It’ll be even better to be surprised.”

For Laura, 16, who had a son with her longtime boyfriend, planning and trying were synonymous:

“[For a planned pregnancy] they’d say like, ‘Okay, this day we’re gonna try, tomorrow we’re gonna try,’ and see what happens.”

A more salient way to think about pregnancy timing for several participants was “readiness,” although what being ready meant differed slightly. For some teens, being ready meant being in the right place financially, emotionally and intimately with a partner. Sofia, 19, believed that timing of pregnancies was less about age and more about individual readiness:

“I think when you’re mature, when you have a good job, when you have a career, then you say, okay I can have a baby because I can give everything to my baby...you know? I cannot say an age because something can happen but I can say you have to live your life first and then think about what you wanna do and then after that you can have babies. It’s not about the age, it’s about doing all the things that you have to do first, because when you have baby, you cannot do the same things.”

While marriage was often not a pre-requisite for having children among the teens interviewed, it was important to virtually all participants to feel confident that their partner would not abandon them while they were pregnant and following the birth of their child. Alejandra, 15, felt that the time immediately following her graduation from college would be ideal to become pregnant if she was in a supportive relationship:

“Like I would have a baby with someone...who’s living with me, and that I know that I can trust him not to walk out on me and stuff like that. So to know that that person won’t walk out on me, I would have a baby with that person at that time...I wouldn’t plan a pregnancy. If it happens, it happens. Like, if in the future, god forbid, I can’t have a baby, then I can’t have a baby. That’s what it is. But if I have a baby, then I have a baby. If I’m out of college and stuff like that, I have my own gear and stuff like that? I’m all set? Then when it happens it happens and that’s fine.”

Likewise, Valeria, 17, emphasized the importance of having children with a partner who would be a “real father” to their kids, once she finished college:

“...If I’m gonna have kids, it’s gonna be with somebody that I know I’m gonna be with that person for a long time and I know that that person is gonna be a real father for my

kids, you know? 'Cause I don't want no man to, like, you see there's a lot of woman that they have kids and for no reason the men just go and leave them with the kids. A real man doesn't do that. So I don't want that to happen to me. So if I'm gonna have a baby it's gonna be when it's the time."

Similarly, Zoe, 17, explained that she and her boyfriend had agreed not to have children until they were "ready." When I asked her what being ready meant, she replied:

"Like, well I want to have a child after I've had my fun you know, like there's people who have children and they still like leave their child somewhere else when they go party. I wanna live my life, financially stable, have everything set and then I'll have a child."

As for whether she saw herself planning to have a child, Zoe explained:

"Um I don't think I would plan for it...I guess I just like...figure out if we're ready but then after that, then if it happens, it happens...I don't think you can really plan it, 'cause anything can happen, so, like, you can try to like organize everything exactly how you want it, but I mean, it just doesn't go however it's supposed to."

Zoe's perspective on planning was echoed by other youth for whom the idea did not resonate, hinting at the limits to which young people felt empowered to shape the direction and course of their lives. In their assessments of the positive and negative aspects of planned pregnancies, several other participants offered insightful comments that illuminated reasons why planning may not be feasible or desirable. For example, Alyssa, 17, associated planning a pregnancy with people who are "desperate for a relationship" and, like Zoe, questioned the value of planning, since life is unpredictable:

"I like an unplanned pregnancy. I don't want a planned...I know people that are really desperate for a relationship. They're never gonna find a relationship because you don't look for things like that... You just let it come; if it happens, it happens... so, I don't think I'll want to plan pregnancy... 'cause when you plan, it usually doesn't go the way you want it to."

Similarly, Nicole, 18, expressed concerns about the necessity to expend effort planning a pregnancy, as the outcome cannot be definitively known or predicted:

“I think it [getting pregnant] will just happen on its own. I think that [“planning” a pregnancy] means they’re planning something that they’ll never know...will happen. Because you can’t plan something ahead of time and then it never goes the way you planned...”

Additionally, for a few participants, planning was associated with scheming or being devious, a finding that relates to an earlier discussion in this chapter regarding HCW attitudes about teens who intend, or are trying, to become pregnant. Lucia, 16, was not using any birth control with her boyfriend of several years, and during the interview stated straightforwardly that she wanted to get pregnant, a rare assertion among the youth interviewed. Her boyfriend knew she was not using contraception, but she had not told him about her desire to become pregnant. When asked whether she would say she was “planning” to become pregnant, she responded:

Lucia: “People will say it. They will say it’s everything planned. That I did this [got pregnant] to hold him down.

Hannah: And what would you say to that?

Lucia: “Nothing, I would just ignore them. They don’t know nothing about my life.”

There were no differences in responses observed by age of participants, nor could a discernable pattern be identified between teens’ selection of contraceptive method and fertility goals. In other words, pill users were just as likely as Depo, patch or LARC users to find the concept of planning future pregnancies salient in the future. Interestingly, although the majority of teens were using some form of birth control at the time of the interview, it was rare that an interviewee mentioned needing to stop using their method as part of their descriptions of pregnancy goals and timing preferences.

EXPRESSIONS OF AMBIVALENCE

For most teen participants, self-reported motivation to prevent a pregnancy at the time of the interview was high and the idea of becoming pregnant was characterized as an unwanted and frightening prospect. There was a wide range of responses regarding how teens would proceed if

this hypothetical outcome occurred, as a significant number of participants would not consider abortion or adoption. Seven participants expressed ambivalence about becoming pregnant, as concluded by responses indicating that they were hesitant about using condoms or other forms of birth control, but did not explicitly state a desire to become pregnant or consider becoming pregnant around the time of the interview to be a positive outcome. Of these participants, two indicated that they were currently not using any method to prevent pregnancy, two reported current condom use, and three were using a hormonal or LARC method. Several scenarios will be presented in order to highlight the diversity of experiences and multitude of ways that pregnancy ambivalence manifested among teens who were using contraception and among those who were not.

Lucia, 16, indicated that she wanted to and was actively trying to become pregnant; however, she expressed uncertainty about this decision, as reflected in the below quote:

“I could maybe change my mind if he don’t change. Even if he changes I’m still, I want to see how it goes, where it leads, and I could change my mind...’Cause I know I would regret it. ‘Cause once I know, oh my god I’m 5 months belly, I would regret it. Regardless or not I would. ‘Cause I know the type of person that he is. I know what he would do...I’m very realistic about it. I prefer to meet another person and just start all over or if not just stay alone for a really long time period. I prefer to stay alone, just get together with myself and you know...at the same time when I’m with him it’s like I’m trapped now. I prefer to be with him than be alone.”

While she was currently not using any method of contraception to prevent pregnancy, Lucia had tried several contraceptive methods over the previous year and a half and until recently was using a hormonal method to prevent pregnancy. Her story illustrated that pregnancy desires changed over time and within relationships, and that users of even highly effective contraceptive methods may be ambivalent about preventing pregnancy.

As described in Chapter Eight, Kamilla, 17, had unexpectedly gotten pregnant the first time she had sex. At the time of the interview, her son was about two. Kamilla started on the

Depo shot shortly after the birth of her son, but had recently stopped using it to see if she could become pregnant, since she wanted to ensure that her son had a sibling near his age. After several months of not being able to conceive, she returned to the clinic and was “convinced” by HCWs to get another Depo shot. Kamilla’s rationale for re-starting on the shot despite initially wanting to become pregnant was multifaceted, reflecting the complexities inherent in understanding and addressing ambivalence:

“...I’m preventing myself, to like, not have a child and to have a child. Before, I was trying [to become pregnant], so it’s kind of in between the two...Do I say, well, okay, I feel that my child needs another brother or sibling to go with him?... If I feel like I’m not gonna get pregnant, I’m just gonna give up. Not that I wanted to, I’m not a quitter, but I just felt like even though I made my decision or I said I wanted to do this, I didn’t feel like going through the struggle. I wanna wait and get through what I need to get through. I’m not gonna get through it if I have two children.”

At the time of her interview, Daniela, 19, had recently returned from the DR, where she had been living with her boyfriend for over a month. While there, they had not used any protection, and Daniela described wanting to become pregnant “in the moment” but reconsidered this desire once she returned to New York. The day of the interview, Daniela was planning to meet with her doctor to discuss starting use of the hormonal implant. Despite this decision to use the most highly effective reversible form of contraception available, when asked her how she would feel if she became pregnant, a half-smile, half-squint appeared on her face, and Daniela responded:

“Yeah, I would be happy. It’s not something...because if I know I’m having difficulties getting a job even for myself, imagine now school, being pregnant, then working to take care of a child...But I know my mom, she’s kind of a person that even though she says no, you’re having a kid you take care of it...when you’re really having it, you see her taking care of it, running back and forth...So I’ll feel happy, yes, because everybody feels happy being a mom. It will be hard, but I know there’s nothing I could do about it.”

The narratives above, although not inclusive of all expressions of ambivalence, underscored the notion that pregnancy desires are often in flux and may shift rather quickly within the same

relationship. Moreover, for some participants, decisions about whether to use contraception and what method to select were not necessarily indicative of greater or lesser interest in or ambivalence about becoming pregnant.

FUTURE GOALS, VISIONS OF SUCCESS, AND REPRODUCTIVE DECISION-MAKING

Lastly, despite prevalent perceptions from adults in this study that many teens were cognitively limited in their ability to plan ahead and consider their futures, most teens interviewed articulated specific visions of what success in life looked like for them, as well as goals for their future with regard to education, employment and family. Moreover, these findings were not limited to particular types of teens (e.g., those who used highly effective forms of contraception, were consistent contraceptive users, had no personal or family history of pregnancy, etc.). Nicole was a senior in high school, and had set a goal to attend college the fall after graduation:

“One thing I do honestly think I wanna go for is be the first person to get my Bachelor’s degree in my family and the first person to go all the way through college...”

“Success” in life most commonly centered on upward social mobility and creating a life for their children that was better than their experiences growing up, achieved by pursuing higher education and procuring stable employment. Justine explained:

“It’s [success] like getting further in life, just I dunno, makin’ it. Being better at whatever you want to do.”

Alyssa saw the career trajectory of her father as inspiration to keep “moving up”:

“I like moving up. Like my dad...he moved up, always. It was never like he was going down or stayed the same....I want to live in a one-bedroom apt by myself... and then I want to have a 2 bedroom apt, then a 3 bedroom. I want to always know that I could do better.”

Jazmin, 15, related success to having a strong family and being able to provide more for her children than her parents did for her:

“Success [to me] is having the family of your dreams and...giving your child...a better life than you always had...”

Laura, 16, had her son in eighth grade but was able to graduate that year and move onto high school without delay. Finishing school was a major priority for her, as was the desire to make her mother, now deceased, proud. Laura’s future plans incorporated goals she set for herself and for her family:

“Um I wanna work, get...a little bit of money saved up...be there for my son especially ‘cause my mom was never there she always worked...I want to drop him off from school, he gets home, home is good, give him his food, help him to do his homework. Be a mother first and then, you know, when he’s in first grade, I wanna start college. ‘Cause I know, people are like ‘Oh, don’t put it on hold.’ But I wanna be there at least for a while for my son. At least I know he’s in the after-school, and I could go to school, I cook and I do everything I have to do, go pick him like at five...and not worry about nothing.”

For some participants, these goals and visions tied directly and indirectly into reproductive decisions they were currently making, such as delaying parenthood until particular milestones (e.g., graduating from college) were passed. Ana, 16, wanted to attend school to be an architect. For her, what made this goal seem more achievable was her parents’ continued support, graduating from high school, and not having a child while in school. Zoe, 17, believed that graduating high school and college without having a child was critical towards meeting her goal of becoming a nurse and not being stressed financially:

“...I see a lot of things that go on, and I just wanna not have to go through, like, the problems that I see people go through. Like, I don’t wanna have to struggle to pay bills, I just wanna be set I guess. Not rich, but I just want to live comfortably.”

While not articulating specific goals beyond completing high school, Fabiana, 15, expressed that she wanted to be a better version of her mother, who had to drop out of school due to a pregnancy:

“I don’t wanna drop out of school and struggle like my mom had to do. I just want to set a better example to my mom that I won’t end up as her and I could actually do something with my life...Even though she does, like, the job, I want to prove to her that I could be better version of what she is...”

For the young women in this study, characterizations of success and avenues by which to achieve upward social and economic mobility largely aligned with the ways in which the broader U.S. society conceptualized them; namely, that hard work, completing high school, and attaining higher education would result in financial security for one’s family and an overall improvement in living conditions from earlier generations. Regardless of whether this formula to achieve the “American Dream” is accurate or equally possible for all young people should not be minimized. However, it is important to note that their visions of success run contrary to the perspectives shared by some adult participants about the lack of hope, interest in self-sufficiency, or future-oriented thinking that were seen to plague low-income individuals, families, and communities.

CONCLUSION

This chapter presented emergent themes regarding the causes of and risks posed by teen childbearing, including the various ways in which RH stakeholders and HCWs conceived of its relationship to social and economic disadvantage. Findings also contrasted RH stakeholder, HCW, and teen perspectives on the meanings ascribed to pregnancy and conceptualizations of and importance attributed to planning. Interviews with youth revealed considerably more nuanced and complex ideas associated with reproductive planning, including the extent to which it seemed feasible or appropriate for some young women. The final chapter will entail a discussion of major themes from this study, contextualized by relevant literature, recommendations for policy leaders and clinical practice, limitations of the research, and potential avenues for further study.

CHAPTER TEN

DISCUSSION AND RECOMMENDATIONS

The final chapter of this dissertation will distill and elaborate upon the major themes uncovered from the in-depth semi-structured interviews conducted with reproductive health stakeholders, healthcare workers, and female youth. In particular, this chapter provides a consideration of the findings in light of the research questions that guided the study, the relevant scholarship in anthropology and public health, and the contributions this study offers to these fields. Subsequently, policy and clinic-level recommendations generated from this research are offered. Finally, limitations of the study are presented, along with future avenues of exploration.

Before examining the predominant themes that emerged, it is instructive to return to the study's methodological framework of the "vertical slice" (Nader 1972; Nader and Gonzalez 2000; Gonzalez and Stryker 2014) and review what this research set out to accomplish. As described in Chapter Four, the vertical slice approach traces relationships, interconnections, and dynamics of power between lay individuals and influential institutions and leaders (Gonzalez and Stryker 2014; Nader 1972). For example, Nader and Gonzalez (2000) documented the contested process by which the "micropolitics of health ideologies" pertaining to adolescent health unfolded in a rural California town (233). In their analysis of a local community project to raise awareness of teen pregnancy, Nader and Gonzalez approach the issues identified from multiple vantage points and levels, thereby making connections between phenomena not conventionally associated with each other, including:

“...The transformation of a local model of medical care based upon local notions of health and illness, to a standardized model of medical care based upon ideas disseminated by the academic medical world, HMOs (health maintenance organizations), health care bureaucracies, and the mass media” (2000:233).

In this research, use of the vertical slice framework allowed for an opportunity to concurrently explore the experiences and priorities of intended recipients of pregnancy prevention messages and programs – female youth – with an interrogation of the values, practices, and ideologies influencing behavior and policy at the clinical and population health levels as embodied by healthcare workers and reproductive health stakeholders. This approach was especially appropriate to examine adolescent reproductive health in NYC given the relative hierarchical structures of clinical institutions and the governmental and non-governmental organizations that promulgate and advocate for citywide policies and strategies with which teens interact both directly and indirectly. Returning to the overarching research aims, this study set out to examine the following questions:

1. **Politico-Legal Landscape of Adolescent Sexual and Reproductive Health (ASRH):** What is the socio-cultural, political, and legal context of adolescent sexual and reproductive health service provision in New York City?
2. **Values, Policies, and Practices:** How do reproductive health stakeholders and health care workers (HCWs) characterize adolescent sexuality, intimate relationships, and sexual decision-making? What causes and outcomes do HCWs and stakeholders attribute to pregnancy and childbearing during adolescence? In what ways do these ideas inform public health discourses and clinical practices and policies relating to pregnancy prevention in New York City?
3. **Healthcare Worker (HCW) Perspective:** What role(s) do HCWs play in contraceptive counseling, uptake, and use among adolescent females in New York City?
4. **Sexual and Reproductive Lives of Female Youth:** How do female youth negotiate and make decisions about using contraception? Specifically, what multi-level factors shape method selection and use? How do female youth envision their social and reproductive future(s) and in what ways do contraceptive decisions relate to these goals?

SOCIO-CULTURAL, POLITICAL, AND LEGAL LANDSCAPE OF ASRH IN NYC

Several prominent themes emerged with regard to the broader landscape of adolescent sexual and reproductive health from interviews with RH stakeholders and HCWs. To briefly review, the former group was comprised of twelve clinical, public health, and policy leaders in NYC with extensive experience in adolescent and/or reproductive health. HCWs were employed at three types of primary care settings that served youth (school-based health centers, a family medicine clinic, and a pediatric clinic), and included nine medical providers, three mental health providers, two health educators, and four clinical support staff, for a total of 18 participants. Interviewees from both groups described a multitude of policies and initiatives that have been established to foster a supportive environment in which teens could prevent unintended pregnancies, most of which involved increasing access to reproductive healthcare, improving the quality of care, and ensuring confidentiality in the delivery of such services. These overarching strategies at the health systems and clinic levels are supported by a plethora of studies demonstrating the need for such strategies to be applied to all women, and in particular, for adolescents (Advocates for Youth 2009; Ralph and Brindis 2010; Kavanaugh et al. 2013; Jones and Boonstra 2005; Loxterman 1997).

Despite these efforts, demographic and economic factors were perceived to shape ASRH outcomes in NYC irrespective of access to and availability of services, most notably, cultural diversity and social and economic inequality. In particular, interviewees frequently noted the challenges of delivering services that are deemed acceptable and appropriate to the multitude of ethnic and immigrant groups in the city, many of which were seen to be more conservative about issues relating to teen sexuality and less supportive of reproductive healthcare. Additionally, some participants remarked on the limits of family planning services when enacted within a deeply inequitable city, where divisions between wealthy and poor continue to widen.

While RH stakeholders disagreed about the best ways to deliver family planning to youth, most emphasized the need for these settings to be “adolescent friendly,” confidential, and integrated with other social, mental health, and support services, aligning with city-level recommendations about the provision of such services that are also supported by national organizations such as Advocates for Youth (2009). Furthermore, echoing national attention, a salient finding among RH stakeholders was the preeminence of LARC in the field of ASRH, a relatively recent development. Renewed clinical and public health interest in LARC has been the result of shifting guidelines from professional organizations and recent studies that have argued that when cost is removed as a barrier and LARC are presented first, a significant percentage of women choose these methods, which eliminate “user error” and have high continuation rates (MMWR 2014; Peipert et al. 2012; Peipert et al. 2011). Following recommendations to present the most clinically effective methods first in contraceptive counseling sessions, increasing access to, and proximally, use of LARC methods, was of keen importance to many RH stakeholders and HCWs in this study; however, several participants warned that enthusiasm about the uptake of particular methods cannot and should not infringe upon patient’s preferences.

The double-edged sword of LARC methods as potential technologies of both empowerment and coercion has been well documented by researchers in international and domestic settings (Takeshita 2011; Moskowitz and Jennings 1996a; Roberts 1997). Moskowitz and Jennings (1996a) articulate:

“...[LARC] can be seen to enhance reproductive freedom by removing the practical obstacles that hinder many women from using contraception effectively – they don’t need to plan ahead, don’t need to think about taking it every day, don’t need to rely on partners – they can remove the burden and the responsibility of “continuous choice”; but it is precisely these qualities – safety, reversibility, and convenience, that create the possibility

that LARC could significantly restrict the reproductive freedom of some women....”
(viii)

Divergence in opinion over LARC among participants in this study is also evident in the broader reproductive health community, as a small number of researchers have begun to critically reflect upon widespread enthusiasm about LARC (Gomez, Fuentes, and Allina 2014; Higgins 2014). In particular, they have reminded their colleagues that women’s autonomy must take priority over the promotion of particular methods, cautioning that attempts to encourage their use among particular groups deemed at “high-risk” of pregnancy may actually restrict, rather than expand, reproductive choice (Gomez, Fuentes, and Allina 2014).

While the promotion of highly effective forms of contraception was the predominant population-level strategy highlighted in this research and regarded as an essential tool to prevent unintended pregnancy among sexually active female youth, RH stakeholders also noted numerous adjoining approaches to ASRH more broadly that many believed would better serve teens and improve their health. Such strategies included youth development rather than problem or crisis-based interventions, service learning, and improving the quality of education and access to meaningful employment opportunities. Ellen, a former executive for a RHS organization, explained:

“I think it’s [family planning] a resource that needs to be available, but I think we really also need to understand adolescent sexuality. I think we have to understand adolescent development and understand how that’s affected by the environment and the education in general and economic opportunities for people...I’m not sure who said it, but I really quote it over and over, you know, that the best contraception is a future...and within that framework I think...the availability of contraception, it will be used if people have a reason to use it.”

A major challenge identified by RH stakeholders with regard to support for ASRH work was funding. In particular, participants frequently noted that there were resource constraints at the federal, state, and local levels to enact the types of programs and initiatives that may be most

effective. One such example echoed by several participants is the Carrera program, which is a pregnancy prevention program that provides resources, support, education, and case management to young people from the age of 11 through the end of high school. It utilizes a holistic youth development model with a focus on tapping into participants' interests and strengths, while enhancing their knowledge of sexuality and health (Children's Aid Society 2015). The dearth of funding was considered by some interviewees to be a reflection of the broader society's lack of investment in the futures of disadvantaged youth. Aimee considered the implications that support for such comprehensive programs would indicate:

"I think if we have any hope for things to work it's those kinds of programs that are very very comprehensive in terms of the links between supportive services, youth development, recreation, educational opportunity, jobs. And it's so hard to do that given funding streams. And that's why that Carrera model keeps getting looked at, 'cause it worked so well for 20 kids! And I think it's important that it did. And we have to look at ourselves as a society and say, well that's what works. But it would be like a socialist revolution, to think about the amount of money that would cost per kid!"

Although participants in this study acknowledged more distal factors and upstream causes of pregnancy and childbearing during adolescence, they continued to evoke and employ technical solutions to address it. This is reminiscent of Lisa Arai's study (2003) in the United Kingdom, which explored the degree of concordance between the national construction of unintended teen pregnancy as a social and health problem and perspectives from community stakeholders and adolescent mothers. While the socio-economic deprivation discourse was widely recognized, it was the explanation that youth are lacking proper sexual health education and receive mixed messages about sex from the broader society that was given prominence in policy and program development. Accordingly, the target of change becomes individuals, rather than, or in concert with, the determinants themselves. Relatedly, funding is typically distributed categorically and from a problem-based perspective, which participants indicated often had the effect of

precluding their ability to address youths' health and wellness more holistically. Ultimately, while most RH stakeholders reflected on the political dimensions of teen pregnancy and how major investment was needed to tackle the root causes, most reverted back into the world of measures, targets and initiatives that the technocratic, myopic funding approach demands, effectively depoliticizing the issue.

Relatedly, most RH stakeholders remarked in various ways upon the ascendancy of data and evidence-based programs in adolescent health with regard to measuring the impact of their work. While some participants valued the ability of quantitative data and “proven” programs to help determine where to direct scarce resources, others questioned the “politics of evidence” and the extent to which the outcomes of more expensive comprehensive and holistic efforts could be quantified. City health officials in particular strongly supported being “led” by the data and using evidence-based programs, and expressed frustration when data did not carry the same weight for leaders in other city agencies that worked with youth. This finding is reminiscent of Nader and Gonzalez’s study (2000) on the development of a local adolescent health coalition, wherein statistical data came to represent reality, cementing particular narratives about health “problems” and appropriate solutions, and shoring up positions of power.

VALUES, POLICIES, AND PRACTICES

Several overarching themes emerged with regard to the values, policies, and practices exhibited and employed by RH stakeholders and HCWs in the characterizations of adolescence and sexuality, which in turn influenced the promotion and delivery of family planning services. First, youth in this research were predominantly conceived as deriving from a developmental perspective that viewed adolescence as a biologically distinct stage of life with particular cognitive and behavioral hallmarks, wherein youth were limited in their capacity to make healthy decisions. Within this context, a deficit and/or risk-based framework was frequently applied to

explain sexual and reproductive health-related behaviors and recommendations for appropriate solutions, particularly among HCWs. RH stakeholders and HCWs frequently compared and contrasted the behaviors of “grown-ups” and “adolescents,” implying that an absolute dichotomy exists between the two.

The predominant focus on biological determinism that underscored much of the thinking on adolescent development and decision-making reflected by participants was often divorced from the structural, political, and social processes that intersect with individual bodies to produce particular outcomes, despite widespread acknowledgement that significant social and health inequities exist for the groups of young people they serve. For these reasons, Linda Burton and other scholars have underscored the critical importance of ethnography as a methodological approach to the study of human development, particularly among youth of color in disadvantaged communities whose experiences and realities may differ considerably from “mainstream” youth populations upon which traditional theories of development are based (1997; Burton, Obeidallah, and Allison 1996).

Traditional developmental views of adolescence were challenged by the experiences of female youth in this study, who often had a considerable set of responsibilities in terms of caring for family members and a mature conception of what is needed for a successful environment for childbearing. Moreover, given the multitude of obligations many teens juggle in the face of formidable obstacles (e.g., limited means to afford college for those who want to attend, difficulties at home, being separated from parents and siblings), their experiences underscore the perseverance, resilience, and strength needed to “succeed.” These points are poignantly illustrated in Laura’s case, who had a baby in 8th grade, the same year her mother died and she and her siblings were embroiled in a protracted custody hearing to be placed with an aunt. Laura

completed 8th grade and went on to find a high school that had a daycare program for her son, where she was currently a sophomore. When asked what she thought the biggest program facing her at that moment was, Laura replied:

“My [older] sister. She’s the only one holding me back from all of this. ‘Cause my sister, I understand you wanna be in charge of me, yeah okay, I got it...but for three years, I’ve been doing it myself. Why now you wanna get involved with my school? It’s the same thing I tell my boyfriend. It’s like my father – he left me when I was little. When I fell no one was there to pick me up. And now that I know how to get myself up you wanna get involved? No! No thank you. And I tell her the same thing...I tell her, think about your son, worry about him and his school and then you worry about me. I do what I want. I’m a mother now, you don’t have to worry about me.”

For Laura, events in her life had transpired, which required her to rely upon herself, including taking care of her son and attending school full-time. Similarly, Kamilla, 17, had her son at the age of 15, after which she re-enrolled in high school. At her new school, teachers and counselors praised the way she conducted herself and served as a positive role model for other students, with whom she frequently discussed their goals and motivations for behavior. She explained:

“I have a lot of people [from my school] that’s from my projects...My main thing is, and what I tell them is, I’m worried about school, I’m focused on school. You keep playin’ in the hallways while I’m gonna get my education. ‘Cause meanwhile...you’re not getting nowhere. You say you wanna do this, you wanna do that...you can’t do that running around in the hallway...The teachers in my school, the secretary? They be like, when you get older you could be a counselor or something ‘cause the way I talk to kids, I tell ‘em, this is what you want, and this is what you don’t want to happen. I grew up to be a street kid, like, I know about the street, but also if I’m gonna know about the street, I have to be school smart too. I can’t just be street smart ‘cause that’s not getting you nowhere. So I learned a lot in my years.”

Responsibilities and experiences such as the ones described by Laura, Kamilla, and other participants in this study challenge prevailing notions of adolescence that are often rooted in class-derived norms and expectations that may not be reflective of all youth experiences. Linda Burton has argued that, “teens growing up in high-risk environments may attach different meanings to adolescence than teens growing up in mainstream contexts” (1997:209). In

particular, she notes the ambiguity of adolescence as a life course for young people in the urban neighborhoods where she conducted long-term ethnographic fieldwork due to three intersecting forces (Burton 1997). The first, an accelerated life course, refers to one's perception that they will have a shorter life expectancy due to high rates of mortality, morbidity, and incarceration in their families and communities. Diffuse age hierarchies relates to ambiguity surrounding the roles and responsibilities associated with being younger or older, which occur due to "age-condensed families, the overlapping work worlds of adults and teens, and the limited visibility of midlife as a viable life-course stage" (Burton 1997:211). Lastly, and perhaps most evident by the quotes from Laura and Kamilla, is the existence of inconsistent role expectations for young people within their families, communities, and other social institutions (Burton 1997:210). For example, Laura's frustration at her sister for getting involved in her schooling seemed inappropriate to her because she did not see herself as someone for whom her sister was responsible; she is a mother.

More broadly, although youth are considered capable of making autonomous decisions about their sexual and reproductive lives, their behaviors were frequently cast as irresponsible and risky, with a limited ability to plan ahead or determine cause and effect. That these two characterizations of young people can exist simultaneously for professionals working with this population reflects the fluidity of constructions of youth and its paradoxical associations with incomplete decision-making abilities, on the one hand, and autonomous agents with control over their lives and actions, on the other.

There was less widespread agreement among RH stakeholders and HCWs regarding constructions of youth sexuality. While both groups of participants tended to emphasize the principles of choice and independence in sexuality, RH stakeholders were more likely to include

pleasure in their conceptualizations. Alternatively, HCWs often couched their definitions in risk-based language that focused on avoiding the deleterious consequences of sexual behavior, namely, pregnancy and STIs. Reflecting the preferential value placed on young women's autonomy in reproductive decision-making, participants from both groups generally regarded young men's involvement in contraceptive decisions with hesitation or negatively.

Additionally, the ways in which some HCWs characterized youth sexualities, in particular among Latina patients, tended to reinforce cultural and gendered stereotypes about sexual and reproductive behaviors and heterosexual relationships. For example, in this research, HCWs often evoked culture to explain the value of motherhood for Latina teens, fatalism towards pregnancy, and power asymmetries within intimate relationships due to traditional gender norms. Heterosexual relationships were often painted in broad strokes as unhealthy and non-monogamous, with young men frequently vilified by HCWs in particular. Emily Mann's study (2012) on the production of Latina youth sexualities at community health centers found similar perceptions among healthcare workers; namely, that pregnancy and childbearing were regarded as wholly problematic and perceived to stem from cultural values about motherhood, conservative views towards sex in Latina families, and significant age differences between Latina teens and their adult Latino male partners (8). Findings regarding the characterization of youths' intimate relationships and sexual behaviors are also reminiscent of research conducted by Carole Joffe with family planning workers in an urban health center, which described their role in the cultural shaping and regulation of their patients' sexuality via the knowledge they do or do not impart to them regarding "...acceptable ways to conduct a sexual life" (1986:4).

BLAMING INDIVIDUALS OR THE ENVIRONMENT?

An important theme that emerged with regard to the values and practices of HCWs and RH stakeholders related to the ways in which participants conceived of the relationship between reproduction and socio-economic disadvantage. As described in Chapter Five, this association has persisted since the early days of the family planning movement in the United States (Roberts 1997). Interviewees referenced numerous factors to illuminate proximal and distal causes of teen childbearing, which disproportionately occurs among low-income youth of color in NYC, with influences identified at the individual, family, community-levels and broader social institutions and structures.

For many participants, and in particular HCWs, causes were rooted in perceptions that their teen patients lived in “toxic” communities with few positive role models, dysfunctional homes, low family or community priority placed on education, and repeating cycles of childbearing perpetuated by each subsequent generation. A small number of HCWs identified the perceived economic value of children within a household in the form of public benefits and subsidized housing to be a powerful motivator, a finding that has been observed in other studies (Chirayath 2007). To some extent, comments such as these are reminiscent of the now widely debunked culture of poverty thesis, a decontextualized and apolitical explanation for poverty, which suggests that poor individuals and communities comprise a distinct subculture with deficient characteristics and values that result in their disadvantage (Lewis 1961; Bourgeois 2001). Its wider application in public discourse and social policy essentially blames the poor for their lot in life.

However, some participants also grappled with linking patient’s choices and outcomes to broader social and structural processes, reflecting a palpable tension between, on the one hand,

an acknowledgment of the structural constraints that limit their patients' agency, and on the other, the narrow clinical gaze on individual behavior. For example, although HCWs recognized the importance of the family planning services they offered, some reflected on the limitations of this model to address the "real" issues:

"I just feel like delaying pregnancy, believe me, I think it's an important thing, but they just have so much other stuff that's going on. The neighborhoods aren't safe, their parents are barely home and often working two jobs...and then there's also the language barrier too. Where my school is in the south Bronx, a lot of them have been in the States for two years and still can't speak good English....It's like, how far are you gonna go if you can't even speak the native language?" (Michelle, SBHC medical provider)

Accordingly, it can be argued that some interviewees were attempting to articulate the structural vulnerability and violence enacted upon teens to produce differential sexual and reproductive health outcomes, a difficult task given that they did not have the language or framework to do so. Moreover, HCWs' interactions with patients were limited and confined to the clinic setting, which rendered feelings of helplessness to affect the larger picture. A recent study among primary care providers about their responsiveness to poverty among their patients similarly found that physicians struggled with its amorphous nature and imprecise pathways through which it impacted or had relevance for medical care (Bloch, Rozmovitz, and Giambrone 2011). Moreover, providers felt that poverty was outside the scope of their role and "beyond their reach" to address (Bloch, Rozmovitz, and Giambrone 2011:4).

For other participants, the biomedical paradigm in which they were trained, which promotes the primacy of empiricism and deduction, tended to obscure the broader relationships and structures that shape behavior and decision-making. This was apparent in interviews with some HCWs. For example, Brianna, a nurse at the PED clinic, had spoken at length earlier in the interview about the endemic poverty her teen patients faced and the difficulty of living in the

clinic's surrounding neighborhoods. Later, when we discussed the fact that weight gain is a chief complaint among Depo users, she commented:

“Ok, everybody's different. One patient goes, ‘But does it make you fat?’ I said, um, everything makes you fat, it's what you put in your mouth... it's hormonal, it goes with your hormones. If it makes me fat it's not necessarily gonna make you fat. If you feel that it's changing, exercise! You know, watch what you eat...”

Brianna's recommendation to a patient concerned about weight gain to simply exercise and eat healthy, both of which are exceedingly difficult to do in the south Bronx, exemplified the ways in which some participants divorced their teen patients' reproductive decisions from their broader social and economic realities.

HEALTH CARE WORKER ROLES IN THE PROVISION AND UPTAKE OF CONTRACEPTION

HCWs with various clinic roles and responsibilities in relation to the provision of family planning services in primary care settings were included in this study. An overarching theme that emerged was the considerable variation found in what is emphasized and omitted by healthcare workers during family planning visits. Accordingly, assorted counseling approaches were employed and different priorities and topics germane to contraceptive method selection and use were addressed, suggesting a lack of uniformity in the delivery of care that was at least partially shaped by individual provider preferences, clinical experience, and training.

As described in Chapter Two, studies evaluating the efficacy of contraceptive counseling in preventing unintended pregnancy have turned up scant reliable evidence as to one particular strategy's superiority over another (Moos et al. 2003). Counseling approaches described in the literature tend to exist along a continuum from more to less “directive,” meaning the extent to which providers actively steer patients towards particular options during the conversation based on evidence and provider knowledge, and similarly, varied in their use of shared decision-

making between providers and patients (Jaccard and Levitz 2013; Dehlendorf et al. 2013a; Moskowitz and Jennings 1996b). Despite inconsistencies, HCWs often described their approach to contraceptive counseling and education in ways that were aligned with some of the principles of patient-centered care, a model that privileges an understanding of and respect for patients' needs and beliefs and emphasizes informed choice (Yee and Simon 2011a; Dehlendorf et al. 2013a). For example, several HCWs elicited what patients already knew about various methods, as well as their attitudes towards method attributes, in order to help them select a method that best fit their lives. Given the widespread variation of female youths' preferences and needs with regard to contraception, this approach seems particularly well suited to uncover what matters for their decision-making process and tailor the information offered and recommendations given appropriately. Interestingly, few HCWs indicated that they presented methods using the "tiered counseling" model, or in order of clinical efficacy, as recently recommended by the CDC (MMWR 2014), highlighting an area of divergence between shifting professional guidelines and clinical practices.

While HCWs often characterized the outcome of contraceptive counseling sessions as shared between themselves and their teen patients, some participants also appeared to base their recommendations on personal preference for specific methods or attempted to "negotiate" continuation of methods when patients wanted to stop using them, underscoring the reality that HCWs can and often do exert considerable control over patients' contraceptive decisions. Dehlendorf and colleagues (2010b; 2013a) have found that while women vary in their preferences regarding the extent and type of provider involvement in contraceptive decision-making and may desire a process of "shared decision-making" with their provider, many rate the importance of autonomy in contraceptive decision-making more highly than for general health

issues. This is particularly evident in studies examining contraceptive counseling preferences among women of color and lower income women, who report experiencing greater pressure to limit their family size and use contraception than white women, as well as receive different recommendations about appropriate methods (Dehlendorf et al. 2010a:217; Dehlendorf et al. 2013b; Dehlendorf et al. 2011). In Yee and Simon's recent study (2011b) of counseling experiences among postpartum women of color, participants rated balanced, non-judgmental conversations that were inclusive of all methods, personalized to patients' needs, and involved women in the decision-making process most highly.

In this research, the delivery of patient-centered contraceptive counseling that gives primacy to patient autonomy was further complicated by the age of patients served by HCWs. As described earlier in this paper, many HCWs held fairly fixed ideas about the limited ability for their teen patients to make "good" decisions, plan ahead, or think abstractly. As a result, some HCWs described the need to "guide" their teen patients' decisions, which may have impacted the information provided and extent to which decision-making was shared.

In addition, the discordant HCW attitudes about medical eligibility and safety issues for particular contraceptive methods evident in this research (most notably, IUDs and Depo Provera) highlight the influence of personal opinion on clinical behavior, and ultimately, the care that is offered. Although not particularly remarkable on its own, an interesting finding that emerged was the inability for most HCWs to acknowledge the evolving accuracy of biomedical evidence for the identified risks of certain contraceptive methods. Given the relative importance that HCWs placed on preventing pregnancy, teen complaints about side effects and concerns were often downplayed or dismissed; yet, at the same time, HCWs shared personal beliefs that were often not reflective of current evidence. For example, several HCWs expressed concerns about

the appropriateness of the IUD for teen patients they perceived as promiscuous or non-monogamous, as they believed these patients were more likely to develop infections from this method. In fact, this still widespread belief among many providers is considered a “myth” based on “older science” and earlier devices that made the risk of an infection traveling to the cervix more likely (Personal Communication 2015).

Literature from the anthropology of biomedicine (Hahn and Kleinman 1983; Lock and Nguyen 2010) has long emphasized the cultural underpinnings and production of biomedical knowledge. Similar to other biomedical phenomena, evidence about contraceptive safety and risk is constantly evolving as new studies are conducted and technologies emerge. Some HCWs in this study changed their practice to align with the most current evidence available, as illustrated by one medical provider’s comment about attending professional conferences to stay up to date with best practices, while others maintained perspectives rooted in earlier forms of biomedical evidence that are, at least in part, influenced by personal values and preferences.

Lastly, interviews with HCWs revealed that pregnancy desires and attitudes towards contraception among young men were rarely elicited. This omission may stem from the largely unquestioned assumption of most study participants that young men do not want to have children as teenagers and a perspective that privileges autonomous female decision-making with regard to contraceptive use. Recent literature, however, suggests that exploring these issues in counseling and education sessions with young men may be important, as they may be involved in or share contraceptive decision-making with their female partner(s) (Kraft et al. 2010; Schwartz, Brindis, Ralph, and Biggs 2011).

SEXUAL AND REPRODUCTIVE LIVES OF FEMALE YOUTH

The 26 female youth who participated in this study represented a range of reproductive and contraceptive decisions that, among other factors, reflect individual histories, diverse sexual

experiences, relationship dynamics, and familial contexts. To briefly summarize, all participants had used some form of contraception, including condoms; 23 participants had used a hormonal or LARC method, with three indicating that they were not currently using any method of pregnancy prevention. Among the young women interviewed, six had ever been pregnant, with four reporting terminations and two continuing the pregnancy.

As described in Chapter Eight, the majority of participants reported being in a relationship at the time of the interview. Findings from female youth in this study suggest a substantially more complex and nuanced view of relationship expectations, power, and influence on reproductive decision-making than the frequently totalizing characterizations made by HCWs. While some participants described cheating, violence, and controlling behavior in their relationships that negatively impacted their lives in numerous ways, others noted their pivotal role as a source of social support. For example, Fabiana, 15, attributed greater self-confidence and involvement in school to her boyfriend:

“Like, he knows everything I’ve been through in the past, and like my family issues...and I have like really bad trust issues, even with my family, and he makes me confident that I actually have someone there so when I’m down and I need someone to talk to ‘cause I can’t go to my mom about some things...he’s there...he tries to help me out and he gives me advice for what to do. So like, before...I used to smoke, I used to do really really bad things, and when I started going out with him, I kinda realized what am I doing? I’m messing up my own life. I used to do really bad in school and everything. He made me realize that what I was doing wasn’t gonna help me at all...So with him there I kinda little by little realized that he’s right...So with him there I felt more confident and I felt like I can actually do this, I can actually do good in school...”

Female youth with intimate partners frequently remarked upon the low importance sexual activity held relative to other aspects of their relationships. It was also fairly common for participants to describe vaginal intercourse as uncomfortable, particularly when using condoms. Higgins and Hirsch (2007; see also 2008) argue that an exploration of sexual pleasure has largely been missing from studies attempting to understand contraceptive decision-making among

women, reflecting a widespread assumption that pleasure is not a factor upon which decisions are based. To the contrary, several participants in this study articulated difficulties achieving sexual arousal as a result of certain methods that subsequently influenced their use. This finding is echoed in a recent study exploring the relationship between contraceptive decision-making and method-related impacts on women's sexual pleasure (Higgins and Hirsch 2008). Further, participants from all three groups in this study (female youth, HCWs, and RH stakeholders) referenced concerns young people have about the safety and efficacy of NYC-branded condoms (e.g., that they break or slip more frequently than other types of latex condoms), which is the type most readily available in public high schools and SBHCs. This mistrust, coupled with the overall lack of discussion about sexual pleasure between female youth and their partners as well as with HCWS, and an almost exclusive focus on condoms in the context of disease prevention, may contribute to female youths' attitudes towards and willingness to use them. While risk and protection are important concepts to include in STI and pregnancy prevention strategies, several studies have demonstrated greater use of condoms when their adoption is eroticized (e.g., incorporated into foreplay) and sexual pleasure is included in public health and clinical messaging (Scott-Sheldon and Johnson 2006; Tanner and Pollack 1988).

For most young women who decided to initiate a hormonal or LARC method, a complex cost-benefit analysis was conducted based on existing and new information, experiences, emotional reactions to the methods themselves, the value attributed to menstruation and importance of maintaining regular periods, and perceived risks associated with either the method itself or side effects. Teens frequently mentioned the importance of gathering input about contraception from several sources, including mothers, friends, and boyfriends, to help inform their decisions, reflecting the influence of teens' social networks in shaping method selection,

which has also been observed in other studies (Yee and Simon 2010). In contrast to what some HCWs and RH stakeholders believed, discussions about reproductive behaviors among youth relationships, such as the selection of a contraceptive method, getting tested for STIs, and using condoms, and attitudes towards pregnancy, reflect elements of shared decision-making with their partners. For example, several female youth jointly decided what method(s) to try after conversations with their partner, who in some cases helped research available options. Returning to literature from the anthropology of reproduction, these findings make clear that reproductive decisions are both personal and embedded within a broader nexus of social and intimate relationships, institutions, and contexts.

Additionally, female youth frequently shared stories or anecdotes about someone they knew or had heard about who had a negative experience with particular methods (e.g., method failure, IUD perforation), illustrating the power of experience (theirs or others) over risk probabilities adopted by HCWs. Also, while it was common for female youth in this study to underestimate the clinical effectiveness of hormonal or LARC methods, participants tended to vocalize the most doubt about the IUD, which is actually one of the most clinically effective methods. The perception that some methods do not work well, or are not as biomedically effective as they are, reflects an interesting example of the disjuncture between population and individual-level risk perception.

Relatedly, HCWs in this study frequently described and expressed puzzlement over the persistence of, from their perspectives, irrational fears and concerns about infertility among many of their teen patients, a finding that was verified in discussions with some female youth as well. While the field of public health typically dismisses the persistence of sterility “myths and rumors” on the basis that they are factually inaccurate, Kaler argues that these rumors tell us

something important about how groups of individuals may imagine their “health, bodies, and the world at large” (2009:1713). Moreover,

“Infertility rumors are particularly powerful because they speak of an injury which is not limited to the present, which extends into the future in the spectral form of children who will never be born. Sterility threatens not only the well-being of individuals and communities as they exist now, but also the future existence of that collectivity” (2009:1713).

Given the power asymmetries between low-income communities of color and mainstream U.S. society, the legacy of reproductive abuses and coercion enacted by the medical establishment against particular groups of women, and the contemporary focus on teen pregnancy prevention efforts in their communities, it is perhaps not surprising that some female youth described female family members’ and partners’ concerns about the safety of contraception.

Importantly, for most teens selecting hormonal or LARC methods, clinical effectiveness did not appear to drive or determine which highly effective option was chosen. For example, participants did not ascribe value to the fact that pills were less effective than Depo, which was less effective than the IUD, at typical use. These findings should be considered and reflected upon in light of the current policy shift to “move” young women onto more effective methods (e.g., condom users to pills, pill users to IUD, etc.), as effectiveness may not be a salient determining factor for hormonal/LARC method selection for many youth.

CROSS-CUTTING THEMES

Several major themes were identified across all three groups of interviewees. First, significant areas of alignment in participant perspectives will be discussed. All groups articulated the importance of confidential reproductive health services, findings that are widely supported by the available literature (Jaccard and Levitz 2013; Dailard and Richardson 2005; Jones and Boonstra 2005; Loxterman 1997; Jones, Purcell, Singh and Finer 2005). A range of

professional associations, including the American Academy of Family Physicians, the AAP, and the American Medical Association, have issued statements supporting adolescents' access to confidential reproductive healthcare (Dailard and Richardson 2005). While many female youth in this study noted the value of such services being confidential, over half indicated that a parent knew they were sexually active and/or using reproductive health services. Survey data of teens accessing family planning clinics show the same result: in a recent study, approximately 50% of adolescent patients reported that a parent was aware that they were using the clinic. However, if parental involvement for receipt of services was required, some respondents indicated that they would not use a contraceptive method requiring a prescription or any method other than withdrawal (Jones and Boonstra 2005; Loxterman 1997; Jones, Purcell, Singh and Finer 2005).

Researchers have noted that health settings are often ill equipped to meet the needs of youth, as services are not always appropriate, acceptable, or delivered in effective ways (Ralph and Brindis 2010; Sisson 2012; Kavanaugh et al. 2013). Moreover, young people often face a number of obstacles in healthcare seeking, including limited ability to pay for services, concerns about confidentiality and parental consent, and a lack of familiarity with the health system or facility (Ralph and Brindis 2010). The benefits of SBHC settings to deliver reproductive healthcare were extolled by RH stakeholders, HCWs in SBHC and non-SBHC sites, and among teen participants. In particular, stakeholders and HCWs highlighted their convenient locations within a familiar setting, no cost service provision, and interdisciplinary staff of medical and mental health providers, attributes that have also been cited in other studies (Daley 2011; Soleimanpour et al. 2010; Crosby and St. Lawrence 2000; Peak and McKinney 1996; Kirby et al. 1991). For female youth, the ease with which they could be seen during the school day, shorter wait times than in community clinics, and high level of trust in the confidentiality of services

were mentioned as key positive features of this setting. Few studies have examined students' attitudes towards receiving RHS in SBHCs or users' satisfaction with these services. This may, in part, be due to the fact that reproductive healthcare is often offered on a limited basis. A recent study in North Carolina, however, found that sexually experienced middle and high school students would go to their SBHC if services were available (Coyne-Beasley et al. 2003).

The ability of SBHCs to deliver reproductive healthcare has been in large part determined by overarching state policies and the level of support given by school districts and sponsoring institutions (Lofink et al. 2013; Daley 2011). In that regard, SBHCs represented in this study do not reflect available services in other cities and states. The most recent national census of SBHCs conducted by the School-Based Health Alliance in 2010-2011 found that the majority (80%) of centers serving middle and high-school students provide at least one reproductive health service, the most common of which were abstinence counseling (82%), pregnancy testing (81%), and relationship violence (77%) (Lofink et al. 2013). However, only 69% provided STI diagnosis and treatment and 65% offered counseling for contraceptive services. Moreover, as of 2011, 50% of SBHCs nationally were expressly prohibited from dispensing contraceptives (Lofink et al. 2013).

Significant areas of divergence were also identified between and among RH stakeholders, HCWs, and female youth, in particular with regard to how a “planned pregnancy” was conceptualized and prioritized and the extent to which planning constituted a salient value regarding reproductive life. First, relating back to predominant characterizations of adolescents, the primacy given to planning with regards to pregnancy by many RH stakeholders and HCWs was not considered to be at odds with the perceived “limited” capacity of teens to plan. There was also little agreement even among RH stakeholders that the concept of intention, often used

interchangeably with planning, was meaningful to all groups of women. Importantly, as the prevailing discourse in NYC privileges intention and planning with regard to adolescent pregnancy, one can presume that *intended* adolescent pregnancies are “acceptable” and thus not the focus of public health initiatives. Some HCWs, however, viewed an intended or planned teen pregnancy to not only be exceedingly rare, but also more unsettling than one that was unplanned, reflecting a discrepancy between broader policy priorities and clinic-level practices.

There was substantial variation in how female youth conceptualized the ideal circumstances under which future pregnancies may occur, with participants employing nuanced definitions and scenarios of what planning, being ready, and trying to become pregnant would look like. For many participants, being “ready,” to have a child, which could mean finishing school, moving out of their parent’s house, or being in the “right” relationship appeared to resonate most, even if a pregnancy was not planned. For other young women, planning was perceived negatively, which may have related to the extent to which planning more broadly in life was considered realistic.

Due to the conceptual and methodological fuzziness of the intention construct, anthropologists have tended to be rather skeptical about its explanatory value (Fordyce 2012; Greil and McQuillan 2010; Kendall et al. 2005; Santelli et al. 2003; Santelli et al. 2009). When considering the substantial variation that exists globally with regard to sexuality, fertility, and family building, a dichotomous category simply fails to capture the diversity of lived experiences and factors that shape them (Santelli et al. 2003:97). Some scholars have interrogated,

“...the applicability of the concept outside of narrow middle class enclaves and have asked whether pregnancies can be ‘planned’ and whether the woman herself - both physically and conceptually - is the locus of control for decision-making about contraception” (Kendall et al. 2005:299).

Accordingly, critics have argued that the concept of intention holds little relevance for women when not considered within the diverse and multifaceted settings in which pregnancies take place (Santelli et al. 2003:97; see also Fordyce 2012; Greil and McQuillan 2010). Additionally, an understanding of the ways in which structural and systemic factors such as poverty and gender inequality restrict women's reproductive decisions and limit access to services is necessary to further explicate how pregnancy intentions are shaped (Santelli et al. 2003:97).

Anthropologists have also examined the primacy given to the notion of planning with regard to pregnancy. Greil and McQuillan note:

“Planfulness appears to be an essential component of contemporary notions of biological citizenship in industrialized societies. Women who did not plan to either become pregnant or not to become pregnant occupy a liminal status in terms of the cultural categories of biomedicine (2010:140).

As prevailing discourses about reproductive health in the United States emphasize women's abilities to control decisions and actions and are informed by narratives of moral and personal responsibility, failure to plan pregnancies is rendered problematic (Greil and McQuillan 2010:140; Fordyce 2012:118). This perspective was evident in a recent editorial from the New York Times, in which the author laments the end of marriage before children and the importance of reversing the trend of couples “drifting” into parenthood by promoting the use of LARC methods:

“If we combine an updated social norm with greater reliance on the most effective forms of birth control, we can transform drifters into planners and improve children's life prospects” (Sawhill 2014:1).

Despite extensive contributions from the social sciences on the limited utility and relevance of the pregnancy intention construct to characterize or explain reproductive life, particularly when divorced from wider socio-cultural meanings, it remains a powerful force in public policy and research. Given the hegemony of planning in reproductive life, coupled with efforts to ensure

widespread access to effective methods of pregnancy prevention, it can thus be seen to constitute a form of stratified reproduction, whereby intended pregnancies are desirable and encouraged and unintended pregnancies are irresponsible and preventable. This stratification is further compounded when such pregnancies occur among female youth (and again, among low-income youth of color) whose reproduction is overwhelmingly represented in public discourse as socially, morally, and medically undesirable.

REVISITING THE INTERSECTION OF CRITICAL AND CLINICAL MEDICAL ANTHROPOLOGY

With consideration of the prominent themes uncovered in this research, it is necessary to briefly revisit and reflect upon the study's overarching theoretical position at the intersection of critical and clinical medical anthropology. As a primary focus of this research was contraceptive decision-making among female youth, an exploration of clinical practices, policies, and interactions was essential to understanding the ways in which particular values and norms about sexuality and reproduction were transmitted and potentially shaped uptake and use of various methods. However, the dispensing of contraception also relates to broader policy goals and social histories; moreover, the management of reproductive life is negotiated within a number of social relationships and structured by wider political-economic forces and inequities. Thus, the strengths of both approaches were drawn upon holistically to elucidate the issues described in this research.

CLINICAL RECOMMENDATIONS

Findings from this research point to several recommendations of relevance to clinic staff and services. First, given the multitude of intersecting values, priorities, and needs articulated by female youth with regard to contraception, HCWs should employ a patient-centered approach to contraceptive counseling and education, as reflected by some participants in this study. In

addition to providing medically accurate information about available contraceptive methods, such an approach entails using open-ended questions and non-judgmental language to elicit patients' preferences, which subsequently inform the delivery of counseling and recommendations (Yee and Simon 2011a). An emphasis on patient-identified issues of importance also helps ensure that HCWs' preferences about what methods are "best" do not guide recommendations.

Further, while youth can self-consent to confidential reproductive health services, an important legal framework given the sensitive and critical nature of this care, contraceptive decisions are rarely made in isolation or without influence from family members and partners. Thus, the role of parents and other family members, peers, and intimate partners in contraceptive decision-making should be integrated into counseling visits. A recent study by Levi and colleagues (2015) on the influence of adolescent and young women's social contexts in contraceptive decision-making found that these patients were much more likely than providers to initiate conversations about their social contexts during counseling sessions, highlighting the need for healthcare workers to better understand and proactively and comfortably discuss patients' broader social influences on reproductive decisions (Levi et al. 2015).

Interviews with young women in this study also suggested a lack of expectations around, interest in, or value placed on sexual pleasure. Moreover, a significant minority of female youth interviewed also described their sporadic or non-use of some forms of contraception (mainly condoms) due to their interference with sexual comfort. Accordingly, there is a need to provide education to healthcare workers on the pleasure dimension of sex and its relation to contraceptive choices so they can better counsel and address these issues proactively with their teen patients, who may be uncomfortable initiating such conversations. Likewise, healthcare workers should

routinely explore power dynamics evident within their patients' intimate partner relationship(s), as several providers in this study described.

Additionally, female youth in this study articulated diverse meanings and values associated with planning pregnancies. Eliciting teens' definitions of biomedical concepts like effectiveness, risk, and planning, in addition to identifying the relative importance placed on such concepts, can provide valuable insight into individual assessments and constructions of risk, which can help inform appropriate messaging and counseling. Relatedly, a modified version of the conceptual models that providers and their teen patients completed in Pamela Erickson's study (1996:65), in which they ranked the features of contraceptive methods, would be helpful to complete in order to elucidate HCWs' biases and better address their patients' contraceptive priorities. While not a focus of this research, findings from female youth also suggest that HCWs engage young men in conversations about their attitudes towards contraception and pregnancy, as they may be important sources of information and/or influence with their intimate partner(s).

Findings from this study also suggest that an assessment of broader life goals concerning education and employment would be relevant and appropriate to include in family planning and contraceptive counseling visits, particularly in the healthcare settings described in this research. Unlike providers in family planning-specific settings who may not see patients regularly, primary care providers benefit from being able to establish rapport and gather information over multiple visits. However, given the challenges raised by HCWs about time constraints to adequately explore these areas with teens, it may be helpful to develop and distribute brief questionnaires that assess broader goals and priorities to be completed while patients are waiting for their appointment.

Finally, Farmer and colleagues (2006) have argued that attempts to ameliorate structural violence, or “social arrangements that put individuals and populations in harm’s way,” can and should be addressed by public health practitioners and clinicians through structural interventions (449). Given the populations that practitioners in this study serve, orientation and training programs for clinic staff should include opportunities to reflect on personal values and biases about adolescent sexuality, including its intersection with gender, and adopt an asset-based approach to working with youth. One potential way through which to facilitate a thoughtful exploration of these issues by clinical staff is the integration of values clarification sessions into staff development days. Conducted in groups or one-on-one with a trained facilitator, the goal of such sessions is to help staff recognize the values and assumptions they hold that influence the care given to patients (Bellas, Asch, and Wilkes 2000; Bruce, DiVenere, and Bergeron 1998; National Abortion Federation 2005). It also affords an opportunity to reflect on where these perspectives may have originated and how best to provide patient-centered and non-judgmental care given the insight garnered through the reflective process. Second, a case-based curriculum, a mainstay of clinical education designed to help learners develop and hone professional skills using patient “cases” (Irby 1994; Thistlethwaite et al. 2012), could be implemented to help healthcare workers better understand the intersection between biological and cognitive development, structural violence and vulnerability, and sexual and reproductive health decisions among their teen patient populations. Discussions resulting from the curriculum could then aid in the development of open-ended questions to patients that would elicit relevant information and provide appropriate referrals to social and mental health resources, community programs, and school or vocational programs. Such a curriculum could also be adapted for use in strategic planning activities undertaken by policy, advocacy, and public health organizations.

PUBLIC HEALTH POLICY RECOMMENDATIONS

Several recommendations germane to public health policy, research, and advocacy are warranted based on this study's findings and recent literature. First, while efforts to make a range of contraceptive methods more accessible to youth are critical, current policy and interventions are increasingly directed towards the uptake and use of LARC, due to their perceived underuse, high clinical efficacy at preventing pregnancy, and presumed role in poverty reduction (Dehlendorf et al. 2015). In line with this emphasis, some have suggested the use of performance measures to incentivize increased use of these methods (Sonfield 2014; Dehlendorf et al. 2015). A recent commentary by Dehlendorf and colleagues (2015) cautioned against the focus on uptake of particular methods, as it could have the unintended effect of encouraging providers to deliver contraceptive counseling and offer method recommendations in ways that are not patient-centered and may potentially be coercive. As the authors note, this is particularly concerning given the legacy of forced sterilization and coercive family planning policies enacted in marginalized communities (Dehlendorf et al. 2015). Instead, they advocate for the adoption of a combination of performance measures that "take into account the importance of both the patient experience of counseling and whether each woman is able to choose the appropriate contraceptive method for her," inclusive of an assessment of provider and systems-level barriers that may limit her ability to do so (Dehlendorf et al. 2015:3). As national conversations regarding the development of appropriate quality family planning performance measures continue, women's needs and preferences must play a central role. The use of qualitative data on women's contraceptive experiences to inform such conversations is one way to ensure that recommendations are grounded in women's reproductive realities and desires.

Moreover, gender studies scholar Jenny Higgins recently questioned the extent to which LARC could ever be a solution to unintended pregnancy, even with greater awareness of and access to them, arguing:

“Even if LARCs were readily available and affordable, and even if clients and providers alike were well informed of LARC’s benefits, women are unlikely to use these methods at the wished-for rates. LARC cannot single-handedly address the myriad relational, social, and cultural factors that may undermine contraceptive use. It would be unwise to depend on any one method to accomplish these social goals; it would also be unfair to place the burden of such social change on women’s bodies and contraceptive behaviors” (2).

In order to further the goals of sexual health equity and reproductive justice, policy and advocacy efforts should not only address issues regarding access to and awareness of contraception, but also support the social, educational, and occupational opportunities of young people, their families, and the broader communities of which they are a part (Sisson 2012; SmithBattle 2012). Given the political and economic contours of teen childbearing, public health policies and programs should employ politically engaged strategies in both clinical and non-clinical settings as part of a multi-sectoral approach. Smith-Battle (2012) suggests the enactment of upstream policies that tackle poverty for low-income youth and their families in more structural ways, such as minimum wage increases, expansions of the Earned Income Tax Credit (EITC), job skills and workforce development training, and educational policies that facilitate access to vocational training and college (449). Practically speaking, in order to better integrate social and economic justice approaches into family planning initiatives in NYC, efforts should be made to convene a cross-section of leaders beyond clinical and public health stakeholders with expertise in education, criminal justice, economic opportunity, and youth development to develop and work towards a youth justice-oriented agenda, of which reproductive health is one interrelated component. Finally, given the challenges articulated by RH stakeholders in this study with

regard to both the limited availability and narrow streams of funding for ASRH, as well as the growing importance of evidence-based/evidence-informed strategies to guide funding decisions, integrated youth development programs used in diverse youth settings and communities must be rigorously evaluated and their findings disseminated. Advocacy at the state and federal levels should then be undertaken to ensure that integrated programs with an evidence base receive adequate funding.

LIMITATIONS OF THE STUDY

This study was not without limitations. First, use of the vertical slice framework presented several drawbacks methodologically. Because the three groups of interviewees understood and approached the study topics from different viewpoints, the breadth of salient topics uncovered was expansive and often divergent. Given the immense production of data that resulted from this approach, it was challenging to develop an analytical plan that adequately allowed for the exploration of cross-cutting themes. Second, a more robust application of the vertical slice would have likely included additional perspectives both within and beyond the city-level, encompassing those from parents of teens, school officials, and religious organizations, as well as national discourses on teen pregnancy and contraception and the influence of pharmaceutical companies that develop and market contraceptives to consumers. Future studies would benefit from the incorporation of such stakeholder groups.

Second, as described in Chapters Five and Six, NYC has a robust healthcare infrastructure, widespread political and public support, and regulations that enable the delivery of ASRH and facilitate teens' access to low-cost or free hormonal/LARC methods. Thus, the results of this study cannot be generalized to other parts of the country, or even of NYS.

Additionally, female youth were recruited exclusively from clinic settings and likely differ in important ways from those youth not seeking healthcare. While these features of the study

setting and sample can be considered limitations, they also allowed for the ability to control or account for access to contraception, which has been highlighted as a prominent potential barrier to hormonal/LARC use in many studies and in other parts of the country. From this perspective, they can also be considered strengths of the study.

As is frequently the case in clinic-based ethnographies, participants were only interviewed once; thus, the methods utilized resulted in a particular snapshot in time, and while anthropologically informed, did not benefit from participant observation or long-term fieldwork (Sobo 2009). While interviews asked youth to reflect upon their contraceptive experiences to date, the study design itself was cross-sectional, limiting the extent to which findings or themes could be explored prospectively. Although it would be a considerable investment of time and resources, longitudinal studies examining how contraceptive use behaviors and reproductive decision-making shift over time would enhance the current evidence. Additionally, information about the content of contraceptive counseling visits was self-reported by both healthcare workers and female youth, which is subject to recall bias. This research would have benefited from the opportunity to observe or record contraceptive counseling visits, a methodology that has precedent in the literature, although primarily in international settings. For example, Maternowska's study (2000) of family planning interactions in Haiti entailed patient-provider observations and interviews with female clients and clinic personnel. Such an approach would allow for better triangulation of data between patients and providers on the content of such visits. Given the important role of social networks and neighborhood dynamics in managing reproduction, future studies would also benefit from involving partners and family members of youth in order to better understand contraceptive behaviors.

Lastly, as an overarching aim of this study was to examine contraceptive practices and meanings ascribed to pregnancy among female youth, its focus was limited to vaginal intercourse within heterosexual relationships. An important next step would be to broaden the scope of the current research to explore the wider context of sexual expression among young women and men and include those who identify as bisexual, lesbian, or gay. This is particularly salient given a recent study's findings that teens in NYC who identified as bisexual, lesbian, gay, or reported having had female and male partners had higher odds of pregnancy than heterosexual teens or those with only opposite-gender sexual partners (Lindley and Walsemann 2015: 1379).

AVENUES FOR FUTURE RESEARCH

In addition to addressing some of the limitations described above, future research would benefit from the inclusion of more participatory youth methodologies. Social science and public health studies utilizing visual methodologies such as Photovoice and photo elicitation have demonstrated potential to “promote reflection and communication about issues that might otherwise be difficult to conceptualize and express” (Drew, Duncan, and Sawyer 2010:1678; Hensel, Newcamp, Miles, and Fortenberry 2011; Richardson and Nuru-Jeter 2012; Wang 1999; Hussey 2006). This is particularly true when researching sensitive topics such as sexual behavior and attitudes. Use of other methods such as contraceptive journals and relationship diaries may also augment this research and illuminate the social and material worlds youth inhabit outside of clinical settings.

Given the substantial number of teen participants who reported being in committed relationships and the extent to which contraceptive decisions were discussed, and in some cases, shared among the couple, it would also be important for future studies to incorporate male partners' perspectives on contraception and attitudes towards pregnancy. Future research

examining youth and HCWs' knowledge about, awareness of, and attitudes towards condoms should also be conducted given their varied selection and widespread availability. Additionally, a substantial percent of teens cited female family members within their or their parents' generation who had been a teen parent, and many related this family history to an impetus for using protection and avoiding pregnancy. Intergenerational research within families who have experienced teen parenthood on contraceptive attitudes and reproductive decision-making would also represent an important area of future research.

FINAL CONCLUSIONS

Grounded in the theoretical traditions of clinical and critical medical anthropology and drawing from disciplinary scholarship on youth, reproduction, risk, and policy, this study examined contraceptive decisions and experiences among female youth of color in the Bronx, exploring the role of clinical interactions, peer, family, and romantic relationships, as well as broader institutions and discourses, in shaping them. It also interrogated the content, approach, and values informing the delivery of contraceptive counseling by healthcare workers and within broader public health policy and messaging about adolescent reproduction and pregnancy prevention in New York City. The “vertical slice” framework (Nader 1972) was used in order to situate perspectives from female youth in the Bronx, healthcare workers in primary care settings, and local leaders in adolescent reproductive health. This dissertation explored the promotion of highly effective contraception as a key strategy to combat unintended adolescent pregnancy from the perspectives of stakeholders at various vantage points of the issue. Specifically, it examined the political, clinical, and socio-cultural landscapes within which youth sexual and reproductive health is situated in NYC, articulating prominent strategies and challenges identified by participants. This study also elucidated particular values, beliefs, and ideologies undergirding

healthcare workers' constructions of youth sexuality and the delivery of family planning services. Juxtaposed to the ways in which reproductive health leaders and healthcare workers characterized adolescent behaviors and decisions were the perspectives of female youth of color on their sexual and reproductive lives. In contrasting the experiences and desires of youth regarding pregnancy prevention and the salience of planning future pregnancies with the priorities of leaders and HCWs, this dissertation revealed areas of alignment and divergence among the three groups. Accordingly, recommendations for clinical practice and public health policy were offered.

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APPENDIX A: TIMELINE OF RESEARCH ACTIVITIES

Research Activity	Dec 2012	Jan 2013	Feb 2013	Mar 2013 -Apr 2014	May - Aug 2014	Sept 2014 – Mar 2015	Apr 2015
IRB submission	X						
Interview guide development/ modification	X	X					
Interview guide pilot testing		X	X	X			
Recruitment				X			
Data collection				X			
Data analysis				X	X	X	
Interview transcription				X	X		
Write-up and revisions						X	
Dissertation defense							X

APPENDIX B: ACRONYM LIST

Adolescent Sexual and Reproductive Health (ASRH)
American Academy of Obstetrics and Gynecology (ACOG)
American Academy of Pediatrics (AAP)
Centers for Disease Control and Prevention (CDC)
Combined Hormonal Contraception (CHC)
Comprehensive Sexuality Education (CSE)
District Public Health Office (DPHO)
Dominican Republic (DR)
Earned Income Tax Credit (EITC)
Emergency Contraception (EC)
Explanation of Benefits (EOB)
Family Medicine Clinic (FMC)
Family Planning Benefit Program (FPBP)
Food and Drug Administration (FDA)
Federally Qualified Health Center (FQHC)
General Education Development (GED)
Health Resources and Services Administration (HRSA)
Healthcare Workers (HCWs)
Healthy Teens Initiative (HTI)
Human Papillomavirus (HPV)
Intrauterine Device (IUD)
Long-Acting Reversible Contraception (LARC)
Medicaid Managed Care (MMC)
Morbidity and Mortality Weekly Report (MMWR)
National Center for Health Statistics (NCHS)
National Survey for Family Growth (NSFG)
New York Civil Liberties Union (NYCLU)
New York Police Department (NYPD)
New York City Department of Education (NYC DOE)
New York City Department of Health and Mental Hygiene (NYC DOHMH)
New York City Human Resources Administration (NYC HRA)
New York State (NYS)
Obstetrics and Gynecology (OB/GYN)
Patient Protection and Affordable Care Act (ACA)
Pediatric Clinic (PED)
Pregnancy Risk Assessment Monitoring System (PRAMS)
Reproductive Health (RH)
Reproductive Health Services (RHS)
School-Based Health Center (SBHC)

Social Cognitive Theory (SCT)
Theory of Planned Behavior (TPB)
Theory of Reasoned Action (TRA)
Transtheoretical Model (TTM)
Unintended Pregnancy (UIP)
World Health Organization (WHO)
Youth Risk Behavior Survey (YRBS)

APPENDIX C: CONTRACEPTION ABBREVIATION REFERENCE LIST

Contraceptive Method	Abbreviation(s)/Alternative References
Depo-Provera	Depo, the “shot,” DMPA
Emergency Contraception	EC, Plan B
Hormonal Implant	Norplant®, Implanon®, Nexplanon® (brands)
Intrauterine Device (IUD)	Mirena®, Paragard® (brands), Copper T380 (type), the “T”
NuvaRing®	The “ring”
Oral Contraceptive Pill (OCP)	The “pill,” the birth control pill
Withdrawal	Pull-out

APPENDIX D: INTERVIEW GUIDES

Reproductive Health Stakeholder Interview Guide (12 interviews, 45 to 150 minutes each)

1. Please tell me a little bit about your educational and professional background.
 - a. Probe: How did you become involved in adolescent reproductive health work?
 - b. Probe: How long have you been involved in this work?
 - i. Probe: Could you please describe previous positions and duties that you have taken on in relation to your work in adolescent reproductive health?
 - ii. Probe: How, if at all, have these experiences informed how you approach issues in adolescent reproductive health in your current position?
2. What do you see as the overarching goal of your work related to adolescent reproductive health?
 - a. Probe: What does “healthy” adolescent sexuality look like to you?
3. What is your current involvement in work related to adolescent pregnancy?
 - a. Probe: What are some of your roles and duties in this topic area?
4. How, if at all, has the dialogue about adolescent pregnancy and prevention changed in New York since you have been professionally involved with this topic? Nationally?
 - a. [If applicable] Probe: In your opinion, what factors were involved in the changing of this dialogue?
5. In your opinion, what are some of the causes to or antecedents of pregnancy and childbearing during adolescence?
6. In your opinion, what do you see as some of the consequences or risks of teen pregnancy? Childbearing?
 - a. Probe: biological, social, economic
7. In your opinion, what is the relationship or connection between poverty and adolescent pregnancy?
8. What is you see as your organization or agency’s role in addressing the issue of teen pregnancy?
 - a. Probe: What strategies have been adopted and how “successful” have they been? What constitutes success?
 - b. Probe: In your opinion, have you seen any limitations to the ways in which your organization addresses teen pregnancy prevention? If so, what?
 - c. In what ways has your organization influenced adolescent reproductive health policy and/or advocacy in New York? Nationally?
9. In your opinion, what is the “lead institution” for addressing adolescent pregnancy prevention in New York?
 - a. Probe: Why?
10. What do you think are some of the most effective strategies to address the issue of adolescent pregnancy?
 - a. Probe: Education, media campaigns, family planning services, youth development

- programs, social justice approaches
- b. Probe: Particular policies/legislation?
 - c. Probe: In your opinion, what makes these strategies more effective than others?
11. How, if at all, are young men involved in your organization/agency's strategy to address adolescent pregnancy?
 - a. Probe: Challenges and successes of your approach?
 12. What are some of the challenges you've seen in attempting to address the issue of adolescent pregnancy and how have they been handled?
 13. Do you agree with the following statement? "All adolescent pregnancies should be prevented." Why or why not?
 - a. Probe: Intended versus unintended pregnancies, younger versus older adolescents, etc.
 14. How do you define pregnancy intention (or unintended pregnancy)?
 - a. Probe: [If applicable] How, if at all, is this classification used by your organization in adolescent pregnancy prevention efforts?
 - b. Do you think pregnancy intention is a meaningful measurement? Why or why not?
 15. What barriers, if any, do you think adolescents face in accessing family planning services in New York City? The Bronx specifically?
 - a. Probe: What policy and programmatic approaches might make these services more available and accessible to this population?
 16. From your perspective, what social and/or economic factors facilitate or hinder the ability for teens to consistently use contraception?
 17. In your opinion, are some contraceptive methods "better" than others for adolescents?
 - a. Probe: Why? What experiences have led you to these conclusions?
 18. Is there anything else that we haven't covered that you would like to discuss before we end our conversation?

Additional Demographic Information

1. Age:
2. Gender:
3. Self-identified ethnic background:

Healthcare Worker Interview Guide (18 interviews, 25 to 86 minutes each)

1. Tell me a little bit about your educational and professional background. How did it lead you to work in this health center?
2. Can you describe for me what your job involves?
 - a. What is a typical workday for you?
 - b. How many patients do you see each day?
3. Can you describe the overall goal of this health center?
4. Can you describe your adolescent patient population for me?
 - a. Probe: age, income, insurance status, foreign-born, race/ethnicity, home residence
5. What are the most common reasons your adolescent patients come to the health center?
6. What are the main reasons for reproductive health visits among the adolescents that you see?
 - a. Probe: Generally speaking, do your patients come in with an “identified” reproductive health concern or are these issues identified through the course of other visits?
7. What does “healthy” adolescent sexuality look like to you?
8. Tell me what you discuss with adolescent female patients who are thinking about going on a birth control method.
 - a. Probe: Do you ever discuss the influence of parents or partners in contraceptive decision-making? How?
9. What are the most common birth control methods used among the adolescent patient population at your health center?
10. Are method switching and/or discontinuation common among the adolescent female patients you see?
 - a. Probe: If yes, why do you think that is?
11. In your opinion, are some contraceptive methods “better” than others for adolescents?
 - a. Probe: If yes, why? What experiences have led you to these conclusions?
12. Vignette 1: A teenage female patient comes in who had used DMPA previously but is now using condoms and sometimes EC. She has been seeing the same partner for the past 6 months and has been pregnant once before. She isn’t interested in starting a regular hormonal/LARC method. What sort of information would you want to discuss with her?
 - a. Probe: What additional information would you want to know from this patient?
 - b. Probe: Is this a common patient scenario in your clinic?
13. Vignette 2: A teenage female patient comes in to obtain STI test results. In the past, she has been on the patch, ring, OCP, and condoms occasionally. She is currently not using anything. What sort of information would you want to discuss with her?
 - a. Probe: What additional information would you want to know from this patient?
 - b. Probe: Is this a common patient scenario in your clinic?
14. Vignette 3: A teenage female patient comes in who has had 2 terminations in the past 3 years. Right now she’s using condoms most of the time. What sort of information would you want to discuss with her?
 - a. Probe: What additional information would you want to know from this patient?
 - b. Probe: Is this a common patient scenario in your clinic?
15. What do you think are the challenges teens face in using birth control consistently?
 - a. Probe: Do you think these challenges are unique to your patient population? Why

- or why not?
- b. Probe: Are these challenges unique to young people? Why or why not?
16. In family planning visits, do you discuss adolescent patients' attitudes about pregnancy? Pregnancy ambivalence? Why or why not?
- a. Probe: In your experience, do you think contraceptive behaviors align with pregnancy intentions? Why or why not?
17. How do you feel the issue of parental/familial involvement should be approached in the provision of family planning services for adolescents?
18. Based on your experience, how easy is it for adolescents to access family planning services in the Bronx?
- a. In your opinion, what are the barriers that adolescent patients deal with when they try to use these services? [probe for each]
- b. What kinds of things would help patients be able to use these services more easily? [probe for each]
19. In your opinion, what are some of the causes to or antecedents of pregnancy and childbearing during adolescence?
20. In your opinion, what do you see as some of the consequences or risks of teen pregnancy? Childbearing?
- a. Probe: biological, social, economic
21. In your opinion, what is the relationship or connection between poverty and adolescent pregnancy?
22. How important/significant do you feel the issue of pregnancy is among your adolescent patient population?
23. Is there anything else you would like to talk about before we end our conversation?

Practice & Patient Information

1. Specialty:
2. Where do the patients that you see come from, in general (i.e., catchment area)?
3. Where did you receive your professional training?
 - a. What year did you graduate?
4. (If not answered) About how many adolescent patients do you see for family planning services each month?

Additional Demographic Information

1. Age:
2. Gender:
3. Self-identified ethnic background:

Female Youth Interview Guide (26 interviews, 24 to 98 minutes each)

Demographics/Background

- 1) How old are you?
- 2) Where were you born?
- 3) Where were your parents born? Grandparents?
- 4) Did you grow up with any religion?
 - a. Probe: How often do you attend religious services?
- 5) Who lives with you now?
 - a. Probe: Tell me a little bit about your home life.
- 6) What do you like to do in your free time?
- 7) [If applicable] Where did/do you go to high school? How did you decide what school to go to?
 - a. [If applicable] Probe: What grade are you in school?
 - b. [If applicable] Probe: Tell me a little bit about school (favorite subject, what interests you the most, etc.)
- 8) Do you have a job? Is it paid? What about any jobs you have that are unpaid? (childcare, making dinner, etc.)
- 9) Are your parents/guardians working outside your home?
- 10) Tell me a little bit about your parents'/guardians' relationship. What's it like?
- 11) Do you have any children?
- 12) Do you know if you have health insurance? If so, what kind?

Sources of information about sexual and reproductive health

- A. Where do you find out or get information about sex, birth control, relationships, etc.?
 - a. Probe: parents/family, peers, health care providers, school, media
- B. What kind of things have you heard?
 - a. Probe: about birth control, relationships, STI prevention, etc.
- C. Do you trust some sources over others? Who or what are the most important sources of information to you? Why?

Sexual/reproductive health and relationship history

- A. What expectations did you have about having vaginal intercourse (sex) for the first time?
 - a. Probe: How did it come about? What was your reaction?
- B. At what age did you first have sex?
 - a. Probe about any conversations she and her partner had about prevention of pregnancy and STIs; birth control methods used; how decisions to use or not use a method were made
- C. Have you ever been in a relationship? How is a relationship different from "going out"?
 - a. Probe: Tell me a little bit about your first relationship.
- D. What kinds of qualities do/would you look for in a partner?
- E. Are you currently in a relationship?
 - a. Prompt: Tell me about this relationship. What is sex like in your current relationship?
- F. Have you ever been pregnant?
 - a. Probe: How many times? What were the results of your pregnancies?

G. Have you ever had an STD? Please explain.

Sexual Health Risk

- A. Do you think there are any risks involved in having sex?
 - a. Probe: If yes, what are they? What about them is risky?
- B. Do you think you could become pregnant (if applicable: again)? Why or why not?
 - a. If applicable: Have you ever been concerned that you couldn't get pregnant? [If yes: Tell me more about that]
- C. What about getting an STD? Why or why not?

Contraceptive knowledge and use

- A. Tell me about the types of birth control you've heard about.
 - a. Probe: where did you learn about them? Did anyone give you advice about going on birth control? What or who did you trust the most? Why?
 - b. Probe: Do you discuss birth control with your friends/family/partner? Do their opinions influence what you decide to use? Do you think they "support" your using birth control? Why or why not? What's it like to talk with your (past and current) partner(s) about birth control?
 - c. [If applicable] How important are your female family members' opinions about birth control? (e.g., mother, grandmother, sisters). What are their thoughts about birth control?
 - d. Who in your family knows that you're sexually active? That you're using birth control?
- B. Why did you first decide to use birth control? What prompted you to make this decision?
- C. What types of birth control have you used?
- D. How have you used it (them)? (Probe: every day/week/month at the same time? Or, only before/after particular events?)
 - a. Probe: With whom?
 - b. Why did you choose that method?
 - c. What are some of the things that you've like about these methods? Disliked?
- E. Have you switched birth control methods?
 - a. What method did you switch to?
 - b. What was the reason for switching methods?
 - i. Who/what influenced your decision to try the new birth control method?
 - c. [If applicable] In your day-to-day life right now, would there be any other scenarios that would make you switch your birth control to something else? Please explain.
- F. Do you think your decisions on which birth control methods to use are similar to your girlfriends? Why or why not?
- G. [If applicable] Have there been times when you've stopped/taken a break from using birth control?
 - a. If yes, what was the reason was for stopping?

- b. [If applicable] What did you do to prevent pregnancy during these times, if anything?
- H. Are there any reasons why you would stop using birth control? Tell me about them.
- I. What do you currently use to prevent pregnancy, if anything?
 - a. Probe: Why are you using this method?
- J. Do you use condoms? How you decide when to use them? Do you use them in addition to another type of birth control? Why or why not?

Access to contraception

- A. Tell me about how you have gotten birth control in the past.
- B. [If applicable] What about now?
- C. Could you describe what your experience has been like getting birth control from a clinic?
- D. Now just thinking about the information and services you've received about birth control at the clinic - what did the doctor tell you?
 - a. Probe: Were you happy with the information and services you got? Why or why not?
 - b. Probe: Was there anything else you think would have been important for them to discuss with you? What?
- E. What are some ways that you think birth control services could be improved?
- F. Have there been times when you've wanted to use birth control and couldn't for some reason? Tell me about that.
- G. Is there anything that makes it hard to use birth control regularly? Tell me a little bit about that.
 - a. Probe: access, availability, cost, partner, not concerned about becoming pregnant, etc.
- H. Are there any other medications you take?
 - a. Probe: Every day? Regularly? Is it difficult to take these? How, if at all, are they different from birth control?

Pregnancy desires and the concept of planning

- A. How important is trying to prevent a pregnancy right now?
- B. How would you feel about becoming pregnant right now? (Rephrase: What do you think would happen if you became pregnant right now?)
 - a. Prompt: positives, negatives, reasons to become pregnant, reasons not to become pregnant.
- C. [If applicable] How would your current partner feel about you becoming pregnant?
- D. What about other people in your life? How would they feel about you becoming pregnant?
- E. When, if ever, do you see yourself becoming pregnant (again) in the future?
 - a. What would you want your life to be like?
- F. When you hear the phrase "planning a pregnancy," what does that mean to you? What is involved in planning a pregnancy, in your opinion?

- a. Probe: What are the pros and cons of planning for pregnancy? Who is involved in the “planning” (partners, family, etc)?
 - b. Do you see pregnancy as something you would plan for in the future? Why or why not?
- G. Is there anyone in your family who had children when they were 18 or younger?

Future aspirations and goals

- A. What are three words that best describe you?
- B. What do you see as some of your strengths?
- C. What do you want your life to be like in the next 5 years? 10 years? (Probe: education, employment, family)
- D. What are some things you hope to achieve in your life?
- E. What might make these things more or less likely to happen?
 - a. How, if at all, would having a baby impact these goals?
- F. There are many problems that we face every day. What are the biggest problems facing you now?
- G. What does “success” in life look like to you?

Is there anything else you would like to talk about before we end our conversation?

APPENDIX E: IRB APPROVAL LETTERS



RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
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1/22/2014

Hannah Helmy
Anthropology
4202 East Fowler Ave
Tampa, FL 33620

RE: **Expedited Approval for Initial Review**

IRB#: Pro00011246

Title: Understanding contraceptive decisions among adolescent females: An exploratory qualitative study

Study Approval Period: 1/22/2014 to 1/22/2015

Dear Ms. Helmy:

On 1/22/2014, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):

Protocol Document(s):

[H Helmy Research Protocol](#)

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.



science in the heart of medicine

Institutional Review Board

Yeshiva University
FWA#00000140

Montefiore Medical Center
FWA#00002688

North Bronx Healthcare Network
FWA#00009807

East Campus IRB

Jack and Pearl Resnik Campus
1300 Morris Park Ave., Belfer 1002
Bronx, NY 10441
718.430.2237 fax 718.430.8817

West Campus IRB

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3308 Rochambeau Avenue
Bronx, NY 10467
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<http://www.einstein.yu.edu/irb>

January 19, 2013

Principal Investigator: Dr. Marji Gold, Department: FAMILY MEDICINE

Protocol Number: 13-01-009

Understanding contraceptive decisions among adolescent females: An exploratory study

Federal Wide Assurance: 00002558

Study will appear on the IRB Agenda of: 01/25/2013

Dear Dr. Gold:

The Einstein Institutional Review Board (IRB) has approved the above-referenced study, on the basis of its scientific merit and risk:benefit ratio, in accordance with the expedited review categories under 45 CFR 46.110 and 21 CFR 56.110. The research risk level is in accordance with 45 CFR 46.404. Under this category of research with children, the permission (written consent) of one parent is sufficient.

IRB approval for this study will expire on **1/18/2014**.

Approved Items:

- Waiver of documentation of informed consent and HIPAA authorization.
- Waiver of parental permission.
- Patient and Provider Oral Informed Consent Scripts, versions dated 28 December 2012.
- Provider Topic Guide, version dated 28 December 2012, and Patient Topic Guide, version dated 16 January 2013.
- Protocol version dated 16 January 2013.

Please do not hesitate to contact me at 798-0406 if you need additional information.

Sincerely,

Qiana Quiles-Placencia, BS, CIP
Senior IRB Analyst
Einstein Institutional Review Board, West Campus

INVESTIGATOR, please note the following:

1. Use only IRB approved copies of the consent form(s), questionnaire(s), letter(s), advertisement(s), etc in your research. Do not use expired consent forms.
2. Any modifications or changes made to the study must be submitted to the IRB for review prior the initiation of said modifications or changes.
3. Any serious and/or unexpected adverse event in a study subject and /or death of a subject is to be reported to the irb within 48 hours followed by a written report within 10 working days of the event.