



University of
Massachusetts
Amherst

Puerto Rican Teens' Perceptions of Teen Pregnancy and Births in Holyoke, Massachusetts

Item Type	Dissertation (Open Access)
Authors	Gilbert, Nancy J
DOI	10.7275/2175062
Download date	2025-03-16 19:05:08
Link to Item	https://hdl.handle.net/20.500.14394/38807

PUERTO RICAN TEENS' PERCEPTIONS OF TEEN PREGNANCY AND BIRTHS IN
HOLYOKE, MASSACHUSETTS

A Dissertation Presented

By

NANCY J. GILBERT

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2011

School of Nursing

PUERTO RICAN TEENS' PERCEPTIONS OF TEEN PREGNANCY AND BIRTHS IN
HOLYOKE, MASSACHUSETTS

A Dissertation Presented

By

NANCY J. GILBERT

Approved as to style and content by:

M. Christine King, Chair

Josephine Ryan, Member

Aline Gubrium, Member

Jean E. Swinney, Interim Dean
School of Nursing

DEDICATION

To Mark David Gilbert
for your love and support

and

To the Puerto Rican teens
who participated in this study
may your voices be heard!

ACKNOWLEDGEMENTS

There are many people, named and unnamed, who provided me support and encouragement throughout my journey in completing this dissertation. I am grateful to all of you.

I would like to thank members of my dissertation committee, Chris King who served as the chair for my dissertation, Jo Ryan who returned from retirement to be on my dissertation committee – you have been a mentor for me throughout my many, many years of nursing education, and Aline Gubrium who often filled in the gaps as necessary. I would also like to acknowledge Jenny Foster who helped me define my dissertation topic, and Cynthia Goss for her cheerfulness and kind words.

There are three colleagues who I would like to acknowledge. Rosa Feldman, my co-moderator, who was invaluable to me and the research, Pam Aselton who kept me on the right path, and Cheryl Shiels who would answer those little questions

Additional gratitude is extended to a network of people in Holyoke who supported this research: Mayor Elaine Pluta, Mary Fago, David Dupont, Maritza Santiago, and countless others.

I am deeply indebted to the Puerto Rican teens who made time to participate in a focus group and graciously share their perceptions. It was a privilege for me to meet you. Thank you for your wisdom and ideas. May all your goals and dreams come true.

I would like to thank my family for their indefatigable support over all these years: Mark for your patience, support, editing, listening, grocery shopping, and cooking; Erica, Scott and Charlie for your understanding and love; Thomas for your encouraging

e-mails, just when I needed to smile; my mother and my father-in-law Ted for always being there.

I would also like to acknowledge the Beta Zeta at Large Chapter of Sigma Theta Tau International, the Elms College Alumni Association, and the Youth Empowerment Adolescent Health network for providing funding for this research project.

ABSTRACT

PUERTO RICAN TEENS' PERCEPTIONS OF TEEN PREGNANCY AND BIRTHS IN HOLYOKE, MASSACHUSETTS

MAY 2011

NANCY J. GILBERT, B.S., UNIVERSITY OF MASSACHUSETTS AMHERST

M.S., UNIVERSITY OF MASSACHUSETTS AMHERST

Ph.D., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor M. Christine King

The high teen birth rate in Holyoke, Massachusetts is a complex problem. The teen birth rate is over five times the state's rate and nearly three times the national rate. Since a majority of these births are to Latinas of Puerto Rican descent it is important to include the perceptions of Puerto Rican teens in approaches to prevent teen pregnancy and reduce the birth rate. Although there is a plethora of research on the topic of teen pregnancy and births, there is scarcity in the area of perceptions held by teens of Puerto Rican descent about teen pregnancy and births, future consequences faced by teen parents, contributing and protective factors of teen pregnancy, and potential preventive interventions. This qualitative study used a series of eight focus groups to gather data and examine perceptions held by Puerto Rican teens living in Holyoke about teen pregnancy and birth. The Ecological Model of Health Behavior provided the theoretical framework. Findings indicate that Puerto Rican teens in Holyoke perceive that: teen pregnancy is largely unintentional and a problem with negative outcomes, a lack of information on sexual health and reproduction contributes to this problem, sexual and reproductive health education should be provided to all teens, social factors may either contribute to or prevent teen pregnancy teens, and they want their ideas heard. These findings suggest

that teen pregnancy and birth is a complex public health problem in need of a comprehensive approach recognizing that interventions focused on individuals are not likely to have powerful or sustained effects. Rather a combination of interventions addressing individual, interpersonal, community and societal levels are needed for risk reduction and effective behavior change.

TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS.....	v
ABSTRACT.....	vii
LIST OF TABLES.....	xiv
LIST OF FIGURES.....	xv
CHAPTER	
1. TEEN BIRTHS.....	1
Introduction.....	1
Background and Significance.....	3
Statement of the Problem.....	7
Purpose of the Study.....	7
Research Questions.....	8
Definition of Terms.....	8
Significance to Nursing.....	9
Conceptual Framework.....	10
Summary.....	11
2. REVIEW OF THE LITERATURE.....	13
Introduction.....	13
Current Status of the Issue.....	13
Teen Perceptions of Pregnancy and Birth.....	21
Teen Pregnancy Intention.....	24
Female Teen Pregnancy Intention.....	25
Male Teen Pregnancy Intention.....	28
Consequences of Teen Pregnancy and Birth.....	29
Prevention of Teen Pregnancy.....	35
Abstinence Education.....	36
Comprehensive Sexuality Education.....	38
Contraception.....	40
Holyoke, Massachusetts.....	41
Immigration.....	42
Puerto Rican Migration.....	43
Holyoke's Environmental Antecedents to Teen Pregnancy.....	45
Summary.....	49

3. RESEARCH METHOD AND DESIGN	52
Introduction.....	52
Focus groups	53
Research Design.....	55
Focus Group Size and Composition	56
Focus Group Structure and Interview Guide	59
Pilot Focus Groups.....	60
Setting	61
Sample.....	63
Participant Recruitment	63
Protection of Human Subjects	65
Data Collection	66
Data Analysis	68
Trustworthiness in Qualitative Research	70
Summary.....	72
4. FINDINGS	73
Introduction.....	73
Participant Demographic Characteristics.....	74
Data Description	75
Focus Group One – 12 th Grade Girls	76
Perceptions of Teen Births.....	76
Future of Teen Parents	77
Reproductive Health Information	77
Contributing Factors	79
Protective Factors.....	81
Prevention Strategies	82
Summary.....	84
Focus Group Two – 11 th Grade Girls.....	86
Perceptions of Teen Births.....	86
Future of Teen Parents	87
Reproductive Health Information	88
Contributing Factors	89
Protective Factors.....	93
Prevention Strategies	93
Summary	95
Focus Group Three – 12 th Grade Boys	98
Perceptions of Teen Births.....	98
Future of Teen Parents	98
Reproductive Health Information	99
Contributing Factors	100

Protective Factors.....	101
Prevention Strategies	102
Summary	106
Focus Group Four – 10 th grade Girls	108
Perceptions of Teen Births.....	108
Future of Teen Parents	109
Reproductive Health Information	111
Contributing Factors	111
Protective Factors.....	113
Prevention Strategies	115
Summary	116
Focus Group Five – 11 th Grade Boys.....	118
Perceptions of Teen Births.....	118
Future of Teen Parents	119
Reproductive Health Information	120
Contributing Factors	120
Protective Factors.....	122
Prevention Strategies	124
Summary	125
Focus Group Six – 10 th Grade Boys	128
Perceptions of Teen Births.....	128
Future of Teen Parents	128
Reproductive Health Information	129
Contributing Factors	129
Protective Factors.....	131
Prevention Strategies	133
Summary	134
Focus Group Seven – 9 th Grade Girls	137
Perceptions of Teen Births.....	137
Future of Teen Parents	137
Reproductive Health Information	138
Contributing Factors	139
Protective Factors.....	140
Prevention Strategies	141
Summary	143
Focus Group Eight – 9 th Grade Boys	145
Perceptions of Teen Births.....	146
Future of Teen Parents	147
Reproductive Health Information	147
Contributing Factors	148
Protective Factors.....	150

Prevention Strategies	152
Summary	155
Categorization of Data	157
Chapter Summary	160
5. DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS.....	161
Introduction.....	161
Overview of Findings	162
Teen Births Are Perceived as a Problem with Negative Outcomes.....	164
Teens Perceive the Need for Sexual and Reproductive Health Knowledge	167
Social Factors that Contribute to or Prevent Teen Pregnancy and Births.....	170
Findings in Relation to the Ecological Model of Health Behavior.....	175
Level 1 - Individual.....	175
Level 2 – Interpersonal	176
Level 3 – Community	177
Level 4 – Societal.....	178
Recommendations for Interventions	179
Level 1 - Individual.....	180
Level 2 – Interpersonal	181
Level 3 – Community	183
Level 4 – Societal.....	184
Summary of Recommendations	185
Implications.....	187
Implications for Nursing Practice	187
Implications for Programs.....	188
Implications for Policy.....	189
Implications for Research	190
Strengths and Limitations	191
Conclusion	192

APPENDICES

A. FOCUS GROUP INTERVIEW GUIDE	194
B. RECRUITMENT FLYER	196
C. STUDENT INFORMATION FORM.....	197
D. PARENT/GUARDIAN CONSENT FORM – ENGLISH.....	198

E. PARENT/GUARDIAN CONSENT FORM – SPANISH	202
F. TEEN ASSENT FORM FOR TEENS UNDER 18 YEARS OF AGE	206
G. PARTICIPANT CONSENT FORM FOR TEENS 18 YEARS AND OLDER.....	211
H. DEMOGRAPHIC DATA FORM.....	215
REFERENCES	216

LIST OF TABLES

Table	Page
1.1 Race/Ethnicity Teen Birth Differences (15-19 year old) in 2005.....	5
2.1 Negative Environmental Antecedents to Teen Pregnancy and Births: Holyoke, MA, US	47
2.2 Comparing School/Academic Data for the 2009-2010 Academic Year.....	49
3.1 Student Data for Holyoke High School 2009-2010.....	62
4.1 Demographic Data of Focus Group Participants	75
4.2 Summary of 12 th Grade Girls Responses to Focus Group Questions	85
4.3 Summary of 11 th Grade Girls Responses to Focus Group Questions	97
4.4 Summary of 12 th Grade Boys Responses to Focus Group Questions.....	107
4.5 Summary of 10 th Grade Girls Responses to Focus Group Questions	117
4.6 Summary of 11 th Grade Boys Responses to Focus Group Questions.....	127
4.7 Summary of 10 th Grade Boys Responses to Focus Group Questions.....	136
4.8 Summary of 9 th Grade Girls Responses to Focus Group Questions	144
4.9 Summary of 9 th Grade Boys Responses to Focus Group Questions.....	156
4.10 Data Presented by Research Question and Emergent Categories	157
5.1 Recommendations for Interventions Based on the EMHB.....	186

LIST OF FIGURES

Figure	Page
1.1 Massachusetts Teen Birth Rates by Region.....	4
1.2 Teen Birth Rates 1990-2008: US, MA, Holyoke, Springfield.....	4
1.3 The Ecological Model of Health Behavior	11
5.1 A Model of the Interrelated Social and Physical Environmental Factors that Influence Teen Pregnancy and Birth in Holyoke.....	180

CHAPTER 1

TEEN BIRTHS

Introduction

Teen births are a national concern and a public health problem. For 14 years there was a steady decline in teen birth rates for 15-19 year olds in the US. The rate in 1991 was 61.8/1000 and in 2005 40.5/1000 in 2005; however, this decline ended in 2006 when there was a 3 percent rise in the rate to 41.9/1000 (Martin, et al., 2009; Ventura, Abma, Mosher, & Henshaw, 2008). Once again the teen birth rate increased nationally in 2007 to 42.5/1000 (Hamilton, Martin & Ventura; 2009). The teen birth rate is the number of live births in a geographic area per 1000 teens ages 15-19 years, using the midyear 15-19 year old female population in same geographic area to allow for comparisons between different geographic locations and groups (Martin, et al., 2007). Young women of color are disproportionately affected by teenage childbearing. Not only are higher teen birth rates occurring among Latinas, more alarming is the fact that they are occurring at much higher rates among poor, urban Latina teens (Doswell & Braxter, 2002; Hamilton, Martin, & Ventura, 2008). This researcher uses the term teen pregnancy and births. Although pregnancy is the precursor to birth, pregnancy rates are estimates and are not reported by all states; whereas, teen birth rates are gathered and reported on an annual basis by all state governments.

Teen childbearing inflicts far reaching long-term disadvantages on the mother, her child, and society. In general, teen births have negative medical, social, and economic outcomes including high risks for premature birth and low birth weight for infants, infant mortality, childhood illness, reduced educational and employment opportunities for teen mothers, increased welfare dependence for mother and child, impaired cognitive

development for the children, increase in childhood behavior problems and poor academic performance, and increased risk of child abuse and neglect (Brindis, 2006; Gueorguieva, et al., 2001; Hofferth & Reid, 2002; Kirby, 2007; Levine, Emery & Pollack, 2007; Logan, Holcombe, Manlove & Ryan, 2007; Phipps, Blume, & DeMonner, 2002; Satcher, 2001; Shore, 2005; Rich-Edwards, 2002; Terry-Humen, Manlove, & Moore, 2005). Teen births are costly. In 2004, US teen childbearing cost taxpayers over \$9.1 billion; these costs include \$1.9 billion for increased public sector health care, \$2.3 billion for increased child welfare, \$2.1 billion for increased costs for state prison systems, and \$2.9 billion lost in revenue due to lower taxes paid by children of teen mothers over their adult lifetimes (Hoffman, 2006). In 2004, teen childbearing costs in Massachusetts were at least \$109 million with the average annual cost of \$6,001 associated with each child born to a teen 17 years old and younger (National Campaign to Prevent Teen Pregnancy, 2006).

US teen birth rates remain considerably higher than those in other industrialized nations (Child Trends Data Bank, 2006; Guttmacher Institute, 2006; Martin, et al., 2009). What is concerning is that data show statistically significant racial differences in US teen births, with Latinos having the highest teen birth rate (83.0/1000), three times that of non-Latino White teens (26.6/1000), followed by non-Latino Black teens (63.7/1000), and nearly five times higher than Asian or Pacific Islander teens (17/1000) (Martin, et al., 2009). Latino teens are an important risk group because one in every two Latinas becomes pregnant at least once before the age of twenty which is nearly twice the national rate for all teen females (Abma, Martinez, Mosher & Dawson, 2004; National Center for Health Statistics, 2006; Shore, 2005; Vexler & Suellentrop, 2007). The 2006

national birth statistics for Latino subgroups reveal a decline in teen birth rates for Mexican teens and an increase in teen birth rates for Puerto Rican teens (69.3/1000) (Martin, et al., 2009).

Background and Significance

The overall teen birth picture in Massachusetts, where rates have remained considerably lower than the national rates, appears positive. The state's teen birth rate decreased from 35.9/1000 in 1989 to an all time low of 20.1/1000 in 2008 (Massachusetts Department of Public Health, 2007), and places the state with the third lowest teen birth rate in the nation (Cáceres, Orejula-Hood & West, 2010; Martin, et al., 2009). However, the picture is not as positive when Massachusetts teen birth rates are closely examined a significant disparity is evident based on geographic location and race/ethnicity.

Within Massachusetts, the Western region had the highest teen birth rate of 31.0 in 2005, and the Boston area rate of 29.4 is higher than that of the state (21.7), but lower than the Western region (West, Hood & Cáceres, 2007). Three regions have similar rates that do not significantly differ from the overall state rate. These are the Northeast region rate of 22.9, the Central region rate of 22.6, and the Southeast region of 23.1 (West, Hood & Cáceres, 2007). The Metro West region's rate of 8.3 is significantly lower than the state rate (West, Hood & Cáceres, 2007). See Figure 1.1.

In 2008 fourteen Massachusetts cities exceeded the national teen birth rate, with four of these cities located in Western Massachusetts. Holyoke ranks first (115.3/1000), Springfield fourth (61.4/1,000), and Pittsfield twelfth (52.7/1000) (Cáceres, Orejuela-Hood & West, 2010). For this study, the city of Holyoke was chosen as the study site because it has consistently had one of the highest teen birth rates in the state over the past

two decades with a nearly 20 point increase in teen births between 2007 and 2008, and the fact that its teen birth rate has been significantly higher than both the state and the national rates. See Figure 1.2.

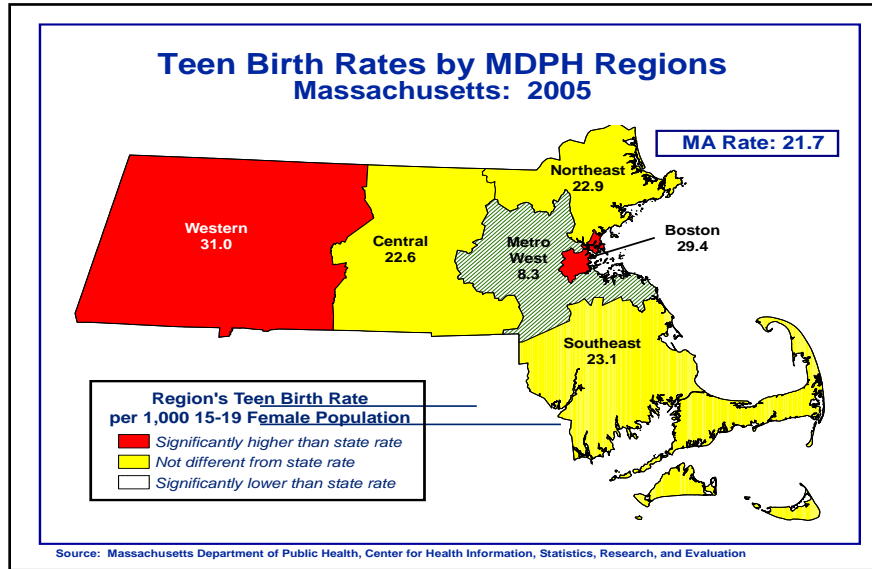


Figure 1.1: Massachusetts Teen Birth Rates by Region

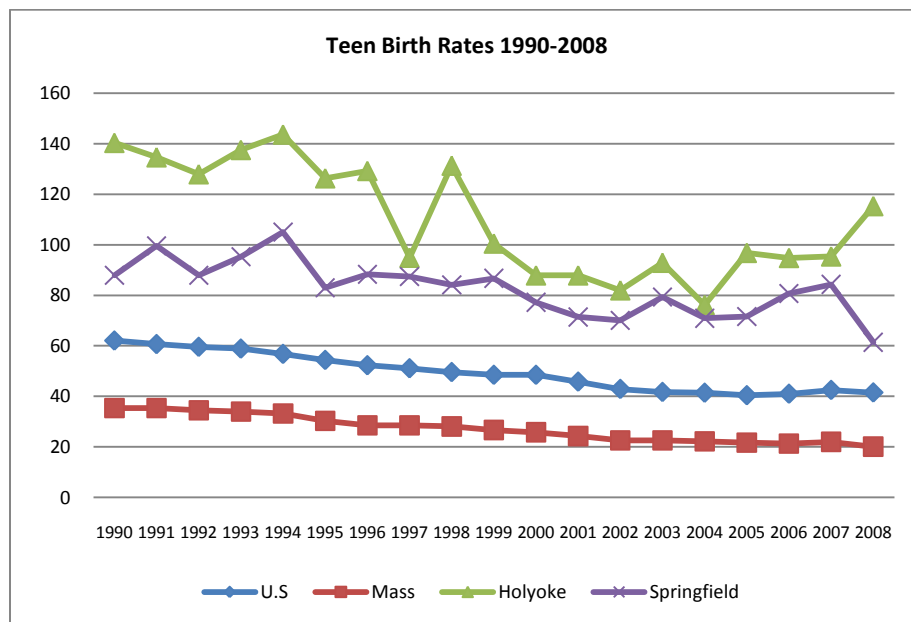


Figure 1.2: Teen Birth Rates 1990-2008: U.S., MA, Holyoke, Springfield

Examining Western Massachusetts teen birth rates by race and ethnicity reveals measures of disparity: Latina teens have a birth rate nearly twice the national rate, nearly six times the Massachusetts rate for White, non-Latina teens, and over twice the Massachusetts rate for Black, non-Latina teens. This disparity follows the national trend of Latina teens having the highest teen birth rates with the smallest decreases since 1991 (Klein, 2005). Scrutinizing both regional and city differences by race and ethnicity reveals even greater levels of racial and ethnic disparity. In Holyoke, the Latina teen birth rate of 83.6/1000 is the highest (West, Hood & Cáceres, 2007). This rate is more than ten points higher than the state’s rate for Latina teen births. It is significantly higher than the national rate for Hispanics (81.5/1000) (Martin, et al., 2007) and the teen birth rate in Puerto Rico (61/1000) (Guttmacher Institute, 2006). See Table 1.1

Table 1.1: Race/Ethnic Teen Birth Differences (15-19 year old) in 2005

	U.S.	MA	Holyoke	Puerto Rico
Teen Birth Rates	40.4	21.7	96.8	61.0
White non-Hispanic	26.0	12.9	11.6	
Black non-Hispanic	60.9	36.4	4.8	
Hispanic	81.5	73.2	83.6	
Asian non-Hispanic	16.9	15.3	---	

Latinos are the fastest growing ethnic group in the U.S., making up 14.8% of the total population (U.S. Census Bureau, 2007). Latinos are a very diverse group. They have no common history or identity, and share few universal characteristics other than tracing family trees to one or more of 20 Latin American countries. Latinos can be of any race, and speak only English, only Spanish, both languages and/or an indigenous language (Driscoll, Biggs, Brindis & Yankah, 2001). US Latinos are of varied origins:

66.9% are of Mexican descent, 14.3% of Central or South American descent, 8.6% of Puerto Rican descent, 3.7 % of Cuban descent, and 6.5% of other Latino origins (US Census Bureau, 2000). In Massachusetts, Latinos comprise the largest ethnic group. This population grew by 49.1% between 1990 (287,549) and 2000 (428,729) with an additional growth by 23.1% between 2000 and 2007 (527,859) (Donta, 2001; MassCHIP, 2008a; US Census, 1990). This growth is more revealing when compared to the total population and non-Latino white population. The total Massachusetts population grew by 5.5% and non-Latino population only grew by 3.3% between 1990 and 2000, and between 2000 and 2007 the non-Latino white population decreased by 2.2%, while the Latino population increased by 8.2% (Donta, 2001, MassCHIP, 2008a). Interestingly, nearly half of the Latino population in Massachusetts is of Puerto Rican descent (Guzmán, 2001; Ramirez, 2004). Within Massachusetts, Holyoke is the city with the largest Latino population with 41.3% of the population identified as Latino; of this population, 88.1% are of Puerto Rican descent (U.S. Census Bureau, 2000). In a national ranking of cities with high Puerto Rican populations, Holyoke is ranked second with 36.5% of its total population of Puerto Rican descent (Shorter, 2005). It is estimated that Latinos will represent 25% of US teens by 2025 (U.S. Census Bureau, 2000). The city of Holyoke's Latino teen population now far exceeds this projection. In 2006, 63.7% of the city's 15-19 year old population was Latino, and 69% of the city's 10-14 year old population was Latino (MassCHIP, 2008b).

Latino teens are an important risk group because one in every two Latinas becomes pregnant at least once before the age of twenty which is nearly twice the national rate for all teen females (Abma, Martinez, Mosher & Dawson, 2004; National

Center for Health Statistics, 2006; Vexler & Suellentrop, 2007). According to the National Center for Health Statistics (2006), the highest rate of teen pregnancy in the U.S. is among teens of Puerto Rican descent (79.3 per 1000), followed by Mexican Americans (65.2 per 1000). Thus, the teen birth disparity for Puerto Rican teens living in Western Massachusetts, especially in the city of Holyoke, is a problem of great magnitude that needs further exploration through research. The Institute of Medicine (IOM)'s report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare" recommends that disparities among non-African American minority groups and sub-groups be assessed (Smedley, Stith, & Nelson, 2003).

Statement of the Problem

Holyoke, Massachusetts has consistently had the highest teen birth rate of all cities in the state. Given the demographic composition of the city, the prediction that one in every two Latinas gets pregnant at least once before the age of twenty (Abma, Martinez, Mosher & Dawson, 2004; Shore, 2005), the recent 20 point increase in teen births between 2007 and 2008, and the fact that teens living in the continental US of Puerto Rican descent have the highest rate of teen pregnancy, Latino teens in Holyoke represent a population at high-risk for teen births.

Purpose of the Study

The primary purpose of this exploratory, descriptive study was to examine the perceptions held by Puerto Rican teens living in Holyoke about teen pregnancy and birth. The aim of this study was to gain knowledge about perceptions related to teen pregnancy and births held by the study's participants. The knowledge generated from this study can

serve as a foundation for future research and inform policy development, nursing practice, and programs that serve Puerto Rican teens.

Research Questions

This study was guided by the following research questions:

1. What perceptions do participants hold about teen births?
 - a. Do participants believe that teen births are a problem?
 - b. Do participants believe that teens are intentionally having babies?
2. How do participants' view the future of teen parents and their future life goals?
3. In relation to teen pregnancy, what do participants identify as:
 - a. contributing factors?
 - b. protective factors?
 - c. prevention strategies?
4. Where do participants get information about reproductive health (sex, contraception and having babies)?

Definition of Terms

Participants: Puerto Rican teens between the ages of 14 and 19 years who have Puerto Rican origins; being born in Puerto Rico or having a parent/grandparent born in Puerto Rico.

Pregnancy Intention: a woman's desire for pregnancy before or at the time of conception (Chuang, Weisman, Hillemeire, Camacho & Dyer, 2009).

Contributing Factor: Individual or environmental antecedents that increase the chances of teens engaging in the sexual behaviors of sexual initiation, contraception use, or pregnancy (Kirby, 2001).

Protective Factor: Individual or environmental antecedents that decrease the chances of teens engaging in the sexual behaviors of sexual initiation, contraception use, or pregnancy (Kirby, 2001).

Prevention Strategy: Any condition, opportunity, experience or activity that reduces the incidence of teen pregnancy (Kirby, 2001).

Significance to Nursing

Although teen pregnancy and birth in the US has received scholarly attention over the past two decades, the sub-population of Latino teens is often viewed as a single entity without differentiating between Mexicans, Puerto Ricans, Dominicans, Central Americans, South Americans, and others. Latino sub-populations are diverse with each group having its own unique cultural values and group norms. Much of the teen pregnancy/birth research has focused on Latino teens of Mexican descent, as they are part of the largest Latino sub-population in the US. However, Latino teens of Puerto Rican descent make up the largest Latino sub-population in the Northeastern section of the US. Limited research has been conducted with Latinos of Puerto Rican descent regarding teen pregnancy and births. Thus, the continued prevalence of high teen birth rates among Latina teens and the limited voice of Puerto Rican teens were motivating forces for this qualitative research of Puerto Rican teens to uncover pertinent factors to these teens and their environments which may serve as contributing factors to this public health problem.

The findings of this study can provide insight into the public health problem and disparity of high teen birth rates in Holyoke, MA. Data generated from this study can help provide a foundation of knowledge for future research. It will potentially be useful

for the development of public policy and the design of intervention and prevention programs to better address the needs of Puerto Rican teens living in Holyoke.

Conceptual Framework

This research was guided by the Ecological Model of Health Behavior (EMHB), a framework that emphasizes the “linkages and relationships among multiple factors affecting health behaviors” (Institute of Medicine (IOM), 203a, p32). Ecological models have been used since the 1980s to study health promotion, with new models proposed and older models refined over the past three decades (Richard, Gauvin & Fine, 2011). The (EMHB) was chosen as the framework for this study because it moves beyond biological risk factors to an awareness of multiple factors that influence health behavior, and can help articulate the complexities of health behaviors and the environmental influences on them. The EMHB is concerned with the physical environment and its relationship to people at the individual, the interpersonal, the community and the societal levels, and its philosophical underpinning is the concept that behavior does not occur within a vacuum (Richard, Gauvin & Fine, 2011; Sallis & Owen, 2002, Stokols, 1998).

The EMHB is a systems model with four systems or levels with specific focuses:

- 1) The individual level focuses on the person and includes characteristic such as gender, age, race/ethnicity, socioeconomic status, and religion.
- 2) The interpersonal level focuses on relationships with family, friends, peers, and others in the individuals’ social network.
- 3) The community level focuses on community organizations and social institutions (e.g. schools, programs, churches, health care settings, community norms, mass media) and the relationships among these.
- 4) The societal level focuses on local, state, and national laws and policies (Sallis & Owen, 2002). Each level is nested in a hierarchy of the other

levels and operates fully within the next larger level. Thus, the integration of the multiple levels can assist the researcher in developing a view of the big picture of teen pregnancy and birth in Holyoke. See Figure 1.3: The Ecological Model of Health Behavior Framework.

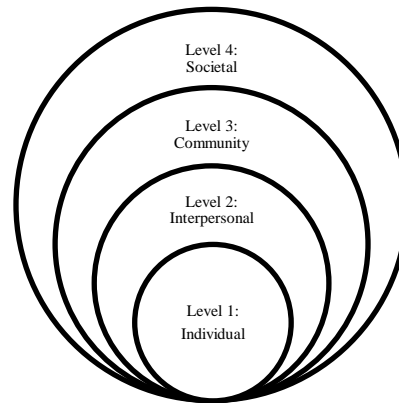


Figure 1.3 The Ecological Model of Health Behavior

Teen pregnancy and birth is a complex phenomenon that does not occur in isolation; it includes individuals within their larger social context of interpersonal interactions, the community, and the greater society. In 2003, the IOM recommended using an ecological model as a guide to: 1) think about the multiple determinants of population health, and 2) develop research to further explicate the pathways and interrelationships of multiple determinants of health. These recommendations support the use of The EMHB as the framework to study the public health problem of teen births in Holyoke, Massachusetts. In addition, it provides a public health perspective for examining the complex issue of teen births.

Summary

In summary, teen births are a complex public health issue. Teen childbearing has potentially negative consequences for the teen mother, her child, and the child's father

with negative health, social and economic outcomes for the teen mother, and her child, and emotional consequences for the child's father. Teen childbearing is costly. Using calculations provided by the National Campaign to Prevent Teen Pregnancies (2006), the cost of teen pregnancies in Holyoke, MA for 2008 was at the minimum \$1,054,174.00. Teen pregnancy and consequential births are often viewed in the narrow view of access and use of contraception. However, teen pregnancies and births are much more complex and require examination from a multi-dimensional framework.

The high teen birth rate among Latinas living in Holyoke, MA, year after year, represented a health disparity that must be addressed. It was therefore essential to use an ecological perspective as the framework to examine and analyze the multiple determinants related to this health disparity in Holyoke.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

The purpose of this study was to gain knowledge about the perceptions held by teens of Puerto Rican descent living in Holyoke, Massachusetts regarding teen pregnancy and births. This chapter provides a review of selected literature related to teen pregnancy and birth published after 1996. It is organized and presented in the following sections: 1) a summary of the current status of the issue, 2) teens' perceptions of teen pregnancy and births, 3) teens' pregnancy intentions, 4) the consequences of teen pregnancies and births, and 5) teen pregnancy prevention strategies. In addition, relevant literature and data on the City of Holyoke will be included in the chapter. Although a plethora of research has been published on the overarching topics of teen pregnancy and births (Child Trends Data Bank, 2006; Kirby 2001, 2002, 2007; Gallup-Black, & Weitzman, 2004; Moore, 2008; Rich-Edwards, 2002; Rosengard, Phipps, Adler, & Ellen, 2004, 2005; Spear & Lock, 2003), there is a paucity of research addressing teen pregnancy and birth among the sub-population of Puerto Rican teens (Foster, 2004a, 2004b; Pieve, 2001; Sciarra & Ponterotto, 1998; Talashek, Alba, & Patel, 2005; Villarruel, 1998). Research on teen pregnancy and birth among minority populations primarily centers on two large sub-populations -- Blacks/African Americans and Mexican-American Latinas.

Current Status of the Issue

In the US, it is estimated that approximately 75 of every 1000, or 750,000, teenage girls between the ages of 15 and 19 become pregnant yearly (Farber, 2009; Guttmacher Institute, 2006; Klein, 2005; Kirby, 2007). Data reveal that the US had

experienced a decline in teen pregnancies between 1991 and 2005 with a rise in teen births nationally in both 2006 and 2007 (Martin, et al., 2007; Hamilton, Martin & Ventura, 2009). However, teen pregnancy rates for Latinas failed to decline as much in this same period as white, non-Latina teens (34%) and Black teens (40%); while the Latina teen pregnancy rate only declined 19% (Guttmacher Institute, 2006; Moore, 2008). Current birth rates for racial/ethnic sub-populations per 1000 female teens between the age of 15 and 19 years are: 81.7 among Latinas, 63 among Blacks/African Americans, 59 among American Indian or Alaskan Natives, and 26.6 among Whites (Martin, et al., 2009). In the past three decades many published studies have addressed factors influencing teen pregnancy and births, recent studies on contributing factors or antecedents of teen pregnancy and births will be discussed.

Kirby (2001, 2002, 2007) has conducted comprehensive research on teen pregnancy in the US. In his study on antecedents of teen pregnancy, Kirby (2002) reviewed over 250 empirical studies published in professional journals after 1975 (post birth control pills and Roe versus Wade), to provide an overview of the antecedents of sexual and contraceptive behaviors and pregnancy. In these studies, more than 100 antecedents were identified as increasing or decreasing, to a significant degree, chances of teens engaging in the sexual behaviors of sexual initiation, contraception use, or pregnancy. Kirby's study included research articles for review, if they: 1) met scientific criteria for publication in professional journals; 2) analyzed data collected during or after 1975; 3) contained data collected on US adolescents 19 years or younger; 4) were based on a sample of at least 100; and 5) measured the relationship between the antecedents and the initiation of sexual activity, use of contraception, or the onset of pregnancy. Kirby

identified three prevailing themes among the antecedents: a) a substantial proportion of risk factors involved some form of disadvantage, disorganization or dysfunction; b) many teens were strongly influenced by their physical and social environments; and c) attachment to people or groups who expressed protective values and modeled positive behaviors reduced sexual risk taking. Antecedents were categorized into two broad groups, environmental and individual, and were further identified as either risk-factors or protective factors. (Risk factors are those that either encourages behaviors that result in pregnancy, or discourage behaviors that prevent pregnancy. Protective factors are behaviors that help to prevent pregnancy. Kirby also noted that all teens experience some pressures to have sex. For teens, the probability of engaging in unprotected sex and becoming pregnant increases as the risk-factors escalate and the protective factors decrease.

Environmental antecedents are those that stem from contexts in which teens live and which influence their sexual behavior. They may be either risk or protective factors. Environmental risk factors include: a) laws that restrict the use of contraceptives by requiring licensing, or prohibiting advertising, or selling of contraceptives; b) living in communities with higher rates of unemployment, violent crimes, teen suicide or stress; c) attending public schools with higher numbers of minority students, free lunch recipients, student dropouts, or vandalism incidents; d) having friends or older sisters who are teen mothers; and e) having a male partner three or more years older than they are (Kirby 2002, 2007). Environmental protective factors are: a) being involved with coordinated programs aimed at decreasing teen pregnancy; b) having policies for discouraging teen pregnancy e.g. comprehensive sexual education, availability of contraceptives; c) having

higher community socioeconomic status; d) living in families with higher parental education, higher income levels, and stronger parental disapproval of teen sex; e) having two parents versus one parent living at home; and/or f) having friends and peers with good grades and few non-normative behaviors (Kirby 2002, 2007).

Individual antecedents are those based on biologic and psychosocial attributes of individual teens. Individual risk factors that increase the chance of teen pregnancy include: a) experiencing physical abuse or general maltreatment by family; b) dropping out of school; c) dating at an early age; d) having multiple sexual partners; e) using alcohol or other harmful substances; f) participating in delinquent behaviors; g) attempting suicide; h) experiencing sexual abuse; and i) perceiving childbearing and parenting as easy. Individual protective factors include: a) strong teen/family connectedness, b) having appropriate parental supervision and monitoring, c) having egalitarian gender and family roles, d) having a positive attitude toward school combined with higher school performance, e) having long-term educational plans, f) being an active member of a church/religious group, g) being a member of the leading crowd, h) participating in sports, i) having a positive self concept, j) having comprehensive sex education, k) perceiving teen pregnancy and child bearing as negative, l) being older age at first sex, and m) being strongly motivated to use contraceptives (Kirby 2002, 2007).

Kirby concludes that there is no single factor about teen sexual risk-taking behavior that contributes to teen pregnancy; thus communities need to address many sexual and non-sexual, environmental and individual antecedents to help teens avoid pregnancy.

The recent increase in teen births between 2005 and 2006 was the impetus for Moore (2008) to examine available data on proximal determinants of teen births (teen sexual activity, use of contraception, and abortion) and distal determinants (social and economic changes). Moore concluded that there had been a substantial change in the proximal determinants of teen births featuring a decline in the proportion of teens that are sexually experienced, a dramatic increase in the use of contraception, especially condoms, and a decline in abortion rates for Whites, Blacks and Latinas. Moore also stated that distal determinants may both influence teens' motivation to avoid pregnancy and affect the proximal determinants, and Moore noted that as major societal and economic changes occur the frequency of early sex, less consistent use of contraceptives, fewer abortions, or any combination of these may affect the phenomena of teen birth rate in the US. Specific economic and social changes occurring in the US that may contribute to an increase in teen birth rate are: a) the increasing economic uncertainty; b) the decrease in family planning services paid for by Title X funds from the federal government; c) the movement by public policy makers to abstinence-only education in public schools since 1996; d) the effects of No Child Left Behind legislation that may encourage marginal students who are feeling discouraged to consider early parenting as an attractive alternative to school; e) the media's focus on pregnant or parenting teen celebrities; f) the increase in terrorism and engagement in war since 2001; and g) the media's attention to infertility, especially the long-term affect of Depo Provera (Moore, 2008). Moore concluded that teen childbearing is uncommon among advantaged teens since they are more likely to delay first sex, have access to and use contraception, and have an abortion if they become pregnant. While disadvantaged teens see fewer reasons

to avoid early child bearing, and tend to have first sex at an earlier age, Moore stated that new approaches are needed to reach at-risk teens, who are harder to reach with messages and services. Although Moore does not address teen births by race and ethnicity, she does emphasize the socio-economic factors that contribute to teen births. These factors often function negatively in Latino populations, and are evident in the City of Holyoke. To support this statement, data is presented later in this chapter.

In 2006, the National Campaign to Prevent Teen Pregnancy conducted a national survey focusing on the attitudes and beliefs of Latino adults and teens about teen pregnancy, with the goals of helping to enhance the nation's understanding of the teen pregnancy problem in the Latino community and reducing the continued high rates of Latino adolescent pregnancy and childbearing (Vexler, 2007). Interviews were conducted in both English and Spanish. The findings reveal that Latino teens (46% of boys and 51% of girls) identify parents as most influential in their decisions about sex; yet, 63% of Latinas are less likely than their peers (74% of white and 66% of Black teens) to have had a helpful conversation with their parents about delaying sex and avoiding teen pregnancy. Interestingly, three-quarters of Latinos (73% of adults and 75% of teens) believe that parents send one message about sex to their sons and a different message to their daughters: with most Latino teen boys (57%) saying that they often receive the message that they are expected to have sex, while half of Latina girls (54%) saying that they often receive the message that attracting boys and looking sexy is important. Over half of Latinas never thought about the consequences of getting pregnant as a teen, and 40% of Latinos believe that teen pregnancy is "no big deal (Vexler, 2007, p. 3)." Latino teens are the least likely of all teens to use contraception

because they decide not to (16%), are afraid their parents might find out (14.5%), or are embarrassed (12.5%). According to Vexler (2007) a majority of sexually experienced Latino teens (62% of boys and 74% of girls) say they wish they had waited, concurrently 82% of Latino teens noted that religious leaders and groups should be doing more to help prevent teen pregnancy. Inversely, Vexler (2007) found that 20% of Latino teens believed that being a teen parent would have no effect (13%) or actually help (7%) them reach their future goals. The report provides valuable information about Latino attitudes and beliefs about teen pregnancy; however, Latino ethnic groups are not identified in the study.

Talashak, Montgomery, Moran, Paskiewicz, and Jiang (2000) developed an explanatory model, the Developmental Maturity Model, to examine teen pregnancy. They used this model in a case control study to predict pregnancy for inner-city teens of African American, Puerto Rican, and Mexican backgrounds (Talashak, Alba, and Patel, 2005). In a secondary analysis of data from a large case control study (n=1,638), the researchers found that the developmental maturity model can predict pregnancy rates for African American, Puerto Rican, and Mexican inner-city teens. It identified both similarities and differences for the racial/ethnic groups when compared to matched, non-pregnant teens from the same communities. All pregnant teens began dating earlier, had more dates per week, and had first sex at an earlier age. Significant findings for pregnant Puerto Rican teens were that they: a) were less likely to have older sisters or siblings; b) were less likely to be employed; c) had experienced more forced sex; d) had a best friend who was a parent, pregnant or sexually active; e) had fewer problem-solving skills; and f) had lower GPAs than teens of African American or Mexican backgrounds (Talashak,

Alba, & Patel, 2005). These contributing factors are similar to Kirby's (2002) risk and protective factors and Moore's (2008) socioeconomic changes that affect teen birth rates, and may be used as variables in identifying at-risk Puerto Rican teens and developing primary preventive interventions for them.

In a small qualitative study, Sciarra and Ponterotto (1998) identified variables influencing adolescent motherhood for Latinas of the Caribbean basin, including teens of Puerto Rican, Dominican, and Honduran descent. The following motivators were identified for fostering adolescent motherhood: a) the absence of a sense of permanence and stability; b) a milieu that keeps the teenage mother linked to her family, especially her mother; and c) teenage antipathy toward abortion, which was described by the adolescents as "killing" and "punishing the innocent" (Sciarra & Ponterotto, 1998, p. 756). In addition, the researchers found that adolescents who were not doing well in school were at greater risk for adolescent motherhood, and noted that the majority of school problems began with the transition from grammar school to middle or junior-high school. These findings have implications on many levels including family networks, living conditions, education, and broad social, economic and cultural conditions. They are congruent with Moore's (2008) recent findings, and provide particulars for Kirby's (2002) category of general antecedents. These move the disparity beyond the individual and family, and forces nurses, other healthcare/human service providers, legislators, and other policy makers (i.e. school committee members) to examine broader issues and policies on the local, state, and federal levels.

As the research illustrates, teen sexual activity and pregnancy combine to produce a complex behavioral phenomenon. Teen pregnancy concerns teens taking risks and

involves both non-sexual and environmental risk factors. A multilevel, collaborative approach involving public health nurses, school nurses, social service providers, educators, community members and teens to address contributing factors is needed supporting the use of the public health ecological model to provide researchers and practitioners with a means to study and address the issue.

Teen Perceptions of Pregnancy and Birth

While there has been considerable research on the broad factual, socio-psychological and economic aspects of teen pregnancy and birth, there has been relatively little research focusing on teens' perceptions of pregnancy and birth. It is important to assess teens' perceptions because study of this aspect can lead to evidence-based interventions to address the teen pregnancy and birth problem.

Using data from a longitudinal evaluation of the Urban Health Initiative to understand the effectiveness of the initiative across five US cities, researchers compared and contrasted perceptions of community leaders, adults, and youth about the extent of teen pregnancy (Gallup-Black & Weitzmen, 2004). In this study, 2,768 randomly selected youth aged 10 to 18 years were interviewed on a variety of problems facing youth in their cities including teen pregnancy, birth, and parenting. The majority of teens (79%) felt that their parents would be upset if they believed that their teenage children were engaging in sex. Yet, the teens themselves were much more tolerant of early sexual activity with 60% reporting that their peers thought it was all right to begin sexual activity before the age of 15. Over half of the teens indicated that their peers felt it was acceptable for anyone to have a baby by 17 years of age, and 33% of the teens whose parental incomes were below \$20,000 believed that their schoolmates thought that

parenting by the age of 15 years was acceptable (Gallup-Black & Weitzman, 2004). The researchers also found that 40% of teens whose parents had incomes higher than \$20,000 and a college education had a friend who had a baby, compared to 55% of teens whose parents had lower incomes and only a high school diploma or GED. The researchers conclude that adults are deeply concerned about teen pregnancy, and teens indicate that teen pregnancy is prevalent and accepted. There is a disconnect between adult concerns and teen actions. In describing the sample, the researchers only identified “White” and “African American” (p. 370) under race, and excluded any ethnic identifiers. Thus, this research and discussion on teen perceptions of teen pregnancy, birth, and parenting was void of Latino voices.

Using qualitative methods, Jewel and Donovan (2001) explored teens’ attitudes about pregnancy and found that teen girls from disadvantaged backgrounds identified earlier ages (17-25 years) as ideal for starting a family than did teen girls from advantaged families who noted that late 20s to early 30s as an ideal time. The researchers also noted that teen girls from disadvantaged backgrounds were less likely to have access to sexual health services and to reliably use contraceptives. Education and social norms influence teens’ knowledge and use of contraception (Jewel & Donovan, 2001). Although race and ethnicity were not included as variables in the study, living in socioeconomically disadvantaged circumstances was associated with the acceptability of early motherhood.

In a recent study, Herman (2008) used focus groups to investigate teen perceptions of the costs and rewards of teen births, and found that the negative perceptions of teen births outweighed positive ones in her sample of 120 low income

teens considered at high risk for pregnancy. The majority (68%) of the participants were African American, followed by White (19%) and Hispanic (11%). The researcher found negative ideas about teen births (losing friends, causing stress on family and relationship with partner, decreasing ability to be an adequate parent, limiting educational options, increasing difficulties in working, limiting incomes, and putting dreams on hold) outweighed positive aspects (affirming relationship with baby's father, caring for baby with partner, providing positive force in family, and having someone to love). In addition, the researcher found that the teens were unable to consider future implications of teen births. In this study, Latinas comprised only a small percentage (11%) of the sample, and specific sub-populations of Latinas were not identified.

Rosengard, Pollack, Weitzen, Meers, and Phipps (2006) used open-ended questionnaires to obtain pregnant teens' ideas about the advantages and disadvantages of having a baby during adolescence. Disadvantages identified included lack of preparedness (being too young and lacking stability), interference with life (changing goals, putting life on hold, missing out on teenage experiences), and negative views from others. Advantages identified included building a family and enhancing relationships at the present time rather than in the future (having a baby to love and be loved by, being closer in age to their child, having family and partner support). The teens identified positive changes (providing a purpose for life, taking more responsibilities, and growing up along with the child) and practical considerations related to teen motherhood (being young and energetic, having future fertility concerns, getting pregnancy over with). A group of participants who did not identify any disadvantages felt that being a teen mother was no different from waiting until they were older. The sample consisted of 247 teens

between the ages of 12 and 19 years. The sample was diverse: 47.3% Latinos, 19.4% White, 17.8% Black, 4.5% Asian, 4% American Indian/Alaska Native, and 17.9% other. Although the largest racial/ethnic group in the sample was Latino, the researchers did not identify the Latino sub-populations.

Using ethnographic methods for a dissertation, Pieve (2001) examined the perceptions of pregnant Puerto Rican teenagers living in a New England city. She found that exposure to crime and violence in their neighborhoods may be predictors of teen pregnancy, and parental loss through separation or death may also be associated to teen pregnancy. Pieve (2001) concluded that effective interventions regarding Puerto Rican teens need to take into account the attitudes, beliefs, and norms of both the teens and their families.

The research findings on teens' perceptions of teen pregnancy and births dovetail with the individual and environmental risk factors identified by Kirby (2002, 2007) and Moore (2008). While there is limited research on teens' perceptions about teen pregnancy and births, there is even less with samples that include Latinos especially those of Puerto Rican descent. Understanding the problem of teen pregnancy and births from the perspective of teens, especially those teens of specific sub-populations, is important for nurses and other professionals working with this population to provide appropriate care and design effective prevention strategies.

Teen Pregnancy Intention

The issue of teen pregnancy intention gained increased national attention in 2008 when the media reported a supposed teen pregnancy pact among teen girls in an eastern Massachusetts town. While there is no literature on pregnancy pacts among teen girls,

research on intentionality of teens pregnancy is found in the literature. More than 75% of teen pregnancies are considered unintentional, with approximately 35% of these ending in abortion; for the 40% of teens continuing their pregnancies to birth approximately 66% of these births are considered a result of unintended pregnancies (Ahluwalia, Johnson, Rogers, & Melvin, 1999; Frost & Oslak, 1999; Rosengard, Phipps, Adler and Ellen, 2004). Male partners influence female teens' pregnancy intentions (Frost & Oslak, 1999). When examining pregnancy intentionality, it is also important to assess male partner's desire for pregnancy. This review will include studies that examine both female and male teen pregnancy intentions. According to Rosengard, Phipps, Adler and Ellen (2004) the term "pregnancy intention (p.414)" is widely used but loosely interpreted; with definitions including degrees of "wantedness, planning, timing, and happiness regarding a pregnancy (p. 453)." Rosengard, Phipps, Adler and Ellen (2004) note that pregnancy intention is often measured during pregnancy or after birth, and they pose that an accurate measurement of pregnancy intention relates to a female's feelings before conception. Joyce, Kaestner and Koreman (2002) sought to ascertain the effect of when teens were asked about pregnancy intention: whether they were asked before pregnancy, during pregnancy, or after birth. They found that retrospective assessments of pregnancy intention are not misleading. This review will note whether the data on pregnancy intentionality had been retrospectively or prospectively collected.

Female Teen Pregnancy Intention

Using a longitudinal examination of teen pregnancy intentions and pregnancy outcomes, Rosengard, Phipps, Adler and Ellen (2004) studied teen pregnancy intentions prospectively collecting data at baseline from 388 sexually active teen girls between the

ages of 14 and 19, and at a six month follow-up interview of 354 of the original teens. The teens were recruited from a health maintenance organization clinic in Northern California; and the sample was racially and ethnically mixed: 27% African-American, 20% White, 17% Latina, 16% Asian, and 19% mixed/other race/ethnicity. At baseline, the researchers found that 76.5% of the teens indicated no plans to become pregnant in the next six months. Findings revealed that a larger percentage of African American (44%) and Latina (21.3%) teens indicated that they had pregnancy plans; the perceptions for other groups were White (5.3%), Asian (13.3%), or mixed/other (16%) teens. Although Latinas were represented in the sample, the researchers did not identify Latina sub-populations.

Heavey, Moysich, Hyland, Druschel and Sill (2008) examined the association between educational status, racial background, and adolescent pregnancy desire using data collected between 1999 and 2004 at a New York state-funded family planning clinic with a sample of 335 pregnant teens between the ages of 14 and 19 years. The sample consisted of African-American (60%), Latina (33%), and White (7%) teens from lower-socioeconomic neighborhoods. Findings indicated that teen pregnancy is associated with educational status and racial/ethnic background. Teens who were not in school were nearly twice as likely to desire pregnancy than teens who remained in school, and Latina teens who were not in school were 12 times more likely to desire pregnancy than African-American teens who were in school full-time (Heavey, et al., 2008a). Sub-populations of Latinas were not identified in the research, and the researchers studied pregnancy desire retrospectively.

Using literature related to Latino reproductive health, published between 1990 and 2000, Driscoll, Biggs, Brindis, and Yankah (2001) estimated that 46% of Latina teens who gave birth were more likely to characterize the birth as intended than African-American and non-Latina White teens. However, these researchers did not disclose whether this estimate was based on prospective or retrospective studies. The intended pregnancies and births were attributed to sociodemographic and cultural factors. Thus, the need for further research that includes Latino sub-populations is supported.

In a study exploring teens' pregnancy intentions, Rubin and East (1999) found that teens who intended their pregnancies came from less chaotic environments, had dropped out of school before conceiving, are older (17-19 years), are Latina, and are married or living with the father of the baby. Teens who reported that their pregnancies "just happened (p. 314)" were more likely to be Black than Latina; received primary financial support from parents, relatives or public assistance; and had run away from home. The sample consisted of 154 teens recruited at their first prenatal visit or subsequent stage of their pregnancies. The study was retrospective, and did not identify Latina sub-populations as a category or compare it with other sub-populations.

In a study prospectively examining teen birth intentions using data from the US National Longitudinal Survey of Labor Market Experience of Youth, Trent and Crowder (1997) examined teen birth intentions in a national sample of 6,038 teens including African Americans, Latinos, and non-Latino Whites. They found that intentions were more likely to vary by race and ethnicity, poverty status, and family structure. Social disadvantages place teens at greater risk for pregnancy and birth. The researchers concluded that teen childbearing is more an unintended result of risky sexual behaviors

than a planned choice. They cautioned “against the liberal use of cultural arguments to explain fertility differences between African Americans and whites and poor and non-poor in the general population for fertility differentials (p. 533)”, but they failed to mention Latinos. In addition, they suspected that if culture affects differences in fertility, it “comes more into play after pregnancies occur (p. 533)”.

Male Teen Pregnancy Intention

In an ethnographic study to explore the experience of fatherhood among young Puerto Rican fathers whose sexual partners were teenagers when their children were born, Foster (2004) found that the majority of the pregnancies were unplanned; however, one-third of the fathers had planned the pregnancies with their partners. The fathers believed that having children gave them the opportunity to consider alternative outcomes other than participating in criminal activities and violence. Foster’s study is important to this proposed study, Foster’s sample of 30 fathers were all of Puerto Rican descent and lived in Holyoke, MA. The fathers’ ages ranged from 14 to 24 years when their first child was born, only 6 had graduated from high school, and all had incomes below the federal poverty level. Foster concluded that males must be considered part of the solution to unintended teen pregnancy.

Rosengard, Phipps, Adler, and Ellen (2005) examined pregnancy intentions of 101 sexually active male teens. This study’s participants ranged in age from 15 to 19 years: 43% Black, 16% white, 15% Latino, 10% Asian, and 13% mixed/other race/ethnicity. These participants’ plans for getting someone pregnant in the next year differed from their assessments of the likelihood that they would get someone pregnant: 75.2% indicated no plans to get someone pregnant in the next 6 months; yet 56.4% of the

same teen males indicated that there was some likelihood of getting someone pregnant in the next 6 months. The researchers found that teen males' mothers' educational attainments differed. Teen males' whose mothers had lower educational attainment (some high school) were more likely to indicate plans to get someone pregnant in the next 6 months and less likely to use condoms. The researchers identified a need to provide teen males with reproductive health services and enable them to participate in discussions about pregnancy intentions would be a useful factor to decrease teen pregnancy.

In a study focusing on the relationship between pregnancy desire among teen girls and their perception of pregnancy desire in their male partners, Heavy, Moysich, Hyland, Druschel, and Sill (2008) found a correlation between the teen girls' feelings about pregnancy and their perceptions of their male partners' feelings about pregnancy. Teen girls were found to be four times more likely to desire pregnancy if their male partners also desired it. The demographic characteristics of the study's participants reveal that 60.9% of the participants were African American, 17.4% were Hispanic, and 21.7% were "other" (p.340).

Consequences of Teen Pregnancy and Birth

Consequences of pregnancy and births for teen mothers, their children, and society are often reported in terms of disadvantages (Chen, Wem, Fleming, Demissie, Rhoads, & Walker, 2007). The issue of teen pregnancy and birth has been associated with a higher incidence of medical complications for both teen mothers and their infants than is experienced by mothers over the age of 19 years and their children. However, researchers who control for the disadvantages presented by teen mothers' backgrounds

have found that negative outcomes are reduced or eliminated (Hotz, McElroy, & Sanders, 2005; Maynard, 1996; Turley, 2003; SmithBattle, 2007a, 2007b). Most research addressing the consequences of teen pregnancy, birth, and parenthood focus on white, Black, and Mexican-American teen populations (Chang, O'Brien, Nathanson, Mancini, & Witter, 2003; Fraser, Brockert & Ward, 1995; Gilbert, Jandial, Field, Bigelow & Danielson, 2004; Phipps, Blume & DeMonner, 2001; Reichman & Pagnini, 1997; SmithBattle, 2007; Taylor, Katz, Moos, 1995). In this section, an overview of teen pregnancy and birth outcomes will be presented followed by a discussion of both medical/health outcomes and psychosocial consequences of teen births on the teen mothers and their children.

Maynard (1996) examined the issue of negative consequences of teen pregnancies and births to both mothers and babies in an attempt to identify whether the outcomes are attributable to teen pregnancy itself or to the wider environment of the teen mothers engaged in child rearing. Using data from eight comprehensive studies focusing on more than 175,000 teens who gave birth before the age of 18, Maynard (1996) attempted to “untangle the pathway of early parenting from the intricate web of social forces that influence the life course of the mothers (p. 5)”; and she noted that when background and socio-economic factors are adjusted for, it is not clear to what extent the negative outcomes are due to teen childbearing or to socio-economic factors. Maynard’s findings included consequences to both teen mothers and their children. Consequences to mothers include: a) 70% of teen mothers dropped out of high school and only 50% of these teen mothers who dropped out of school subsequently completed high school during their adolescent and early adult years; b) teen mothers who completed high school achieved

lower academic grades in basic skills than mothers > 20 years of age; c) teen mothers found fewer employment opportunities and had higher levels of poverty than those > 20 years of age; d) 80% of the teen mothers received welfare during the 10 years following the birth of their first child, with even higher rates of poverty among Black and Latina teen mothers; e) teen mothers showed a strong likelihood of being single parents and sole providers for their children, and of living in poor communities/neighborhoods with poor housing, high crime, poor schools, and limited health services; and g) teen mothers were either victims of abuse or at-risk for physical and/or sexual abuse. When compared to children of women > 20 years of age, the children of teen mothers experienced more far reaching negative consequences. That is, they are: a) more likely to be born prematurely; b) twice as likely to repeat a grade and perform significantly lower on cognitive development tests; and c) twice as likely to be abused or neglected. Teen daughters of adolescent mothers were approximately 83% more likely to become teen mothers than teen daughters of older women, and teen sons were nearly three times more likely to be incarcerated than teen sons of older women (Maynard, 1996). Examination of the socio-economic factors that influence negative outcomes of teen pregnancies and births reveal that they are also contributing factors to teen pregnancy.

In a study examining the pregnancy outcomes of over 300,000 teenage deliveries in California, Gilbert, Jandial, Field, Bigelow, and Danielsen (2004) found that all teen pregnancies were associated with higher rates of poor obstetric outcomes when compared to pregnancies of women aged 20-29 years. These researchers used a data base that linked vital statistics (births/deaths) and patient discharge records of all civilian hospitals in California from 1992 through 1997 to study the adverse outcomes of infant/neonatal

death, premature birth, and low birth weight. The sample included white, Latina, African American, and Asian/pacific islander mothers. One of the study's findings was that higher teen pregnancy rates, lower socioeconomic status, and limited or late access to prenatal care contributed to poor teen pregnancy outcomes. In addition, these researchers found a consistent increase in pyelonephritis for all teen groups regardless of race or ethnicity, and a lower rate of preeclampsia for Latinas. Thus, this study supports the belief that social and economic factors contribute to poor outcomes for ethnic groups.

The research of Chen, Wem, Fleming, Demissie, Rhoads, and Walker (2007) focuses on age as a determining factor for birth outcomes of teen mothers and provides a counter point to the negative effects of socioeconomic status on teen births. Using a nationally linked infant birth/infant death data set from the Centers for Disease Control and Prevention that yielded a sample of 3,886,364 pregnant women <25 years of age who had never previously given birth, these researchers studied whether teenage pregnancy was associated with increased adverse birth outcomes independent of known socio-demographic confounding factors (being a member of a minority racial or ethnic group, living in poverty, having a low level of formal education, or being unmarried). For the study, the birth outcomes for teen mothers aged 10 to 19 years were compared with birth outcomes for parturient women aged 20 to 24 years, and the findings revealed that teen pregnancies and births were associated with high risks of very pre-term delivery (live infant delivered at < 32 weeks gestation), pre-term delivery (live infant delivered at < 37 weeks gestation), very low birth weight (<1500g), low birth weight (<2500g), infants small for gestational age (live infants with birth weights below the 10th percentile for gestational age and gender), low and very low Apgar scores (below 6) at 5 minutes, and

neonatal mortality. The researchers attributed the poorer outcomes to maternal age and not socioeconomic status, inadequate prenatal care, or inadequate weight gain during pregnancy. In this study, the researchers classified maternal race as white, Black, and other than black and white; the category Latina/Hispanic was not included.

Resnick et al. (1999), using multivariate analysis, assessed the long-term effects of perinatal and sociodemographic risk factors on educational placement for children entering kindergarten in Florida public schools between 1992 and 1994. They found that educational placement was influenced by both perinatal and sociodemographic factors. Perinatal factors had an effect on the requirement of special education programs, with birth weight <1000g having the greatest effect, and sociodemographic factors (being of non-White race, living poverty, having low maternal education) produced mild educational disabilities. These researchers concluded that sociodemographic factors had a greater impact than perinatal factors on educational outcomes. Using the same data, Gueorguieva, Carter, Ariet, Roth, Manhan and Resnick (2001) assessed the effect of teenage pregnancy on both educational disabilities and educational problems for children entering kindergarten in Florida public schools between 1992 and 1994. When only the mother's age was taken into account, children born to mothers < 20 years of age had higher odds of detrimental effects i.e. placement in special education classes and higher occurrence of mild educational problems than children of older mothers. However, when maternal education, marital status, poverty level, and race were also factored in, the detrimental effects of having teen mothers disappeared and some protective effects were observed. According to these researchers, confounding sociodemographic factors

seemed to have a greater influence on educational disabilities of kindergarten children than teen maternal age.

In a more recent study examining how children fared in kindergarten, Terry-Humen, Manlove and Moore (2005) compared children born to teen mothers aged 17 and younger to children born to mothers aged 18-19, 20-21, 22-24, and 25-29. Using data from the national Early Childhood Longitudinal Study, Kindergarten Class of 1998-1999 (ECLS-K), the researchers obtained a sample of 6,228 first-born, first-time kindergarteners living with their biological mothers. The children born to the youngest mothers (aged 17 and younger) were found to be primarily Latino or non-Latino Black, and to have low birth weight. The study's dependent variables were: cognition and knowledge, language and communication skills, approaches to learning, emotional well-being and social skills, and physical health and well being. Bivariate and multivariate analyses were used to detect differences in school readiness and educational outcomes. Controlling for background characteristics (mother's marital status, socioeconomic status, and education level), the researchers found that children of teen mothers aged 17 and younger: a) had lower general knowledge scores; b) were less likely to read simple books independently and demonstrate early writing ability; c) scored lower on eagerness to learn, creativity, task persistence, concentration, and responsibility; d) were more likely to argue, fight, and get angry; e) were overactive or impulsive; and f) suffered from anxiety, loneliness, low-self-esteem, or sadness. An incongruent finding for children of teen mother aged 17 and younger was their ability to perform higher on assessment of gross and composite motor skills.

SmithBattle (2007b) studied teen mothers' views regarding their school aspirations and educational progress. The sample consisted of 19 pregnant teens between the ages of 15 and 18, who were expecting to raise their babies, and one parent or surrogate of the teen mothers; the sample included Black and white teens only. The teen mothers were followed longitudinally from the third trimester of pregnancy to 10 months postpartum. The researcher found nearly three-quarters (74%) of the teens reevaluated their priorities and were motivated to remain in or return to school. On the other hand, 26% of teens were alienated from school, had experienced adverse childhoods, and dropped out of school before becoming pregnant.

These research findings on consequences of teen pregnancy and births indicate that they are influenced by sociodemographic factors as well as maternal age. However, over half of the studies do not identify Hispanics or Latinos in their samples, and the other 3 studies do not identify sub-populations of Latinos. When the sociodemographic factors on outcomes are examined, it becomes apparent that they also are contributing factors to teen pregnancy. Sociodemographic factors, including ethnicity, and maternal age need to be investigated exhaustively in order to develop primary prevention strategies from an ecological perspective to improve outcomes and decrease negative consequences for both teen mothers and their children.

Prevention of Teen Pregnancy

Teen pregnancy is not just about sex; it has numerous environmental and individual antecedents as noted earlier. Consequently, multiple and varied prevention interventions on the individual/intrapersonal, micro/interpersonal, and macro/community levels are needed. Today there are numerous prevention programs to reduce teen

pregnancies. Many of these programs have been discussed in the literature, and include: abstinence and abstinence only education, comprehensive sexuality education, use of contraception, abortion, and non-sexual community programs. These will be discussed.

Abstinence Education

Abstinence education programs, also known as abstinence-only education (AOE), teach that abstinence from sexual activity out-side of marriage is the standard for all adolescents. They stress that sexual activity outside of marriage will have harmful psychological and physical effects, and exclude teaching basic facts about contraception (Social Security Administration, 1996). AOE education is funded by the federal government under the Public Health Act, Title XX and the Social Security Act, Titles V and XI. Federal support for AOE programs had greatly expanded since 2001 with financial support of \$73 million in 2001 to \$158 million in 2005 (Government Accountability Office, 2006).

A growing number of both scientific researchers and some governmental bodies are examining and evaluating AOE programs; they find the long-term effects of the programs limited. For example, a congressional committee, in its comprehensive evaluation of the AOE curricula content, found that 80% of the abstinence-only curricula promulgate inaccurate, distorted, or misleading information about reproductive health, including scientific errors, false information, and blurring of religion and science (Waxmen, 2004). In a review of federally-funded, state AOE programs, the U. S. Government Accountability Office (GAO) (2006) found that governmental efforts to evaluate AOE programs have been limited; the GAO identified inaccuracies in some AOE programs' educational materials.

Scientific research also finds AOE programs inefficacious. For example, Kirby (2007) reviewed 56 studies of curriculum-based programs that were primarily implemented in low-income, urban areas and found that AOE programs failed to produce evidence to support claims that they delay initiation of sex, foster a return to abstinence, or reduce the number of sexual partners of teenage girls. In a non-randomized control study assessing the effectiveness of *For Keeps* (a 5-day, school based, county-wide, AOE curriculum), Borawski, Trapl, Lovegreen, Colabinanchi and Block (2005) found that the curriculum could affect short-term sexual behavior among adolescents (it produced an increase in knowledge about sexually transmitted infections and fostered intentions to remain abstinent); however, the study does not provide an assessment of long-term sexual behavior. In addition, the researchers found that *For Keeps* triggered a reduction in condom use among sexually inexperienced teens. In a congressionally-authorized, multi-year study to evaluate the long-term effectiveness and impact of AOE programs on the outcome measures of sexual behavior and knowledge and perceptions of risks associated with teen sexual activity, Trenholm, Devaney, Fortson, Quay, Wheeler, and Clark's (2007) had similar findings for both the control group and program group (AOE): 49% of both groups remained abstinent; of participants who reported having had sexual intercourse, participants in both groups had similar numbers of sexual partners and initiated sex at the same mean age; and 23% of both groups reported always using a condom when having sex. The researchers concluded that the AOE programs "show no impact on rates of sexual abstinence (p . xvii)".

Comprehensive Sexuality Education

Comprehensive-sexuality education (CSE) programs, also referred to as abstinence-plus programs and/or science-based programs, includes information about both abstinence and contraception. CSE programs provide teens with accurate information about human sexuality, reproduction, birth control, and disease prevention; teach teens interpersonal and communication skills; and help young people explore their own values, goals, and options (Bleakley, Hennessy & Fishbein, 2006; Kirby, 2001, 2007; Lindberg, Santelli & Singh, 2006). Despite the reported success of CSE, Lindberg, Santelli and Singh (2006) found a decline from a comprehensive approach to sexual education to an abstinence-only approach with significantly lower proportions of teens receiving formal education about both abstinence and birth control. A contributing factor to this decline was the expansion in federal funding for AOE. This regressive process continues even though widespread support for comprehensive-sexuality education programs comes from scientific institutions, health professionals, and health professional organizations (Kirby, 2001, 2007; Lindberg, Santelli & Singh, 2006). Since 1996, the following scientific and professional organizations have released public statements in support of CSE: the American Public Health Association, the American Academy of Pediatrics, the American Medical Association Council on Scientific Affairs, the American College of Obstetricians and Gynecologists, the Office of National AIDS Policy, the Institute of Medicine, the National Institutes of Health, and the Centers for Disease Control and Prevention (Advocates for Youth, 2001; Kirby, 2007; Lindberg, Santelli & Singh, 2006).

Ten years post legislation requiring AOE as the statewide curriculum for public schools in North Carolina, Ito, et al. (2006) conducted an anonymous, cross-sectional telephone survey with a sample of 1,306 parents of public school children in grades K-12 to assess parental opinion about sexuality education in North Carolina public schools. They found that the majority (91%) of all participants felt that sexuality education should be taught in North Carolina public schools; of these participants, 35% thought that the education should start in grammar school, over 50% thought it should start in middle school, and the remainder thought it should start in high school. Parents agreed that the content of sexuality education should be determined by parents and public health professionals, with 93% opposing politician involvement. The findings of this study directly oppose the current AOE policy in North Carolina's public schools, and provide evidence that parents of North Carolina's public school students desire CSE programs without legislated content.

Using a cross-sectional survey, Bleakley, Hennessy and Fishbein (2006) examined public opinion on sex education in schools by assessing preferences for three different school sex education programs: AOE, abstinence plus education/CSE, and CSE including condom instruction. The researchers obtained a national sample of 1,096 U.S. adults (18 to 83 years of age) through the Annenberg National Health Communication Survey. They found that adults, regardless of their political ideology (conservative, moderate, or liberal), support CSE rather than federally funded AOE programs. AOE received the lowest level of support, whereas CSE programs (including abstinence and methods to prevent both pregnancy and sexually transmitted infections) were supported by 82% of the participants, and 68.5% of CSE supporters also supported teaching the

proper use of condoms. These findings provide data that national public opinion supports CSE rather than the federal government's policy of AOE

Surgeon Generals Richard Carmona, David Sacher, Joycelyn Elders, and C. Everett Koop issued statements supporting comprehensive sexuality education for children and adolescents (Advocates for Youth, 2003). In 2001, the American Academy of Pediatrics issued a policy statement on sexuality education for children and adolescents noting that "children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behavior as adults (American Academy of Pediatrics – Committee on Psychosocial Aspects of Child and Family Health and Committee On Adolescence, 2001, p. 498)". Despite policy statements and research findings, the previous Administration continued to fund only AOE programs. There is a need for school-based, CSE in the U.S.

Contraception

Contraception, or birth control, is achieved by any method, drug, or device that prevents pregnancy by interfering with any of the essential steps in the normal process of conception -- ovulation, fertilization, or implantation. Different types of birth control methods act at various phases in the conception process; they may be categorized as 1) barrier or non-barrier types, or as 2) mechanical or chemical types. There are many effective contraceptive methods and devices available for teens: condoms, oral contraceptive pills, combination contraceptive patches, combined hormonal vaginal rings, progestin-only injections, copper-containing intrauterine devices, levonorgestral intrauterine systems, combined hormonal monthly injections, and single-rod contraceptive implants (As-Sanine, Gantt, & Rosenthal, 2004). Condoms are the most

common form of contraception (54%) used by teens, followed by birth control pills (25%), and withdrawal (8%) (Centers for Disease Control and Prevention, 2006).

Anderson, Santelli, and Morrow (2006) analyzed seven Youth Behavior Risk Surveys (YRBSs) of high school students conducted from 1991 through 2003, and found students with the following characteristics are more likely to report the use of withdrawal or no contraceptives: Latinos and those who think about suicide or feel sad or hopeless.

Although contraceptive use among sexually active teens in the U.S. has increased in the past two decades, its use remains inconsistent. Using data from the National Survey of Family Growth – 2002, Abma, Matinez, Mosher, & Dawson (2004) found that Latino male and female teens (ages 15-19 years) are less likely to use contraceptives at first sex compared to non-Latino, White and non-Latino, Black males and females; and Latina teens have the lowest proportion who ever used oral contraceptives (18%) compared to Non-Latina, Whites (68%) and non-Latina, Blacks (55%).

Holyoke, Massachusetts

Holyoke, with an estimated population of 39,765 in 2006, is the fourth largest city in Western Massachusetts (US Census Bureau, 2009). Located on the banks of the Connecticut River, it became the first US planned industrial city, incorporated in 1850. The development of the city's infrastructure and its industries relied on the cheap labor of immigrants from Europe and Canada (Borges-Mendez, 1993. & Hartford, 1990). In the 1960s and 1970s migrants from Puerto Rico began to arrive in the city (Borges-Mendez, 1993; Hardy-Fanta & Bassols-Martinez, 2002). Today the city's major ancestry groups are: Latinos 42% (38% Puerto Rican and 3% other Latino groups), Irish (17%), Polish (10%), French (10%), German (10%), Canadian (6%), and African American/Black (4%)

(US Census Bureau, 2000). This section will provide: a brief overview of Holyoke as a city of immigrants and the migration of Puerto Ricans to the city; and a summary of data from current reports that relate to environmental antecedents of teen pregnancy and births present in Holyoke.

Immigration

As the first planned industrial city in the US, Holyoke has been identified as a working class city that attracted immigrants for employment in its mills and factories. Immigration and migration had an early and continuing role of importance in Holyoke. The first wave of immigration to Holyoke began in the 1840s when the Irish immigrated due to the Irish potato famine, and found employment building the dam and canal system for the planned-industrial city (Borges-Mendez, 1993; Hartford, 1990). Immigration of large numbers of Irish continued into the 1870s; the immigrants worked in the factories and mills built along the canal (Green, 1938; Williams, 1992). During the mid-1860s large numbers of French-Canadians immigrated to Holyoke to work in the textile factories; the French-Canadian immigration was followed by smaller numbers of immigrants from Europe including: Polish (late 1860s), French and Germans, (1870s and 1880s), Italians (late 1880s), and Portuguese (late 1890s and early 1900s) (Green, 1938; Hartford, 1990). By 1880, 52% of Holyoke's population was foreign born (Williams, 1992). At that time, the Irish comprised the largest immigrant group and the French-Canadians the second largest (Green, 1938). Immigrant groups tended to be divided by the factories in which they worked, with the Irish primarily working in the paper mills and the French-Canadians working in the textile factories (Green 1938). Throughout the various waves of immigration, the newest group of immigrants resided in two adjacent

sections of the city known as “The Flats” and “South Holyoke.” These neighborhoods are located at the lowest point in the city near the factories and mills, had been comprised of tenements, and separated from the city center and finer neighborhoods by the canal. There has been a pattern of movement for immigrant groups from these two neighborhoods. As an immigrant group’s income and social status improved, they moved to neighborhoods rising up the hill and away from the factories and mills. One of the desired neighborhoods is known as “The Highlands.” This migration up the hill provided vacant housing for the next group of immigrants.

After the 1920s, immigration decreased due to restrictive immigration policies and deindustrialization (Borges-Mendez, 1993). After World War II and into the 1950s many of the factories and mills moved from the city, and younger residents moved out of the city leaving empty buildings and large portions of the Flats and South Holyoke in deteriorating condition (Hardy-Fanta & Bassols-Martinez, 2002). By the 1960s these neighborhoods were considered slums. At the same time, many of the remaining residents feared a decline in property values and sold their properties with the new owners becoming landlords and raising the cost of rent (Hardy-Fanta & Bassols-Martinez, 2002; Hook, 1988). Until the early 1960s, Holyoke had fewer than 100 Latino residents (Foster, 2003).

Puerto Rican Migration

A second wave of immigration to Holyoke began in the 1960s and continued in the 1970s. According to Foster (2003) the influx of Puerto Ricans to Holyoke was prompted by three separate phenomena: 1) High unemployment rates with low wages in Puerto Rico which left 40% of the island’s population living outside of the island by 1950

(Rodriguez, 1989). 2) Operation Pressure Point in New York City, tactics used to force Puerto Ricans to relocate to other cities (Foster, 2004). 3) The displacement of residents from Springfield neighborhoods due to the construction of Interstate 91 in the mid 1960s.

After World War II Puerto Rico suffered high rates of unemployment and low wages, with wages remaining higher for Puerto Ricans migrating to the US due to the deteriorating economic conditions on the island. As the economic conditions continued to worsen on the island, members of the Puerto Rican Department of Labor negotiated work contracts with tobacco and other farmers in the Connecticut River Valley in 1948 (Foster, 2003). The farm workers initially lived in labor camps during the summer months and returned to Puerto Rico for the winter; however, due to a steady decline in agricultural work, increasing unemployment, and low wages on the island, many workers stayed in Western Massachusetts taking jobs in the surrounding towns including Holyoke and Springfield. This migration of workers to Holyoke was also fueled by the remaining manufactures in Holyoke who were restructuring and seeking sources of cheap labor (Borges-Mendez,1993).

According to Foster (2003) the New York City government, in the early 1960s, began actions to remove the undesirable, including Puerto Ricans, from the city. This secret campaign was known as “Operation Pressure Point” (Foster, 2003, p. 38). As a result of this campaign some Puerto Ricans moved back to Puerto Rico, while others moved to other cities in the Northeast where housing was both available and less expensive. As noted earlier, during this time residents of South Holyoke were moving from the neighborhood and selling their properties to landlords leaving both available and relatively inexpensive housing. The adjoining city of Springfield also had inexpensive

housing stock to rent to Puerto Ricans migrating from New York City. Both Holyoke and Springfield witnessed a growing influx of Puerto Ricans during the 1960s and 1970s.

The migration of Puerto Ricans to Holyoke was also added to by the building of Interstate 91 as part of the government's Interregional Highway Plan of the 1950s (Georges, n.d.). Interstate 91 is the federal highway that runs from New Haven, CT north through Springfield and Holyoke, MA, through Vermont to the Canadian border. Construction of the highway in Springfield, MA began in 1964, when several neighborhoods in Springfield were displaced by both the construction of the interstate and accompanying urban renewal funds (Georges, n.d.). The timing of the "white movement out of the Flats and South Holyoke was synchronous with the displacement of Puerto Rican families in Springfield (Foster, 2003, p. 40)." Thus began the migration of large numbers of Puerto Ricans from Springfield to Holyoke.

Holyoke's Environmental Antecedents to Teen Pregnancy

In the late 1970s the paper and textile industries began to decline, and jobs disappeared. Holyoke witnessed a closing of many of its factories, and the Puerto Rican community suffered high rates of unemployment and economic, political, and social barriers to prosperity (Hardy-Fanta & Bassols-Martinez, 2002). Holyoke is the poorest city in the state (Borges-Mendez & McCormack, 2006). The Latino poverty rate in Holyoke grew. Today, Holyoke has unemployment and poverty rates that are higher than both the national and the state average rates. The national unemployment rate for July 2009 was 9.7; the Massachusetts unemployment rate for the same time period was 8.9, and the Holyoke unemployment rate was 12.8 (Massachusetts Government Registry, 2009). The estimated median household income in 2007, the most recent statistics

available, was \$35,128 in Holyoke with an estimated median household income for Massachusetts at \$62,365, which is nearly twice that of Holyoke's, at the same time the national estimated median household income was \$50,233 (City Data, 2009; US Census Bureau, 2008). This left 29.9% of Holyoke's residents living below the federal poverty level and an additional 12.5% living below 50% of the federal poverty level; thus more than 42% of Holyoke's residents are living in poverty (City Data, 2009). Holyoke's poverty rates are exceedingly higher than the state's poverty rates (9.9% below the federal poverty and 4.4% below 50% of the federal poverty level, for a total of 14.3%), and more than twice the nation's poverty rate (12.5% below the federal poverty level)(City Data, 2009; US Census Bureau, 2008). There are even greater percentages of children living below the poverty level (44.8%) in Holyoke than in Massachusetts (12.6%, which is nearly four times lower than Holyoke), and nationally (17.4%, which is over two times lower than Holyoke)(City Data, 2009; US Census Bureau, 2008). These poverty rates do not reflect the effects of the national economic downturn beginning in September 2008.

In addition, the rate of crimes in Holyoke is significantly higher than both the state and national rates. In 2008 the property crime rate in Holyoke was (6,198/100,000) which is more than double that of the state's rate (2,368.8/100,000) and nearly double the national rate (3,212.5/100,000); the City's violent crime rate (1,129/100,000) was also more than double that of both the state (449/100,000) and national rates (454/100,000) for the same time period (Massachusetts Executive Office of Public Safety and Security, 2009; US Department of Justice, 2008).

Holyoke’s high unemployment and poverty rates, accompanied by high crime rates, are environmental antecedents to teen pregnancy and births. These negative environmental antecedents are presented in Table 2.1.

Table 2.1: Negative Environmental Antecedents to Teen Pregnancy and Births: Holyoke, MA, US

	Holyoke	Massachusetts	United States
Unemployment Rate – July 2009	12.8	8.9	9.7
Median Household Income – 2007	\$35,128	\$62,365	\$50,233
Poverty Level – 2007	29.9%	9.9%	12.5%
Children Living in Poverty – 2007	44.8%	12.6%	17.4%
Property Crime Rate – 2008	6,198	2,368	3,212.5
Violent Crime Rate – 2008	1,129	449	454.5

School and academic statistics for the Holyoke School District provide examples of additional environmental antecedents/risk factors to teen pregnancy and births: high percentages of Latino and low income students; a significant number of students for whom English is not their first language; high school drop-out rates exceeding 10% with concomitantly low four-year high school graduation rates; and greater percentages of students who need academic improvement in relation to Grade 10 scores on the Massachusetts Comprehensive Assessment System (MCAS) tests. Note: The MCAS tests are designed to meet the requirements of the Education reform law of 1993 and dictate that students must pass the grade 10 tests in English Arts and Mathematics as one conditions of eligibility for a high school diploma (Massachusetts Department of Education, 2009). For the 2008-2009 academic year, the Massachusetts Department of Educated (2009) gave the Holyoke School district a low performance rating in English

Language Arts, and a very low rating in Mathematics, with greater percentages of students in need of academic improvement or failing in relation to scores on the Massachusetts Comprehensive Assessment System (MCAS) tests (Massachusetts Department of Education, 2009).

Holyoke High School has a student body of 1,252 a student body of 663 (Massachusetts Department of Education, 2009). When examining the state collected demographic data and MCAS test results, a great disparity between the state and Holyoke High School is evident. Table 2.2 provides these data for comparison.

Table 2.2: Comparing School/Academic Data for the 2009-2010 Academic Year

Student Characteristics	Holyoke High School	MA Public High Schools
Number of Students Enrolled	1,268	955,563
Males	601	490,363
Females	667	465,200
Latino Students	64.7%	15.4%
African American/Black Students	4.6%	8.2%
Asian Students	1.0%	5.5%
White Students	29.7%	68.0%
Low Income	64.0%	34.2%
Students receiving free lunch	58.7%	29.1%
Students receiving reduced lunch fees	5.3%	5.1%
First Language NOT English	44.4%	16.4%
Special Education	13.7%	17.0%
High School Completion		
Grades 9-12 Drop Out Rate	21.4%	2.9%
4 Year Graduate Rate	67.0%	82.1%
GED Rate	2.8%	2.0%
Grade 10 English Arts MCAS results		
Advanced	12%	26%
Proficient	54%	52%
Needs Improvement	27%	18%
Failing	6%	4%
Grade 10 Mathematics MCAS results		
Advanced	40%	50%
Proficient	26%	25%
Needs Improvement	20%	17%
Failing	14%	7%
Grade 10 Science & Technology MCAS results		
Advanced	2%	18%
Proficient	29%	47%
Needs Improvement	56%	17%
Failing	18%	8%

Source: Massachusetts Department of Education (2010)

Summary

It can be seen from this literature review that considerable research has been published on teen pregnancy and birth. The literature is rich in some areas: antecedents to and prevention strategies for teen pregnancy, teen pregnancy intention, and the

consequences of teen births; while meager in the area of perceptions held by teens about teen pregnancy and births. Current research tends to reduce teens into populations of White, non-Latinos, Black/African-Americans, and Latinos. A recent national survey focusing on attitudes and beliefs of Latino adults and teens about teen pregnancy conducted by the National Campaign to Prevent Teen Pregnancy (Vexler, 2007) failed to identify specific Latino sub-populations. In current literature, if researchers identify a Latino sub-population, it most frequently is the sub-population of Mexican-Americans. Relatively little is known regarding views held by teens of Puerto Rican descent about the high teen birth rates, the future consequences faced by teen parents, the contributing and protective factors of teen pregnancy, and potential preventive interventions for themselves and their cohort.

Talashek, Alba, and Patel (2005) found six distinct predictive criteria related to teen births for Latinas of Puerto Rican decent that differed from predictive criteria for Mexican American Latinas. There is a gap in the literature regarding the sub-population of Puerto Rican teens. Of the five studies reviewed focusing on teens' perceptions of pregnancy and births, two did not include Latinos, and of the three that included Latinos only one, Pieve (2001), included Puerto Rican Latinas. Eight studies on pregnancy intentions of adolescents were reviewed; five focusing on females' intentions and three on males' intentions. Four of the five studies of female intentions included Latinas but none identified the sub-population of Puerto Ricans. All three of the studies on male intentions included Latinos; only Foster's (2004) study focused on Puerto Rican Latinos. Only three of the seven studies reviewed on consequences of teen births included Latinos, and none of the researchers identified Puerto Ricans as a sub-population in the sample.

The Latino community is diverse. There is a dearth of scientific literature that gives voice to Puerto Rican teens' perceptions of teen pregnancy and births. There is a need for qualitative research in this area.

CHAPTER 3

RESEARCH METHOD AND DESIGN

Introduction

This descriptive study used focus groups to explore perceptions held by the participants related to teen pregnancy and births in Holyoke, MA. Since teen pregnancy and births are complex public health problems, the researcher chose a qualitative research design to allow participants to construct the reality of teen pregnancy and births from their worldviews. Focus groups provided the researcher with rich communal knowledge about the real-world problem of teen pregnancy and birth.

The purpose of this qualitative study was to examine the perceptions held by Puerto Rican teens living in Holyoke about teen pregnancy and births. The aim was to gain knowledge about the participants' perceptions, with a view to using this knowledge as both a foundation for future research and a means to inform policy development, nursing practice, and programs that serve Puerto Rican teens. The four research questions that guided this study were: 1) What perceptions do participants hold about teen births? 2) How do participants' view the future of teen parents and their future life goals? 3) In relation to teen pregnancy, what do participants identify as: contributing factors, protective factors, prevention strategies? 4) Where do participants get information about reproductive health (sex, contraception and having babies)? Focus groups were chosen for the method because they encourage spontaneous exchanges of ideas, opinions, thoughts, feelings, attitudes, and concerns among participants (Burns & Grove, 2005 Kamberelis & Dimitriadis, 2008; Kruger & Casey, 2000; Patton, 2002; Webb & Kevern, 2001), and allow researchers to be open to whatever emerges.

This chapter presents an overview of focus groups and the use of focus group in research involving teens. This is followed by the research design and a discussion of the study's setting, the sample, methods of participant recruitment, steps taken to protect human subjects, and data collection. The process for data analysis is then presented.

Focus Groups

Focus groups are considered the counterpart to quantitative surveys (Sadelowski, 2000) where the researcher gathers information by listening to the discussion of participants and observing their interactions to understand how they feel or think about an issue (Krueger & Casey, 2000). Focus groups are an appropriate method for gaining knowledge about participants' opinions, beliefs, attitudes, ideas, and concerns. Thus, the method was consonant with the study's purpose and provided an appropriate venue for gathering data from teens. Furthermore, focus groups have been found to be of value in studying issues in socially marginalized groups (Kidd & Parshall, 2000), and to be a culturally sensitive information gathering method used in research with Latinos (Madriz, 1998), considered important as the study's target population was Puerto Rican teens living in Holyoke, MA.

The use of focus groups enabled the researcher to gather collective testimony from Puerto Rican teens. The focus groups provided teens with a setting to share, verify and confirm their experiences with others of similar socioeconomic and ethnic backgrounds; and the groups served as a sensitive tool to recover and use knowledge acquired from these participants' subjective experiences of everyday life (Madriz, 1998). The focus groups brought together small numbers of participants, providing them a permissive, non-threatening environment for a planned discussion on teen pregnancy and

births that made the most of the synergism and dynamics of group interaction to assist the participants in expressing and clarifying their views, and enabled the researcher to obtain valid experiential data.

Hockenberry and Wilson (2007) note that teens talk freely when given an opportunity; they like to express their feelings, and are more willing to discuss sensitive issues with adults outside, rather than within their families. Use of focus groups with teens was preferable to individual interviews or questionnaires because focus groups provided the participants with: 1) a means to spontaneously discuss teen pregnancy, births and related issues; 2) a social-interaction setting, appropriate to their developmental stages; 3) a milieu for teens to reflect on and share their social realities, cultural values, and group norms (McLafferty, 2004; Robinson, 1999); and 4) a sense of a secure environment for sharing information, ideas, and perceptions (i.e. safety in numbers – participants were not obligated to respond to every question) (Burns & Grove, 2005; Sim, 1998). Focus groups provided the researcher with 1) checks-and-balances to weed out false or extreme views (Kruger & Casey, 2000); 2) a means to gain information and data not readily captured through traditional research methods (Patton, 2003); 3) a venue to elicit critical comments and information essential to providing a picture from teens' combined perspective (Webb & Kevern, 2001), 4) a setting to uncover teen views and attitudes on a teen pregnancy and births that would be difficult to discover through surveys, questionnaires, or polls (Waterton & Wynne, 1999), and 5) rich detailed perspectives on the issue through the participants' sharing and comparing of responses (Coté-Arsenault & Morrison-Beedy, 1999).

A primary advantage of using focus group methodology in this study was that it encouraged spontaneous exchanges of ideas, thoughts, and attitudes among participants, who freely interacted and built ideas upon responses of others (Kruger, 1994; Nyamathi & Shuler, 1990; Stewart, Shamdasani & Rook, 2007). Additional advantages included:

- 1) Participants were able to partake in the study without needing the skills to read or write English. (Participants lived in households where either Spanish or Spanish/English were spoken and may have had limited skills to read or write English. One participant noted that “some kids in school really can’t read.”)
- 2) Teens of Puerto Rican culture were encouraged to participate in this study when they often had felt excluded from the mainstream culture. (The topic of Puerto Rican teen’s exclusion was identified by participants during the focus groups. One participant stated: “I think this [the focus group] is pretty cool, because it is about Puerto Ricans and that doesn’t happen a lot.”)
- 3) The researcher was able to gather in-depth information in participants’ own words and was able to clarify ambiguous statements and terms that had different meanings.
- 4) Participants had the security of being in a group with teens of similar ethnic and cultural backgrounds while discussing sensitive issues related to sex, sexual health, and academic achievement.
- 5) The moderator and co-moderator of the focus groups were able to interact directly with participants; this de-centered their authority and provided participants with a sense of shared power.

Research Design

The use of focus group methodology expanded the researcher’s role beyond interviewer to that of moderator (Krueger & Casey, 2000). For this study a research team, consisting of the principal investigator as the moderator and a co-moderator (a

young female adult of Puerto Rican ethnicity, who had grown up in Holyoke and graduated from Holyoke High School) was used for this study. Dreachslin (1998) advises the use of bicultural co-moderators when race or ethnicity are salient issues in the research. The moderator was responsible for facilitating a non-threatening climate, conducive to open discussion and different points of view; introducing and guiding the discussion by keeping it focused; posing questions; encouraging input from all participants; keeping the discussion on track as appropriate; discouraging the domination of one or two participants; and taking notes for follow-up questions or probes. The co-moderator's role included asking questions, observing interactions, taking notes, and meeting the potential needs of any participant who might find a topic disturbing to her/him.

In preparation for meeting with the focus groups, the moderator and co-moderator discussed the purpose and process of focus groups including techniques for leading group discussions. In addition, the research team conducted two pilot focus groups as part of the preparation process to practice guiding discussions based on the research questions and following the research protocol.

Focus Group Size and Composition

Focus groups with teens offer unique challenges due to gender difference, peer-cohesion, and differing levels of development and maturity (Krueger, 1994). Special care was taken in the formation of groups and included the size of groups, homogeneity, developmental stages of teens, and acquaintance versus stranger participants.

The number of participants in a group affects the quality and depth of discussion. Smaller groups generally provide more time for each participant to actively contribute to

the discussion, allow for in-depth insights (Kruger, 1994), and are more appropriate with emotionally charged topics (Morgan, 1995). Krueger (1994), Morgan (1995, 1998b), and Stewart, Shamdasani, & Rook (2007) suggest that the number of participants for each focus group be six to twelve. In their 2002 study on using focus groups in pediatric health care research, Heary and Hennessy suggested a group size of four to six participants with children over 6 years old. Hoppe and colleagues (1995) used focus groups in their research with children and note that a minimum of three participants is necessary to generate “good cross-talk (p. 106),” and in groups larger than six it is difficult for moderators to hold the attention of all participants and draw out quieter ones. With teens, it is advantageous to have a group on the smaller side to provide all participants the opportunity to express opinions. Given the sensitivity of the topics for discussion, in the current study the researcher elected to have four to seven participants per focus group.

Focus group composition was determined prior to recruitment since group composition may affect discussions, and hence the quality of data collected. The focus groups were homogeneous to enable participants to benefit from their shared experiences (Kitzinger, 1995) by encouraging free-flowing conversations (Morgan, 1997). Homogeneity was preferred because differences in sex, age, socio-economic background, community status, race, and ethnicity may inhibit some participants from speaking candidly, if at all.

Teens are self-conscious and search for a unique social identity; they seek a sense of belonging in a group and view peers as more important and influential than parents or guardians (Burns, Dunn, Brady, Starr, & Blosser, 2004). Given the psycho-social

developmental aspects of teens, homogeneity in focus groups was chosen to enhance the likelihood of open communication and discussion. The focus groups of this study were composed solely of either males or females in order to decrease the possibility of distraction and self-consciousness and to provide a milieu that encouraged participants to be honest and straightforward with their opinions.

The recommended number of focus groups is usually three to six; justification for this number of groups is that repetitious data often occurs after three or four groups (Krueger & Casey 2000; Morgan 1995, 1998b). Krueger and Casey (2000) refer to this as “saturation -- the point when you have heard the range of ideas and aren’t getting new information (p.26).” Morgan (1996) suggests that diversity in either the participants or the range of topics covered will increase the number of groups needed. For this study, participant diversity was limited by inclusion criteria, and the topic was focused solely on teen pregnancy and births in Holyoke.

The researcher chose to consider developmental stages of adolescents in deciding on the number of focus groups to conduct and in the formation of groups, rather than saturation in determining the number of focus groups to include. It was decided to have two focus groups (one for males and the other for females) for each grade (9th, 10th, 11th and 12th) at the high school for a total of eight focus groups.

Another consideration in determining group composition was whether or not to have people who know each other in the group since the dynamics of groups consisting of strangers are different from those consisting of acquaintances (Morgan, 1997). There are arguments for both acquaintance and stranger groups. During the teen years, peer groups often begin to replace family as the teen’s primary social focus; these groups

assume importance to teens because they provide validation for their tentative choices and support in stressful situations (Burns, Dunn, Brady, Starr, & Blosser, 2004). Hence, having teen groups consisting of individuals acquainted with one another may enhance group discussion. Given this study's purpose, population and setting, prior acquaintance of participants was not an exclusionary criterion; thus focus groups had acquaintances in them.

Focus Group Structure and Interview Guide

It was decided to have each focus group meet approximately 60 to 90 minutes, and to use a semi-structured format with a Focus Group Interview Guide (Appendix A). The Focus Group Interview Guide was used in a flexible manner that allowed the moderator freedom to probe more deeply where necessary, to skip over areas that had already been discussed, and to follow new topics as they arose (Morgan, 1998a). The interview guide was based on the study's purpose and was developed using the research questions:

1. What perceptions do participants hold about teen births?
 - a. Do participants believe that teen births are a problem?
 - b. Do participants believe that teens are intentionally having babies?
2. How do participants' view the future of teen parents?
3. In relation to teen pregnancy, what do participants identify as:
 - a. contributing factors?
 - b. protective factors?
 - c. prevention strategies?

4. Where do participants get information about reproductive health (sex, contraception and having babies)?

Pilot Focus Groups

Krueger (1988) and Morgan (1998a) recommend conducting a pilot focus group if a researcher plans to conduct multiple focus groups or rely solely on focus group data without triangulation. For this study, the researcher used multiple focus groups as the source of data, and utilized two pilot focus groups, one for male participants and the other for females, to test the focus group protocol and the Focus Group Interview Guide on teens similar to those who were in the study. This was done to ascertain whether the questions were clear, whether they would produce the needed information, and whether participants had the knowledge to answer them.

Participants were recruited for the pilot focus groups from the Adolescent Advisory Board (AAB) of the Youth Empowerment and Adolescent Health (YEAH) Network. The AAB consisted of 12 high school students who met twice a month to learn about sexual and reproductive health and participate in leadership development activities. The AAB members were current students at the high school and resided in Holyoke. For the pilot groups the research protocol was followed.

During the pilot focus group meetings, the moderator and co-moderator assessed the order and content of questions, the room arrangement, and the group composition. At the end of both pilot groups, the moderator asked participants whether they understood the questions or whether an important topic was left out. The participants noted that the questions were understandable and that no related areas were omitted. These findings were used in the assessment of the focus group protocol and interview guide. There were spontaneous interactions and discussions

during the pilot focus groups, and no major modifications were made; however, two questions were reordered in the focus group interview guide.

Setting

The setting for the study's focus groups was the Teen Clinic of the Holyoke High School. A description of both Holyoke and Holyoke High School were provided in Chapters One and Two, and a description of the Teen Clinic follows. The researcher is a public health nurse and had spent over two years participating in city and regional meetings that addressed issues related to teen births in western Massachusetts. Through this work, the researcher developed a connection with the nursing director of Holyoke's school-based health clinics. It was through these activities that access to the Teen Clinic at Holyoke High School was obtained. The Teen Clinic is a school based health center, staffed by licensed Nurse Practitioners under the direction of a Medical Director, and administered by the River Valley Counseling Center of the Holyoke Medical Center. With parents' permission, the Teen Clinic provides basic primary care services such as immunizations, comprehensive health assessments and physical exams, sports physicals, health education, mental health services (including screening and treatment for depression and suicide prevention), dental screenings, and referral service to primary or specialist care. During the 2008-2009 academic year approximately 1,900 visits were made by 300 students to the Teen Clinic at Holyoke High School (M. Fago, personal communication, January 4, 2010). The Teen Clinic was specifically chosen as the site for the study because, although it is situated in the high school, it is a separate entity that is focused on health and is not directly connected with academics.

Holyoke High School was chosen because it is the only non-vocational, public high school in the City of Holyoke. The city has had a continuously high teen birth rate

for over two decades. For the academic year of 2009-2010 Holyoke High School had a student body of 1,278; of these students 626 were male, 652 were female, with 65.3% identified as Latino. A review of the school’s student body is presented in Table 3.1.

Table 3.1: Student Data for Holyoke High School 2009-2010

Student Data	Holyoke High School
Number of Students Enrolled	1,278
Males	626
Females	652
Latino Students	65.3%
African American/Black Students	4.1%
White Students	29.7%
Other	0.9%
Low Income	51.7%
Students receiving free lunch	46.2%
Students receiving reduced lunch fees	5.6%
Special Education	12.4%
High School Completion	
Grades 9-12 Drop Out Rate - 2009	23.1%
4 Year Graduate Rate – 2009	62.4%
GED Rate – 2009	1.9%
1 st Language not English	46.6%

Source: Massachusetts Department of Education (2010)

The focus groups met in a small conference room located in the back of the Teen Clinic. This provided privacy and comfort for the participants, and it was quiet and conducive to conversation. The room had limited space, which the researcher used efficiently. Refreshments were set out on a desk in baskets lined with cloth napkins. There was a small round table covered with a cloth tablecloth for the focus group discussion. Chairs were arranged around the table to provide enough room for participants to feel comfortable. The researcher attempted to provide a setting that was private, inviting, relaxed, and gave the participants a sense that they were important contributors.

Sample

Teens of Puerto Rican heritage, born in Puerto Rico or having a parent or grandparent who were born in Puerto Rico, living in Holyoke and attending Holyoke High School comprised the target population for this study. Both females and males were included in the sample. Females who were not pregnant nor had a child and males who did not have a partner who was pregnant now nor were fathers were included. Additional inclusion criteria were: 14-19 years of age, ability to understand and speak English, willingness to volunteer, and provision of written parental/legal guardian permission with participant assent for teens under the age of 18 years.

Participant Recruitment

To foster support for this study and the recruitment process, the researcher had spent over two years developing relationships with community leaders. These leaders included: the director of the city's school-based health clinics, the Mayor; members of a City Council sub-committee who are examining the problem of the high teen birth rates, staff members of three Holyoke teen programs, and the director and board members of a community coalition working to motivate the leaders of communities in Hampden County to address the high teen birth rates in local cities, including Holyoke. In addition, the researcher obtained support for the study from the high school's principal. Prior to beginning data collection, the researcher held discussions with the director of the Teen Clinic regarding both the study and recruitment process. The director suggested using a recruitment flyer (Appendix B) posted in the Teen Clinic, and to conduct direct recruitment during lunch time in the school's cafeteria.

Incentives were included to enhance recruitment and encourage participation. Kruger and Casey (2000), Morgan (1999) and McCormick et al. (1999) note that incentives are necessary as a stimulus to have participants come to the focus group meeting. For this study, each participant was given a \$15.00 stipend for the meeting that he/she attended, and refreshments were provided. The stipend compensated the teens for their time and input in the focus group discussion.

The recruitment process was guided by suggestions proposed by McCormick and colleagues (1999), and Morgan (1998). The researcher identified potential participants through advertising in the school-based health center and the school's cafeteria, screened potential participants for eligibility via the Student Information Form (See Appendix C), followed-up with phone calls and text messages, and offered incentives of food and a monetary stipend to encourage participation.

The recruitment flyer was posted in several areas of the Teen Clinic. The researcher enlarged the flyer and made a tri-fold poster which was used in the cafeteria for recruitment where the researcher set up the poster on a table with copies of the flyer, Student Information Forms, and a basket of candy. As students stopped by the table, the researcher described the study and its requirements. If a student met the inclusion criteria and expressed interest in participating in the study he/she was asked to fill out the Student Information Form. Potential participants under the age of 18 were given copies of Parent Consent Forms (these are discussed under Protection of Human Rights) in Spanish and English. All potential participants were given written a copy of the flyer and a schedule of the dates for focus groups by grade and gender. The researcher recruited in the cafeteria during the high school's three lunch periods for 2 consecutive days. This

yielded 20 completed student information forms. This was followed by an additional 2 days of recruiting in the cafeteria following the school's week-long spring vacation which yielded an additional 27 completed student information forms. The recruitment flyers posted in the Teen Clinic generated response from 10 teens. The researcher did not receive enough student information forms from 9th grade boys. To reach this group of students, the researcher went to two 9th grade health classes to describe the study and recruit participants for this specific focus group. Direct recruitment in a classroom yielded the nine potential participants for this focus group. When the researcher was in the health class describing the study and past recruitment activities, one student stated, "No one pays attention to anyone in the cafeteria." A total of 66 teens were recruited for the study, of this number 39 participated in a focus group.

Protection of Human Subjects

This study met all requirements for the protection of human rights and was approved by the University of Massachusetts' Institutional Review Board. The researcher followed Massachusetts laws regarding the legal status of teens under the age of 18 years as minors. For this study, teens under the age of 18 years required parental/guardian consent (see Appendix D: Parent Consent - English; Appendix E: Parent Consent - Spanish) and teen assent (Appendix F) to participate. Teens 18 years and older signed their own written consent for study participation (see Appendix G).

The study involved minimal risks to the participants. There was a potential risk of psychological distress for participants if they disclosed personal experiences. To minimize this risk, participants were informed that at any time during the focus group they could choose not to answer a question or end their participation in the study. Plans

to refer participants to the counseling services at the Teen Clinic were in place, if needed; but no participant demonstrated signs of psychological distress. Although no participant indicated that someone was harming her or him, a mechanism was also in place to notify appropriate authorities as needed.

Confidentiality cannot be assured in focus groups due to the public nature of the methodology and the number of participants in a group (Kamberelis & Dimitriadis, 2008; Krueger & Casey, 2000). Approaches to promote the protection of confidentiality in this study included: 1) Statements made in focus group opening directions and closing comments emphasized the importance of respecting the privacy of each other by not sharing information with others, including members of the group, friends, acquaintances, and family. 2) The moderator emphasized the importance of not revealing the identities of other participants or quoting what they said during the discussions. 3) Focus group recordings and documents were kept in a locked file drawer in the researcher's home. 4) Names were not on the transcripts nor were they included in findings.

Data Collection

All focus groups were conducted in the high school's Teen Clinic. Four days prior to a scheduled focus group the researcher contacted participants either by phone or text message to remind them of the meeting and, for under 18 year old participants, to bring the signed parent/guardian consent form. The researcher was not always able to reach participants, phones were disconnected or phone numbers did not accept incoming calls for several teens. On the evening prior to the focus group, second reminder phone

calls were made or text messages sent to the teens. There were a total of thirty nine participants in eight focus groups.

Each focus group followed a standard protocol. Upon arrival in the teen clinic students were directed to the room where the focus groups were held and offered a variety of refreshments. Parent consent forms were collected and participants completed either an assent form or a consent form, as appropriate for participants' age; then a Demographic Data Form (Appendix I) was filled out by each participant. Once all participants were present, had refreshments, and completed all required forms, the focus group began. The interview guide provided a uniform format for presenting an overview of the research, giving guidelines for privacy and confidentiality, and establishing guidelines for the discussion.

Following each focus group, the research team held a debriefing session to discuss interactions during the focus group, the participant responses, and the emerging themes. The following questions were utilized: 1) What were the apparent themes? 2) What were helpful quotes? 3) What was surprising? 4) Does anything need to be changed for the next focus group? 5) How was this group similar or different from earlier groups? These data and the researcher's journal are included in data analysis.

Following data collection, tapes were transcribed verbatim by a professional transcriptionist at the Qualitative Data Analysis Program at the University of Massachusetts, Amherst. These transcriptions did not contain any names or other identifying data related to individual participants. The accuracy of all transcriptions was checked against the recordings by the researcher, corrections to the transcripts were made as necessary. Confidentiality of audio-recorded focus group interviews was maintained

by keeping the tapes in a locked drawer accessible only by the researcher. After the completion of the study, all audio recordings will be destroyed by the researcher.

Data Analysis

For this study, each focus group was the unit of analysis. Initial steps to organize the data included filing all data elements for each focus group as a single unit. These data elements consisted of the transcription, debriefing notes, and demographic information. One aim of data analysis was to look for trends and patterns that reappear within a single focus group and across focus groups.

Data collection and analysis occurred concurrently utilizing both Krueger's (1998b) continuum of analysis and Rabiee's (2004) interconnected stages. This gave structure to the process: 1) familiarizing the researcher with data by both listening to each focus group transcript, 2) developing codes and coding data using inductive and deductive processes, 3) indexing -- "highlighting and sorting quotes (p. 657)", 4) charting -- "lifting quotes from their original context and re-arranging (p. 658)" them by research question, and 5) interpreting coded data (Rabiee, 2004). This data analysis plan assisted the researcher in developing a trail of evidence that can be verified.

As noted, data analysis began during the data collection process. After the debriefing the researcher became familiar with the data by listening to the recordings which immersed the researcher in the teens' world views. Once the transcripts became available, the researcher read the transcripts several times in their entirety to obtain a sense of the whole. Next the researcher wrote memos in the margins and identified codes, using the teens' words to develop *In Vivo* codes, which helped preserve the meaning of the teens' views (Patton, 2003). The text was then coded with each code

given a working definition. A constant comparison of codes from new transcripts was done to more fully develop the properties of the overarching definitions for the codes (Glasser & Strauss, 1967). The researcher developed an operational definition for each code. Each word segment was coded in the left-hand margin of the transcription. This process continued until no new codes emerged.

The phases of indexing and charting were combined. The researcher used a low-technology data management strategy developed by Krueger and Casey (2000) where the researcher examined the coded data and used the research questions to organize the coded quotes for each focus group. Using an iterative, progressive, comparative process, the data were sorted, shifted, and searched by the researcher where quotes were examined and reexamined, arranged and rearranged, compared and contrasted. This phase involved highlighting and cutting quotes from the transcripts, and pasting specific quotes under the appropriate research question: the third research question was sub-divided into contributing factors, protective factors, and prevention strategies. (See Appendix I)

Indexing, allowed the researcher to shift and sort quotes, and charting allowed the researcher to lift quotes from their original context and re-arrange them under the developed themes. These processes provided a means for the researcher to prepare the data for interpretation. In this phase the researcher looked for patterns and relationships within a focus group and across focus groups. Through sorting, shifting and examining data, discoveries emerged.

The researcher kept observational notes and a reflective journal throughout the research process. Doing so, both added another lens to the research process and data analysis, and brought triangulation to the research for corroboration and assurance of

trustworthiness (Cresswell, 1998; Denzin & Lincoln, 2005; Jansick, 1998; Lincoln & Guba, 1985; Patton, 2002). Reflective journal writing assisted the researcher in addressing subjectivity by providing a forum to examine personal assumptions and goals, clarify individual belief systems, and create transparency in the research process (Ortlipp, 2008; Richardson & St Pierre, 2005). The journal contained three sections: 1) methodological decisions and rationales to justify changes, 2) field notes, and 3) personal self-reflection. The journal provided a mechanism to transcend time and bring the researcher back to the focus groups and impressions of that time. Through this journal the researcher was able to acknowledge experiences, opinions, thoughts, and feelings as part of the research process. Thus, it served as a mechanism to create transparency in the research.

Trustworthiness in Qualitative Research

The aim of trustworthiness in qualitative research is to support the contention that the study's findings are "worth paying attention to" (Lincoln & Guba, 1985, p.290). Trustworthiness of this study was established through the use of Lincoln and Guba's (1985) four criteria: 1) credibility, 2) dependability, 3) confirmability, and 4) transferability. To further trustworthiness, the researcher included the debriefing notes and reflective journal entries in the data analysis.

Credibility is an evaluation of whether or not the research findings represent a "credible" conceptual interpretation of the data drawn from the participants' original data (Lincoln & Guba, 1985, p.296). To enhance credibility of this study, the researcher spent extensive time in the community setting to develop rapport and relationships to prepare for the study. In addition, the researcher incorporated member checking during each

focus group where the researcher summarized information and then asked the participants to determine accuracy and additional comments. The participants affirmed that the summaries reflect their views, feelings, and experiences, or that they did not reflect these experiences and they clarified their views, feelings, and experiences.

Dependability refers to the ability of another researcher to follow the thinking, decisions, and methods used to derive the study's findings. Lincoln and Guba (1985) suggest the use of an "inquiry audit (p. 317)" to enhance dependability in qualitative research. The researcher created an audit trail which allows reviewers to examine both the process and the product of this study for consistency.

Confirmability is a measure of how well the inquiry's findings are supported by the data collected (Lincoln & Guba, 1985). It is the extent to which the study's findings were shaped by the participants and not the researcher's bias, motivation or interest. Confirmability was the achieving of reflexivity, by attending to the effect of the researcher at every step of the research process. Inclusion of the researcher's field notes and self-reflection journal in data analysis supported reflexivity and confirmability.

Transferability refers to the extent to which findings from this study can be applicable beyond its context (Lincoln & Guba, 1985). In this study, the thick descriptions of the community and high school are provided. In addition, the researcher includes participants' direct words. Both of these offer detail for the reader to evaluate the extent to which the conclusions drawn are transferable to other settings, times, situations, and people (Lincoln & Guba, 1985). Additionally, the thick descriptions and

quotes give other researchers the ability to transfer the conclusions of this inquiry to other cases, or to repeat, as closely as possible the procedures of this research.

Summary

Focus groups were chosen as the best qualitative methodology to explore perceptions held by Puerto Rican teens living in Holyoke, MA as they relate to teen pregnancy and births in the city for this descriptive exploratory study. This naturalist view best represents the study's aim to gain knowledge about the participants' perceptions.

Focus groups, homogeneous sampling of a minority population, the iterative process of data analysis, and the writing of a reflective journal are all important parts of this study to gain an understanding of the participants' world. Both the researcher and co-moderator were affected by and changed by the teens' discussions. The teens in turn were able to have their voices heard. The knowledge gained through this study will serve as both a foundation for future research and a means to inform policy development, nursing practice, and programs that serve Puerto Rican teens. In addition, this study provided a venue to add Puerto Rican teens' voices to the discourse on teen pregnancy and births.

CHAPTER 4

FINDINGS

Introduction

Major findings of this study are presented in this chapter, and give voice to Puerto Rican teens' perceptions of teen pregnancy and birth. The findings are based on the participants' perceptions of teen births in Holyoke. They are interpretations made by the researcher derived from the audio-recordings, transcripts, and field notes from eight focus group meetings. As noted in Chapter 3, data analysis utilized Krueger's (1994, 1998b) framework and Rabiee's (2004) interconnected stages. Data analysis was directed by the problem of teen births in Holyoke, and guided by the following research questions:

1. What perceptions do participants hold about teen births?
 - a. Do participants believe that teen births are a problem?
 - b. Do participants believe that teens are intentionally having babies?
2. How do participants view the future of teen parents and their future goals?
3. In relation to teen pregnancy, what do participants identify as:
 - a. contributing factors?
 - b. protective factors?
 - c. prevention strategies?
4. Where do participants get information about reproductive health (sex, contraception, and having babies)?

Transcription-based data analysis was a continuum that began with the accumulation of raw data, continued with a description of the participants' comments and an interpretation of these comments, and ended with recommendations. Data description

will be presented in this chapter and include: 1) A presentation of the participants' demographic characteristics. 2) A description of each focus group meeting organized by research questions. A discussion of both data interpretation and recommendations based on the findings will be presented in Chapter 5.

Participant Demographic Characteristics

Thirty-nine teens, who self-identified themselves as Puerto Rican, participated in the study; 21 (54%) were female and 18 (46%) male. All participants lived in Holyoke and attended Holyoke High School. Demographic data are presented in Table 4.1. Demographic characteristics of interest include: age range by grade, income/free lunch, and languages spoken at home.

The customary age range for high school grades are 14-15 years for ninth grade, 15-16 years for tenth grade, 16-17 years for eleventh grade, and 17-18 years for twelfth grade. Using these ranges four focus groups had participants who exceeded the customary age. The ninth grade boys group had five participants (83%) who were 16 years of age, and the ninth grade girls group had three participants (75%) who were 15 years of age. The tenth grade girls group had one student who was 17 years old and another 18 years old (33%). The eleventh grade boys group had one 19 year old participant (50%).

To estimate participant family income, the US Department of Agriculture's (2009) Child Nutrition Programs – Income Eligibility Guidelines were used. Of the 36 participants who answered the question about lunch fees, 89% came from families with incomes at or below 130 percent of the federal poverty level, and 9% came from families with incomes between 130 percent and 185 percent of the federal poverty level.

Both Spanish and English were spoken in 31 (85%) of the participants' homes, and in two of these a third language was also spoken, Polish in one and French in the other. Spanish was the only language spoken in two homes (5%), and English was the only language spoken in four homes (10%).

Table 4.1: Demographic Data of Focus Group Participants

Focus Group	Ages	Income/Free Lunch	Place of Birth	Parents Place of Birth	Languages Spoken at Home
12 th Grade Girls n = 4	2 17 yrs 2 18 yrs	2 free lunch 1 reduced rate 1 pays in full	1 New Jersey 3 Western MA	3 Puerto Rico 1 Columbia 1 New York City 1 New Jersey 2 Holyoke	4 English/Spanish
12 th Grade Boys n = 7	5 17 yrs 1 18 yrs 1 19 yrs	7 free lunch	3 Puerto Rico 4 Western MA	7 Puerto Rico 1 Columbia	4 English/Spanish 1 English/Spanish/ French 1 Spanish only
11 th Grade Girls n = 6	3 16 yrs 2 17 yrs 1 18 yrs	4 free lunch 1 reduced rate 1 no response	3 Western MA 3 Bronx NY	6 Puerto Rico 5 New York City 1 New Jersey	6 English/Spanish
11 th Grade Boys n = 2	1 18 yrs 1 19 yrs	2 free lunch	1 Brooklyn NY 1 NYC	1 Puerto Rico 2 Brooklyn NY 1 Bronx NY	1 English/Spanish 1 English only
10 th Grade Girls n = 7	3 15 yrs 2 16 yrs 1 17 yrs 1 18 yrs	6 free lunch 1 no response	3 Puerto Rico 4 Western MA	6 Puerto Rico 1 Dominican Rep. 2 Holyoke	6 English/Spanish 1 Spanish only
10 th Grade Boys n = 3	3 16 yrs	2 free lunch 1 no response	3 Western MA	4 Puerto Rico 1 Brooklyn NY	1 English/Spanish 1 Spanish only 1 English only
9 th Grade Girls n = 4	1 14 yrs 3 15 yrs	4 free lunch	3 Western MA 1 Chicago	3 Puerto Rico 2 Western MA	3 English/Spanish 1 English only
9 th Grade Boys n = 6	1 14 yrs 5 16 yrs	5 free lunch 1 reduced rate	4 Western MA 1 NJ 1 Poland	3 Puerto Rico 4 Western MA 1 Poland	4 English/Spanish 1 English/Spanish/ Polish 1 English only

Data Description

Data from eight focus group meetings provided rich communal knowledge about the real-world problem of teen pregnancy and birth in Holyoke from Puerto Rican teens' perspective. The participants appeared enthusiastic about having an opportunity to

express and share their views. This was supported by participant statements such as: “Finally, someone is interested in what Puerto Rican teens have to say, because no one listens to us.” “It was a good way to, like express what we were feeling about the issues that are going on.”

Raw data, representing exact statements of participants in the eight focus group meetings, were organized and reduced to summary statements of participants’ comments followed by supporting examples. In this section each focus group meeting is presented in the order that it was held. The research questions were used to organize the data under the following sub-headings: 1) perceptions of teen pregnancy and births 2) future of teen parents, 3) reproductive health knowledge, 4) contributing factors, 5) protective factors, 6) prevention strategies.

Focus Group One – 12th Grade Girls

The first focus group was composed of four twelfth grade girls, consisted of two dyads of girls who knew each and met for 105 minutes. The participants initially appeared guarded but quickly progressed to a more at ease demeanor. The girls were supportive and respectful of each other’s views, thoughts, ideas, experiences, and feelings. Their discussion was gregarious.

Perceptions of teen births

These participants viewed teen births as a problem that both gave girls living in Holyoke a negative reputation, and placed blame for the city’s high teen birth rate directly on Puerto Ricans.

[Teen pregnancy] is a problem here in Holyoke with so many big bellies walking around in the high school. It gives us a bad name. People think that all Puerto Rican girls are sluts in Holyoke, but that isn’t true. I’m still a virgin and so are many of my friends.

The participants noted that their mothers do not want them to become teen parents. One girl relayed a conversation she had with her mother about having a baby during high school years. Her mother did not condone teen births and described negative outcomes of being a teen parent. Nonetheless, this mother valued education and would support her daughter to continue with her education if she should get pregnant.

My mom talked to me about having a baby. “If you end up getting pregnant, I will take care of the baby while you're in school. I want you to finish your education. But once you get home from school and on weekends, that baby is yours. You'll have no more time for friends, no more time to go out, or nothing. Everything's gonna be about that baby. But I still want you to finish school and go to college. So I will watch your baby during school.”

Future of teen parents

Collectively, these participants viewed the future of teen parents negatively: “They have no social life.” “They can’t get ahead and will always be poor.” “If a teen father gets a job he really doesn’t make enough money to afford a baby. Babies are expensive.” “Maybe they’ll graduate from high school, but college isn’t a reality.”

Reproductive health information

All participants noted that teens most frequently gain knowledge about sex and contraception from friends, and that this was not good because teens “mostly get the wrong information.” They openly discussed their reproductive health knowledge. Two received reproductive information through a program at Girls Inc¹.

¹ Girls Inc was established in 1981. Its’ mission is to inspire all girls to be strong, smart and bold by providing them the opportunity to develop and achieve their full potential. Girls aged 5-18 are provided youth development programs. The organization’s priority is listening to girls, responding to their needs and providing them with the opportunity to make positive change in both their community and in their own lives (Girls Incorporated of Holyoke, n.d.).

I learned at Girls Inc, they teach us so much there. Not just about sex and contraception but about getting into college and how to apply. At first I wouldn't look. They'd bring out these pictures of vaginas and penises. I was yuck. But then I learned. We had wooden penis and had to practice putting on condoms correctly – leaving that air space. And boys are so – they'll tell girls if you love me you won't use a condom, it decreases my pleasure...I'm a virgin but I carry around condoms and give them to my friends because of what I learned at Girls Inc. [My friends] know I'm the person to go to if they're thinking about having sex and want protection.

Another participant received her reproductive knowledge through frank discussions with her mother. “My mother, she's real cool. She told me about sex and birth control. She even gave me condoms.” These three participants noted that they were all virgins and hope to remain so through college. The fourth participant who received her initial reproductive health education from friends, and was no longer a virgin, described her experience of gaining correct information through the high school's Teen Clinic².

My friends told me about sex, but I didn't know. I was having sex and had lots of unprotected sex and was worrying about being pregnant or getting an STD. That really can affect you -- worrying about being pregnant or having a disease. I finally went to the Teen Clinic. They were real nice and taught me stuff. They gave me all these condoms, different colors, flavored ones. I never knew about these. My boyfriend wanted to have unprotected sex because of how it felt. He said a condom would ruin the feeling for him or they wouldn't fit him.

An interaction occurred at this point in the focus group meeting that provides an example of peer education. One of the participants who gained reproductive health knowledge through Girls Inc shared her knowledge on contraception, discussing the correct way to apply a male condom and insert a female condom, with the girl who was sexually active but lacked knowledge about birth control. She provided a demonstration

² The Holyoke High School Teen Clinic is a school-based health center coordinated by a nurse practitioner under the direction of a medical director. Parental consent is required for participation. Services include: immunizations, comprehensive health assessments and psychological exams, sports physicals, health education, mental health services, and referral service to primary or specialist care.

by putting a condom on a water bottle, and then putting a condom over her clenched fist stating: “He can’t be bigger than that.” She then had the participant who lacked comprehensive reproductive health education check the expiration date on a condom package, open it, and put the condom over the water bottle. This girl posed an important question to the group: “How come you are virgins and know all about birth control? I’m the one having sex, and do not know this stuff about sex.”

Lack of reproductive health knowledge was recognized as a contributing factor to teen pregnancy and birth. The participants quickly identified the inability to ask parents about sex and contraception as a risk factor, and that this risk factor was made worse by inadequate reproductive health education at the high school.

Many girls don’t know about their bodies, sex and contraception. If you’re a Latina you really can’t ask your parents. If you try and ask your mother about sex or anything, she’ll assume that you are having sex and get mad at you, punish you and keep you in your house. So Latinas just won’t ask their mothers. We get nothing here [at the high school]. In 9th grade health class you see a movie and have to read stuff about your body, and this is how a baby grows, but they don’t give you the important stuff that we really need to know about our bodies and sex and where to go to get birth control.

A latter discussion on protective factors centered on teens’ reproductive health knowledge including contraception which was identified as a key protective factor by these participants.

Contributing factors

When these participants were shown the teen pregnancy graph depicting teen births in Holyoke, Springfield, Massachusetts, and the USA between 1990 and 2009 (Figure 1.2: Teen Birth Rate Graph), an animated discussion transpired. The initial topic focused on abortion, followed by lack of after school activities for teens.

The participants acknowledged that abortion is often not a choice for Puerto Rican teens, and that this is exacerbated by Puerto Rican culture/religious beliefs.

Whites get pregnant too, but they have more options – abortion and adoption. If a Latina gets pregnant she has to keep her baby. Her mother won't let her abort or give the baby up. Like I have a white friend who has had at least seven trips to the abortion clinic in [names a neighboring city] since she was 14. Her mother even takes her there.

[People] say it's basically Latinas are the ones getting pregnant, but most of the Latinos have their culture – Catholic, or the type of religion that don't believe in abortion and most of the white kids, like I know their parents will go out, and their parents will have them get an abortion. And most Latinos don't believe in it.

Lack of activities for teens in Holyoke was identified by all participants as a possible contributing factor. Lack of access to meaningful after school activities, according to these participants, can lead to boredom and sexual activities.

Girls hang out with friends. Guys play basketball and girls go watch 'em. But we can't stay in the parks after dark and can't go to the mall unless we're with parents. So there is nothin' to do if you aren't involved in a program. So kids hang out with each other, get bored and have sex.

Limited choices of activities and participation fees were also included in the discussion about activities.

Girls need more opportunities to do activities like art shop, where you could do art, or write poems, or dance, or somewhere to go to like Girls Inc, and the YMCA. More places that people could afford cause there's places of dance or stuff like that, or classes, and some of it costs a lot and some parents can't afford it. The YMCA, it costs and parents can't afford, so the kids can't go. I think that some things are, like, too expensive for people.

Ineffective parenting was identified as another contributing factor. It was presented through a variety of experiences relayed by the participants that included rebellion against parents, parents who are not involved with their children, and home-life situations that are troublesome.

I know this pastor's daughter. She's wild – having sex with so many different guys. She's just rebelling against her strict father. That's what I did. I rebelled against my mother when she was strict, and had sex with my boyfriend. I lost my virginity. After my mother found out I wasn't a virgin she talked to me and told me about condoms.

Some [teens] go out and get pregnant, some even hate their parents, some of them don't listen at all. They don't listen at all. They basically do what they want and they commit the mistakes that they do and they think they're basically big enough to do what they want to do. Their parents don't care.

I think a lot of pregnant girls are in foster [care]. They want to get out of a bad situation and think having a baby will give them their own apartment and get out of foster. They think life will be better and they'll have this baby to love...It isn't welfare, that isn't the reason 'cause welfare doesn't last.

Other contributing factors included the influence of present day media on teen's behavior and a means to keep a boyfriend. The following quotes elucidate these.

There's that show *Sixteen and Having a Baby*. Girls just want to continue playing house. But, it's like, hello this is a baby. A baby is different than a playing with a doll. A baby is a responsibility, not an accessory. You can't do nothin'. You have no social life. Some parents kick you out of your house. It isn't perfect like on TV.

Some girls are having babies to keep their boyfriends, but they only keep them for a little while then they're gone. He goes on to the next one [girl] but you got that baby forever. ... I have a friend who wanted this dude's baby so he would stay with her but as soon as she got her belly he was so out of there.

Protective factors

In addition to having comprehensive, science-based reproductive health knowledge, these participants identified establishing future goals and receiving support from mothers as important protective factors. These participants, as seniors nearing graduation, spent a substantial amount of time discussing their future goals and plans. All four noted that they would be the first in their families to go to college and attributed their success to support from their mothers.

I'll be the first in my family to go to college. My mother is supportive and keeps encouraging me. My father keeps putting me down. He says, "Why you need that, you're a girl." I won't let him get me. I take it as a challenge to see how much I can do. I am going to [name of college] next year. It's my dream. I'll be the only one in my family [to go to college]. I think my father put me down because he dropped out of school after 8th grade. My mother finished high school. They got married when she was 18. She is so supportive. She always helps me. Girls Inc also helped me with my college application. Last weekend we went to [name of college] for a new student reception. My mom and my dad came too. We had all these meetings and tours. After that my dad finally told me he was proud of me. I felt so good.

I'll be the only one in my family who graduates from high school. I want to be a kindergarten teacher and hope to go to [name of college]. If I don't get in, I'll go to [name of a local community college] then transfer. My brother dropped out of high school. He had some learning problems. I don't know why my sister dropped; she just did. I'm graduating in June. My mom wants me to go to college – I'll go.

Prevention strategies

The need to begin comprehensive reproductive health education before teens "ever think about having sex" was identified as key to prevention. The participants acknowledged that beginning reproductive health education in "5th or 6th grade" would be ideal and continuing this education throughout the high school years was paramount.

Get 'em and teach 'em about everything that happens. And then keep going, like every year in high school. Make it like a mandatory course, not like an elective. Cause most girls are going to probably be wondering about sex, and they gotta learn somewhere.

Additional suggestions related to reproductive health education included: providing separate reproductive health classes for girls and boys, having interactive educational materials available, and expanding reproductive health education to include parents so that parents gain knowledge and skills to talk with their children about reproductive health. The following quotes highlight these points:

Put the girls with the girls and the guys with the guys. So nobody will get uncomfortable talking about the topic... Small groups of just girls and small

groups of just boys learning in health class 'cause boys think they're so, you know, they brag about how many girls they've had. Small group stuff with hands on would be much better than that movie they show in health class. It is sooo boring and sooo unhelpful.

And try to get their parents involved, because I know a lot of parents are embarrassed to talk to their kids about that kind of stuff....Some of these parents are strict and don't want their kids having sex, but once these kids start, everyone knows they're not going to stop. So, like a way to try to get parents also involved in the program, too. But there's a problem 'cause a lot of Puerto Rican parents are private and they're very private about those conversations.

The need for more after-school, community-based programs for teens was the second prevention strategy identified. The participants noted that Holyoke “needs more programs like the one at Girls Inc for everyone.” Other existing community programs, including Getting Ready (an after school college preparatory program), Upward Bound (another after school college preparatory program) and the Girls and Boys Club, were identified as helpful programs in Holyoke. One participant noted that although these programs and any new programs are worthwhile, they often require “incentives to get kids to participate.” Another participant described other activities that may be of interest to teens, and suggested the creation of a teen center.

We need more activities or more clubs, or teen centers, like for kids that will actually, be, like, actually want you to join. Like have a lot of field trips too and, like have a place where like she mentioned before where you can dance and stuff -- every Friday and Saturday and pay like 5 dollars. And bring artists and stuff like that. So kids who have no motivation are like, “oh, I'm so excited, this artist is gonna be there.” So it's pretty good, they'll have more options here.

Expanding on the theme of programs for teens, the participants stressed the need of mentoring programs for teens. Mentoring programs could possibly provide at risk teens with “someone they can talk to and who can give them the right information.” Mentoring programs could offer additional “resources for kids who don't have support at home or who are lazy.”

As the focus group discussion on mentoring progressed, another participant related positive coverage of Latino teens who are successful and make a difference in the community as a potential protective factor. She based this recommendation on the fact that the media primarily covers negative events in Latinos lives, and that coverage of positive events and success of Latinos would provide positive role models for others.

Most people look on the negatives, on what the Latinos do. They don't see the positive things that they're doing. It's better to focus on the positives on the kids. 'cause most kids might, like, feel bad that they're only (pause) every time you hear something about a Latino on the news, it's because they were arrested, or one got shot and stuff like. You don't hear about a Latino got accepted into one of the good colleges – one of the best colleges, you don't hear about Latinos trying to make a difference.

In addition, coverage of successes and positive events would offer a mechanism to educate the community about the Latino population and dispel myths.

Summary

The twelfth grade girl participants acknowledged that teen births in Holyoke were a problem and that teen parents face negative outcomes in their future. Table 4.2 provides a schematic summary of the common ways in which these participants responded to the focus group questions. In addition, as the girls left the meeting room they discussed what happened during the focus group. One stated the group was very meaningful and “gave her a sense of power.” Another girl she said: “This group was so helpful. Our school should learn from this and have small groups to teach us kids about sex and birth control.” A third girl’s exiting remarks stressed that small group meetings are advantageous for teens; her exiting comment was: “This was so helpful today – talking with a small group of girls. The school should use small groups to teach kids about sex, reproduction, and birth control.”

Table 4.2: Summary of 12th Grade Girls Responses to Focus Group Questions

Focus Group One – 12th Grade Girls Responses	
Focus Group Questions	Participant Responses
Perceptions or teen births	Problem Negative reputation Puerto Rican teens blamed Mothers don't want daughters to get pregnant
Future of teen parents	Negative outcomes ~ No social life ~ Can't get ahead ~ Poor ~ Drop out of school
Reproductive health information	Sources ~ Primarily friends = wrong information ~ Girls Inc ~ Mothers Lack or reproductive health knowledge = contributing factor Reproductive health knowledge = protective factor
Contributing factors	Abortion not a choice for PRs Lack of activities Ineffective parenting ~ Rebellion against strict parents ~ Parents who don't care ~ Negative living situation – foster care Media ~ <i>16 and Having a Baby</i> ~ Positive portrayal of teen mothers in magazines Keeping a boyfriend
Protective factors	Comprehensive science based reproductive health knowledge Establishing future goals ~ College ~ Career
Prevention strategies	Comprehensive science based reproductive health education ~ Starting 5 th or 6 th grade, continuing through high school ~ Separate classes for boys and girls ~ Interactive educational materials ~ Include parents – so they can talk with their children More after school activities ~ More programs like Girls Inc ~ Expand other programs – Getting Ready, Upward Bound, Boys and Girls Club ~ Create a teen center Mentoring programs -- especially for at risk teens Local coverage of successes and positive events of Latinos

Focus Group Two – 11th Grade Girls

The second group was composed of six eleventh grade girls and met for 85 minutes. The dynamics in this group were different from those found in the first focus group. Initially, the participants appeared more reserved and less effusive in their comments. There were frequent periods of silence during the meeting, which were broken by prompts from either the moderator or co-moderator. One participant held her back-pack on her lap during the entire meeting; this participant also provided the fewest responses during the discussions.

Perceptions of teen births

After the introductions and getting acquainted activity, the moderator opened the discussion by asking: “Please tell us what you think about teens having babies here in Holyoke?” This was followed by 2 minutes of silence. The moderator then stated: “Anyone can start.” More silence followed. The first participant to speak set the initial tone for this group. Her response was:

I guess I can [start]. Well, I don't think [teens having babies in Holyoke] is too bad of a thing, like it could be reduced. I mean it shouldn't be happening as much as it is but it's not the worst thing that could happen in our city. Like there, it could be a lot worse things happening. So it's not too, too bad a thing that's happening.

Another period of silence occurred which was broken by the moderator who stated:

“You think that teens having babies is not great, and there could be worse things happening.” The first participant again responded: “Yeah. Kids could be out there, like doing drugs and being in gangs.”³ The moderator stated: “[Name] has one point of view.

³ It is important to note that during spring vacation, the week prior to this focus group meeting, a 17 year old male was killed in a gang-related incident in Springfield, a neighboring city.

Do others want to express their points of view?" The other participants cautiously looked at one another before another participant responded. Her response was:

I think we should wait [to have babies] so like that, they can umm give the baby the best. Like, a lot of girls just have their babies and leave them with their moms. And I think it's important for you to be with your baby, reaching out to your kids; so that, they can have the best life.

This statement was followed by affirmative head-nodding by two participants, and "yeahs" by three other participants. The first participant's belief that teen births were not as bad as gang membership and the use of drugs was not challenged by the other participants.

Three participants linked the high teen birth rate in Holyoke with a negative reputation that is associated with Holyoke teens. One participant provided an example:

"Like if we go to parties, they'll be like oh you're from Holyoke – oh you're so bad."

This was followed by another girl's connection of teen pregnancy to Puerto Rican teens.

I think it's coming from the fact that we have so many Puerto Rican's in the city that they're just zoning in on us because we have a lot of them. Which is crazy? 'Cuz I saw a white girl pregnant.

Future of teen parents

After a second long period of silence, the co-moderator asked: "What happens to teens when they have babies?" The participants responded to this question more spontaneously. Their overall belief was that teen mothers' lives change and that they are faced with additional responsibilities and difficulties such as balancing child care and school, the need to work, and the challenge of coping with a sick child.

If you have a kid, and try to go to college, you have to pay for tuition and you have to pay for day care, and you have to work to support your kids. You have to think about what are you going to do with the baby. Like, not all the time the baby is going to be okay and be able to go to daycare. It's gonna get sick and stuff. You have to take care of the baby.

Other participants expanded upon the challenges faced by teen mothers that included having the father of their baby either leave or deny his paternity, having their parents ask them to move out of their home, and being all alone. These challenges affect teen mothers' ability to remain in high school, with teen mothers "often dropping out of school." One participant described how having a baby at the age of seventeen negatively changed her sister's life.

I have an older sister and she got pregnant when she was 17. She used to be this pretty outgoing, out all the time, having fun, then she had this baby, and now she's in the house, with the kid. And she's a nurse's assistant. So she works crazy hours. She never has any energy basically. When I go to visit, she's in her room doing nothing.

Another participant added a different point of view that the parents of some teen mothers will accept responsibility for their babies and the teens will continue life without accepting responsibility for their children.

Some kids, not all, some kids just accept that they're pregnant because it is their child. They accept that they're pregnant because their parents will help them with it. And they don't see that it's their child a lot of the time. They just have it because they know they'll have their parents to lean on.

This was corroborated by another participant who said: "Some kids don't think that [having a baby] is a big deal because they think other people will come to save them."

After this discussion on the future of teen parents, the participants appeared more comfortable speaking and did not look toward each other to assess other participants' reactions to their comments. The discussions became more spontaneous.

Reproductive health information

The participants stressed that teens attending the high school "don't get any [reproductive health education]." Mothers and a community program, Girls Inc., were

identified as their sources for reproductive health knowledge. One girl stated: “My mom talks to me about sex.” Three other girls responded in unison with “Yeah.” Another girl described her experience at Girls Inc: “There's, like, Girls Inc programs that are always trying to get people to talk about [reproductive health].”

Another participant remarked that “some [teens] are just embarrassed and don't wanna talk about things like [birth control] with other people.” This led to a discourse on teens' lack of reproductive health knowledge as a reason why teens do not have access to or use contraception. Participants noted that parents often do not discuss sex with their teens because sex is a taboo topic, and if sex is not discussed with teens, it will not occur. Two participants countered that this approach does not work and may in fact encourage teens to have sex.

Like some parents don't even wanna hear their kids bring about the word sex and I think that's why kids go out and do more of it. Because they're curious about it and no one will tell them. So they just try it. And try to find like, what it's like.

Some parents don't talk about sex, because they think if they don't talk about it it's not gonna happen. Yeah, it does happen more often when you don't talk about it.

The discussion proceeded to identifying comprehensive reproductive health education as a prevention strategy which will be discussed latter in this section.

Contributing factors

A major contributing factor identified by all participants was lack of activities for teens. Participants associated teen pregnancy with lack of activities.

There aren't a lot of things for teens to do in Holyoke...I think that the lack of resources and things to do is a big factor. I think that if there were more things for teens to do, maybe we wouldn't see so much pregnancy.

As the discussion on activities continued, participants noted that the Holyoke Mall, as a place for teens to go, was not an available option due to mall regulations. One participant

stated: “Like they don't have a lot of places for us to go and that we'll be interested in except the mall, and you can't even go after 4 [pm], unless you're with parents.” Another participant added the topic of registration fees as a barrier to participate in afterschool activities or programs. She related her own predicament. The following dialogue between this participant and another illustrates her point.

Participant 1: I can't get into any programs because they tell me my mom makes too much money.

Participant 2: You don't have to be on welfare.

Participant 1: I know but like even with jobs in the city, you try to get a job and they'll tell you like, say you try to go to United Farm Workers. And like, 'cuz my mom's not on welfare or disability... Even though I qualified for Upward Bound because we're low income, some places consider [our income] too high. I'm like, “No it's not.”

Participant 2: Right. So they don't feel like you need a job just as well as somebody who's low income. And a lot of times they [low income teens] don't even take the opportunity. Just because your parents have money doesn't mean they're not struggling also. Or that they're giving you money.

Religion, especially Catholicism, was included as a contributing factor.

For some teens, religious doctrines and beliefs prohibit both using birth control and having an abortion. “You can't have an abortion. You can't do anything. You're basically stuck.” The participants did not view this as helpful. “Some parents refuse to let their kids go on birth control because of their religious or moral standing. And that's not really helping their kid.” Other girls supported this belief.

Like, a lot of Latino parents will be like birth control is against our religion. And well, the parents will be like, “Well birth control is like a sign that you are having sex, so you can't have it.” Well really, it's not birth control what's making them have sex.

Religion too, because a lot of Puerto Ricans are Catholic and you can't use condoms. They can't use anything because they think it might add to kids having sex and basically it's not stopping sex but causing pregnancy

Ineffective parenting in the form of limited support and supervision of teens was linked to contributing factors. One participant articulated this contributing factor, and two others quickly added their observations.

Participant 1: I would say teens not having support from their parents. 'Cuz a lot of teens, their lives are like somehow the way their parents brought them up. (Pause) Like not having that support from their mother and father and will probably trigger them to do other things, bad things.

Participant 2: A lot of times the moms don't even care. [Teens'] moms are out and about, never home.

Participant 3: A lot of times parents don't check on their kids as much. 'Cuz they don't check anymore. They're like if you get home, then that's good enough.

The influence of the neighborhood environment in which a teen lives was discussed. The participants believed that the neighborhood in which teens live and interact can affect lives either negatively or positively. Different neighborhoods were contrasted. The following sequence relates to the affects of different neighborhoods on teen activities and segued into the overall negative reputation of Holyoke in the area related to high teen pregnancy rates.

Participant 1: I think the Flats and the Highlands are completely different.

Participant 2: Like I've lived all over Holyoke before. I lived in the Flats, South Holyoke, and everywhere and now I'm in the Highlands, and there's a big difference between the Highlands and South Holyoke and the Flats.

Participant 3: I think it's cuz there are more programs here [referring to the Highlands]. Like more things, like places for teens. Mmm hmm.

Participant 4: It's just the people that you're surrounded by are different in the Flats and South Holyoke.

Participant 1: Yeah, 'cuz they like to destroy everything down there [in the Flats and South Holyoke]

Participant 2: A lot of people down in South Holyoke, they can't see nothing nice.

Participant 4: Well, the people you're surrounded with... (interrupted by next speaker).

Participant 5: Its Holyoke. Like, we'll go to a lot of places, and they'll be like oh you're from Holyoke or like we're the worst place. It's because it has the highest rate of pregnancy. Holyoke is looked at bad.

Another participant moved the discussion from neighborhood environments to home environments as a contributing factor. She described her personal experience with two young cousins coming to live in her home as foster children. This narrative also includes the media and ineffective parenting as contributing factors.

My little cousin is 7 years old. And she'll see a boy and she's like ooh look at that boy; and I'm like, "Whoa." At 7 years old, I was thinking about my Barbies. And a lot of the time it does have to do like, with the environment they live in. Like, ever since my little cousins have come, like we have foster kids, but they're my family. Ever since they've come, I've realized that a lot of who you are has to do with the environment. Like, one's seven and one's four. And these little girls will dance for you like girls from music videos, like, you'll put Spanish music on and they'll start going to the floor, they'll stick out their tongue, like, they're like -- I don't know it's like sexual, and I'm like whoa. When I was little we didn't know none of that stuff. I don't know. You'll see them and you'll be like, "Stop! What are you doing?" (groan) I was always told like, you need to respect yourself and like not to act like that. It's just crazy the way these little girls were brought up. 'Cuz they're brought up around big people, and people smoking in front of them and, like, I don't know, it's crazy stuff. A lot of times the parents don't even like care about what their kids are doing. I think if parents were more like, more worried about what their kids were doing a lot of things wouldn't happen.

The media were also included in possible contributing factors. The participants included music, television and a specific television program, *Sixteen and Pregnant*, as providing negative role models for teens and glamorizing teen parenthood.

So all you see on TV is about sex and drugs. Music is all about it. I think the media, enables teens to think that parenting is easy. Like “Sixteen and Pregnant,” that’s a favorite show, and I think that it just shows making it [having a baby as a teen] look like it’s easy.

Protective factors

These participants identified trusting relationships with mothers who provide support and supervision as preventive factors in their lives. The following discussion illustrates parental input as a protective factor.

Participant 1: My mom still calls my brother and he's 19 years old. “Where are you? And what time are you going home?” She’s like that with me. I'll get a phone call around that time. And if it's later, my mom will be like, “You are coming home now!”

Participant 2: Well my mom has definitely built trust with me but she's like that with everyone in my family. Even though she probably shouldn't be with some of us. But she's like that with me because of trust.

Participant 3: Yeah. My mom knows that if I'm gonna stay somewhere. She knows where the person lives.

Participant 4: I know when I'm out my mom texts me like, nonstop. But, when I go to my aunt’s house, I'll ask for my cousin. She’ll be like he didn’t come home yesterday. Like it doesn't faze her. It’s different for girls. Because when my cousin, a girl who was in the same household, when she was his age, she couldn't even be out past like 10:00.

Participant 5: When my brother was my age, he couldn't even go downstairs without my mom watching through the window. And now my mom, she trusts us three girls and we always come home.

Prevention strategies

Reproductive health education was expounded upon by these participants. In their discussion they incorporated education at school and peer education by teen parents. The following quote captures the need to begin school-based comprehensive reproductive health education prior to high school.

I think that kids should be taught about sex a little earlier, like in middle school, like not too early but so that they know that when they get to that point where they're thinking about it – they've already learned everything they need to know and it stuck with them.

This education needs to continue throughout the four years of high school according to the participants. “Assign space to sex ed all four years in high school.” The participants also saw a need to expand participation in existing programs such as Girls Inc and the high school’s Teen Clinic. Parent education on how to talk with their children about sex was also included. The following conversation illustrates these recommendations.

Participant 1: [There is a] need to have more education...like at the teen clinic here [in the high school], and education in the schools. You don't get none now.

Participant 2: We need to have more education, and we need like some sort of teen center, and education in the school.

Participant 3: Yeah! Help programs during school, and I don't know, maybe another program like the teen clinic.

Participant 4: I think if parents talked about sex, like, and not be so awkward about it when they do it. It would help.

Participant 5: Yeah! Parents need education too.

The girls expanded their discussion to include having teen mothers come to school and speak about their experiences. In addition, they thought that experiential educational activities such as an infant simulator, Baby Think-It-Over, would enhance prevention education. The following sequence centers on these recommendations.

Participant 1: Teen moms can come in and tell us what their life is like

Participant 2: So I know I don't wanna have that life. So having teen moms tell us how their lives have changed would help.

Participant 3: And like she said like bring in teen moms. Also like using those dolls that are like real babies. Taking care of them for a month can

teach us what it's like to have a real baby. [This participant was referring to "Baby Think It Over."]

The second prevention strategy agreed upon by all participants was the need to "have more out-of school activities for teens, so that they "have more things to do instead of going out and getting pregnant." One participant predicted that "if there are more resources" for teens in Holyoke, there will be "a drop in teen pregnancy."

Mentors and mentoring programs were also included in the prevention recommendations made by these girls. Four participants identified mentors as resource for at-risk teens that do not have parental support. One stressed the importance of mentors: "It's kind of important for teens without parents in their lives, to have mentors." A mentor may assist a teen to "feel that they do matter to somebody," according to another girl. A third identified the role a mentor may have in a teen's life: "Kids need someone that they could talk to. So that they can feel like they're loved and somebody does care. Like a mentor, if they don't have a good parent." The four summed up the possibility of positive outcomes for teens who have mentors:

I think they should have a program with like mentors and stuff so like kids have somebody to talk to. And that they don't have to go out there and do stuff that is gonna end up being bad for them at the end.

This statement was followed by verbal affirmation from three participants.

Summary

The eleventh grade girls added several new topics in their responses when compared to the responses of the twelfth grade girls. They noted that some parents are unable to discuss sex with their teens because they view sex as a taboo topic or they are embarrassed to discuss sex. Both neighborhood and home environments were added to potential contributing factors. Reproductive health education was expanded to include

peer education from teen parents and experiential learning through *Baby-Think-It-Over*. Table 4.3 provides a schematic summary of these participants' responses to the focus group questions.

Table 4.3: Summary of 11th Grade Girls Responses to Focus Group Questions

Focus Group Two – 11th Grade Girls Responses	
Focus Group Questions	Participant Responses
Perceptions or teen births	<p>Could be reduced – shouldn't be happening as much</p> <ul style="list-style-type: none"> ~ Gangs and drugs are worse <p>Wait</p> <ul style="list-style-type: none"> ~ Babies are a responsibility ~ Be able to provide for your child <p>Give Holyoke teens a negative reputation</p> <ul style="list-style-type: none"> ~ "you're so bad" ~ White girls get pregnant too
Future of teen parents	<p>Additional responsibilities</p> <ul style="list-style-type: none"> ~ Balancing child care and school ~ Caring for a sick child ~ Need to work <p>Difficulties</p> <ul style="list-style-type: none"> ~ Abandoned by baby's father ~ Move out of parent's home ~ Drop out of school <p>Some teens do get assistance from their parents</p>
Reproductive health information	<p>None at high school</p> <p>Mothers</p> <p>Some parents do not discuss sex with teens</p> <ul style="list-style-type: none"> ~ Embarrassment ~ Taboo topic <p>Community Program – Girls Inc</p>
Contributing factors	<p>Lack of activities</p> <ul style="list-style-type: none"> ~ Participation fees for some programs, activities <p>Religious beliefs</p> <ul style="list-style-type: none"> ~ No abortion ~ No birth control/contraception <p>Ineffective parenting</p> <p>Environments</p> <ul style="list-style-type: none"> ~ Neighborhood ~ Home <p>Media</p> <ul style="list-style-type: none"> ~ Music ~ TV programs
Protective factors	Trusting relationship with mothers
Prevention strategies	<p>Reproductive health education</p> <ul style="list-style-type: none"> ~ School-based ~ Peer ~ Baby-think-it over ~ Education for parents <p>Activities</p> <p>Mentors and mentoring programs</p>

Focus Group Three – 12th Grade Boys

The third focus group was the first male group, and consisted of seven twelfth-grade boys. This group met for 85 minutes. The participants were a little guarded in their discussion at first, looking at each other to gauge each other's reactions to their statements. Within 5 minutes, they became more relaxed and freely participated in the discussion. Interestingly, all participants knew a teen father.

Perceptions of teen birth

The discussion on teen births was short and to the point. These participants thought that teen births “happen very often” and at “earlier ages than expected.” It was felt that most teen pregnancies and ensuing births were “accidents” and that “nobody plans out having a baby at this age.”

Future of teen parents

In general these participants viewed the future of teen parents in negative terms, and noted that having a baby as a teen could “ruin your life.” “Difficult” and “stressful” were used to describe the future of teen parents.

Two participants connected future outcomes of teen parents' to whether or not they receive support from their parents. They concluded that teen parents, who received support from their parents, had better futures than those of teen parents who did not. One participant provided an exemplar: “My neighbor, she is 18 and she had a baby but she got financial help from both of her parents so she is doing alright.”

All participants had known a teen father and described negative outcomes that included dropping out of school, working to support their child, not having enough money, and abandoning the teen mother and her baby.

And half the time the [teen] fathers are never there, so the girls are screwed. And the thing that gets me upset is, if you were man enough to make the baby, then why would you run away from your girl? Stay there and actually raise up your son with the girl that you did it with.

Another boy provided a contrast case for teenage boys who do not become parents. He stated, “Teens who do not father children go all through their education and receive better jobs.”

Reproductive health information

The primary source of information about reproduction for these boys was peers, followed by parents. They noted that teens frequently are uncomfortable in discussing sex with their parents. The following provides a glimpse into these boys’ comfort level talking with parents about sex.

Participant 1: I learned about sex from peers, some from my parents.

Participant 2: Parents? Some parents feel comfortable, some parents don't feel comfortable. Do your parents feel comfortable talking about sex with you?

Participant 1: Depends on the situation.

Participant 3: Also depends if the kid wants to talk to their parents because it could be embarrassing to ask them.

Participant 4: Yeah.

Participant 5: That's why most people go their friends.

Participant 2: Going to friends is a pretty big way to learn about things.

Group: Indicated agreement by saying “Yeah” or nodding their heads.

Participant 5: You know it makes sense.

Participant 6: Some parents are old school, the second you ask, they say, “Oh my god, you are having sex.”

Participant 7: Yeah, damn straight. Yeah, real straight.

Participant 1: My mom is open. Right away as I am going to my friend's house. My mom [asks], "You are having sex?" (*laughter among all*) No mom.

As in the prior focus group meetings, lack of reproductive health knowledge was identified as a contributing factor. Their discussion centered on condoms, specifically the application of condoms and teen's access to condoms. One participant noted that: "Guys think they know how to put [a condom] on correctly, but they really don't. They forget the tip holding thing." Another participant attributed incorrect application of condoms to the haste in which a condom is applied "I think sometimes when you're desiring to do it, that you just hurry up and rush into things and bad results happen." Teenage boys often do not use condoms because either they "don't feel comfortable going out and buying condoms," or they are "shy about asking for a condom." One participant offered a solution to the problem: "Kids need a place where they can get free condoms."

Contributing factors

Lack of both after-school activities and jobs for teens play a role in sexual activity of teens, the use of drugs, and gang membership according to these boys. "In Holyoke there is not much to do and it kind of explains itself. It's like what else is there to do – sex, drugs, and gangs." The conversation on lack of activities included two specific neighborhoods, the Flats and South Holyoke, where few activities and programs are located which can lead to non-normative behaviors for teens who live there.

There is absolutely not a lot to do. I have been down there since my parents – we all lived down in South Holyoke. And there was really nothing to do. A lot of teens especially down there are known to just mess everything. 'Cuz they don't have better things to do.

This discussion segued into the need for employment opportunities in Holyoke for teens. Three participants had tried to find employment but were not successful. During this discussion another participant noted that if your parents were not “low income,” it would be difficult to obtain a job. The following dialogue illustrates two teens’ experiences in obtaining jobs.

Participant 1: I think for 2 years I have applied [for jobs] and nothing. I’ve been to Career Point⁴ but haven’t found none yet.

Participant 2: There is some Youth Works. I saw a sign. It's like an application you give, and you go find a job.

Participant 1: You got to be low income. My parents make too much. I have been to Career Point. But I haven't found none yet.

Other contributing factors identified included ineffective parenting, peer pressure, and, for girls, keeping a boyfriend. One participant described “bad parenting” as having parents who “just don’t care.” Another noted that having a baby as a means for a girl to keep her boy friend frequently does not have the desired outcome for the girl.

Some girls may plan on having a baby to keep their boyfriend, but then again [the boy] might get tired of her and may want a new [girlfriend]...Guys don’t try to find girls with babies.

Protective factors

Activities and programs that appeal to teens, in addition to jobs for the youth of Holyoke were identified as protective factors by these participants. They believed that activities provide an alternative to having nothing to do and engaging in sex. A

⁴ Career Point is a private, stand-alone, not-for-profit corporation, serving the workforce and economic development needs of individual job seekers, social service agencies, and the business community throughout Hampden County and beyond. It was established in 1996 and is fueled by a combination of federal, state and private funds. (Career Point, n.d.)

participant who is involved with the Holyoke Youth Commission⁵ described his point of view on activities and programs as protective factors.

I actually work for the Holyoke Youth Commission and we are actually working on a bike shop to bring to Holyoke but it is still in progress that is why we are trying to make new places and spend time with other teens, keep them on track from having relationships all the time. Life is not always about relationships so we could just enjoy Holyoke and see how Holyoke could be better.

Prevention strategies

As with the participants in the previous two focus groups, these boys identified the need for school-based comprehensive reproductive health education, activities for teens in Holyoke, and mentoring programs as prevention strategies.

All participants contributed to a lively discussion on ways to improve reproductive health education. Three boys used their prior educational experiences in New York, New Jersey, and Puerto Rico and advocated for sex education to begin in the 6th grade, include instruction on the use of condoms, and be added to all gym classes.

Like in New Jersey. I lived there when I was in 6th grade. I also saw the birth movie and everything. Pretty interesting... They teach you everything from like prevention and how to use condoms, everything.

What do they do over here [in Holyoke] is they don't teach health till 9th grade. And over there [in Puerto Rico] it is in middle school, and during high school well in gym because it's physical education, it is not actually gym [in Puerto Rico]. They teach you about condoms, using condoms. You have to take notes and study too. It's a class, and they teach you every year but they don't teach you anything in gym here [in Holyoke].

⁵ The Holyoke Youth Commission was initiated in 2000. Its mission is to bring about positive change in Holyoke by developing the knowledge, skills, and critical thinking of its members and proving that Youth can be the change-makers in a community. The commission is comprised of approximately 20 youths, ages 13-21, who reflect the economic and racial diversity of Holyoke, and represent multiple neighborhoods and wards. The teens meet weekly to work on projects and programs to meet the needs of Holyoke youth. (Holyoke Youth Task Force, n.d.)

Two boys added to these recommendations and suggested that reproductive health content be added to existing science classes.

Teach it [reproductive health] in science classes too, like biology and anatomy. All those kinds of things, they could teach you that in science classes. I mean especially Biology because it is the study of life.

A third supported this suggestion and noted that adding reproductive health content to existing science courses “would be helpful,” because “it would prevent students from not paying attention.” He concluded his recommendation with the caveat that students “are not paying attention in those science classes” and that this content would improve both class attendance and participation. Other suggestions for school based reproductive health education having separate classes for boys and girls, and having teachers of both genders available to students.

I would like for both males and female teachers so we can have a person like us that has gone through it or is going through it. They [students] can ask some questions and [the teacher] can either give them warnings or give them like hints or points.

Increasing access to free condoms for teens was another prevention strategy. All participants participated in this dialogue.

Participant 1: The thing I think is they should have is distribution of condoms at stores free. Just have the jar there like they do at the nurse's office.

Participant 2: They have that here [at the teen clinic] but everybody is shy.

Participant 1: Well if you are out in a store you may feel a little bit more comfortable. It's like yeah I am the store, I know this guy. I buy things from him a lot.

Participant 3: Like if there were just certain spots in Holyoke where kids knew they could go and just get condoms and have any questions. Like the Holyoke Health Center.

Participant 1: If places had free condoms, where kids could take ‘em that would be helpful.

Participant 4: Yeah, that would help.

Participant 5: Teens don't feel comfortable buying condoms.

Participant 6: No.

Participant 7: Not really.

Participant 1: So, there really are a lot of corner stores and there is always one close to your home, and you know you can always go and grab a few, when necessary, without having to ask.

Several ideas were generated on ways to increase activities for teens in Holyoke.

One participant suggested community service at "any church" or "cleaning out the park, [to] make the place better and awesome." Another proposed creating an internet café for teens, and this was followed for the need of "more places just to chill." Program costs and fees were also included as deterrents to participation in activities/programs. The additional space and location for teen programs was discussed and the following need was identified: "Since there are a lot of teens that are interested in art, music, and sports. Basically we just need more facilities in which [teens] can do what they like to do best."

A vision for a place where Holyoke's teens could gather was put forth:

A place where you have all the necessities to do whatever you want, play any sport, and a pool to swim. That would get guys to come to see girls. You could talk to your friends but of course there has to be chaperones. A place to hang out and chat. Where there is a supervisor, someone just watching everyone.

The Holyoke Youth Commission was identified as a resource for teens that provides activities, trainings, and youth development opportunities.

But the place I work for is the Youth Commission. It has been trying to work more with Holyoke trying to open new stores and everything to make youth work and make them keeping busy and all that. That is why we are coming up with a bike shop. I can't say when it going to be done or nothing. It's really fun and we do a lot of work. We do public speaking. We go to trainings and train other

youth houses and it is a really good experience. We go on retreats and learn more about other youths that we meet.

Since these participants were 17 to 19 years old, employment was a concern for them. Jobs would not only provide activities, they would also provide an income for teens. Thus the creation of more employment opportunities for teens in Holyoke was identified as possible prevention strategy. One participant connected jobs with prevention; he stated, “having some jobs available would help decrease teens having babies.”

Mentoring programs were identified as a strategy to assist teens to “work to their full potential.” Mentors could be peers who provide “inspiration’ to others. Two participants suggested the need for teen youth leaders who “guide and inspire” other teens “to make a change.”

Youth leaders could show up and be group leaders. Um, where you can get together and do something to show all the youth that you can make a change. Older youth working with younger youth, or just youth in general, with guidance.

The co-moderator asked if guidance counselors at the high school could act as mentors. One participant felt that school guidance counselors “don’t do or accomplish anything.” Another added that “if you need to talk to [a guidance counselor], you need to have an appointment,” and that guidance counselors are “usually too busy to see [students] anyways.” A third boy differentiated between a guidance counselor who “helps with college stuff” and a mediator “who helps you solve a problem.” He noted that the high school had had a helpful mediation program but “they didn’t have enough funding so they had to cancel it.”

Summary

During the discussion on teen births in Holyoke, five participants expressed their views about abortions. The discussion was not connected to either contributing factors or preventions strategies, but reflected the participants' personal values and beliefs. One boy noted that it "was very important" to him that if a girlfriend became pregnant that she "not have an abortion" because he would "feel very upset and disappointed." Another stated, "Abortion is something I am against." A third notes that "abortion feels like you are killing another human." "You are" was the response of two others. A fifth participant commented about the actions of boys contradicting their position on abortion, and stated: "I think it is just certain people [who] feel that abortion is bad, but then they still go out and do these things that shouldn't be done."

Many topics presented during this first boys' focus group were similar to those in prior girls focus groups. Education on the use of condoms and access to condoms without cost were two needs addressed by these participants. They recommended adding reproductive health education to both existing science class and gym which is required at all levels in high school. Another suggestion was to have teachers of the same gender teaching students to decrease embarrassment and increase communication. Lack of employment opportunities was added in the discussion on lack of activities as a contributing factor. All participants were eligible by age to be employed. Table 4.4 provides a schematic summary of the twelfth grade boys' responses to focus group questions.

Table 4.4: Summary of 12th Grade Boys Responses to Focus Group Questions

Focus Group Three – 12th Grade Boys	
Research Question	Participant Responses
Perceptions or teen births	Happen very often At earlier ages Accidents – nobody plans on having a baby at this age Abortion ~ 5 did not support ~ 1 boys actions contradict their beliefs ~ 1 no comment
Future of teen parents	Ruined Difficult and stressful Drop out of school Work to support child Fathers abandon the teen mothers of their children Support from parent = better outcomes for teen mothers
Reproductive health information	Peers Parents ~ Parents uncomfortable discussing sex ~ Teens embarrassed to ask parents Teens lack accurate knowledge about condom use
Contributing factors	Lack of after school activities and jobs ~ Can lead to sex, drugs, and gangs ~ Costs are a barrier ~ Less activities for teens in the Flats and South Holyoke ~ Limited employment opportunities for teens Bad parenting Peer pressure Girls – keeping a boy friend Lack of access to free condoms
Protective factors	Activities and programs ~ Sports ~ Holyoke Youth Commission ~ YMCA
Prevention strategies	Reproductive <i>health</i> education ~ Begin in 6 th grade ~ Teach use of condoms ~ Add to existing science classes ~ Incorporate in gym classes ~ Separate classes for boys and girls ~ Teachers of same gender Increase access to free condoms Activities ~ Volunteer work ~ Create an internet café ~ Places to chill e.g. teen center ~ Holyoke Youth Commission Mentors/mentoring programs ~ Return mediation program to high school

Focus Group Four – 10th Grade Girls

The fourth focus group was composed of six tenth-grade girls and met for 95 minutes. The participants were relaxed and spoke freely throughout the entire meeting. The girls were pleased to participate in the study. One remarked: “It was pretty cool that [the researcher] asked for Puerto Ricans [to participate in this study], because it doesn’t happen a lot. For me, I think it is the first time.” Two girls supported this statement with responses of “Yeah,” and “It’s true.” Another participant stated, “Yeah. I mean, everybody else’s voice is heard except for Puerto Ricans. They don’t know what we’re doing. Like, they always judge us as a group, instead of seeing there are actually people who are actually making a difference.

Perceptions of teen births

Participants quickly expressed their perceptions of teen births in Holyoke which were viewed as a “problem” that they “did not like.” The girls acknowledged that teens having babies was “ridiculous” because teens are too young to properly care for babies.

Honestly I don’t like it. ‘Cause you’re too young. You can’t even take care of yourself. How are you going to take care of a baby? It’s like a child taking care of another child. There are a lot of teens who don’t realize how hard it is to raise a child.

Remarks related to blaming Puerto Rican girls for the high teen birth rate in Holyoke were made by several girls. One stated, “When someone says it’s the Hispanic culture, teens having babies, it gets me bad.” Another girl noted that she was “embarrassed” by the community’s belief that “only Puerto Rican girls are getting pregnant and having babies” Others agreed, and added their comments about this stereotypical point of view.

I'm embarrassed. "Cause they'll be like: "Oh it's the Puerto Ricans who get pregnant." I'm Puerto Rican and I'm not like that. My friends aren't [like that either], and they're Puerto Rican too. Yeah! It gets me.

Well it just gets me mad for the fact that 'cause it's like everywhere you go you have so many so many eyes on you: "Well she's PR or she's Hispanic so she's easy. She's easy, you know. We can get on her 'cause she's easy. She's Hispanic." So they don't really care. At the same time you are mad because people are judging you like that. Why are people judging me for other people's mistakes?

You know what bothers me. They say, "you're not going to make it to 18 and watch you're going to get pregnant." And I'm 18 and I'm not pregnant and I thank God for that. And I'm not going to get pregnant until I get married. Because they are like: "Watch, every Latina does this and this and this and that." It is not about every girl. It's about you. I'm going to be different. (This was said with conviction and in a strong voice.)

Another participant offered an example of how outsiders view Holyoke, as a city where teen pregnancy and violence are prevalent.

Yeah like once I went up to Chicopee to visit a school up there. 'Cause, um, me and my parents were thinking of moving, and I was talking to some girls up there and they were talking about their schools and this random girl comes up to me and she's like, "Where are you from?" I'm like, "Holyoke." And she's like, "Oh my god, are you ok?" And I'm like, "I'm fine." And she's like; "I heard that Holyoke is so bad and they kill people over there, when you walk down the street they grab you and rape you and then you end up pregnant." I'm like, "Holyoke is not like that. Like there are some parts were yeah maybe there will be a couple gang fights but not that they'll grab you and rape you in the middle of anywhere you know." People [are] seeing like Holyoke as a bad place you know

Future of teen parents

These girls believed that becoming a teen parent negatively affects a teen's life and that a teen parent "doesn't have a future" According to these participants, teen mothers frequently drop out of school and "ruin" their future. One participant presented an illustration of this perception.

Like I once knew this girl. She wanted to be a doctor. She had this huge career in front of her but then she found out that she was pregnant. Her career was ruined. She couldn't go to school much because she was having a lot of bad effects from

being pregnant. Her future was just ruined because of the baby. I'm not saying that the baby is a bad thing but a baby at that age is -- being so young and having a child is so bad. Like you can't take care of the child and make sure that your future is going to go the right way the way you wanted it. 'Cause now you have to add [the baby] to your family. It's just like another problem that you have to deal with -- waking up and everything. She had to drop out of school.

Additional problems faced by teen mothers included: difficulties in securing a job, struggles in obtaining basic resources for the baby, challenges in continuing their education, and becoming a victim of bullying. The following quotes relate to these problems.

[Teen mothers'] education is interrupted because having a baby means you have to go to school for a certain amount of time and then you have to get out of school. So it's like 3 months you have to leave school and it's kind of hard because it interrupts with your education and your future.

I'm a safe school ambassador and we were talking about teen pregnancy and there was a group there from the school and we were talking about the bullying and we were talking about how many pregnant girls get bullied 'Cause they are like: "Look at her. She's easy or she's a ho and whatever."

According to these girls, teen mothers' lives "are left even worse" than those of teen fathers, because teen mothers "not only have a child but [they] are alone." Teen fathers "just leave" when they find out their girlfriend is pregnant. One participant succinctly described this: "Guys mostly see it as just have some fun now. Oh she became pregnant. Oh I'm going to leave. You know I still have my life." Teen fathers often leave because they do not want to accept responsibilities of parenthood.

Most teen fathers leave. They don't want to give up life, like "I'm young. I still want to party. I can meet other girls and so it's, it's your fault you opened your legs. I'm a guy. I don't get pregnant. You did. You stay with it [the baby]."

Raising children is a serious undertaking that many teens do not realize. One girl shared her life experience of assisting with the care of young cousins and how this has shaped her perceptions of parenthood.

There's a lot of people who don't realize how hard it is to have a child. Like I don't have children but I did help raise my 4 little cousins and I'm gonna tell you it's hard waking up in the middle of the night because they're crying and because they are hungry. It's hard. I wasn't their mother but I do see them as my own children. And it was hard to do that you know and I'm only 15. So imagine me taking care of 4 cousins and they're not even my children. It was hard, and [teens] don't realize that.

Reproductive health information

Peers, mothers and community programs were the primary sources for these participants reproductive health information. They stressed that many teens in Holyoke do not receive accurate reproductive health information, because “sex and birth control” are not included in the present high school health curriculum, and peers frequently provide “misinformation.”

According to these girls, the inability of teens to seek reproductive health information from parents, teachers, or health care professionals was a barrier to gaining accurate reproductive health knowledge and accessing condoms. “[Teens] are like scared or the just don't want to tell people that they are having sex.” Therefore, they do not ask for information on reproduction or contraception.

Contributing factors

These participants concurred that lack of accurate reproductive health information, especially knowledge related to contraception, contributes to teen pregnancy in Holyoke.

I bet most of the girls and guys who are out there having sex. I bet you, they don't know half the things that they are doing because they don't know. They might not have [had] classes on it and they might not know what to do. Because I have friends who are like what can we do? They didn't know about birth control. They need classes on it.

They noted that not only do girls lack knowledge about the correct use of condoms, but boys also “don’t know how to use them [condoms].” One participant gave an example from her own experience to illustrate this point.

Not all guys know how to use [condoms]. ‘Cause I know a guy who was struggling. Ok, I’m going to be honest. I’m not a virgin but thank God I haven’t been pregnant. And there was this guy who was struggling. He said, “Oh this is a piece of crap.” [I responded:] “No it is you dude. You don’t know what you are doing.” He said: “No, it’s this piece of crap; it’s too small.” I said: “It’s not small. It’s you; you don’t know how to put it on.” So I put it on. And he was getting all red.

The participants made an observation that some girls get pregnant and have a baby as a tactic to either keep their boyfriends or to escape negative living conditions.

I know this girl that got pregnant. The only reason she got pregnant was to keep her boyfriend. She didn’t want to let him go. She loved him so much. But he didn’t even love her. He was messing around with a lot of other girls. But she was like: “I want him, I want him.” It was all for nothing because now he hits her. Now everyone tells her she didn’t get the guy, and she has to pay the consequences. But she thought she loved him.

There are a lot of teens who also, like the reason they get pregnant is because they have family problems. They don’t like to stay home. So they end up on the street and they end up hanging out with people who they shouldn’t be with because they latter on push them to do things that they don’t want to do and that’s how many people actually end up pregnant.

External pressures from peers and boyfriends were also identified as possible contributing factors for teens to initiate sexual activities and risk becoming pregnant.

One participant stated: “[Boys] put the pressure like towards the girls to have sex.

These girls associated living in a neighborhood that has limited resources and evidence of dysfunction with an increase in teen pregnancy and births. They discussed the Flats and South Holyoke as two such neighborhoods. The following dialogue provides description of life in these neighborhoods.

- Participant 1: I know a 13 year old who is pregnant. She lives on my street. I live in the Flats.
- Participant 2: I don't find it funny. I get mad at how like in the Flats, you would be surprised, like I go outside and I see one pregnant girl right there. You go to the corner and you see another pregnant girl. It's like wow and they're like pushing the strollers, and they're like trying to get some boy. It's like you don't learn your lesson. It's like you're like 14 years old and you have a kid and you don't learn your lessons. He's just going to take advantage of you. I don't think that they learned their lesson. They are like look at my kid. I have a kid. La, la, la. They're like look at my kid and everybody does. Oh, ok you now have 2 kids. They say see that girl see how young she is. She has a kid. It is ridiculous. Some of the girls are so young.
- Participant 3: I live in the Highlands and it isn't crazy there. Sometimes there's a little craziness, but it is like really calm and I don't see a lot of girls pregnant. If I do see it is probably because they live somewhere else and go up there.
- Participant 4: The more messed up, the more gang members or the gang complexes there are in a neighborhood, the more pregnancy you see. Because it is like the bad influence gets to you. I always thought that. Usually if you ask the girls who are pregnant downtown most of their boyfriends are in a gang. Half of the girls [who are pregnant] probably have a boyfriend who is in a gang. And if they don't, the boyfriend is probably in the process of getting into a gang, or locked up.
- Participant 5: There's a problem. If you live down there [in the Flats or South Holyoke], you're stuck. There are no programs. The kids down there want programs. All they can do is hang-out at the basketball court. And there is like nothing. And then to top it off they tell you to go to the Boys and Girls Club but the distance and they have no way to get there. They don't have transportation to go that far and stuff.
- Participant 6: Some people say every time we try to do something down there [in the Flats or South Holyoke] they mess it up.

Protective factors

These participants provided descriptions of their personal protective factors.

Having future goals were identified as a protective factor.

I'm not having sex. Like I got offered, but I said no because I have set goals. I set goals like I want to be successful. I don't want to be dependent on anybody. I don't want to be like with your man so he can pay your bills. I want to be (pause) like I can do it on my own. You don't need guys like for help. Like the help would be ok but at the same time we want to show them that we, as women, we are strong and we can do it. I set goals.

The girls posited that recognition and acknowledgement of teens' accomplishments can encourage teens to continue work toward positive goals. One participant relayed her experience in high school and noted that it is important for "teachers to recognized students who are actually trying to make a difference in their lives." Another declared:

I personally got a letter from one of my teachers saying that he's proud of me for actually getting good grades, for actually trying to make a difference in my future. That actually boosted me so high like getting a letter from my teaching telling me that he actually is proud of me you know because I'm trying to do something with my life. You know for people to actually notice the hard work you're trying to do for yourself.

This statement was quickly followed by another participant's response: "Yeah, it feels good when you get recognized for things."

Volunteer work at an after-school program for younger students was a powerful protective factor for one girl. In addition to providing this girl with a meaningful after-school activity, it provided her with recognition of her accomplishments and opportunities to interact with teachers who in turn served as mentors to her. Her description provides a moving example of her experiences.

I work. I'm a tutor at [the] Peck School for young kids. There are young kids in middle school. The program is like – you know how some programs only take the good kids. Our program is not like that. We like to take kids off the street, like we have a group of kids. They are like, "that program is wack and we're not actually going to go." And I actually talked to them, and tell them, "You guys are actually going to like it. There's lots of things that you guys are going to like." So they tried out the group and they liked it so much that they've been in the group for two years and they like it because it helps with your homework and it helps you with your grades. You can get a one-on-one tutor with you just on subjects that you need help with and then when you are done

with all of your homework and if you have any questions and you need to talk to somebody you can. Um, we go to clubs and there's a basketball club for boys and girls, there's volleyball, there's a step club where um it's really cool because they do activities there and they challenge you like they'll tie up your hands and they are like ok try to get out without untying the knots, and you have to get out so it makes the kids interact with one another and have communication and trust.

This made me almost cry. Like, I was like oh my God I don't like know how people see me. I got good grades, and then I got a letter saying how they [the Peck School program coordinators] thought that I [would] be perfect for this because I have a good personality and [am] good around people. It made me like more excited to get involved with the program. At the after school program a kid came up to me the day they got their report card, and he was hugging me, and I was like, "Why are you hugging me?" He's like: "Cause you like, you helped me so much. Look what you made me get on my report card." He actually had had an F and he brought it up to a B+. He's like: "I hated this class and you, because of you. You made it so much fun. I'm interested." And he's like: "I'm going to come to this after school program every day just because of you." So it made me like: "OK [name of boy] you're gonna make me cry now." But yeah, it feels good when you get recognized for things.

I see it like it's my third family because it takes so many bonds to grow up. Here you are really close and you can talk to each other and you can trust people. It's like you break the ice, the iceberg there because you are hanging around with the teachers. The teachers are knowing a little about you and you are learning more about the teachers and you start growing a bond and it's like that wall that you have that you can never bring down. You are actually bringing it down low, and lower, and lower, and you are like hanging around with them [the teachers].

Two girls had family care-giving responsibilities. One cared for a 2 year old cousin and the other assisted a disabled aunt. Another girl played basketball every day after school, and another went home to "hang out" with her mother, complete her homework and attend church activities. Thus, after-school activities can serve as protective factors for teens in Holyoke.

Prevention strategies

Reproductive health education and knowledge were identified as key to prevention by these girls. One participant recommended that all girls need to attend Girls Inc Programs to gain reproductive health knowledge.

Go to Girls Inc they'll teach you. They taught us how to put the condom on. Men don't know how to use them. You need to know. They won't break. We put them on our fists, so they'll fit any man. You need to know how to use them properly because you need to know how to protect yourself.

Another girl urged girls not to have sex but if they do it is important to use contraception.

She emphatically stated: "Tell girls not to open their legs at all, but if you are going to have sex, at least think about using protection." This was followed by another participant's direction: "Do everything not to get pregnant—try everything, the pill, the shots, the condoms, whatever is out there and use it." Thus, knowledge about reproduction and having access to contraception are important prevention strategies.

Another girl posited the idea that not being alone with a person of the opposite sex would decrease the opportunity for sexual activity. She made the following recommendation:

My advice is just don't be alone with a guy. Even if you say that you don't want to [have sex]." If you are in the moment, your body is going to ask for it even if you really don't want it. An you are just going to end up doing it and sometimes guys don't even have condom and you'll do it without protection. You don't think about consequences when you are in the moment.

Summary

These participants provided additional support to the findings of the previous focus groups. Not being alone with a member of the opposite sex was an added prevention strategy. Table 4.5 provides a schematic summary of the tenth grade girls' responses to focus group questions.

Table 4.5: Summary of 10th Grade Girls Responses to Focus Group Questions

Focus Group Four – 10th Grade Girls	
Focus Group Question	Participant Responses
Perceptions or teen	<p>Problem</p> <ul style="list-style-type: none"> ~ Teens too young to care for child properly ~ Puts blame on Puerto Rican girls ~ Projects a negative image of the city
Future of teen parents	<p>Don't have a future Ruined Drop out of school Challenges</p> <ul style="list-style-type: none"> ~ Getting a job ~ Continuing education ~ Becoming a victim of bullying <p>Girls – worse outcomes</p> <ul style="list-style-type: none"> ~ Alone ~ Abandoned by father of their child
Reproductive health information	<p>Peers = misinformation Mothers Girls Inc Afraid to ask parents teachers or health care professionals</p>
Contributing factors	<p>Lack of reproductive health information</p> <ul style="list-style-type: none"> ~ Contraception ~ Correct use of condoms <p>Tactic to</p> <ul style="list-style-type: none"> ~ Keep a boy friend ~ Escape a negative living situation <p>Pressure from</p> <ul style="list-style-type: none"> ~ Boyfriend ~ peers <p>Neighborhoods</p>
Protective factors	<p>Future goals Recognition and acknowledgement of accomplishments Volunteer work After-school activities</p> <ul style="list-style-type: none"> ~ care giving ~ sports ~ church
Prevention strategies	<p>Reproductive health education Don't be alone with a member of the opposite sex</p>

Focus Group Five – 11th Grade Boys

The fifth group was composed of two eleventh-grade boys and met for 90 minutes. Although six boys were recruited, only two attended. The researcher decided to hold the group with only two participants because the information obtained in the prior four focus groups had consistent information. These participants were very talkative and spoke without qualms. Of interest was the fact that both boys were active in their Pentecostal churches and believed that “there is no sex before marriage,” and this framed the discussion.

Perceptions of teen births

One participant voiced his observations that numerous teens in Holyoke have babies: “I knew there were so many teens having babies – like everywhere I go, I see someone with a baby.” Both boys articulated that having a baby is a responsibility that should not be cast aside.

I think [having a baby] is a really big responsibility. Like, for one I don't think you should have sex before marriage or something like that. People make stupid mistakes but if you have a kid, you should be there for it. Like it's your kid, it's your responsibility. It's like your own genetics. So you should be there, like put the time and effort and the money to make sure that the kid grows up to have a good life.

To me I think if you are having a kid. Um, take care of it. And, put your time to it cuz um, it was your responsibility of having that situation happen.

Both boys commented that their parents do not want them to become teen fathers. One described an interaction he had with his mother. “My mom’s always telling me, ‘be careful when you’re at [name of girlfriend]’s house. I don’t want you to do something you’re gonna regret.’ I’m like, ‘Mom, I think you’ve raised me better than what you think of me right now’.”

Future of teen parents

Remarks related to the future of teen parents were based on the participants' observations. Teen parents struggle and frequently drop out of high school, lose the opportunity to attend college, and have to work. One participant relayed a story about a friend who became a teen father.

I have a friend whose name is _____. He's Puerto Rican and Vietnamese. And like, when I met him, he didn't do anything stupid. He was very smart and he was a very good kid. Now, I see him walking down the street the other day. I was working that day also. I saw him, and I was like I hope you treat [name of girl] right and stuff like that. But he's actually mature enough to work for her, with the girl and everything. He's paying rent and everything. He's gonna get a car, he's gonna get his GED, like he thought it out, like he's being responsible.

Teen mothers endure more negative experiences than teen fathers. The boys pointed out that teen mothers may be abandoned by their baby's father, bullied by classmates, and cast aside by their family.

I know a lot of guys that like, like they get the girl pregnant like the first couple weeks they're like" "Oh, I'm gonna do this for the kid, I'm good for the kid." And by the time her belly gets bigger, they're like, "Oh I can't handle the stress." Or "I can't, like provide for the kid I'm gonna have." So they just bounce and leave the girl alone. And I feel bad for the girl, because everyone starts calling her names and stuff like that. Like inappropriate things if she got pregnant. The guys should be, like, if he like, spent the five minutes, or like ten minutes with her in bed, he should like be able to be there for her when she's going to be in a bed, giving birth to a kid. Instead of just going around and sleeping with other people.

Well sometimes it does happen, cuz sometimes guys think, "Oh you got a girl pregnant, you're the man." Whatever, but once it comes down to having a girl be pregnant, um a lotta words start going, coming through the school that um. "Oh, she has a baby, look at her."..."She's too young." I've seen a girl that she was 13 years old, and she was pregnant in this school. It was last year. She had to drop out of school cuz uh, she had to take care, cuz her mom wouldn't help her with the baby. So she had to leave, go live with her boyfriend. And they had to support the baby. And I still haven't seen the girl since.

These boys suggested the establishment of an early childhood program with a day-care center at the high school. Their rationale for this was that it could both assist

teen parents in continuing their high school education and provide educational opportunities for students who are interested in an early-childhood career. Accordingly, such a program could have secondary gains for the community by providing parenting courses to increase parenting skills and decrease mistreatment of children.

Sometimes, the teen parents treat their kids wrong. I see them on the street that hit their kids out of nowhere. Like they're little kids and they slap them around. They just slap their kids around, and then you see like their mood in their face. You know the vibe that's coming from them. You can feel it. ..But parents treat kids bad and that's how they'll be treating everyone else.

Reproductive health information

Church youth groups were a source of reproductive health knowledge for both boys who believed that reproductive health education is the responsibility of parents, churches, and schools.

My parents taught me about my body at age seven. Once I worked myself up, and my mind was mature enough, once I hit middle school, they taught me about the girls. Um, how, um, their reproductive systems work, and how our systems work when we're together. I also got this through my church. Once I got to high school I learned all about um, sex and um, about the responsibility that comes [with] it and how you're supposed to act.

The other boy pointed out that “most” teens learn about reproduction through videos at school which was an ineffective teaching strategy.

Most people like, the first time they learn about sex education is when they see the video in middle school or high school. And like, it doesn't really show it in all detail, but it's just showing you, like what you do with your body parts when you do it with someone, and how to reproduce. It doesn't show you like how much it can affect each of you. Like, you can be with one person one day, have sex with another, have sex with that person the next day and you're gonna feel totally different, totally awkward and stuff like that.

Contributing factors

Both boys noted that “sex was everywhere,” it was “so easy for people now to have sex,” and teens are “gonna be wanting to have sex.”

Teens think sex is the coolest thing that's happening in the genre right now, like in Holyoke. All teens just wanna do is have sex, and sometimes they use protection but sometimes the protection that they use is not enough to prevent [pregnancies].

According to both boys, sex was a consistent theme in present day media with lyrics in popular music, dancing in music videos and behaviors of teen performers pressuring teens to engage in sexual activities and "havin' girls who are 8 or 9 want to be like 30." As a consequence, "media is a big contributor [to teen pregnancy], like how everyone thinks about sex. The electronic generation – everything has to be like cool." In contrast, today's media lacks positive role models for children and teens, degrades women, and exposes children to inappropriate material.

Like all the mainstream music, it just puts everything down. Like, it shows and degrades women. It shows nudity. These kids shouldn't be seeing this even if they're like twelve. They shouldn't be able to see a naked person. Here's an example right now of what's happening: Like, a 14 year old talking about getting a girl in a position. He's not even supposed to know [this] at his age. You know what I'm saying. Little kids are becoming singers and watching videos. From that stage, they're gonna start getting girls and having sex...Shows have stuff they're not supposed to be talking about because of young kids, you know. And people call-in and talk about sex; I've heard it a whole bunch of times. And honestly little kids are going to be hearing stuff that they're not supposed to hear. You know, 'cause that can also influence kids to do stuff that they are not supposed to be knowing about like sex.

The media also influences clothing styles which are more suggestive according to one boy. His analysis of today's fashions linked clothing choices with teen behaviors.

The style now is tight clothes and skinny jeans and stuff like that. Like you see kids do a gang pose and they're all wearing tight jeans...Like the more sluttier girls' clothes look, the more easier it'll be to get into bed with them. I think the more modest she looks, the smarter she is.

Peer pressure was a factor contributing to teens having sex. "If everyone's having sex that means you're gonna be cool if you are having sex too." The use of alcohol and drugs were identified as contributing factors to teen pregnancy: "Drinking is a problem.

If you are a girl and you are drunk you don't even remember having sex, and then "Oh, my god I'm pregnant." The other boy described an experience he had which illuminates these contributing factors.

I went to a pool party and everybody was drinking. I got to the party and everything was there. There was alcohol. There was weed. You know. No parents. See that's what happens. Parents leave the house, [and] kids decide to do whatever they want to do in the house. You know. Well there were drinks. There was weed. I think that can lead you to have sex. Once you're drunk, once you're high. Your mind tells you, you just wanna do something (pause) like have sex. Once you're drunk, once you're high, you don't think about what you're doing.

Both boys noted that how parents raise their children will either negatively or positively affect teens' behaviors. Thus parenting can contribute to or protect against behaviors that lead to teen pregnancy. Parenting, if it is ineffective, can be a contributing factor.

The more you grow up and like the way [your parents] raise you is the way you're gonna be treating your friends. If my mom or dad raised me up to be like a looser and make everyone feel bad, I'm gonna end up treating my girlfriend bad.

From what I think, for me it's how you are raised. I think that's like the principal of everything. How you're raised. If you're gonna be raised as a good person you're gonna grow up as a good person. But if you're raised as a bad person, you might as well grow up as a bad person...I, like, do a lot of things to help around and whatever. Um, but it's like the percentage of how many people is like opposite... More people are doing the opposite of what the right thing to do (pause) 'cuz of how they were raised.

Protective factors

Both boys identified support from parents and family members as protective factors. One stated, "From what I think, for me it's how you are raised. I think that is that's the principal of everything." Throughout the focus group meeting, these boys interjected examples of how their parents' values influenced their own values and actions.

My parents, my mom, well my foster mom, also taught me all this -- respect and be a gentleman. Respect, showing respect, you know. Um, the first time I went to my girlfriend's house, it was on her birthday. I bought her a pack of roses. I bought her balloons, and it was always in front of the parents, a kiss on the cheek. Respect, showing respect, and you know always bring something for the mother. You have to, you have to do that. That's how my how my parents literally taught me how to be.

My mom tells me to show respect for others. Like I'll tell my mom where I'm going and what time I'll be back home. My mom says if you ever take someone on a date and you're the male, you pay for them. You show respect for them. You're just taking them out to show that you actually wanna spend time with them. She grew up in Puerto Rico. She was full Puerto Rican. She speaks a little bit of English. She is straight up old school Puerto Rican culture and stuff like that.

One participant provided a poignant description of his life and the influence his family, his girlfriend and her family, and his goals and values have had on his life.

I was born in Puerto Rico. My house was made of cement. I slept on the floor, a cement floor. There was a crack on the floor. My house was made of wood with tin. So like when it rained, the rain would get in the side and whatever, ya know. And my mom died. So once I turned 5 years old, my father came to Florida, and we flew to Florida, and so did my uncle. My uncle helped us out, ya know, and grew us up. My dream has always been to be a professional football player. And everybody, all my family they, how do you say that, they believe in me, ya know. In my mind, I'm doing something right now. My freshman year was the first year I ever played football. And I did like the best I can and the coaches started looking at me. My sophomore year, I started playing in the Varsity, started Varsity. I got 51 tackles, 51 sacks and that got me to Western Mass my sophomore year. That's never been done, a sophomore become Western Mass. So this is my junior year. I played this year and I got ranked again in Western Mass. So next year I'll have my college scouts. And my girlfriend's mother told me think about your future before you do something you're gonna regret. Think about going to college, making your life in college, and just try to keep going up. Don't go down, keep taking a step up...I'm always thinking about school. I'm not a really big fan of school, but without school, I'm not gonna go anywhere. I'm not gonna get a good job to pay for my family when I'm gonna have one. "Get your school out of the way first," that's what mom said. She really wants me to be a teacher, a doctor, or a nurse. She tells me: "Once you finish school and all that stuff's done, and you're gonna be making so much money you're not gonna know what to do with it. So give some to charities and stuff like that."

Prevention strategies

As with all prior focus groups, these boys identified reproductive health education as an important prevention strategy. They agreed that this education needs to begin early, when children “can read and comprehend what is happening around them” and continue through high school.

Kids need knowledge about their bodies starting at the age of 6 or 7. And then move on to sex in middle school years so teens have the knowledge to make decisions. The teaching needs to be more than 8 hours in freshman year.

Including discussions with teen parents in reproductive health classes was suggested as an educational strategy. According to the boys, having teen parents describe their lives and experiences as parents would enhance learning.

Like have a session on what teen pregnancy is like. Having both teen mothers and fathers come and talk, like have them come into the school and talk, have a session in the auditorium and let them speak [about] what they are going through and what their life is like. So that everybody else could think about it before they could act.

Marketing of safe sex was suggested as an additional educational strategy. One boy proposed this approach taking into account marketing strategies to encourage use of seatbelts and bicycle helmets, and not drinking and driving. The other boy suggested having safe sex posters in the high school, “especially in the bathrooms.”

We should be everyday reminded, every other day or something. Everywhere we go to think smart. Everywhere I go now, I'll see like something like ‘Wear your seat belt’ and stuff like that. When you're driving, you see like ‘drink responsibly – don't drink and drive’ or like ‘wear a bike helmet,’ but you don't ever see a sign down the highway that says like, it shows like a party and says ‘If you are going to a party, think what you're gonna do before you do it.’ Like, ‘what are you gonna do before you go in the door with someone else in a secluded area,’ ya know. They don't have nothin' like that. They only have car accidents and stuff like that. Like how much money does a baby cost and stuff like that?

Involvement in after-school activities was recognized as a prevention strategy.

One participant described positive outcomes for teens who participated in sports and programs such as the Boys and Girls Club and Girls Inc.

Activities, I think would work for some people. ‘Cuz I know, I do know of people who have changed their way of being by the center, the Boys and Girls Club. The Boys and Girls Club, Girls Inc and stuff like that ya know. ‘Cuz I’ve known girls that were known to be the freaks of the school. Then, they started getting into sports, and putting more attention to school, and doing more activities. They forgot all about that, all about getting with people and stuff like that. Yeah. I do the Boys and Girls Club, I do sports in the Boys and Girls Club, and I box. You know. I think by me doing a whole bunch of activities, doing my sports and stuff like that. It takes my mind off all the way from doing the bad stuff.

The need for a place where “teens can hang out” was added to the topic of after-school activities by the other participant. He made the following recommendation: “We need teen drop in centers in several places [that are open] from 6 pm to 10 pm after school and on weekends.” He also proposed having music gatherings at the old Mountain Park in the summer, and then described his vision for the music gatherings as “something like a Woodstock for teens, with supervision...where we can talk about things, listen to music, talk politics – teen political views, talk about things, listen to music, talk politics – teen political views, talk about piercings, meditate and stuff.”

Summary

Again the topics discussed in this focus group were similar to the previous focus groups. These boys noted that their mothers did not want them to become teen fathers. They suggested that the high school add an early-childhood education program that would provide day-care for teen parents, offer learning experiences for students who are interested in early-childhood education careers, and provide parenting education for teen parents. In their recommendations for prevention they added the need to market safe sex

to teens. Table 4.6 provides a schematic summary of these participants' responses to the focus group questions.

One participant reported incidents that were alarming to this researcher, indicating possible negative affects that teachers may have on Latino students. In his discussion, he stated that "white kids were more intelligent." The participant also posited the idea that humiliation of students may contribute to their dropping out of school, which in turn lead to additional negative outcomes.

To me, not to be a bad person, but I have teachers that really don't care. I had this one teacher that -- this kid, he is always in class and he fools around and whatever -- and the teacher literally told him "I don't care about your life. I'm here because it's my job." And my algebra teacher last year (sophomore year) -- I'm a person that it's really hard for me to learn things you know, so I have to keep going after that, and I was like "Miss, I don't understand this." And she was like: "I know you don't, that is why I'm going to see you in 3 or 4 years on the street, living on the street, asking for money." That's what my teacher told me. My mom came into the school and talked to [name of the principle] and talked to [name of the superintendent] and they told her saying that to one of us could ruin us 'cause that's what you are going to be thinking for the rest of your life, that's what you are going to be putting in your head and thinking of dropping out [of school]. I don't think of race, but I do see it happen. You know but sometimes white kids they are very smart. When you come to think about it, white kids are so very smart, like they have so much. They have brains.

Table 4. 6: Summary of 11th Grade Boys responses to Focus Group Questions

Focus Group Five – 11th Grade Boys	
Focus Group Question	Participant Responses
Perceptions or births	So many teens having babies Responsibility Mothers do not want sons to become teen fathers
Future of teen parents	Teen parents struggle ~ drop out of high school ~ loose opportunity to attend college ~ must work Teen mothers ~ abandoned by baby’s father ~ cast aside by family ~ bullies Suggestion – early-childhood program at high school
Reproductive health information	Church youth groups Parents School – most teens learn about sex through videos at school
Contributing factors	“Sex is everywhere – coolest thing in the genre Media Peer pressure Alcohol and drugs Ineffective parenting Unsupportive teachers
Protective factors	Support from parents, family, and others Religious beliefs – abstinence
Prevention strategies	Reproductive health education ~ begin early ~ teen parents Marketing of safe sex Participation in activities ~ sports ~ Boys and Girls Club ~ Girls Inc Teen center ~ Open 6 to 10 ~ Evenings and weekends Woodstock like gathering at Mt Park

Focus Group Six – 10th Grade Boys

The sixth focus group was composed of three tenth grade boys and met for 80 minutes. The boys appeared comfortable and spoke without hesitation throughout the meeting.

Perceptions of teen births

Discussion on teen births in Holyoke was succinct. “Ridiculous,” “dumb” and “sad” were the terms used. One participant noted that he had heard that Holyoke had “the highest teen birth rates.” The other two participants expressed their view that teen births would be increasing in Holyoke because one had three friends who were pregnant, and the other had “two friends tell me they were pregnant in the last two weeks, and you look around school and there’s a lot more [pregnant girls].”

Future of teen parents

Negative outcomes were denoted by these participants for teen parents. They all agreed that teen parents “won’t get to college,” and are at high risk for “dropping out of high school.”

To like have a baby in the teens without money, without a job, you know. Where are you gonna go in life? How are you gonna get the baby clothes and something to eat? You know!

All participants viewed teen mothers’ futures as worse than those of teen fathers. They noted that teen fathers frequently leave teen mothers before the baby is born and “move on.”

Like, [boys] just leave ‘em flat and like she's pregnant and um and then the boy doesn't even want nothin' with her. He just tells her nah, nah get outta my face and keeps on moving on. And they do the same thing to a different girl.

Reproductive health information

Peers were the primary source of reproductive health information identified.

Parents and schools provide limited information on sex and contraception, as revealed in the following dialogue about gaining information on “sex, contraception, pregnancy, and having babies.”

Participant 1: My mom, she taught us a little bit but mostly health class ‘cause I went to health class and we were talking about it. First we were talkin’ about the body and then we got a little more further in the year and we were talking about pregnancy and excuse me and um what you can get.

Participant 2: My friends cause my friend is active and he tells me like don't do this, don't do that, but I pay no mind because I believe in abstinence so I, I guess there is no worry about me.

Participant 3: My parents never taught me nothing about it. Um, I actually came to know about sex, looking back it was in the 5th grade, but it was because people would tell me, and I'm like what is that? Now-a-days it's it's really hard even to avoid that subject of sex, because that's what's in most people's minds. All they do is talk about it or I wanna do this.

Participant 2: Yeah, I agree. And you know my mom is like, “don't even talk about that subject.”

Participant 3: So it's really hard, it's really hard you know to not know about sex. I mean in my case, when I did start doing it, one of my friends were explaining to me cause my parents they didn't even like to talk about it at all. You know, I just kinda like self taught myself.

Contributing factors

According to these boys, “most [teen pregnancies are] unplanned.” They thought that abortion was not acceptable choice in Holyoke, and implied that there is an association between religious beliefs and the exclusion of abortion as an option for Puerto Rican teens. “Honestly, no one like really around here is up for abortion, only a select few.”

Limited choices of after school activities were associated with “nothing to do” which in turn led to sexual activity and the possibility of teen pregnancy.

I think [that the] reason why many teens like do sex now-a-days is ‘cause, you know, they have probably nothing else to do and that's the first thing that comes to their mind you know have a good time and they just don't know the risk, you know -- they just never know it could happen to them. You know, a baby.

According to these boys, girls may be pressured by their boyfriend to have sex, or they may consider having a baby to add permanence to their relationship with a boyfriend.

Some people have kids ‘cause like they were boyfriend and girlfriend and the guy usually pops up with the question, “if you love me you'll [have sex] with me.” And the girl she just gets caught up in the moment, and she doesn't think about the thing, ‘cause she thinks she's like in love and she just has sex with her boyfriend. The boyfriends, like, they talk to [girls] just to get them into having sex with them just to leave ‘em flat and then next thing you know she's pregnant and um and then the boy doesn't even want nothin’ with her.

Like she wants him to stay with her so she thinks that if she were to have sex and have a baby that he woulda stayed with her. A lot of [girls] think about it that way.

Lack of parental supervision and ineffective parenting were observed and attributed to deviant behaviors among teens including teen pregnancy.

Well parents don't take care of their own sons. The just leave ‘em on the streets and they don't even know what they're doing, so the go around drinking, smoking, you know. The kids are around, like 15 or even lower like 14. They're looking around and they see drug dealers selling and everything, so they teach them stuff. And then they start smoking, selling drugs, getting engaged and doing other stuff and that's the point that they get into, let's say some of them like rape people or something like that. It's like so, like their son is doing whatever in the street.

The topic of neighborhood environments was discussed and the boys noted that there were “big problems” related to drugs and violence in both “the Flats and South Holyoke” where teens “only think in the moment,” while there are fewer problems in the

Highlands. They noted that many pregnant and parenting teen girls are seen in the Flats and South Holyoke.

It was agreed upon, that clothing styles worn some girls was provocative and sent a sexual message to males. The clothing was described as “the tiny skirts” and “shirts that show booby.” One participant viewed the choice of revealing clothing as a sign that the girl does not respect her body and wanted to “provoke guys.”

It's the women, and what they wear. They wanna wear things just to get somebody to, you know, to notice them. It's like, “Oh look at me. Look what I'm wearing.” And everybody's noticing and everybody's like I gotta have her or something like that. And it's just sending a message, like an invitation, you know and now-a-days guys don't like to waste time. It's just like right there and she's giving me the message, so let's go!

To decrease the provocative clothing in the high school setting, boys recommended that girls “should have like a class in being a young lady and covering yourself” and that the school require uniforms for students. “There's uniforms stuff like that so there's not a lot of pressure about how this person looks.”

Protective factors

A central idea in the discussion on protective factors was the role parents have in the development of their children. Parent supervision, teaching, and discipline were identified as effective parenting techniques.

You know, one of the things that [my parents] always did. Um when we got brought up and raised is that even if they went to the movies or anywhere we go we always had to be with them. They never liked to drop us off with any people or you know, even the family they wouldn't let us barely go.

I think discipline is key, you know, like my parents were always really hard on us but you know at first we were always like you know trying to rebel against them you know like why we can't do this with our friends. They always told us: “Well you're not your friends. You're you. You are my son and I'm going to teach you the way it's supposed to be.” I can't be in the streets. If I wouldn't been home,

my mom would have been like, “Yo, I don't want you in the streets, I want you right in front of me where I can see you.”

The main principle is always at the home where you learn at the beginning your first words from everything to the way your parents are, certainly friends are going to have influence on you but if your parents really get deep with you and discipline you right from wrong, even when you make the wrong decisions the next time you know you're going to make the right ones because their voices are always in your head and I could always say my mom she's not afraid to be a parent, let's just put it like that.

Having future goals was associated with protective factors – “having a child would not help at all to achieve my goals.” One boy suggested that teens “also have to have a second goal just in case the first doesn't happen.” Each participant shared a stirring story related to his goals.

Um, my goal is to, you know, fulfill my Dad's dream. My dad past away when I was 13, so 3 years ago. Well you know, he would always teach me and tell me that I could do everything. I could do anything I set my mind to with the help of the Lord. There's always been struggles, you know, to find and to look for ways, you know, you always want to help your family and I always think giving back to your community that is something great that everyone should do. My goal is to, you know, like live up to my expectations that I've been set up with every since I was a little child, you know. [My parents] always tell me I could do things, I could achieve things, I could be somewhat successful, someone admirable. And, you know, I'm planning on doing that, because, since that's my goal in life, a kid would not help me at all to achieve my goal. I mean, I would honestly, since I grew up like, religious; um, I would also like stay abstinent and um if I were to ever have like relations, sex with my girlfriend I would be smart about it and make sure like it's not that I don't. I honestly don't want any kids right now but um if whatever happens, happens but um I just like try and keep away from it cause that's not like what I want right now.

Well, honestly because my father, he's pretty much like a very bad man and he said I would not grow up to anything so my main goal in life is to prove him wrong. Like once, once I have like, like some sort of like (pause). I'm not going to let him put me down. No, not at all, that's my number one goal. That's my number one goal, to prove him wrong!

Well, what I want is to make my mom happy so she wants me to graduate, she wants me to get good grades and all that and she wants me to. She might see myself in good statistics, in something good, not going around and selling drugs

or something so she wants me to get out there and do something good and achieve it and stick with it.

Prevention strategies

Reproductive health education was identified as a prevention strategy, with early reproductive health education deemed as an important approach to increase children and teens' knowledge about sex and decrease misinformation.

Well, kids should start learning when they are small. About 9 or 10, because, like I think, that's the point that they're getting bigger and bigger so they're starting to learn more and try to do more stuff and get more active. So, you know, they probably come out and tell you some boy was talkin' about sex. What it is? And then, you know, other kids'll be talkin' about the subject. Then he wants to try, you know what I mean, he comes up and asks some girl stuff, you know. It's like if the mother don't teach him early, they fall into the wrong stuff that their friends say.

A suggested teaching strategy to assist students in understanding the consequences of having a baby was having "teen parents come and talk to us, help us figure out the costs and responsibilities of having babies."

Teaching parents how to talk with their children about sex and contraception was suggested. "Not only teach teens, why not their very own parents?" Parental attitudes and beliefs were identified as a barrier to this suggestion: "I know probably a lot of parents would say don't teach me how to teach my child."

In addition to sex education, the boys identified a need for parenting classes to be offered in the high school. "We have driver's education and sex education for teens, why not parenting education?" Another participant related his mother's educational experience to the need for parenting classes in Holyoke.

My mom was born in Puerto Rico, but I guess you could say she grew up in Patterson, NJ. And they had some schools [where] they taught you pretty much how to become a parent and stuff. It gets you ready for the outside world to know what you're looking forward to, and over here in Holyoke they do not have things

like that. And my mom told me if they had that like around here we would be so much better off because you learn like what you're supposed to know as an adult.

Developing more after-school activities for teens was highlighted by all participants. One described what he thought would be an ideal program; this description could be used as a prototype in future planning.

I would say to make a program, an active program that runs and lets people do what they feel like achieving. Let's say they wanna play some basketball and like you have some trainers to teach them how to play and team and everything and help them with their jobs or works, their school work. They should be like you do first school work and then you go to the trainers and they show them how to do stuff and like they would like keep them active and keep them learning.

Religion was briefly noted as protective factor by two participants. Their religious beliefs encouraged them to remain abstinent until marriage.

The only thing that has saved me from [having sex] so far is because I come from a Christian background and therefore you know. Um. Yeah, therefore you know, I already know that it always says never do this before marriage so I'm more on that basis.

Summary

An interesting observation was that while the participants pointed out the important role that parents have in their children's lives, only one participant lived in a two-parent household. Another participant's father had died, and he lived with his mother and grandparents, and the third participant's father had left the family.

In addition, a discussion by the participants concerning the treatment of students by teachers was also part of this group's discussion. The boys reported that: "teachers put you down," "tell you you're stupid [and] you don't know what you're doing," and that "puts kids down, degrades their confidence in doing well, [and] kids rebel against that teacher," which leads to additional "problems." One teen provided an illustration of this progression.

Like one of my friends said [to a teacher], “if you respect me I will respect you.” My friend doesn't trust nobody. He walks around paranoid. So he was talking like teachers don't give the students help, they take them down, like they put ‘em down and he doesn't like that and he fights with the teacher and sometimes the teacher is wrong and he tries to prove that he is right and they send him out just because he told the teacher what was right.

The boys concluded that “teachers should respect students, like students have to respect teachers.”

The discussion in this focus group was similar to the prior groups. Table 4.7 provides a schematic summary of these participants’ responses to the focus group questions. One participant provided a summary of the teen birth problem in Holyoke. “The problem is that there is so many negative stuffs that it’s really hard to talk about the solution.”

Table 4.7: Summary of 10th Grade Boys responses to Focus Group Questions

Focus Group Six – 10th Grade Boys	
Focus Group Question	Responses
Perceptions or teen births	Ridiculous, sad, and dumb Holyoke has the highest teen birth rate Teen birth rate will be increasing
Future of teen parents	Negative outcomes ~ At risk for dropping out of school ~ Won't go to college Teen mothers face worse outcomes ~ Abandoned
Reproductive health information	Peers Parents School
Contributing factors	Unplanned Religious beliefs, decrease abortion option Nothing to do Pressure from boyfriend Keep a boy friend Ineffective parenting Neighborhood environments Provocative clothing, suggestion of uniforms
Protective factors	Parents ~ supervising ~ teaching ~ disciplining Future goals
Prevention strategies	Reproductive health education ~ 9-10 years old ~ Teen parents --understand consequences of having a baby ~ Teach parents how to talk about sex Parenting courses in HS After school activities Religion

Focus Group Seven – 9th Grade Girls

The seventh focus group was composed of four ninth grade girls and met for 55 minutes. The girls were very animated throughout the discussion. All participants acknowledged that their mothers were teen mothers, and that their mothers do not want them to become teen mothers.

Perceptions of teen births

To these girls teen births were “wrong”, because “teens are too young to have children,” and teens who do have babies “are immature.” When shown the teen birth graph, the immediate responses were: “daaaamn,” “oh my God,” and “that’s crazy.” The girls did not believe that teens who have babies understand the responsibilities associated with motherhood.

Like, we are babies. We not for having babies, we [are] still babies so I think it's wrong. They think now that they have a baby that they're old enough to live on their own and they're old enough to go out and be by themselves. It's not that, it's like, you have to understand you have a baby you have to be responsible to it, you can't just go out and party and everything else you have to stay with your child

Yeah! I think it’s wrong ‘cause like they don't know what they're going into – like they don't know what they're gonna go through. They don't think. They still got to do school, support their babies and all those other stuff, and they're young. How are they supposed to get a job?

Future of teen parents

Having a baby negatively impacts the future of teen parents, with girls experiencing more difficulties than boys.

[The future of teen mothers] gets destroyed! It does! Cause when you're teen mother you can't just like put your child aside and go to college or you can't just put your child aside and not have money, not have a house, or car, or clothes.

The consensus was that the “majority” of teen fathers do whatever they want to do, go to parties, and are not responsible. One girl noted that her “biological dad just started to pay

child support, after 15 years.” All agreed that it was “way rare” for teen fathers to stay, help with the baby, or pay child support.

The girls discussed difficulties teen mothers face in continuing their education and identified two alternative means for teen mothers to receive an education. One was the Care Center⁶ in Holyoke which provides General Education Development (GED) classes to prepare girls to take the GED exam, day care, parenting classes, and other resources for pregnant and parenting teen mothers. One girl noted that there are “online courses” that teen mothers could take “towards a GED.” The girls agreed that it was important for teen mothers to either graduate from high school or get a GED.

Reproductive health information

All girls identified peer education on “the streets” as the primary source of their reproductive health information. They noted that teens do not “really learn much” in the high school’s ninth grade health class about sex and contraception because the course does not provide education that “is deep, so we would know.” All four girls had taken the high school’s required health class during this academic year. The overall rating of the class was poor. “We really don’t learn about sex.” They consider the health teacher ineffective. “You don’t learn nothing from that class. All the teacher does is gossip,” and “she mostly talks about the same things we already know.”

The girls added that boys’ knowledge about sex and contraception is lacking. Boys have to increase their knowledge about reproductive health including condoms

⁶ Care Center, established in 1993, is an alternative education program for pregnant and parenting teens mothers between the ages of 16 and 21 who have dropped out of high school. It is modeled after “prep schools” and offers GED preparation classes, comprehensive child care, bridge to college courses, arts and humanities, athletics, and support services (nurse practitioner, support counselors, transition counselors). Approximately 60 students are enrolled in the program at any one time, and 120 young women are educated each year. (Care Center, n.d.)

because they “don’t know how to put them on right,” or “don’t believe in condoms.” The girls pointed out that boys “don’t believe you can get sick from sex,” and “don’t even know or heard of STDs and all that.”

Contributing factors

Lack of reproductive health knowledge was the first contributing factor identified.

The girls’ discussion centered on the need for accurate information about sex, reproduction and contraception.

Yeah, I think teens need to be [taught] more about sex and the consequences. Not having sex is a good, but hello! Like protect yourself, use condoms, use something, and use birth control, anything. Some girls don’t know about this stuff.

Teens often think that a girl will not get pregnant the first time she has intercourse.

“Some people are like, ‘Oh it’s first time, it’s not gonna be nothing.’ Getting pregnant isn’t gonna happen, like people need to start thinking.”

The participants consigned some blame for teen pregnancy to parents of teens:

“It’s not always the teen’s fault. They made a mistake and some got pregnant, but their parents don’t know how to raise a child.” Hence, ineffective parenting skills were acknowledged to be a contributing factor: “If you were raisin’ a child the right way, then the child wouldn’t be up there pregnant.” An example was put forth in which a mother left her teenage daughter alone at home on weekends, and now she is pregnant.

Okay, my friend, I have a friend, she’s 14, and she’s pregnant. Well, my friend is about to give birth like this month, she’s at home, having contractions, she called me this morning. Alright but her mom left her almost every weekend; she would go away with her boyfriend, and left her child with her boyfriend alone in her house. She’s not gonna be there praying. Believe it or not, they’re gonna do something. Okay, her mom has trust in her but; you have to have some kind of dirty mind. Oh and the dad, that’s his second one, and the first one, he has never seen her. He’s 17, and he don’t even have a job.

Solving problems by escaping from home was a third contributing factor identified. “Some girls think that [having a baby] will solve all of their problems.” According to the participants, pregnancy may provide teenage girls with a means to: be taken care of -- the father of their baby will “take them home and take care of them;” to decrease stress – “Oh, I need to have a baby so I don’t have to be in stress no more;” or to leave home – “Half of them just want to go out of the house so they get pregnant. They don't wanna be back at the house. I'm gonna go have sex so I have a baby, so my boyfriend can take me out of my house.”

Protective factors

In the case of these participants, being daughters of teen mothers served as protective factor for these girls. Their mothers educated them about the negative consequences of having a child during teen years. One girl’s mother told her “not to make the same mistake.” After witnessing their mothers’ experiences, the other girls have decided not to get pregnant. “Like I hear my mom’s stories and like it tells me, yeah, I’m not going to do that because I don’t wanna go through what my mom went through.”

Planning for the future and setting goals were agreed upon as protective factors. Career planning was seen as integral in this process.

It's just teens think, “Damn, I'm not gonna have a good life when I'm living here I'm gonna have like uh a better one like, when I grow up.” They're planning on what they're gonna do like go to college, what they're gonna be, and it's like that they wanna plan out their life. They wanna do something. They don't wanna sit there and just go and get it too late. They're just gonna be like, “You know, forget about it.” They're looking forward to doing all this, and they're putting that as their goals.

One girl identified a career planning course offered at the high school that can assist teens to develop plan for their future.

It's like, they help plan you for what you wanna be when you get older and how much years it's gonna be and why do you wanna take it to make sure there are courses taking and everything.

Other participants identified additional programs in Holyoke that help teens plan for the future and “keep you off the street.” Upward Bound and Girls Inc were two specific programs. Another participant described a program that she attended; it occurs during the school year and offers a summer camp experience.

There are like, other programs like, um six, like they have it during the year. And in the summer, like the summer is a six week thing. And you say what classes you gonna take next year, so when you go on twelve classes, you're ahead. And you sleep at a camp for three weeks. You sleep in a hammock for three weeks.

Preventive strategies

Reproductive health education was the only prevention strategy discussed. They thought that hands on learning activities would be helpful. The girls drew on their knowledge about reproductive health education in a neighboring city's high school and in Puerto Rico, and spent a great deal of time elaborating on ways to educate teens about the responsibilities of teen parenthood. Possible teaching strategies included having teen parents speak about their experiences and the responsibilities of teen parenting, and using experiential learning to engage teens on a personal level. The discussion was spirited and directed at the use of Baby-Think-It-Over, an infant simulator.

Participant 1: Like you know in Chicopee, they're in Chicopee schools—and I came from Chicopee schools and um Chicopee High and Chicopee Comp (Comprehensive High School). They have this baby thing where you can take home the baby and it goes to the bathroom and it cries. They give you a real feeling. They give you a baby that has all the real effects.

Participant 2: Yeah, and they have like uh a recorder in it, so the teacher will know how you talk to the baby, and if you change his diaper. Like if you said, “Oh shut up,” and whatever. The teacher knows.

Participant 3: They have that in Puerto Rico. It's a class. And you work harder. Like in Puerto Rico, they do it like 9th to 10th grade. They have it.

Participant 4: It's like one of the mandatory courses in Puerto Rico. And when you get older you're gonna have to know how to take care of a child. Like my cousin took that when I was in Puerto Rico, when she took it, like even the babies like, it's a toy, a doll, cause it'll cry. It'll go to the bathroom. It'll wake up like three or four times in the night.

Participant 2: Baby into it. No, Baby-Think-It-Over, that's it!

Participant 3: That's great, you know. It's a great idea. That's like, you know how, like, I'll be like, I'm never gonna have the baby.

Participant 2: Yeah it's like, yeah that will help a lot.

The girls concluded that Baby-Think-It-Over would be beneficial if added to the existing ninth grade health class. Additional recommendations for the health class included: 1) demonstrations of contraceptives --“Show us how to use condoms or something.” 2) separate classes for boys and girls – “Cause sometimes it feels uncomfortable.” 3) same gender teachers for younger teens.

Yeah, like last semester I had my sex-ed and a boy was teaching it. So it felt like really uncomfortable to ask questions on your concerns. So I think they have to like a male health teacher for boys and a female health teacher for girls, so they like could open up.

Summary

These girls stressed the need for experiential learning about the responsibilities of caring for an infant as an important aspect of reproductive health education. They believe that using Baby-Think-It-Over would encourage teens to think about the consequences of having a baby during their teen years, and choose to postpone having a

child until after high school. They were concerned that teens that do have children are provided with options to continue their education. Table 4.8 provides a schematic summary of these participant's responses to the focus group questions.

Table 4.8: Summary of 9th Grade Girls Responses to Focus Group Questions

Focus Group Seven – 9th Grade Girls	
Focus Group Question	Participants Responses
Perceptions or teen births	Wrong Teens are too young to have children Crazy
Future of teen parents	Negative ~ Future of teen mothers gets destroyed Teen fathers ~ Not responsible ~ Party ~ Don't pay child support Care Center can provide education for teen mothers
Reproductive health information	On the street Do not learn much in health class Boys do not know ~ contraception and condom application ~ STDs
Contributing factors	Lack of reproductive health knowledge Ineffective parenting Escape from home
Protective factors	Being daughters of teen mothers Setting goals, establishing future plans Programs ~ Upward Bound ~ Girls Inc
Prevention strategies	Reproductive health education ~ Baby Think It Over ~ Teen parents talking about their experiences ~ Demonstration of contraceptives ~ Separate classes for boys and girls ~ Same gender teachers

Focus Group Eight – 9th Grade Boys

The last focus group was composed of six ninth grade boys and met for 70 minutes. These participants were very enthusiastic and openly discussed teen sex, pregnancy, and births. As noted earlier in the chapter, five participants were 16 years of age which is beyond the customary age range for ninth grade (14 to 15 years).

Perceptions of teen births

The boys reported that teen pregnancy and births are prevalent in Holyoke. “You see girls getting pregnant, you see girls pushing strollers. You see it every day.” Two participant’s mothers were teens when they had their first child, and another boy commented that many teens in Holyoke have parents who were teens when they had their first child. Only one boy judged teen parenthood negatively, the other thought that it was “not that bad” because teen parents gain maturity, become responsible, and have a reason to survive while the other two have less positive views. The following excerpt provides a glimpse into the reasoning for these perceptions.

Participant 1: I don't think it's actually that bad. Cuz, for me I think back when America was getting started, kids used to be having babies at 14 years old. Because they used to die at their 20s and stuff. So I really don't think it's a bad thing. Because you know, they do mature and gain responsibility.

Participant 2: I kind'a don't think it's all that bad. Because, like, most of our parents had us at teenage, and they're alright. And they're fine.

Participant 3: I think if they have a baby, they would mature more quickly than the average teenager who doesn't get pregnant at a young age.

Participant 4: So I think that umm having a baby is the will to survive. Because my mom had my brother at 16 and she came from Puerto Rico to the states. With no family members, no job, no nothing. And she survived and also had everybody else.

Participant 5: I say for me there [are] two points of view: actually the good and the bad. The good is that it helps [teens] mature...The bad part is that it takes away teens' freedom.

Participant 6: I think it's not really smart because [teens] are not really thinking of the consequences that could happen of having a kid at such a young age.

Different "criteria" are often used to judge boys and girls sexual behaviors, according to these boys. "Like if a guy has three different girls, he's a G. But if a girl has three different guys, she's a ho." Three boys added that girls instigate negative name calling as a form of bullying which in turn can become a self-fulfilling prophecy for girls to have multiple sex partners.

The other girls are jealous that she has more guys than her. The guy just calls her a ho, cuz the other girls calls her a ho. That just goes around. I've never called a girl a ho...Some girls, I think, become a ho, because the word sticks to them. And when it sticks to them, they start to actually become one. They don't care anymore.

Future of teen parents

The future of a teen parent was presented dichotomously; teen parents either "grow up quickly" or "ruin their life." The general belief was that teen mothers face numerous challenges and responsibilities which often results in dropping out of high school. Two boys remarked that many teen mothers quit high school because they "can't handle the stress." Another noted that "without an education" teen mothers "won't have a life." Two commented that some teen mothers were able to continue their education, because these teen mothers "think that they can do better" and "have a lot of faith." The last participant described support and motivation as variables that can affect teen mothers' ability to continue with school.

I don't think all women do quit [high school]. Some do make it. And that should be like motivation for other girls that do end up pregnant. They should have the motivation too. Cuz if one girl can do it why can't another one? There [are] different situations in their lives, family problems. And maybe the other girl, she has like, has no money. But it's just all on them.

The overall perception of teen fathers was that they do not accept responsibilities of parenthood and abandon teen mothers and may regret this in the future.

Participant 1: Cuz the father could like bail out at any time. Like he doesn't have to be there if he doesn't wanna be. Like the girl, she's stuck with it. She's gonna carry it for nine months and then she's gonna raise it. The dad doesn't have to be there.

Participant 2: The guy doesn't feel the same way [as a girl]. If a guy has a baby, that's just a burden on him.

Participant 3: A guy at a teenage age doesn't wanna be stuck in the house taking care of a kid. He wants to be out clubbing, havin' fun.

Participant 4: [Teen fathers] don't wanna stay cuz most of them don't. They bail.

Participant 5: Yeah! They go on to another girl.

Participant 6: He's gonna regret it if he doesn't stick to it. He's going to regret it if he abandons his child.

Reproductive health information

Mothers, fathers, and other family members such as uncles and cousins were identified as the participants' sources of reproductive health information. However, much of the information was often inadequate or incomplete. "Parents don't talk about the consequences of [having a baby]; so how would you know?" Sex was a taboo subject, and teens cannot ask questions related to sex, because asking such questions equated to engaging in sexual activities.

What I know is that, because people think sex and you know everything that goes along with that, is a subject that is not to be talked about. That's not a subject that is to be talked about, or they think that once you learn [about sex], that you're gonna go out and do it. So they try to keep it away.

Parents don't talk about the consequences of [having a baby]. So how would you know? And teenagers here, they see [babies as] fun, playing, smiling, but they don't see that babies can wake up at 3 in the morning. They have to change them, feed them; they have to wake up really early just for the baby.

Much of the discussion related to condoms and their correct use. According to four boys, teens "just know how to use a condom," and this knowledge was gained through "experience," "doing it all the time," or "reading directions on the back of the package." Two boys voiced concern that teens do not know the correct use of condoms. "It's easy to put [a condom] on, but some don't know the rules that you have to be like an inch away from the tip of it." Another provided a personal example of using a condom incorrectly: "...last summer, I used contraception, but I guess I put it on the wrong way. Or I guess I put it way too close cuz it broke inside." When asked by the co-moderator if the topic of condom application was included in the high school's health class, the response was negative. "No, that would never happen because Holyoke doesn't care." According to these boys, the prevention of drug use was a major focus of the ninth grade health class. "I think that in health, they're just more focused on drugs and other things. They don't have enough sex talked about."

Contributing factors

Lack of meaningful activities was again identified as a contributing factor. There are no activities for teens in Holyoke except for going to the Mall according to these boys, but there is a caveat "teens can't be [at the mall] on Friday, Saturday or Sunday without a parent." The conclusion was that teens have no life and are bored.

There's so much nothing to do that I watch TV so much that it is getting boring.

I do homework and pretty much watch TV like I have no life. That's pretty much what everyone does in Holyoke.

I think all of my friends, you know, it's like in Holyoke life is boring. It's hard for us to get out of Holyoke. There's not much good here.

The boredom can lead teens to experimenting with sex.

I think [that] there's not a lot of things in Holyoke, so we try to find something to do, and sex is the way out of it.

Holyoke is so limited that people are just willing to try new things. And I guess sex is the main source. It's a thing everyone wants to do.

A 16 year old participant who was often bored connected this with having sex.

I do it [have sex] all the time. I mean, I'm not saying that it is a good thing. This is a jump off⁷, just a hook-up. I mean, when I'm bored, I just, you know. I call up one of those peoples, and I just bring them over. At first we start talking and then it ends up in my room.

This participant also shared the fact that he does not have any goals for the future and lives for each day. When asked by the co-moderator, "Do you have a plan for your future?" His response was: "I don't wanna stop. I don't know (pause) I think you can't just write your future down. You just have to live it day by day. You just can't write it down." Thus, lack of future goals and lack of meaningful activities for teens in Holyoke can be contributing factors.

The boys believed that teens are not solely to be blamed for teen pregnancy, but "parents who don't care" contribute to the problem.

We can't always blame the teens. There are some parents who don't care and they're like, "You know what, what the hell. You can go and have sex." They don't really care; some parent's don't really care.

Neighborhoods were discussed in light of being a contributing factor. All mentioned that living in the Flats could be a contributing factor, and that living in other neighborhoods could be a protective factor.

⁷ Jump off is defined as a casual sexual partner or girlfriend (Peckham, 2005).

I used to live down there, in the Flats, and it was always drug use. There was always alcohol, and there's always hookers around. They are usually the ones who were pregnant when they were teenagers. So if you lived in the higher class, the Highlands or above, you don't see it often. So it doesn't come to mind as much. So you won't have sex.

Keeping a boyfriend and escaping depression were acknowledged as contributing factors to girls desire to have a baby.

Girls what they do is that they just wanna get pregnant on purpose. Because maybe they just wanna be with their man at all times. Yeah, like my friend she got pregnant just to be with her man.

I think that sometimes [girls get pregnant] because of depression. Stress and depression... The depression like, they're not happy with their lives so they get pregnant and think that their parents would probably treat them differently. So yeah, a new life.

Protective factors

Having future goals and the motivation to achieve them were key protective factors discussed. The participants associated having future goals, graduating from high school and attending college as incentives not to have a baby. For one boy, his goal to graduate from high school “because my mom and dad didn’t graduate and I wanna graduate ‘cuz I’ll be the first one out of my whole family to graduate” was a deterrent for him to father a child. Others presented their goals as their deterrents.

My goal is to graduate high school, graduate from college, and then go for 8 to 10 years to a college again to become a gastroenterologist. And then my plan B for my future is, um, to go into the criminal justice field, to become a BAU [a member of a Behavioral Analysis Unit] and then once all that is settled, then I can you know, get married, um, have a kid, and provide for my family.

I think you have a view. Your view always changes. You find that thing that really kinda fills you up. My view right now is to become an accountant. But I really don't know if that's where I wanna be. That's just something that I'm looking to see if I could become. ‘Cuz you don't know exactly what you're gonna be. You know, but you're gonna look into the future. You're always gonna want something different. That's how that works.

Motivation for success was subsequently added to the discourse on goals and the future. The participants identified motivation and success as protective factors.

Participant 1: I think that the fact that I just want my life to be successful that's the only reason why I wanna continue on to graduation. Graduating, going to college for whatever I want to do. Live in a house with a wife. And just have a nice family.

Participant 2: Yeah, cuz I think success is you doing what you want to do and you know, eventually having a family and all that.

Participant 3: Having the motivation!

Moderator: You mentioned motivation. What do you mean about motivation?

Participant 3: It's like if you wanna reach a goal to become successful, not to give up on it. Just because someone tells you not to do it because they don't think it'll get you anywhere. Or something like that. And you don't have motivation, then you're not gonna make it anywhere.

Participant 4: Some people lose their motivation, not actually like give up, but it's like retired. Not retired, I mean, um, like suspended. Cuz when you try for something and it doesn't work out, and you keep on trying and trying and it doesn't work out. It kinda kills your motivation you know.

Both reproductive health knowledge and the ability to read were associated with protective factors. One participant identified “knowledge” as “key in reducing teen sex” because “the more knowledge, knowing how to put on the condom, knowing how to use it right, and all that stuff will reduce [teens having babies].” Another participant added that it is important for people to “learn how to read.” He disclosed that his father did not know how to read or write, and stated that “it's important to read.” Another boy commented that “some kids in school really can't read,” and a fourth participant stated, “Or even if you know how to read, actually take the time to read.”

One boy described how he keeps his physical desire for sex constrained: “I do the same routine every day. I just, I have feelings that I should be having sex sometimes, but I know how to keep my mind straight.” Another added that, although sex provides a positive sensation, the apprehension of having a baby or contracting a Sexually Transmitted Infection (STI) can motivate him not to have sex.

I gotta admit, someone else already said it. Sex does feel good. It feels good but the outcome doesn't. You don't wanna have a baby and you don't wanna have an STD.

Prevention strategies

The boys deliberated on the details of comprehensive reproductive health education. The need to begin sex education before ninth grade was emphasized because “some people start [having sex] young,” and “that’s when we start getting sexual feelings.” Once students reach high school age, it was deemed important to have reproductive health education in all four years. There was much back-and-forth discussion on whether reproductive health education classes should have students of both genders together or separate. Three ideas were proposed: 1) To have separate gender classes for freshmen and sophomores, and then have combined classes for juniors and seniors when students are “more mature.”

They should have a boy class and a girl class separately for the beginning, and as they go on [with] their education they could talk about it all together [starting in the] junior year when they're more mature.”

2) To provide teens opportunities for selecting the learning environment they prefer, either a combined gender class or separate gender classes.

You should choose if you wanna be in a separate [class] or not. You wanna be open about it... ‘Cuz there’s people that are open and there’s some that are shy. What I think is talking about sex, is that some people would like to talk...and

others don't want to talk about it because they think it's a subject they shouldn't be talking about.

3) To have teen parents come in to health classes and talk with students about their experiences, an idea proposed in other focus group meetings.

Have teen parents talk to students and like show what they're going through. Like you don't wanna go through what I'm going through. You have a chance now. Don't have a baby.

Characteristics of an ideal reproductive health teacher were identified. A teacher's comfort with the subject matter and her/his ability to relate to students were critical to effectiveness.

Participant 1: Some teachers feel awkward talking about [sex].

Participant 2: You have to have a teacher that's very comfortable. You can't just have a teacher that can talk about it. You have to have a teacher that can relate.

Participant 3: Experience.

Participant 4: Like a people-person. Not just a person that knows.

Participant 5: Cuz if you have a person that knows but cannot connect with the student. Then she's not gonna succeed.

Participant 6: So the teacher has to have a connection to us. And the students have to trust the teacher.

The discussion progressed to the need for mentors, especially for teens that are "alone." Mentors "can talk with them and help them make a plan, figure out courses to take, and stuff," and serve as role models "cause it's hard for people to like do something if they don't know how. Give them positive role models." Characteristics of effective mentors are similar to those identified for effective health teachers. A mentor cannot be "just anybody, it has to be somebody you can trust." The boys identified three characteristics needed by mentors: the ability to listen, "relate to," and develop a trusting

relationship with teens. Teachers and guidance counselors at the high school often do possess these characteristics according to these boys.

Participant 1: You need [a mentor] you can trust. Not like any person, “do this or that.” Cuz then you’re not gonna listen to that person. You’re not trusted. Trust is the key I think.

Participant 2: I don’t even trust the guidance counselor. You know. Cuz I just gotta feel the person. Like, you gotta know the person.

Participant 3: You gotta know the person. You can’t like trust anyone.

Participant 4: Yeah! I agree.

Participant 5: It’s pretty much being someone that can relate to you. What they went through and what you’re going through. You gotta find that person you can relate to.

Participant 6: Sometimes you don’t have that person. Like sometimes, teachers act like they were never kids or something like that... When you’re a grown up, obviously you are going to act like one. But teachers they just don’t care about anybody else then they lose that trust in us succeeding.

The last prevention strategy suggested the need to develop “more things for teens to do in Holyoke.”

I think if there's more things to do in Holyoke that are cheap, keeps minds off having sex. It'll keep [teens] occupied, doing different things. If you're in a group, in a place you tend not to think about sex, and you tend not to have sex ‘cuz you're not alone with a girl at someone's house.

Another boy would like to have a movie theater in Holyoke. He made a pleas for this:

I wish we could have a theater in our community, where you could walk with a couple of friends and watch a movie. Now you gotta go to West Springfield. It takes gas and money and some parents, they’re too busy to take you.

This was followed by a proposal for a teen center that “could be a teenage hangout, without parents.” The boys stressed the importance of having input from teens in the development of programs or services for them. “Like actually talking to kids, and see

what they want to have.” They brainstormed what they would like in a teen center: “more sex talk,” “a music room,” “stuff to keep your mind off of sex,” and “dances every Friday and Saturday with chaperones.” One boy asked an important question: “Where will we get the funds for this?” Another participant responded: “Yep, that’s always the problem in Holyoke.”

Summary

At the close of the focus group meeting all participants identified “sex education” as the most important topic addressed. Additional comments related to having personal goals, mentors, support, and activities. One boy noted the importance of having “a dream for the future to keep me going.” He added, “teens need opportunities for dreams and hopes.” Another emphasized the important of having “teens participate,” and not “putting them down.”

The topics included in this focus group meeting are similar to those in the prior groups. These boys identified characteristics needed for a teacher to be effective. Table 4.9 provides a schematic summary of these participants’ responses to teen births in Holyoke.

Table 4.9: Summary of 9th Grade Boys Responses to Focus Group Questions

Focus Group Eight – 9th Grade Boys	
Focus Group Question	Participant Responses
Perceptions or teen births	Prevalant in Holyoke 2 had teen mothers, many parents had babies in their teen years 1 viewed it “not smart” 5 – not bad, gain maturity, become responsible
Future of teen parents	Group up quickly Ruin their life Teen mothers ~ Face numerous challenges and responsibilities ~ Often quit high school ~ Parental support = better outcomes, Teen fathers ~ Do not accept responsibilities ~ Abandon teen mother and baby ~ Don’t “wanna be stuck in the house” -- continue partying ~ Will regret not being part of child’s life
Reproductive health information	Parents Other family members – uncles and cousins Inadequate inaccurate or incomplete Sex a taboo subject = cannot ask questions Boys do not know how to correctly use condoms 9 th grade health class focuses on drug use
Contributing factors	Lack of meaningful activities ~ Mall ~ No activities = boredom = experimenting with sex Lack of future goals Ineffective parenting Neighborhoods – the Flats For girls, keeping a boyfriend
Protective factors	Having future goals Motivation for success Reproductive health knowledge The ability to read Balancing the desire for sex with abstaining from it
Prevention strategies	Comprehensive sex ed ~ Begin in middle school ~ All 4 years of high school ~ Separate classes in 9 th and 10 th grade ~ Same gender teachers ~ Teen parents to talk with teens Characteristics of a sex education teacher ~ Comfortable with subject ~ Can relate to students ~ Trust Mentors Activities – teen center

Categorization of Data

Findings from the eight focus groups were organized by research question, included categories and sub-categories, and are presented in Table 4.10. Patterns and connections were examined both within and across categories, and themes were developed. Three reoccurring themes emerged: 1) Puerto Rican teens perceive pregnancy as largely unintentional and as a problem with negative outcomes. 2) Puerto Rican teens perceive a lack of information on sexual health and reproduction. 3) Puerto Rican teens are able to identify social factors that contribute to or prevent teen pregnancy, and they want their voices heard.

Table 4.10: Data Presented by Research Question and Emergent Categories

Question	Categories -- Responses to the question were sorted into:
1: What perceptions do participants hold about teen births?	Negative terms <ul style="list-style-type: none"> - ridiculous - sad - dumb - crazy Problem <ul style="list-style-type: none"> - teens too young to have children - blame Puerto Ricans - negative image of city Prevalent in Holyoke <ul style="list-style-type: none"> - will increase - could be reduced - accident (no one plans on having a baby at this age) Mothers do not want -- teen to become a teen parent

Question	Categories -- Responses to the question were sorted into:
<p><i>2: How do participants' view the future of teen parents and their future life goals?</i></p>	<p>Negative</p> <ul style="list-style-type: none"> - Future destroyed, ruined, difficult, stressful - Do not have a future - No social life - Poor - Have to work - Drop out of school - Loose opportunity to attend college <p>Grow up quickly</p> <p>Teen mothers (worse outcomes than teen fathers)</p> <ul style="list-style-type: none"> - Abandoned - Drop out of school - Bullied - Cast aside by parents <p>Teen fathers (do not accept responsibilities)</p> <ul style="list-style-type: none"> - Continue with life - Move on to another girl <p>Teens who get assistance = better outcomes possible</p>

Question	Categories -- Responses to the question were sorted into:
<p><i>3a: What do participants identify as contributing factors?</i></p>	<p>Lack of reproductive health information</p> <p>Lack of activities</p> <p>Lack of future goals</p> <p>Ineffective parenting</p> <p>Peer pressure</p> <p>Environment</p> <ul style="list-style-type: none"> - Neighborhoods - Home <p>School</p> <ul style="list-style-type: none"> - Unsupportive teachers <p>Media</p> <ul style="list-style-type: none"> - TV shows - MTV - Lyrics to songs - Clothing styles <p>Religious/cultural beliefs</p> <ul style="list-style-type: none"> - no abortion - no birth control <p>Use of alcohol or drugs</p> <p>Girls</p> <ul style="list-style-type: none"> - keep a boy friend - escape from home

Question	Categories -- Responses to the question were sorted into:
<p><i>3b: What do participants identify as protective factors?</i></p>	<p>Participation in activities Comprehensive reproductive health knowledge Having goals and future plans Recognition for achievements Programs <ul style="list-style-type: none"> - Girls Inc - Upward Bound - Holyoke Youth Commission - YMCA - Sports School <ul style="list-style-type: none"> - Supportive teachers who encourage teens - Athletics - Clubs and other school sponsored activities Trusting relationships with mothers Support from parents, family, others Religious beliefs – abstinence</p>

Question	Categories -- Responses to the question were sorted into:
<p><i>3c: What do participants identify as prevention strategies?</i></p>	<p>Comprehensive reproductive health knowledge School based reproductive health education <ul style="list-style-type: none"> - separate classes (boys and girls) - same gender teachers - characteristics of effective teachers - teen parents (discuss their experiences) - interactive educational materials - Baby-Think-It-Over After school activities/programs <ul style="list-style-type: none"> - expand existing programs <ul style="list-style-type: none"> reduced fees provide transportation - develop teen center(s) - internet café for teens Education for parents <ul style="list-style-type: none"> - how to talk with teens about sex, reproduction, and contraception Education for school system faculty and staff <ul style="list-style-type: none"> - staff development on reproductive health, cultural awareness, and communicating with Latino teens Marketing of safe sex Mentoring programs Don't be alone with member of the opposite sex Access to contraception and free condoms Being daughters of teen mothers</p>

Question	Categories -- <i>Responses to the question were sorted into:</i>
<p>4: <i>Where do participants get information about sex, contraception, & having babies?</i></p>	<p>Peers</p> <ul style="list-style-type: none"> - on the street - inaccurate information <p>Mothers/parents</p> <ul style="list-style-type: none"> - dependent upon <ul style="list-style-type: none"> parent's relationship with teen comfort with topic - often limited or none <ul style="list-style-type: none"> embarrassment for both teen and parent taboo topic <p>Girls Inc</p> <p>Highs School - health class</p> <ul style="list-style-type: none"> - do not learn much - focus on drugs <p>The Media</p> <p>Church</p>

Chapter Summary

For this study each focus group was the unit for analysis which included the transcript, field notes, and debriefing notes. The chapter began with a presentation of participant demographic characteristics by focus group. The data description, the first phase of data analysis continuum, followed and culminated with data categories for each research question. From the categories three themes emerged: 1) Teen births are a problem in Holyoke. 2) Teens desire accurate information about sex, contraception, and sexuality. 3) Teen behavior including sexual risk taking is influenced by social and physical environments. The next steps in the data analysis continuum will be data interpretation and recommendations. These will be presented in Chapter 5.

CHAPTER 5

DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

Introduction

Teen births in Holyoke have consistently been the highest in the state for over two decades. In 2008, Holyoke's teen birth rate was 115.3/1000, which was an increase of 20 points from the 2007 birth rate of 95.4/1000 (Cáceres, Orejuela-Hood & West, 2010). Of greater concern is the fact that Holyoke's teen birth rate in 2008 was 95.2 points higher than the state's rate of 20.1/1000 (Cáceres, Orejuela-Hood & West, 2010). In addition Holyoke has the largest Latino population in the state with 41.3% of the population identified as Latino, and of this population 88.1% are of Puerto Rican descent (US Census Bureau, 2000). With the estimate that one in every two Latinas becomes pregnant at least once before the age of twenty (National Center for Health Statistics, 2006; Vexler & Suellentrop, 2007), Puerto Rican teens in Holyoke represent a population at high risk for teen pregnancies and births.

The purpose of this study was to examine perceptions held by Puerto Rican teens living in Holyoke about teen pregnancy and birth with the aim of gaining knowledge that will provide a foundation for future research and will inform policy development, nursing practice, and programs that serve Puerto Rican teens. It also provided a voice for Puerto Rican teens concerning the complex phenomena of teen pregnancies and births.

This final chapter provides an overview of the findings centering on three themes that were identified as a result of a series of eight focus group meetings held with Puerto Rican teens at Holyoke High School, and aimed at addressing issues of teen pregnancy and birth in the city. It connects the findings to the study's framework, the Ecological

Model of Health Behavior, and presents recommendations for interventions framed by both the findings and the Ecological Model of Health Behavior. Future recommendations are presented, and implications and conclusions are discussed in the chapter's last section.

Overview of the Findings

The study's findings are based on analysis of data obtained from eight focus group meetings with Puerto Rican teens representing all grade levels at Holyoke High School. The focus group interview guide was designed to gain knowledge about the perceptions these participants held about teen pregnancy and birth. Focus groups were chosen as the data collection method to examine the study's four research questions: 1) What perceptions do participants hold about teen births? 2) How do participants view the future of teen parents and their future goals? 3) In relation to teen pregnancy, what do participants identify as: contributing factors, protective factors, and prevention strategies? 4) Where do participants get information about reproductive health (sex, contraception, and having babies)? Focus groups provided teens a social interactive setting that included checks and balances, a milieu for spontaneous exchange of ideas, thoughts and attitudes, while allowing teens to reflect on and share realities, cultural values, and group norms.

Based on the research questions, the review of the literature, and the findings drawn from the data analysis continuum (raw data, data description, data interpretation, and recommendations), the evidence indicates that for Puerto Rican teens participating in this study, perceptions of teen pregnancy and births in Holyoke are congruent with the literature. Puerto Rican teens participating in this study perceive that:

- 1a. teen pregnancy and birth in Holyoke is a problem, and gives both Puerto Rican teens and the city a “bad reputation.”
- 1b. the majority of teen pregnancies are unplanned, and for girls who desire pregnancy and birth they more than likely have suffered maltreatment, live in a dysfunctional home setting, or desire to keep their boyfriend.
2. teen parents “have no future” and face life-long struggles with teen mothers and their children enduring long-term negative outcomes.
- 3a. lack of science-based, comprehensive reproductive health knowledge, boredom that leads to sexual activities, and “poor parenting” contribute to teen pregnancy and birth in Holyoke.
- 3b. accurate reproductive health education, access to condoms and other forms of birth control, trusting relationships with mothers, participation in activities, and receiving support from parents, teachers, friends and others in their social network offers protection against becoming pregnant and having babies.
- 3c. having comprehensive reproductive health knowledge and access to contraception, participating in after-school programs and activities, having parents who are educated about reproductive health and share this information with their teens, and educating parents of teens on how to talk with their teens about sex, reproduction, and contraception are necessary prevention strategies.
4. friends are more often than not the primary source of reproductive health information, followed by parents, school, and the media.

Following careful analysis of the data and review of the major findings presented in data interpretation, three major themes were identified. These themes represent the distinct voices of Puerto Rican teens heard in response to the research questions, and are: 1) Puerto Rican teens perceive pregnancy as largely unintentional and as a problem with negative outcomes. 2) Puerto Rican teens perceive a lack of information on sexual health and reproduction, and believe that education should be provided to all teens. 3) Puerto Rican teens are able to identify social factors that contribute to or prevent teen pregnancy and want their ideas heard. Each of these will be discussed.

Teen Births Are Perceived as a Problem with Negative Outcomes

Puerto Rican teens in this study perceive teen births as a problem in Holyoke producing negative outcomes for teens, their children, and the community. Pessimistic terms, e.g. ridiculous, crazy, sad, and dumb, were used in all but one focus group to describe the participants' views of teen births, and these perceptions were based on participants' belief that teens are too young to have babies and their observations of the harmful consequences faced by teen parents and their children. Participants reported that teen parents in general "do not have a future" because they drop out of high school, lose the opportunity to attend college, must work, and suffer economic consequences in the future. According to participants, teen mothers face more adversity than teen fathers, many of whom often do not accept the responsibilities of fatherhood, abandon teen mothers, and "move on" to other girls. A collective description of teen mothers' future is one of reoccurring detrimental experiences: being abandoned by the father of their child, being cast out by their parents, enduring harmful comments made by classmates and others, and dropping out of school. Participants noted that teen mothers who receive

support and assistance from parents or others may experience a different trajectory and better outcomes. The participants also noted that teen births reflect poorly on both Puerto Ricans and the city of Holyoke. According to the female participants, blame for Holyoke's high teen birth rate was placed on Puerto Rican girls and also gave them an unfavorable reputation throughout the community. Both boys and girls agreed that the high teen birth rate in Holyoke projected an image that parts of the city should be avoided because of widespread rape, violence and other forms of non-normative behaviors.

These perceptions are consistent with those identified in earlier research by Herman (2008), Maynard (1996), Terry-Humen, Manlove, and Moore (2005) and Rosengard, Pollack, Weitzen, Meers, Phipps (2006), and Vexler 2007. The researchers found that for low income teens considered at high risk for pregnancy, negative perceptions (losing friends, causing stress with family members and partners, decreasing the ability to parent, limiting educational options, increasing difficulties in working, limiting incomes, missing out on teenage experiences, and putting dreams on hold) outweighed positive perceptions (building a family, providing a purpose in life, taking on more responsibilities, having family and partner support, and enhancing teen-partner relationships).

Four of the six ninth grade boys did not perceive teen births as a serious problem. Three thought that teen parents "mature and gain responsibility;" and one noted that "having a baby is the will to survive." It is worth mentioning that one boy noted that in Holyoke many teens' parents were teens when they had their first child, two boys had mothers who were teens when they had their first child, two connected having children during the teen years with survival, three used their mothers' experiences as comparative

cases, and all four were 16 years old which was older than the age range of 14-15 years for the ninth grade. In addition to the previously cited research, Foster's (2004) ethnographic study on Puerto Rican partners of teen mothers in Holyoke found that having children provided some fathers with an alternative to participating in violence and criminal activities. The small percentage (>1%) of this study's population who viewed teen parenthood positively is less than findings of Vexler (2007) who in a national study on Latino's views of teen pregnancy found that 7% of Latino teens believe that being a teen parent would help them achieve their future goals.

In this study, participants felt that parents do not want their children to become teen parents, that most teen pregnancies are unintended and more often unplanned than planned. Researchers estimate that more than 75% of teen pregnancies are considered unintentional and 66% of teen births are a result of unintended pregnancies (Ahluwalia, Johnson, Rogers, Melvin, 1999; Rosengard, Phipps, Adler & Ellen, 2004). For teen girls who desire to have a child, two contributing factors were reported by participants: a means to keep a boyfriend, which was noted in all focus groups regardless of participants' ages, genders, or grades, and a way to escape difficult home situations, which was discussed in all girls' focus group meetings. These findings are consistent with the research findings related to advantages of teen births noted above. In addition, male partners influence female teens' pregnancy intentions (Frost & Oslak, 1999); girls who come from disadvantaged backgrounds (Jewel & Donovan, 2001; Kirby, 2007), experience maltreatment or abuse by family members (Jewel & Donovan, 2001; Kirby, 2002, 2007), or lack a sense of permanence and stability (Sciarra & Ponterotto, 1998) are more likely to be motivated to become mothers.

One finding of concern was the fact that the participants predicted that the teen birth rate in Holyoke would once again rise. This was based on the number of pregnant girls observed by the participants in both the high school and the community. A twelfth grade girl's statement summarizes many of these beliefs:

It's a problem here with so many big bellies walking around the high school. It gives us a bad name. People think that all Puerto Rican girls are sluts, but that isn't true. I'm still a virgin and so are many of my friends.

Teens Perceive the Need for Sexual and Reproductive Health Knowledge

All participants regardless of age or gender identified lack of information on sexual health and reproduction as a key contributing factor to teen pregnancy and birth in Holyoke, and conversely science-based comprehensive reproductive health knowledge as a protective factor. This view is consistent with the literature. Kirby (2002, 2007) acknowledged that comprehensive reproductive health knowledge and access to birth control were protective factors; and the American Academy of Pediatrics (2001) in a white paper, *Sexuality Education for Children and Adolescents*, noted that "children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behavior (p.498)".

The most frequent way in which teens in Holyoke obtained information about sex, contraception, and having babies was from friends, followed by parents, other family members, teachers, the media, and through church groups. According to Bleakley, Hennesy, Fishbein, Coles and Jordan (2009), learning about sex from parents, grandparents, teachers, and religious leaders was associated with delaying the initiation of sex, and learning from friends, cousins, and the media was associated with the

likelihood of having sexual intercourse. Thus, the source of reproductive health knowledge can influence a teen's sexual behavior.

Participants noted that reproductive health information from friends was incomplete and inaccurate, and information from parents was limited. Several teens acknowledged that they received information from their parents, especially mothers, and that this education was dependent upon the teen's relationship with his/her parent and the parent's comfort with topics related to sex, sexuality and reproduction. However, for the majority of participants, this information was restricted due to the embarrassment associated with the subject, the taboo nature of the topic, the limited knowledge and skills that parents have to discuss the topic, and teens' discomfort in asking parents for this information. This is supported by Vexler's (2007) research, who used data from a national survey to assess attitudes and beliefs of Latino teens and adults about teen pregnancy. He found that Latinos are less likely than their peers to have had a helpful conversation with their parents about delaying sex and avoiding pregnancy, and one reason for not having this conversation was the embarrassment related to discussing the subject of sex and reproduction. Another inhibiting factor presented by the teens was that if a Puerto Rican teen asked her/his mother about sex, contraception or reproduction, the mother may assume that the teen was having sex, become upset, and possibly punish her/him.

Girls Inc, a community-based program for girls in Holyoke, was repeatedly identified in all of the girls' focus groups and two of the boys' focus groups as a community-based program that provides girls with accurate information on sexual health and reproduction, a means to develop life skills, and guidance in establishing personal

goals with plans to achieve these goals. In combination, these strategies can have a powerful affect on teens' desire not to become a teen parent. Three boys in two different focus groups identified teen groups in their churches as contributing to their reproductive health knowledge. Interestingly, Vexler (2007) found that 82% of Latino teens believe that religious leaders and groups should be doing more to help prevent teen pregnancy.

All participants regardless of age, gender or grade described the reproductive health education provided in the ninth grade health class as inadequate, and articulated that much of the course content is on alcohol and drug prevention. They made recommendations on ways to improve the *Health and Wellness Education*⁸, the mandatory 2.5 credit course taken one semester during the ninth grade. These will be discussed in the recommendations for interventions section of this chapter.

Religion was discussed as both a protective and a contributing factor. Several teens included the term “culture” when they discussed religion, and associated religion as part of the Puerto Rican culture. Religious beliefs that are anti-abortion and against the use of birth control were viewed as contributing to the problem of teen births in Holyoke by some teens. Two boys presented a counter view, that religious beliefs promote abstinence and thus may be a protective factor.

Access to and proper use of condoms was discussed in all focus group meetings. The use of at least one, if not multiple forms of contraceptives, was also discussed in all of the girls focus groups. Both boys and girls described situations in which they either did not have access to condoms or used condoms improperly. It was stressed by the

⁸ This course provides student with an understanding of current health issues as they relate to teens. The object of the course is to develop strong decision making skills based on accurate current information relative to teen issues. Topics include wellness/safety, stress/mental health, violence, substance abuse, nutrition, and human sexuality. (Holyoke High School Course selection Guide 2010-2011)

participants that teens need easy access to condoms and other forms of contraceptives, and that they need accurate knowledge about contraception methods and correct use of these. In a study using national data, Abama, Martinez, Mosher and Dawson (2004) found that Latino teens were less likely to use contraceptives at first sex than non-Latino White and Black teens, and Latina teens had the lowest proportion who ever used oral contraceptives. Kirby (2007) noted that laws or policies that restrict the use of contraceptives by teens are a risk factor that discourages behaviors that prevent pregnancy. Thus providing teens with knowledge about sex and reproduction, and access to contraceptives is a needed prevention strategy in Holyoke. A tenth grade boy's statement supports this:

When I did start doing it, one of my friends was explaining to me 'cause my parents didn't even like to talk about it at all. You know, I just kind'a like self taught myself.

Excerpts from twelfth grade girl's discussion illustrates how having sex and reproductive health knowledge and establishing goals serve as possible deterrents to teens engaging in sexual activities, and thus pregnancy and birth.

I learned at Girls Inc, they teach us so much there. Not just about sex and birth control but about getting into college and how to apply... I got into [name of college]. I'll be the first in my family to go to college... I'm a virgin but I carry around condoms and give them to my friends because of what I learned at Girls Inc.

Social Factors that Contribute to or Prevent Teen Pregnancy and Births

According to participants the social and physical environments in Holyoke influenced teen behaviors including participation in sexual activities. They discussed both positive and negative effects that people, activities, and environments had on teen behaviors and described factors that could either increase or decrease teens' chances of

becoming pregnant and having a baby. Additional factors perceived as contributing to the likelihood of teen pregnancy and birth included: being alone, especially with a member of the opposite sex; having “nothing to do” or “hanging out” downtown or in parks; lacking personal goals and plans for the future; attending un-chaperoned parties where alcohol and drugs may be present; having parents who do not “care” or do not provide “support” or “supervision;” being exposed to media messages that encourage sexual behaviors or teen parenthood; having teachers who “do not understand” or “put teens down” which can lead to poor performance in school and subsequent “dropping out;” having friends who are teen parents; experiencing peer pressure; lacking positive role models or mentors; and living in two neighborhoods that manifest signs of poverty and delinquency. These factors are congruent with the literature in which risk factors are defined as environments that expose teens to some form of disadvantage, disorganization or discomfort (Kirby, 2007), and included experiencing general maltreatment or abuse, using alcohol or other harmful substances, participating in delinquent behaviors; living in communities with higher rates of unemployment, stress, violence, delinquency and vandalism; and having friends or older siblings who are teen parents (Kirby 2002, 2007; Moore, 2008; Talashek, Alba & Patel, 2005; Sciarra & Ponterotto, 1998). Factors identified by participants as protecting teens against or decreasing the chance of pregnancy and births included having comprehensive knowledge about sex and reproduction, goals and future plans, parents who are involved and interested, activities such as sports and community programs to participate in, and mentors to serve as role models. In addition, receiving recognition especially at school and support from others were identified as protective. These protective factors are consistent with those identified

in the literature in which protective factors are based on attachment to people or groups who expressed protective values and modeled positive behaviors and include: having strong teen/family connectedness, having appropriate parental supervision and monitoring, having better reproductive health knowledge and access to birth control, having a positive attitude toward school with higher school performance, having long-term educational plans, being an active member of a church/religious group, participating in sports and other activities, and having a positive self concept (Kirby 2002, 2007; Moore, 2008; Sciarra & Ponterotto, 1998; Talashek, Alba & Patel, 2005).

Participation in community-based programs, after-school activities, and sports was discussed as a way to prevent teen pregnancy during all focus group meetings, whereas lack of things to do was associated with being bored, which in turn leads teens to engaging in sexual behaviors, and contributing to teen pregnancy and birth. Two overall recommendations made by the teens were: do not to be alone with a member of the opposite sex in environments without other people, and participate in activities. During the discussions, community-based programs (Girls Inc, the Holyoke Boys and Girls Club, the Holyoke YMCA, and the Holyoke Youth Commission), after-school clubs and sports at the high school, and volunteering were listed as the primary forms of organized activities for teens in Holyoke. The participants provided a list of possible barriers to program participation that included: programs are not appealing or were viewed negatively by teens; programs such as music, dance, martial-arts, and gymnastics are expensive; registration/participation fees are not affordable for parents who are classified as “earning too much money;” teens do not bring program information home to parents,

and both athletics and clubs at the high school have “requirements” (e.g. skill level, academic grades) that some Puerto Rican teens may not meet.

Ineffective parenting was proffered as a contributing factor in all but the ninth grade girls’ focus group meetings. Statements used to describe ineffective parenting included having parents who “don’t care,” who leave teens alone at home for several days, who hit and scream at teens, and who do not provide supervision. The teens felt that these types of parent behaviors lead teens to experiment with non-normative behaviors (hanging out on the streets at night, using alcohol and drugs, engaging in sexual activities, participating in gangs, dropping out of school).

The topic of the media’s role in teen pregnancy and births was discussed in the eleventh grade boys’ group and both the eleventh and twelfth grade girls’ groups. These teens associated the media with the glamorization of teen births and parenthood which convey the wrong messages to teens, the positive coverage of teen celebrities as parents positively, the explicit use of sex in lyrics and other forms of media, and the unmonitored access to the media by children and teens as contributing factors. Bleakley, Hennessey, Fishbein, Coles and Jordan (2009) noted that 83% of television programs watched by teens include sexual content and are sources of sexual information that can affect teens’ beliefs about sex. This research supported an eleventh grade boy’s suggested prevention strategy -- marketing safe sex through various forms of media.

Two of Holyoke’s neighborhoods, the Flats and South Holyoke, were described by teens as neighborhoods with gangs, drugs, prostitutes, violence, and vandalism. Participants noted that numerous teen mothers are visible throughout the neighborhoods, and that non-normative behaviors are frequently observed. Objective indicators support

the teens' perceptions that these neighborhoods suffer from disadvantage. The indicators are: high poverty rates (51% of families in the Flats and 63% of the families in South Holyoke are living below 100% of the poverty level); a majority of single female-headed families (85.7% of the families in the Flats and 85.1% of the families living in South Holyoke); and adults, those over 25 years, with lowest education attainment (38% of adults in the Flats and 51% of adults in South Holyoke do not have a high school diploma or equivalent) (Massachusetts Fair Housing Center, 2006). The teens concluded that either living or socializing in these neighborhoods puts teens at great risk for teen pregnancy and birth. Kirby (2007) substantiates this view, identifying living in communities in which there is violence, substance abuse, and poverty as presenting a greater chance for teen behaviors resulting in pregnancy or sexually transmitted infections.

The school environment was viewed as both a protective factor and a risk factor depending upon the situation. Four girls provided examples of receiving positive recognition from teachers at school. A tenth grade girl's poignant description of an experience she had two years earlier in which she received an honor illustrates this.

I remember in the eighth grade I was told I was a rising star and for me that was, "Oh my God." When they gave me that paper that said I was chosen as a rising star and I got it home, my parents they started crying. They called my aunt and my uncle in Puerto Rico. They called everybody. And when I went to the ceremony where they awarded us, I was the only Puerto Rican that was a rising star.

This description illustrates the far reaching affect that recognition by the school can have on both students and families. This girl's closing statement that she was the only Puerto Rican to receive this honor suggests that Puerto Rican teens may not frequently receive positive recognition in the school environment. Descriptions by a tenth grade boy of an

incident in which his friend was “put down” by a teacher in front of classmates, and an eleventh grade boy’s interactions with teachers which led him to believe that “Latinos are less intelligent” than whites were included in the data description section. The boys’ negative interactions could be harmful to a teen’s self image and possibly influence a teen’s decision to drop out of high school, while the girls’ positive interactions with teachers can promote a teen’s positive self-image.

Findings in Relation to the Ecological Model of Health Behavior

The study’s findings suggest that teen pregnancy and birth is a complex problem in Holyoke, teen pregnancy is generally seen as unintended, and teen births are described in negative terms by Puerto Rican teens. The Ecological Model of Health Behavior (EMHB), as discussed in Chapter 1, provided a framework for the researcher to explore the participants’ perceptions of individual, interpersonal, community and societal influences on teen pregnancy and births in Holyoke. The model consists of four system levels with each level nesting in a hierarchy and each level operating fully within the next larger level. In this section each of the EMHB four system levels is used to frame the findings, to gain a greater understanding of the teens’ views, and to support recommendations.

Level 1 – Individual

This level focuses on teen characteristics including age, gender, race/ethnicity, education, knowledge, beliefs, and behavior. Participants were male and female teens of Puerto Rican descent who lived in Holyoke and attended Holyoke High School. Important findings at this level relate to knowledge, beliefs, and behavior and include: 1) Comprehensive, science-based reproductive health knowledge is a protective factor, and

lack of this knowledge is a contributing or risk factor. There is a need for accurate science-based comprehensive reproductive knowledge. Knowledge is inversely connected to outcomes: teens who have greater knowledge are at a decreased risk for pregnancy, and teens who have incomplete and inaccurate knowledge are at an increased risk for pregnancy. 2) For teens who believe that child bearing and parenting are easy and glamorous, the likelihood of teen pregnancy and birth increases. 3) Teens who have set goals and developed plans to meet these goals, especially if they are long-term goals related to education and careers, are less likely to become pregnant or have a baby. 4) Teens who use alcohol and other substances are at a higher risk to for initiating sexual behaviors without considering the consequences or using contraction.

Level 2 – Interpersonal

The focus of this level is on relationships teens have with family, friends, peer groups, teachers, mentors and others in their social networks, with those in the closest social circle having the greatest influence. The impact of these relationships may both increase or decrease teens sex-related behaviors, and thus their desires to become pregnant and have a child. Important findings at this level relate to relationships with parents, boyfriends and teachers, and include: 1) Ineffective parenting may contribute to teen pregnancy and births. Teens who are not connected to or supervised by parents/guardians, unable to communicate with parents/guardians, or are treated inappropriately (maltreatment and abuse) are at greater risk for becoming pregnant and having a child. 2) Parents who are unable or unwilling to discuss sex, reproduction, and birth control with their children increase their children's risk of teen pregnancy and birth. 3) Teens, especially girls, who experience a dysfunctional home life and/or mistreatment

are at greater risk because they associate having a baby with a way of escape. 4) A girl's wish "to keep a boyfriend" may increase teen pregnancy intentionality according to both girls and boys in all focus group meetings. 5) Teachers who provide support, encouragement and recognition for students' accomplishments increase teens' positive self concept and encourage them to set future educational goals. Teachers who provide this support serve as a protective factor, and conversely, teachers who do not function in this manner may negatively influence teens' self concepts and contribute to their risk of teen pregnancy and birth. 6) Mentors who offer teens encouragement, support, guidance, suggestions, kindness and positive role modeling can assist at-risk teens to stay focused and motivated in school and other activities. The sense of structure, encouragement and assistance that mentors provide adds to the layer of protective factors for teens.

Level 3 – Community

The focus of this level is on community settings, such as schools, workplaces and neighborhoods, where social relationships occur with an exploration of the interaction of the setting and identification of their protective or contributing factors. Findings at this level relate to community organizations, schools, and neighborhoods, and include: 1) The identification of five community-based, after-school programs that provide activities and services for teens and function as a protective factor due to the safe environment they provide for teens to gather, activities for teens to participate in, and in one case, comprehensive reproductive health education to increase teens knowledge. These programs include Girls Inc, the Girls and Boys Club, Upward Bound, the YMCA and the Holyoke Youth Commission. Interestingly, replication of the youth development

programs and comprehensive reproductive health education at Girls Inc was suggested by both male and female participants as a way to increase teens' knowledge to make informed decisions. It was noted that program fees, locations of the programs, and lack of transportation to or from programs may be participation barriers for some teens. 2) The high school's limited reproductive health curriculum and the difficulty for teens to access condoms at school contribute to the risk of teen pregnancy. Of interest is the fact that general school nurses and community-based health care providers were not identified by participants as a source of either reproductive health information or access to contraception. However, nurses located in the school's Teen Clinic were identified as providing these services. In addition, physicians, nurse practitioners, physician assistants or other health care providers were not identified as a source of reproductive health information by participants. 3) Crime, delinquency, graffiti, and other signs of dysfunction in the Flats and South Holyoke neighborhoods were associated with a higher risk for teen pregnancies and births for teens who live and/or socialize in these neighborhoods.

Level 4 – Societal

This level focuses on laws and policies at the local, state, and national level and also includes the media. Policies established by the Holyoke School Committee affect teen pregnancy and birth. The policy that sets parameters for reproductive health education and access to contraception can either increase or decrease risk factors. Limiting reproductive health education to a portion of a health course that is only required to be taken for a half semester in ninth grade restricts teens' access to accurate knowledge about sex, reproduction and contraception. A clear school policy about

distribution of and access to condoms and other forms of birth control is necessary. The media is often overlooked as tool, that if correctly used, can provide information and education to community members and positively influence teens' sexual related behaviors.

Recommendations for Interventions

Using the study's findings, recommendations for interventions are made. This, the last phase of data analysis, incorporates the participants multiple perspectives of teen pregnancy and birth in the development of recommendations for future courses of action, and uses the study's framework, the Ecological Model of Health behavior (EMHB), to categorize these recommendations. A diagram of the EMHB Model with factors that influence teen pregnancy and births in Holyoke identified through focus group data is presented in Figure 5.1. This model provides a visualization of the complexity of teen pregnancy and births, and supports the need for a comprehensive approach to the problem recognizing that single level interventions are not likely to have powerful or sustained effects. A combination of interventions at the individual, interpersonal, community and societal levels are needed for risk reduction and effective behavior change. Using this model, recommendations for developing multilevel interventions will be presented.

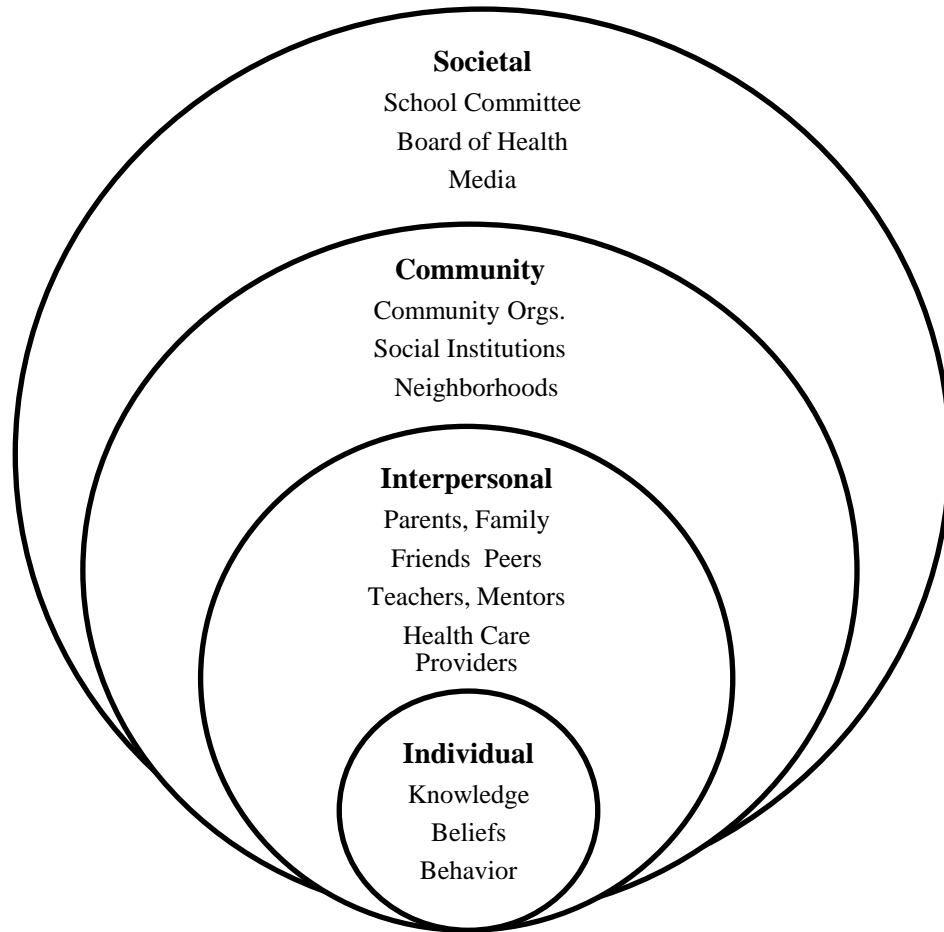


Figure 5.1: A Model of the Interrelated Social and Physical Environmental Factors that Influence Teen Pregnancy and Birth in Holyoke

Level 1 - Individual

Interventions at this level are education centered and focus on the individual. Teens who receive comprehensive science-based reproductive health education are at less risk for becoming pregnant (Advocates for Youth, 2001; Kirby 2002, 2007; Lindberg, Santelli & Singh, 2006; US Dept of Health & Human Services, 2010). Suggestions for ways to improve school-based reproductive health education are developed from the study's data and include: 1) Initiating school-based reproductive health education before a pre-teen becomes sexually active, with the fifth grade as an appropriate level to begin this

education. 2) Not limiting reproductive health education to the ninth grade but incorporating it throughout all high school grade levels. (The teens suggested adding reproductive health to existing required science courses, and/or incorporating it into required gym classes.) 3) Providing reproductive health education during the school day and not as an add-on after school program because “not a lot of kids would go.” 4) Having sex education teachers who are knowledgeable and comfortable with the subject matter, are able to relate to students, and foster a classroom milieu where students are at ease speaking and asking questions. 5) Having separate classes for boys and girls, especially for students in earlier grades, with teachers of the same gender to enhance teaching-learning. 7) Inviting selected teen parents as guest speakers who can share experiences with teens, describe the responsibilities of being a parent, and the effect that having a child has had on their lives. 8) Including learning activities such as correctly applying condoms on wooden penises and displaying other contraceptive methods to increase both boys and girls knowledge about and comfort with the use of contraceptives. 9) Expanding educational opportunities for teens who may be at a higher risk for teen parenthood by the use of experiential teaching strategies such as baby simulators (e.g. Baby-Think-It-Over). 10) Developing peer education programs for peers to provide accurate information about sexuality and reproduction to teens. 11) Encouraging health care providers (physicians, nurse practitioners, physician assistants, nurses) to include sexuality and reproductive health information in their routine encounters with teens.

Level 2 - Interpersonal

The influence that people in teens’ social networks have on teens’ knowledge, beliefs, and behaviors is examined at the interpersonal level. Members of the social

network in teens' lives to consider are parents, family members, friends, peers, teachers, and mentors. They can influence teens' sexual behaviors either positively or negatively, and enhance or inhibit the emotional and psychological growth and development of teens. At this level, interventions that include both education and support are valuable.

Classes for the parents of teens and the use of peer educators may increase the quality of and expand reproductive health education opportunities for teens. Parent education programs can provide parents with resources to gain skills to talk with their children about sex and related subjects. These educational programs may help parents increase their knowledge about reproduction, sex, and contraception so that accurate information is conveyed. An additional aspect of education is to offer parents of teens parenting workshops to increase their knowledge about the developmental needs of their teens, how to meet these needs, and how to increase their parenting skills.

Mentors can serve as role models for teens who are at risk for teen pregnancy and other non-normative behaviors. Mentors do not take the place of parents. They provide teens with a nurturing relationship and offer companionship and guidance. Mentors may be helpful for teens who lack parental connection or live in dysfunctional homes. The recommendation for using mentors can be expanded to providing mentors and/or support groups/services for parents who are facing stress, difficulties, instability or other crisis.

Other people in teens' social networks who need education are school teachers and staff members. Staff development programs on reproductive health, cultural awareness, and support of at-risk students may assist teachers and staff members who are in frequent contact with students to increase their knowledge and skills to meet the ever changing and challenging needs of teens in today's world.

Level 3 - Community

Community organizations, social institutions, neighborhoods and the relationships among these and their influences on teens within their social networks are considered for interventions at the community level. Five community-based programs were identified by the participants and included the Boys and Girls Club, Girls Inc, Upward Bound, the YMCA, and the Holyoke Youth Commission. Girls Inc was the program most often discussed by both girls and boys who described this program as an ideal model for activities, youth development and reproductive health education. All of the programs provide teens with a safe environment and activities. To increase teen participation in these programs there is a need to market them in a manner that makes them appealing to both parents and teens, develop a fee schedule that is affordable for teens and families in Holyoke, provide transportation, and secure public funding to increase the capacity of these existing programs to serve more teens.

Participants repeatedly discussed the need for more activities that are available after school, during evening hours (6-9pm) and on weekends because these are the time periods that teens are most likely to “have nothing to do,” become bored, and engage in sexual activities and other non-normative behaviors. They suggested that the city have both a movie theater and a teen center. The recommendation for a theater was based on the fact that Holyoke does not have a local movie theater and traveling to theaters in nearby communities is difficult for many teens due to lack of transportation. The need for places in which teens could safely gather and participate in activities was discussed in all focus groups. An outcome of these discussions was the idea to create a teen center. The participants described components of an “ideal” teen center. This center would include:

1) A large gym that could be used for sports, martial-arts, lessons, performances, chaperoned dances on Friday or Saturday nights, parties and large gatherings. 2) Smaller spaces for quiet activities such as writing poetry and reading. 3) A space to gather and participate in social activities and to watch television/videos. 4) A multipurpose game room. 5) A kitchen and eating space. 6) A conference room for meetings. In addition to the teen center, smaller drop-in centers were suggested to increase the availability of teen activities and safe places in neighborhoods with ever present risk factors (e.g. the Flats and south Holyoke). These suggestions can be used for further exploration of the range of activities and programs created to enhance teen development and decrease both teen sexual activity and non-normative behavior.

Level 4 - Societal

Health behaviors are affected by social and political processes. Interventions at the societal level relate to the media, and laws, regulations and policies. An examination of school policies and regulations associated with reproductive health education and access to contraception is recommended. To make informed decisions about policies related to reproductive health in schools, school committee members need to be provided with research based information on comprehensive sexuality education and how the policies that they make affect teens, teen pregnancy and birth, and the future of Holyoke. In addition the city needs to address the economic disparity between neighborhoods within the city. This disparity contributes not only to teen pregnancy and birth but other risk factors that inhibit adolescent development and health.

Parents and other community members must be educated, encouraged and supported in lobbying efforts to advocate for a reproductive health curriculum that

provides a balance of information about abstinence and contraception, and skills needed by teens to clarify values, identify goals, develop plans and advocate for themselves.

A city wide condom distribution policy that increases teens' access to condoms and public messages about reproductive health by the Holyoke Board of Health and other city departments may establish a community-wide message. Policy development would assist the school nurses in their roles as health care providers in schools.

Marketing safe sex may increase teens' exposure to information about sex and contraceptives. The goal of this approach is to increase teens' awareness of risks associated with teen sex and to decrease their sexual risk taking behaviors. Marketing safe sex provides a new approach to reach at-risk teens with messages, and may be a worthwhile step for the city to take.

Summary of Recommendations

The EMHB provided a lens to examine the study's findings and identify potential interventions for each level of the model. These recommendations are summarized with the study's findings in table 5.1.

Table 5.1: Recommendations for Interventions Based on the EMHB

Level	Study's Focus	Findings	Recommendations
Individual	Knowledge Beliefs Behavior Race/ethnicity	Reproductive health knowledge ↑knowledge ↓risk Views of parenting glamorous, easy ↑risk Personal goals and future plans lack of ↑risk development of ↓risk Use of alcohol or other substances ↑risk	EDUCATION Comp. sex ed. in school start 5 th or 6 th grade all 4 yrs in high school earlier grades – same gender students with same gender teachers education on responsibilities experiential learning Baby Think It Over teen parents panel peer educators encourage PCPs to take an active role Teen development decision making setting goals planning for future Alcohol and drug prevention education
Interpersonal	Social Networks Parents Family Friends Peers Teachers Mentors	Ineffective parenting ↑risk ↓monitoring & supervision ↓parent/teen connection ↓communication Parent's inability to talk about sex with teen ↑risk Dysfunctional home life ↑risk Keeping a boyfriend ↑risk Supportive teachers ↓risk	Parent Education how to talk about sex how to parent Peer education programs Mentoring programs Marketing of safe sex Faculty and staff development
Community	Community Orgs. Social Institutions Neighborhoods	Program participation ↓risk Girls Inc Boys & Girls Club Upward Bound YMCA Youth Commission. Dysfunctional neighborhoods ↑ risk	↑ access to programs and activities HS participation policies marketing affordability transportation funding to ↑ capacity develop a teen center
Societal	Laws and Policies Local State National The Media	School Committee Policies reproductive health education access to condoms restrictive policies ↑ risk Board of Health regulations and policies Poverty and crime rates	Education Lobbying Advocacy Policies and regulations

Implications

The aim of this study was to generate knowledge that can be used as a foundation to inform nursing practice, programs that serve Puerto Rican teens, policy development, and future research. Based on the perceptions of Puerto Rican teens who participated in this study and the study's findings, each of these areas will be discussed.

Implications for Nursing Practice

Given the prevalence of teen pregnancy and birth in both Holyoke and communities with similar populations, nurses and other health care providers may benefit from a greater understanding of what Puerto Rican teens view as contributing and protective factors. Based on their health assessments, nurses in a variety of settings (school health, clinics, pediatric/adolescent health offices) have opportunities to provide teens with accurate sexual and reproductive health knowledge and access to condoms and other forms of birth control. The role of the nurse as educator should not be overlooked or undervalued. Thus, it is important for nurses to use this professional skill and provide sexual and reproductive health information in a manner that will foster protective behaviors among the Puerto Rican teen population. It is essential for nurses to become aware of their own cultural biases in working with individuals of other cultures. Cultural misunderstandings may lead to negative outcomes of care. While cultural competence⁹ may assist nurses and other health care providers to improve their knowledge, attitudes, and skills, and thus improve outcomes of their interactions with Puerto Rican teens and their families (Cooper & Roter, 2003).

⁹ Cultural competence is the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences (Cooper & Roter, 2003).

Implications for Programs

Findings from this study underscore the important role that after-school activities and community-based programs have in teen pregnancy prevention. They provide teens a safe environment, meaningful activities, opportunities to increase knowledge and skills, and positive interpersonal relationships. The study's findings may be used to guide the expansion, development and evaluation of programs that are tailored to the needs and the social contexts of Puerto Rican teens and youth. It is important to use a youth development framework in program development to address the multiple risk factors teens in Holyoke face. There is need to continue and strengthen the collaboration and cooperation among schools, agencies, programs, churches, and others in planning and implementing multifaceted activities and programs for the youth of Holyoke. Efforts need to capitalize on the community's assets with important lessons to be learned from successful programs; these programs may be used as models for other programs that reach out to teens. In addition, findings from this study support the idea that programs which focus exclusively on individuals without acknowledging their interpersonal relationships, social networks, the community in which they live, as well as policies, will not meet the needs of Puerto Rican teens and their families. It is important to include teens and families who are served by prevention and intervention programs in program development and evaluation. They can assist in identifying appropriate prevention and protection strategies, assessing the appropriateness of these strategies, and evaluating the effectiveness of both the strategies and the programs/activities.

Implications for Policy

Political processes and established policies affect both health care and health behaviors. This was emphasized by the Ecological Model of Health Behavior used in this research. Politicians and policy makers (e.g. School Committee and Board of Health members) must consider the effect that regulations and policies have on health.

Changing policies that address sexual and reproductive health of Puerto Rican teens will require continued shifts in political agendas. The Holyoke School Committee members voted to include eleven lessons on sexuality and reproduction to the ninth grade health class beginning with the 2010-2011 academic year (Holyoke Public Schools, 2010).

According to Helen Gibson, Science/technology Director for the Holyoke Public School System, the school committee will be considering adding sexuality and reproductive health content to the middle school science course (personal communication, April 14, 2011). This movement toward providing comprehensive sexual reproduction education and access to contraception including condoms must continue.

It is important for researchers and policy makers to understand the potential contributions of research to evidence-based policy. Research-based data is necessary for politicians and policy makers to make informed decisions and recommendations. The World Health Organization (2001) stressed that policy makers should have scientifically solid and up-to-date information, especially in the area of reproductive health, as a prerequisite for evidence-based policy formation.

There is a need for the city of Holyoke to have a uniform message that the city is going to be a community that addresses all areas of health including sexual health and urges the prevention of teen pregnancy and birth. Care must be taken in the delivery of

these messages. They must be delivered in ways that do not alienate members of the Puerto Rican community because teen childbearing is common among low-income Puerto Rican families and occurs within multi-generational cycles. Most teens in Holyoke will have personal experiences with teen pregnancy and births within their family or social network.

Implications for Research

While there is a plethora of research on teen pregnancy and births, studies with samples of Puerto Rican teens are limited. It is essential that scholarly research creates a context in which the voices of Puerto Rican teens and voices of other disenfranchised groups can be heard. This is necessary to increase the knowledge about and understanding of teen pregnancy and births, and develop evidenced-based, comprehensive plans with a goal of decreasing this public health problem in the US.

This study indicates a need for continued exploration, and provides a foundation for a program of research which can add to the findings of this study. First, studies can be done with other groups and stakeholders including pregnant and parenting teens, teens who attend the city's vocational high school, teens who have dropped out of school, parents, community members, teachers and health care providers with the aim of: 1) determining the perceptions of others concerning teen pregnancy and births, 2) identifying others' perceptions about the sources of sexual and reproductive health knowledge for teens, 3) identifying the scope of protective and contributing factors to teen pregnancy and birth, and 4) determining the range of prevention strategies necessary to decrease the teen birth rate in Holyoke. Second, research can be done with larger samples to examine developmental ages in teens' perceptions of teen pregnancy and

birth, and if developmental ages impact contributing factors, protective factors, or prevention strategies. Third, research can be extended with samples that include other racial and ethnic groups, and other Latino sub-populations (e.g. from other countries in the Caribbean, Central America, and South America), with a comparison of similarities and differences across the findings. Fourth, additional studies can be designed using quantitative methods. Lastly, research can be used to evaluate the effectiveness of teen pregnancy prevention interventions and policies.

Strengths and Limitations

This study provided Puerto Rican teens in Holyoke an opportunity to voice their perceptions about teen pregnancy and births. Puerto Rican teens' voices are often overlooked or excluded, and limited in the literature. Puerto Rican teens are rarely given an opportunity to express their thoughts and ideas about teen pregnancy and births, a public health problem that continues to plague their city. This study presents Puerto Rican teens' viewpoint as a counterpoint to the view framed by residents of European and Canadian heritage who live in the city.

This study has several limitations. One limitation related to group size and homogeneity of the sample. The final sample size was slightly less than initially proposed. Each focus group was to have had four to six participants. However, the tenth and eleventh grade boys groups had respectively one and two less participants than desired. It was thought that using more rather than less participants could provide a greater variety and more in-depth discussions about teen pregnancy and birth. Given the consistency of topic categories presented in the prior four focus group discussion, the researcher decided to hold these groups with fewer participants.

The transferability of findings beyond the study sample is limited because this study used purposeful sampling and was guided by a qualitative research design. Thus, the findings are not representative of all Puerto Rican teens in Holyoke. In addition, the representativeness of the sample is limited by the fact that the participants were recruited from the city's high school and excluded pregnant or parenting teens. Students who attended other schools or had dropped out of school were not included. However, the intent of this study is not to represent the perceptions of all Puerto Rican teens in Holyoke. Rather, the intent is to present a description of perceptions held by this sample of Puerto Rican teens about teen pregnancy and births in Holyoke. Their perceptions are not intended to be considered a universal view. Instead the transferability lies in the ability to emphasize the importance of the social and physical environments in Holyoke that assist in the formation of these perceptions.

Conclusion

This research provided a description of teen pregnancy and births in Holyoke from the perception of Puerto Rican teens. For over two decades, numerous strategies have been implemented in an attempt to lower the city's teen birth rates. The rates have decreased only to rise again, and they remain the highest in a state with one of the lowest teen birth rates in the nation. The social context in which teen pregnancies and births are occurring in disproportionately high rates among Latino teens is complex. These births are a public health problem that affects the entire city of Holyoke. Collaboration and cooperation among multisectoral groups are necessary to develop and implement preventions interventions. Interventions that include education and support will be useful at the individual and interpersonal levels with interventions that address development of

partnerships, capacity building, and lobbying efforts useful at the community and societal levels. To be successful interventions must be developmentally appropriate, culturally sensitive, and developed with teens and community members as equal partners.

In summary, this study was able to present the voices of Puerto Rican teens in the city of Holyoke concerning teen pregnancy and birth. These teens were eager to have an opportunity to discuss their perceptions, opinions and ideas. Puerto Rican teens in Holyoke are often perceived as part of the city's teen birth problem. But they are also part of the solution. They are wise, critical thinkers who have much to offer. We must invite them to add their voices and ideas to the discussion, and we must listen, for their voices are important.

APPENDIX A

FOCUS GROUP INTERVIEW GUIDE

Good afternoon. Thank you for taking the time to join our discussion about teen births in Holyoke. My name is Nancy Gilbert. I am a nurse, a graduate student at the University of Massachusetts, and a member of the Youth Empowerment Adolescent Health Network (YEAH! Network) in Holyoke. I will be your moderator for the discussion. Assisting me today is Rosy Feldman who is the co-moderator and also a nurse; she grew up in Holyoke, and graduated from Holyoke High School.

Before we begin, let me review our roles and share some guidelines for the discussion:

- My role as moderator will be to guide the discussion. I may write down some notes to direct future questions for the group
- Sarah, as co-moderator, may also ask questions and write down notes to follow-up on what is said.
- Cristin will be taking notes during our discussion so we don't miss any of your important comments.
- Remember to only use first names.
- Please turn off your cell phones, pagers, and other electronic devices so that they don't disturb the discussion
- Only one person may speak at one time, so we can hear everything that is said.
- Also, please speak up so that we can all hear your comments
- You don't need to agree with each other but you must listen respectfully as others share their views
- All information said during this discussion is to be kept confidential, that means not sharing it with others once we leave this room. This includes members of this group, all friends and acquaintances, and family members.

Does anyone have any questions before we begin?

At this time, please place your name cards in front of you. This will help us remember each other's names.

Get acquainted activity (5 minutes):

Let's find out more about each other by going around the table and introducing ourselves, and tell us one thing you like to do for fun.

Opening Transition Question: (5-10 minutes)

Tell us about teens having babies here in Holyoke?

Key Questions: (30 min)

Provide each participant with the graph representing teen births in Holyoke, Springfield, Massachusetts and the US

1. Do you think that teens having babies is a problem in Holyoke? Why or why not?
 - a. Is it different for boys and girls?

2. Why do you think so many teens are having babies in Holyoke?
3. Do you think that teens are intentionally having babies? Why or why not?
4. Describe for us how you see the future for teen parents.

Now we are going to change our focus a little

5. What is happening where you live that causes teens to get pregnant and have babies?
6. What is happening that lessens the chances of teens getting pregnant and having a baby?
7. What can be done where you live to reduce the number of so many teens having babies?
8. Where do teens learn about sex, contraception, pregnancy, and having babies?

Ending Questions: (15 min)

9. Let's summarize the key points of our discussion. (Co-moderator gives 3-5 minute summary) Does this summary sound complete? Do you have any changes or additions?
10. Of all that we've talked about so far, what is the most important thing to you?
11. Is there anything else you think we should know related to teens having babies?

Thank you very much for your participation today.

Just a quick reminder -- All information said during this discussion is to be kept confidential, that means not sharing it with others once we leave this room. This includes members of this group, all friends and acquaintances, and family members.

APPENDIX B
RECRUITMENT FLYER



Photography by Ralph E. Smith Guardian Chronicle.com

Hola Teens of Holyoke:

I would like to invite you to participate in a study on what you think about teens having babies in Holyoke.

The study will involve approximately 40 teens between the ages 15 - 19 who live in Holyoke. It is an effort to give Puerto Rican teens a voice about teen births in Holyoke. Girls and boys will each take part in separate conversations known as focus groups. The focus groups will last no longer than 2 hours.

If you are a teen of Puerto Rican descent you may be eligible.

I would like to have a conversation with you about your views on teen births, teens becoming parents, and reproductive health education. All focus groups are confidential, and no identifying information will be shared.

I hope that you will be interested in becoming a participant in this effort.

If you are interested please call the number below and leave your first name, and a number by which you can be reached (indicating the best times to call). I will follow-up with a telephone call and will tell you more about the focus group process. To compensate you for your valuable time, a gift certificate for \$15.00 to the Holyoke Mall will be provided at the end of the focus group. Snacks will also be provided on the day of the focus group.

This study has been approved by the University of Massachusetts – Amherst’s Institutional Review Board: Study #:

Nancy Gilbert RN
Graduate Student
University of Massachusetts – Amherst
e-mail: gilbertn@elms.edu

APPENDIX C

STUDENT INFORMATION FORM

Study: Puerto Rican Views of Teen Births in Holyoke
Interested Students' Information Sheet

What grade are you in? 9th 10th 11th 12th

How old are you? _____

Do you live in Holyoke? Yes No

Are you Puerto Rican? Yes No

Girls: *Are you currently pregnant? Yes No Have you ever had a baby? Yes No*

Boys: *Are you currently expecting a baby? Yes No Do you have a child? Yes No*

The focus group meeting will be held after school at 3pm in the Teen Clinic. **Snacks and drinks will be provided.** To compensate you for your time, **a stipend of \$15.00 will be given to you** at the end of the focus group meeting.

If you are interested in participating, I will need to get some information:

Name: _____

Home phone number: _____

Cell phone number: _____

E-mail address: _____

What is the best way to contact you about the date, time, and place of the focus group meeting?

Text Message Home Phone Cell Phone E-Mail Other _____

I will contact you with information about the date and time of the focus group meeting.

APPENDIX D

PARENT/GUARDIAN CONSENT FORM - ENGLISH

Consent Form for Your Teen to Participate in a Research Study

University of Massachusetts Amherst

Principal Investigator: Mary Christine King RN, EdD, Faculty School of Nursing
Student Researcher: Nancy Gilbert RN, MS, Doctoral Student School of Nursing
Study Title: Puerto Rican Teens' Perceptions of Teen Pregnancy and Births
in Holyoke, MA

My name is Nancy Gilbert and I am a nurse and doctoral student at the University of Massachusetts, School of Nursing. As part of my doctoral work, I am doing research with teens by asking them their views of teen births in Holyoke. Your teenage daughter/son is being invited to voluntarily participate in a study that will help me understand what teens think about teens having babies. You are being asked to read the following material to make sure that you are informed of the nature of this research study and how your teenager will participate in it. If you give your permission, signing this form will indicate that you have been informed and give your consent for your teenager to participate. Your teenager will also give her/his assent by reading and signing a similar form, called a Teen Assent Form, prior to the study.

Please sign both copies of this form. One copy is for you to keep and one copy is to be returned to me in the enclosed, addressed-stamped envelope. Thank you.

WHAT IS THIS FORM?

This form is called a Consent Form. It will give you information about the study so you can make an informed decision about your son/daughter's participation in this research.

You are being asked to read the following material to make sure that you are informed of the nature of this study and how your teenager will participate in it. If you give your permission, signing this form will indicate that you have been informed and give your consent for your teenager to participate. Your teenager will also give his/her assent by signing an assent form. (A copy of the ASSENT FORM is enclosed.)

WHO IS ELIGIBLE TO PARTICIPATE?

Teens between 15 and 19 years of age who are of Puerto Rican heritage, live in Holyoke understand and speak English, and are not pregnant or a parent. A parent or guardian must give her/his consent for a teen under the age of 18 years to participate in this study.

WHAT IS THE PURPOSE OF THIS STUDY?

I am conducting this research study to understand what Puerto Rican teens think about teens having babies in Holyoke. I hope to gain knowledge about the attitudes, beliefs, and perceptions of teen pregnancy and births among Puerto Rican teens living in Holyoke.

WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?

The study will take place at the high school, after school, and will involve one meeting of approximately 90 minutes.

WHAT WILL Your Teen WILL BE ASKED TO DO?

The study involves your teenager participating in a focus group, which is a group discussion with 4 to 7 other teenagers of the same gender. The focus group will take approximately one and one-half to two hours. It will meet only once.

Prior to the focus group your son/daughter will be asked to fill out a demographic form that asks about her/his age, gender, race/ethnicity, grade in school, place of birth, place of parents and grandparents birth. During this time snacks will be served.

The focus group will be conducted by myself as the moderator, and Dr. Sarah Perez-McAdoo as the co-moderator -- she is a Latina, physician and director of the Youth Empowerment and Adolescent Health (YEAH) Network. Cristin O'Grady will be assisting us and taking notes. The focus group interview will be audio-taped so that I will be able to study and review what the teenagers have talked about.

The topics that will be discussed relate to: what teens think about other teens having babies in Holyoke, and where teens get information about sex, contraception, pregnancy, and having babies.

Participants will receive a \$15.00 gift card to the Holyoke Mall at the end of the focus group to compensate them for their time.

What are the benefits of being in this study?

Any specific benefit gained by your teenager's participation in this study is unknown, although talking about her/his views related to teen pregnancy and birth may benefit your teenager in ways we do not realize. The benefits from this research study will be giving voice to Puerto Rican teens related to their views about teen pregnancy and birth. Other Puerto Rican teens may be helped by the information gathered in this study.

7. WHAT ARE THE RISKS OF THIS STUDY?

We believe there are no known risks associated with participation in this research study. It is possible that your teenager may have negative feelings after telling members of the focus group about any personal experiences.

how will YoUR TEEN'S personal information be protected?

Information from the focus group will be kept confidential by the researchers. Also, all members of the focus group will be asked not to repeat anyone's comments outside of the room. During the focus group questions will not be directed to individuals, but instead

will be posed to the group. Your teenager may choose to respond or not respond at any point during the discussion.

If a teenager discloses any information about either child abuse or neglect, the research must report this according to state laws.

The following procedures will be used to protect the confidentiality of the study's data and your teenager's identity:

- The audio-recordings of the focus group will be transcribed by a transcriptionist who has completed a course in the Responsible Conduct of Research.
- The researcher will give each participant a pseudonym (a made-up name different from her/his real name) in the transcripts used for data analysis.
- The researcher will be the only person who has access to the stored audio-recordings and original transcriptions.
- All audio-recordings and original transcripts will be destroyed upon completion of the of the researcher's doctoral dissertation.
- Information derived from the study will not identify your teenager by name.
- Data that will be shared with others will be coded with a pseudonym to help protect your teenager's identity.
- At the conclusion of this study, the researcher may publish the findings. Information will be presented in summary format and your teenager will not be identified in any publications or presentations.

WILL You or your teen RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?

To compensate participants for their time, each participant will receive a \$15.00 gift certificate to the Holyoke Mall at the end of the focus group.

WHAT IF I HAVE QUESTIONS?

Take as long as you like before you make a decision about permitting your teen to participate in this study. I will be happy to answer any question you have about this study. If you have any questions about this project or if you have a research-related problem, you may contact me, Nancy Gilbert, the student researcher at (413) 549-6976, or the principal investigator, Dr M. Christine King at 413 545-5095.

If you only speak Spanish and have questions about the study, please contact Sarah Perez-McAdoo at 413 xxx-xxxx.

If you have any questions concerning your teenager's rights as a research subject, you may contact the University of Massachusetts Amherst Institutional Review Board (IRB) at (413) 545-3428 or humansubjects@ora.umass.edu.

WHAT IF I REFUSE TO GIVE OR WITHDRAW MY PERMISSION?

You should recognize that your son/daughter's participation in the focus group is voluntary and that you may refuse to give permission him/her to participate. In addition, he/she may refuse to participate or may withdraw assent and discontinue participation in the study at any time without prejudice.

WHAT IF My Child is INJURED?

The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human subjects research but the study personnel will assist you in getting treatment.

SUBJECT STATEMENT OF VOLUNTARY Permission

By signing below, I the parent/guardian confirm that the research study has been explained to me including its purpose, its procedures, and the possible risks and discomforts as well as benefits that my teenager may experience. I have read and I understand this form, and give my permission for my son/daughter to participate in this study.

Name of teenage participant:

Print Name

Parent/Guardian Signature

Print Name

Date

By signing below I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document:

Signature of Researcher

Print Name

Date

APPENDIX E

PARENT/GUARDIAN CONSENT FORM - SPANISH

Documento de consentimiento para que su hijo/a adolescente
participe en un estudio de investigación
University of Massachusetts Amherst

Investigadora principal: Mary Christine King RN, EdD, Profesora de la Facultad de Enfermería
Investigadora estudiante: Nancy Gilbert RN, MS, Estudiante de Doctorado de la Facultad de Enfermería
Título del estudio: Percepciones de los adolescentes puertorriqueños con respecto a los embarazos y partos de adolescentes en Holyoke, Massachusetts

Mi nombre es Nancy Gilbert y soy enfermera y estudiante de doctorado de la Facultad de Enfermería de la Universidad de Massachusetts. Como parte de mi trabajo de doctorado, estoy haciendo una investigación con adolescentes donde les pido su punto de vista con respecto a los partos de adolescentes en Holyoke. Se invita a su hijo/a adolescente a participar voluntariamente en un estudio que me ayudará a saber lo que piensan los adolescentes con respecto a tener bebés. Le pedimos que lea el siguiente material porque queremos asegurarnos de que esté informado de la naturaleza de este estudio y de cómo su hijo/a adolescente participará en él. Si usted da su permiso, su firma en este documento indicará que está informado y que da su consentimiento para que su hijo/a adolescente participe en este estudio de investigación. Su hijo/a adolescente también dará su asentimiento leyendo y firmando un documento similar, llamado documento de asentimiento del adolescente, antes del estudio.

Por favor, firme ambas copias de este documento. Una copia es para que la guarde usted y otra para que me la entregue a mí. Muchas gracias.

¿PARA QUÉ SIRVE ESTE DOCUMENTO?

Este documento se llama documento de consentimiento. Es un documento que le dará información sobre el estudio para que pueda tomar una decisión informada sobre la participación de su hijo/a en esta investigación.

Le pedimos que lea el siguiente material para asegurarnos de que está informado de la naturaleza de este estudio y de cómo su hijo/a adolescente participará en él. Si usted da su permiso, su firma en este documento indicará que está informado y que da su consentimiento para que su hijo/a adolescente participe en este estudio. Su hijo/a adolescente también dará su asentimiento firmando un documento de asentimiento. (Se adjunta una copia del DOCUMENTO DE ASENTIMIENTO).

¿QUIÉNES PUEDEN PARTICIPAR?

Los/las adolescentes de entre 14 y 19 años que tienen ascendencia puertorriqueña, viven en Holyoke, entienden y hablan inglés, **y no están embarazadas ni son padres o madres**. Para que un/a adolescente menor de 18 años participe en este estudio, el padre, madre o tutor debe dar su consentimiento.

¿CUÁL ES EL PROPÓSITO DE ESTE ESTUDIO?

Estoy realizando este estudio de investigación para saber lo que piensan los adolescentes puertorriqueños acerca de otros adolescentes que tienen bebés en Holyoke. Espero adquirir conocimiento sobre las actitudes, las creencias y las percepciones de los adolescentes puertorriqueños que viven en Holyoke con respecto a los embarazos y partos de otros adolescentes.

¿DÓNDE SE LLEVARÁ A CABO EL ESTUDIO Y CUÁNTO DURARÁ?

El estudio se llevará a cabo en la escuela secundaria, después de clases, y consistirá en una reunión de entre 90 y 120 minutos.

¿QUÉ LE PEDIREMOS QUE HAGA A SU HIJO/A ADOLESCENTE?

El estudio implica que su hijo/a adolescente participe en un grupo focal, es decir, en un grupo de debate integrado por entre 5 y 7 adolescentes del mismo sexo. El grupo focal se reunirá solo una vez.

Antes del grupo focal, le pediremos a su hijo/a que rellene un formulario demográfico que contiene preguntas sobre su edad, sexo, raza o etnia, grado al que va en su escuela, lugar de nacimiento y lugares de nacimiento de sus padres y sus abuelos. Se adjunta una copia de este formulario. Durante este periodo se servirán refrigerios (*snacks*).

Yo seré la moderadora del grupo focal y Rosa Feldman será la co-moderadora. Ella es una mujer latina puertorriqueña que es enfermera matriculada y se graduó en Holyoke High School. La entrevista del grupo focal se grabará para que yo pueda estudiar y repasar lo que los adolescentes hayan comentado.

Los temas que se debatirán serán: qué piensan los adolescentes sobre otros adolescentes que tienen bebés en Holyoke, y dónde obtienen información los adolescentes sobre sexo, anticoncepción, embarazo, y tener bebés.

Al finalizar el grupo focal, los participantes recibirán una tarjeta regalo de \$15.00 para gastar en Holyoke Mall como compensación por dedicarnos su tiempo.

¿CUÁLES SON LOS BENEFICIOS DE PARTICIPAR EN EL ESTUDIO?

No se conoce ningún beneficio específico para los adolescentes por participar en este estudio de investigación, aunque expresar sus puntos de vista en relación con los embarazos y los partos de adolescentes puede beneficiar a los participantes de maneras que desconozcamos.

Los beneficios de este estudio de investigación serán adquirir conocimiento sobre las actitudes, las creencias y las percepciones que tienen los sujetos del estudio con respecto a los embarazos y los partos de adolescentes, y permitirles a los adolescentes

puertorriqueños expresar su opinión con respecto a los embarazos y los partos de adolescentes. El conocimiento generado a raíz de este estudio puede servir como base para futuras investigaciones y puede aportar al desarrollo de políticas, a la práctica de la enfermería y a programas que prestan servicios a adolescentes puertorriqueños. Además, la información que se recopile mediante este estudio puede ayudar a otros adolescentes puertorriqueños.

¿CUÁLES SON LOS RIESGOS DE ESTE ESTUDIO?

Creemos que no se conocen riesgos asociados con la participación en este estudio. Es posible que su hijo/a adolescente pueda tener sentimientos negativos después de contarles experiencias personales a los demás integrantes del grupo focal.

Aunque enfatizamos a todos los participantes que comentarios hechos durante la reunión del grupo focal serán confidenciales, es posible que en el futuro algunos participantes repitan algunos comentarios fuera del aula. Por eso, queremos que ustedes sean tan honestos y abiertos como puedan, a la misma vez siendo concientes de nuestros límites protegiendo su confidencialidad.

¿CÓMO SE PROTEGERÁ LA INFORMACIÓN PERSONAL DE MI HIJO/A?

Las investigadoras mantendrán la confidencialidad de la información derivada del grupo focal. Además, se les pedirá a todos los integrantes del grupo focal que no repitan los comentarios de nadie fuera del aula. Las preguntas no irán dirigidas a nadie en particular durante el grupo focal, sino que se harán para el grupo en general. Su hijo/a adolescente puede elegir responder o no responder en cualquier momento del debate.

Si alguno de los adolescentes revela información sobre abuso o abandono infantil, las leyes nos exigen que denunciemos dicha información ante las autoridades pertinentes.

Se seguirán los siguientes procedimientos para proteger la confidencialidad de los datos del estudio y la identidad de su hijo/a adolescente:

- Un transcriptor se encargará de transcribir las grabaciones del grupo focal. Este transcriptor es una persona que ha realizado un curso sobre Conducta Responsable en Investigaciones.
- La investigadora le dará a cada participante un seudónimo (es decir, un nombre inventado que será distinto al nombre real del participante) en las transcripciones que se utilicen para análisis de datos.
- La investigadora será la única persona que tendrá acceso a las grabaciones y a las transcripciones originales archivadas.
- Todas las grabaciones y las transcripciones originales se destruirán al terminar la tesis doctoral de la investigadora.
- La información derivada del estudio no identificará a su hijo/a con su nombre.
- Los datos que se les faciliten a otras personas tendrán el seudónimo de su hijo/a para contribuir a proteger su identidad.
- Al concluir este estudio, la investigadora puede publicar los resultados. En tal caso, la información se presentará en formato de resumen y no se identificará a su hijo/a en ninguna publicación o presentación.

¿ME PAGARÁN A MÍ O A MI HIJO/A POR PARTICIPAR EN ESTE ESTUDIO?

Les daremos una compensación a los participantes por dedicarnos parte de su tiempo. Al final del grupo focal, cada participante recibirá una tarjeta regalo de \$15.00 para usar en Holyoke Mall.

SI USTED TIENE PREGUNTAS

Tómese todo el tiempo que quiera para decidir si le permitirá o no a su hijo/a participar en el estudio. Le contestaré con agrado todas las preguntas que usted tenga sobre este estudio. Si tiene preguntas sobre este proyecto o si tiene algún problema relacionado con la investigación, puede contactarme a mí, Nancy Gilbert, la estudiante investigadora, llamando al tel.: (413) 549-6976, o a la investigadora principal, la Dra. M. Christine King llamando al 413 545-5095.

Si solo habla español y tiene preguntas sobre el estudio, llame a Rosa Feldman al tel.: 413 461-6712

Si tiene preguntas con respecto a los derechos de su hijo/a adolescente como sujeto de investigación, puede comunicarse con la Junta de Revisión Institucional (*Institutional Review Board*, IRB) de la Universidad de Massachusetts Amherst llamando al (413) 545-3428 ó a humansubjects@ora.umass.edu.

¿QUÉ PASA SI ME NIEGO A DAR MI CONSENTIMIENTO?

Usted debe saber que la participación de su hijo/a en el grupo focal es voluntaria y que usted puede negarse a darle permiso para que participe. Además, su hijo/a puede negarse a participar o puede retirar su asentimiento y dejar de participar en el estudio en cualquier momento sin ningún perjuicio.

¿QUÉ PASA SI MI HIJO/A SE LESIONA?

La Universidad de Massachusetts no cuenta con un programa para compensar a sujetos en caso de lesiones o complicaciones relacionadas con investigaciones con sujetos humanos, pero el personal del estudio le ayudará a su hijo/a a conseguir tratamiento.

DECLARACIÓN DE PERMISO VOLUNTARIO

Al firmar al pie, yo, el padre, madre o tutor, confirmo que he leído y comprendido este documento, y doy mi permiso para que mi hijo/a adolescente participe en este estudio.

Nombre del participante adolescente: _____
Nombre en letra

Firma del padre, madre o tutor Nombre en letra Fecha

Al firmar a continuación, indico que el participante ha leído este documento y que, a mi entender, comprende los detalles que contiene este documento:

Firma de la investigadora Nombre en letra Fecha

APPENDIX F

TEEN ASSENT FORM FOR TEENS UNDER 18 YEARS OF AGE

ASSENT Form for Participation in a Research Study

University of Massachusetts Amherst

Principal Investigator:	Mary Christine King RN, EdD, Faculty School of Nursing
Student Researcher:	Nancy Gilbert RN, MS, Doctoral Student School of Nursing
Study Title:	Puerto Rican Teens' Perceptions of Teen Pregnancy and Births in Holyoke, MA

My name is Nancy Gilbert. I am a nurse and doctoral student at the University of Massachusetts, School of Nursing. As part of my doctoral work, I am doing research with teens by asking them their views of teen births in Holyoke. I am inviting you to voluntarily participate in a study that will help me understand what teens think about teens having babies.

Your parent/guardian is aware of this project and has given consent for you to participate in this research study. You are being asked to read the following material to make sure that you are informed of the nature of this research study and how you will participate in it. Signing this form will indicate that you have been informed and give your assent to participate in this research study

WHAT IS THIS FORM?

This form is called an Assent Form. It will give you information about the study so you can make an informed decision about your participation in this research study.

You are being asked to read the following material to make sure that you are informed of the nature of this research study and how you will participate in it.

WHO IS ELIGIBLE TO PARTICIPATE?

Teens between 15 and 19 years of age who are of Puerto Rican heritage, live in Holyoke understand and speak English, and are not pregnant or a parent.

WHAT IS THE PURPOSE OF THIS STUDY?

I am conducting this research study is to understand what Puerto Rican teens think about teens having babies in Holyoke. I hope to gain knowledge about the attitudes, beliefs, and perceptions of teen pregnancy and births among Puerto Rican teens living in Holyoke.

WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?

The study will take place at the high school, after school and will involve one meeting between one and one-half to two hours.

WHAT WILL YOU BE ASKED TO DO?

The study involves your participation in a focus group, which is a group discussion with 4 to 7 other teenagers of the same gender. It will meet only once.

Prior to the focus group you will be asked to fill out a demographic form that asks you about your age, race/ethnicity, place of birth, parents and grandparents place of birth, grade in school. During this time snacks will be served.

The focus group will be conducted by myself as the moderator, and Dr. Sarah Perez-McAdoo as the co-moderator -- she is a Latina, physician and director of the Youth Empowerment and Adolescent Health (YEAH) Network. Cristin O'grady will be assisting us and taking notes. The focus group interview will be audio-taped so that I will be able to study and review what the teenagers have talked about.

The topics that will be discussed relate to: what you think about teens having babies in Holyoke, and where teens get information about sex, contraception, pregnancy, and having babies.

You will receive a \$15.00 gift card to the Holyoke Mall at the completion of the focus group to compensate you for your time.

WHAT ARE THE BENEFITS OF BEING IN THIS STUDY?

Any specific benefit gained by your participation in this study is unknown, although talking about your views related to teen pregnancy and birth may benefit you in ways we do not realize. The benefits from this research study will be giving voice to Puerto Rican teens and your views about teen pregnancy and birth. Other Puerto Rican teens may be helped by the information gathered in this study.

WHAT ARE THE RISKS OF THIS STUDY?

I believe there are no known risks associated with participation in this research study. It is possible that you may have negative feelings after telling members of the focus group about any personal experiences.

HOW WILL YOUR PERSONAL INFORMATION BE PROTECTED?

Information from the focus group will be kept confidential by the researchers. Also, all members of the focus group will be asked not to repeat anyone's comments outside of the room. During the focus group questions will not be directed to individuals, but instead will be posed to the group. You may choose to respond or not respond at any point during the discussion

If you disclose any information about either child abuse or neglect, this must be reported according to state laws.

The following procedures will be used to protect the confidentiality of the study's data and your identity:

- The audio-recordings of the focus group will be transcribed by a transcriptionist who has completed a course in the Responsible Conduct of Research.
- The researcher will give each participant a pseudonym (a made-up name different from your real name) in the transcripts used for data analysis.

- The researcher will be the only person who has access to the audio-recordings and original transcriptions.
- All audio-recordings and original transcripts will be destroyed upon completion of the of the researcher's doctoral dissertation.
- Information derived from the study will not identify you by name.
- Data that will be shared with others will use a pseudonym to help protect your identity.
- At the conclusion of this study, the researcher may publish the findings. Information will be presented in summary format and your teenager will not be identified in any publications or presentations.

WILL YOU RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?

To compensate you for your time, you will receive a \$15.00 gift certificate to the Holyoke Mall at the end of the focus group.

WHAT IF I HAVE QUESTIONS?

Take as long as you like before you make a decision about participating in this study. I will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact me, Nancy Gilbert, the student researcher at (413) 549-6976, or the principal investigator, Dr M. Christine King at 413 545-5095.

If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Institutional Review Board (IRB) at (413) 545-3428 or humansubjects@ora.umass.edu.

WHAT IF I REFUSE TO GIVE OR WITHDRAW MY CONSENT?

You should recognize that your participation in the focus group is voluntary and that you may refuse to participate and stop participating at any time. There will be no bad feelings if you don't want to do this. You can ask questions if you do not understand any part of this study.

WHAT IF I AM INJURED?

The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human subjects research but the study personnel will assist you in getting treatment.

SUBJECT STATEMENT OF VOLUNTARY PERMISSION

This assent form is similar to the consent form that your parent/guardian signed to give you permission to participate in this study. Please sign both copies of this form. One copy is for you to keep and one copy is for me to keep.

By signing below, I confirm that the research study has been explained to me including the purpose of the study, its procedures, and the possible risks and discomforts as well as benefits that I may experience. I have read and I understand this form, and give my assent to participate in this study along with my parent/guardian's permission.

Signature

Print Name

Date

By signing below I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document:

Signature of Researcher

Print Name

Date

APPENDIX G

PARTICIPANT CONSENT FORM FOR TEENS 18 YEARS AND OLDER

Consent Form for Participation in a Research Study

University of Massachusetts Amherst

Principal Investigator:	Mary Christine King RN, EdD, Faculty School of Nursing
Student Researcher:	Nancy Gilbert RN, MS, Doctoral Student School of Nursing
Study Title:	Puerto Rican Teens' Perceptions of Teen Pregnancy and Births in Holyoke, MA

My name is Nancy Gilbert and I am a nurse and doctoral student at the University of Massachusetts, School of Nursing. As part of my doctoral work, I am doing research with teens by asking them their views of teen births in Holyoke. I am inviting you to voluntarily participate in a study that will help me understand what teens think about teens having babies. You are being asked to read the following material to make sure that you are informed of the nature of this research study and how you will participate in it. If you give your permission, signing this form will indicate that you have been informed and give your consent to participate in this study.

Please sign both copies of this form. One copy is for you to keep and one copy is for me to keep.

WHAT IS THIS FORM?

This form is called a Consent Form. It will give you information about the study so you can make an informed decision about your participation in this research study.

You are being asked to read the following material to make sure that you are informed of the nature of this research study and how you will participate in it. If you give your permission, signing this form will indicate that you have been informed and give your consent for participation.

WHO IS ELIGIBLE TO PARTICIPATE?

Teens between 15 and 19 years of age who are of Puerto Rican heritage, live in Holyoke understand and speak English, and are not pregnant or a parent. If you are 18 years of age or older, you must give your consent to able to participate in this study.

WHAT IS THE PURPOSE OF THIS STUDY?

I am conducting this research study is to understand what Puerto Rican teens think about teens having babies in Holyoke. I hope to gain knowledge about the attitudes, beliefs, and perceptions of teen pregnancy and births among Puerto Rican teens living in Holyoke.

WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?

The study will take place at the high school, after school and will involve one meeting between one and one-half and two hours.

WHAT WILL YOU BE ASKED TO DO?

The study involves your participation in a focus group, which is a group discussion with 4 to 7 other teenagers of the same gender.

Prior to the focus group you will be asked to fill out a demographic form that asks for your age, gender, race/ethnicity, school, grade, place of birth, place of parents and grandparents birth. During this time snacks will be served.

The focus group will be conducted by myself as the moderator, and Dr. Sarah Perez-McAdoo as the co-moderator -- she is a Latina, physician and director of the Youth Empowerment and Adolescent Health (YEAH) Network. Cristin O'Grady will be assisting us and taking notes. The focus group interview will be audio-taped so that I will be able to study and review what the teenagers have talked about.

The topics that will be discussed relate to: what teens think about other teens having babies in Holyoke, and where teens get information about sex, contraception, pregnancy, and having babies.

Participants will receive a \$15.00 gift card to the Holyoke Mall at the end of the focus group to compensate them for their time.

WHAT ARE THE BENEFITS OF BEING IN THIS STUDY?

Any specific benefit gained by your participation in this study is unknown, although talking about your views related to teen pregnancy and birth may benefit you in ways we do not realize. The benefits from this research study will be giving voice to Puerto Rican teens and their views about teen pregnancy and birth. Other Puerto Rican teens may be helped by the information gathered in this study.

7. WHAT ARE THE RISKS OF THIS STUDY?

I believe there are no known risks associated with participation in this research study. It is possible that you may have negative feelings after telling members of the focus group about any personal experiences.

HOW WILL YOUR PERSONAL INFORMATION BE PROTECTED?

Information from the focus group will be kept confidential by the researchers. Also, all members of the focus group will be asked not to repeat anyone's comments outside of the room. During the focus group questions will not be directed to individuals, but instead will be posed to the group. You may choose to respond or not respond at any point during the discussion

If you disclose any information about either child abuse or neglect, this must be reported according to state laws.

The following procedures will be used to protect the confidentiality of the study's data and your identity:

- The audio-recordings of the focus group will be transcribed by a transcriptionist who has completed a course in the Responsible Conduct of Research.
- The researcher will give each participant a pseudonym (a made-up name) in the transcripts used for data analysis.
- The researcher will be the only person who has access to the stored audio-recordings and original transcriptions.
- All audio-recordings and original transcripts will be destroyed upon completion of the of the researcher's doctoral dissertation.
- Information derived from the study will not identify you by name.
- Data that will be shared with others will be coded with a pseudonym to help protect your identity.
- At the conclusion of this study, the researcher may publish the findings. Information will be presented in summary format and your teenager will not be identified in any publications or presentations.

WILL YOU RECEIVE ANY PAYMENT FOR TAKING PART IN THE STUDY?

To compensate you for your time, you will receive a \$15.00 gift certificate to the Holyoke Mall at the end of the focus group.

WHAT IF I HAVE QUESTIONS?

Take as long as you like before you make a decision about participating in this study. I will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact me, Nancy Gilbert, the student researcher at (413) 549-6976, or the principal investigator, Dr M. Christine King at 413 545-5095.

If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Institutional Review Board (IRB) at (413) 545-3428 or humansubjects@ora.umass.edu.

WHAT IF I REFUSE TO GIVE OR WITHDRAW MY consent?

You should recognize that your participation in the focus group is voluntary and that you may refuse to participate and stop participating at any time. There will be no bad feelings if you don't want to do this. You can ask questions if you do not understand any part of this study.

WHAT IF I AM INJURED?

The University of Massachusetts does not have a program for compensating subjects for injury or complications related to human subjects research but the study personnel will assist you in getting treatment.

SUBJECT STATEMENT OF VOLUNTARY PERMISSION

By signing below, I confirm that the research study has been explained to me including its purpose, its procedures, and the possible risks and discomforts as well as benefits that I may experience. I have read and I understand this form, and give my permission to participate in this study.

Signature

Print Name

Date

By signing below I indicate that the participant has read and, to the best of my knowledge, understands the details contained in this document:

Signature of Researcher

Print Name

Date

APPENDIX H

DEMOGRAPHIC DATA FORM

Name: _____

Address: _____

Age: _____ Date of Birth: _____

Gender: male _____ female _____

What grade are you in? 9th 10th 11th 12th

What school are you attending? _____

Are you eligible for free lunch at school? YES NO

Are you eligible for a reduced free for lunch at school? YES NO

What race or ethnicity do you consider yourself: _____

Where were you born? _____

Where were your parents born? _____

Where were your grandparents born? _____

Languages spoken: _____

Females: *Are you currently pregnant?* Yes No *Have you ever had a baby?* Yes No

Males: *Are you currently expecting a baby?* Yes No *Do you have a child?* Yes No

REFERENCES

- Abama, J. C., Matinez, G. M., Mosher, W. D., & Dawson, B.S. (December 2004). *Teenagers in the US: Sexual activity, contraceptive use and child bearing*. National Center for Health Statistics. *Vital Health Stat*, 23 (24).
- Advocates for Youth. (March 2001). Scientific & medial institutions support comprehensive sexuality education. *Transitions*, 12 (3), 5. Retrieved November 14, 2007, from <http://www.advocatesforyouth.org/PUBLICATIONS/transitions/transitions1203.pdf>
- Advocates for Youth. (May 2003). Advocates for youth commends new Surgeon General's support for comprehensive sex education. Retrieved December 21, 2007, from <http://www.advocatesforyouth.org/NEWS/press/2003/051403.htm>
- Afable-Munsuz, A. & Brindis, C. (2006). Acculturation and the sexual and reproductive health of Latino youth in the United States: A literature review. *Perspectives on Sexual and Reproductive Health*, 38(4), 208-219.
- Agar, M. & MacDonald, J. (1995). Focus groups and ethnography. *Human Organization*, 54(1), 78-86. Ahluwalia, I., Johnson, C., Rogers, M., & Melvin, C. (1999). Pregnancy risk assessment monitoring system (PRAMS): unintended pregnancy among women having a live birth. *Journal of Women's Health and Gender-Based Medicine*, 8(5), 587-589.
- Alan Guttmacher Institute. (2007). *Minors' access to STD services*. Retrieved December 30, 2007, from http://www.guttmacher.org/statecenter/spibs/spib_MASS.pdf
- Allen, R. & Goldberg, A. (2007). Emergency contraception: a clinical review. *Clinical Obstetrics and Gynecology*, 50(4), 927-936.
- American Academy of Pediatrics, Committee on Adolescence. (1996). The adolescents' right to confidential care when considering abortion. *Pediatrics*, 97(5), 746-751.
- American Academy of Pediatrics, Committee on Adolescence. (2001). Condom use by adolescents. *Pediatrics*, 107(6), 1463-1469.
- American Academy of Pediatrics, Committee on Adolescence. (2005). Policy statement – emergency contraception. *Pediatrics*, 116(4), 1026-1035.
- American Academy of Pediatrics – Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence. (2001). Sexuality education for children and Adolescents. *Pediatrics*, 108(2), 498—502.
- American Nurses' Association. (2001). *Code for nurses with interpretive statements*. Washington, DC: The Author.

- Anderson, J., Santelli, J., & Morrow, B. (2006). Trends in adolescent contraceptive use, unprotected and poorly protected sex, 1991-2003. *Journal of Adolescent Health, 38*, 734-739.
- Asbury, J-E. (1995). Overview of focus group research. *Qualitative Health Research, 5*(4) 414-420.
- As-Sanine, S., Gantt, A., & Rosenthal, M. (2004). Pregnancy prevention in adolescents. *American Family Physician, 70*(8), 1517-1524.
- Bauer, G., Davies, J.K., Pelikan, J., Noack, H., Broesskamp, U., & Hill, C. (2003). Advancing a theoretical model of public health and health promotion indicators development. *European Journal of Public Health, 13*(3), 107-113.
- Blake, S., Ledsky, R., Goodenow, C., Sawyer, R., Lohrmann, D. & Windsor, R. (2003). Condom availability programs in Massachusetts high schools: Relationships with condom use and sexual behavior. *American Journal of Public Health, 93*(6), 955-962.
- Bleakley, A., Hennessy, M. & Fishbein, M. (2006). Public opinion on sex education in US schools. *Archives of Pediatric and Adolescent Medicine, 106*, 1151-1156.
- Bleakley, A. Hennessy, M. Fishbein, M. Coles, H. & Jordan, A. (2009). How sources of sexual information relate to adolescents' beliefs and sex. *American Journal of Health Behavior, 33*(1), 37-48.
- Borawski, E., Trapl, E., Lovegreen, L., Colabianchi, N., & Block, T. (2005). Effectiveness of abstinence-only intervention in middle school teens. *American Journal of Health Behavior, 29*(5), 423-434.
- Borges-Méndez, R. (1993). The use of Latino immigrant labor in Massachusetts manufacturing: Evidence from Lowell, Lawrence, and Holyoke. In E. Melendez, R & M. Uriate (Eds.). *Latino Poverty and Economic Development in Massachusetts* (pp 104-124). Amherst, MA: University of Massachusetts Press.
- Borges-Méndez, R. McCormack, J. (November 16-18, 2006). CBOs and non-profits in policy intermediation in new Latino settlements: The cases of Holyoke and Lawrence, Massachusetts. retrieved March 29, 2008, from <http://www.naccouncil.org/pdf/Borges-Mendez%20ARNOVA2-1-4-07.pdf>
- Brindis, C. (2006). A public health success: Understanding policy changes related to teen sexual activity and pregnancy. *Annual Review of Public Health, 27*, 277-295.
- Burns, C.E., Dunn, A.M., Brady, M.A., Starr, N.B., & Blosser, C.G. (2004). *Pediatric primary care: A handbook for nurse practitioners*. St. Louis, MO: Saunders.

- Burns, N. & Grove, S. (2005). *The practice of nursing research (5th Ed)*. St Louis, MO: Elsevier.
- Cáceres, I., Hood, M. & West, J. (2009). *Massachusetts births 2007*. Boston, MA: Massachusetts Department of Public Health – Bureau of Health Information, Statistics, Research and Evaluation, Division of Research and Epidemiology.
- Cáceres, I., Orejuela-Hood, M. & West, J. (2010). *Massachusetts births 2008*. Boston, MA: Massachusetts Department of Public Health – Bureau of Health Information, Statistics, Research and Evaluation, Division of Research and Epidemiology.
- Caplan, S. (2007). Latinos, acculturation, and acculturative stress: A dimensional concept analysis. *Policy, Politics, & Nursing Practice*, 8(2), 93-106.
- Career Point. (nd). *Who we are*. Retrieved March 14, 2011, from <http://www.careerpointma.org/AboutUs.html>
- Care Center. (n.d.) *The care center about us*. Retrieved march 17, 2011, from <http://www.carecenterholyoke.org/about/>
- Catalano, R., Berglund, M., Ryan, J., Lonczak, H. & Hawkins, J. (1998). *Positive youth development in the U.S.: Research findings on evaluations of positive youth development programs*. Retrieved December 26, 2007, from <http://aspe.hhs.gov/hsp/PositiveYouthDev99/>
- Centers for Disease Control and Prevention. (2006). Surveillance summaries, 2005. *MMWR* 2006, 55(No. SS5).
- Centers for Disease Control and Prevention. (Sept 25, 2007). *The social-ecological model: a framework for prevention*. Retrieved October 25, 2009, from http://www.cdc.gov/ncipc/dvp/social-ecological-model_DVP.htm
- Charmaz, K. (2006). *Constructing grounded theory a practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications
- Chang, YK, Voils, C.I., Sandelowski, M., Hasselblad, V., & Crandel, J.L. (2009). Transforming verbal counts in reports of qualitative descriptive studies into numbers. *Western Journal of Nursing Research*, 31(7), 837-852.
- Chen, X., Wem, S., Fleming, N., Demissie, K., Rhoads, G., & Walker, M. (2007). Teenage pregnancy and adverse birth outcomes: A large population based retrospective cohort study. *International Journal of Epidemiology*, 36(2), 368-373.
- Child Trends Data Bank. (2006). *Teen births*. Retrieved October 30, 2007, from <http://www.childtrendsdatabank.org>

- City Data. (2009). *Holyoke, Massachusetts*. Retrieved April 12, 2009, from <http://www.city-data.com/city/Holyoke-Massachusetts.html>
- Cohall, A., Dickerson, D, Vaughan, R. & Cohall, R. (1998). Inner-city adolescents' awareness of emergency contraception. *Journal of the American Medical Women's Association*, 53, 258-261.
- Commonwealth Fusion Center. (November, 2006). *Crime in Massachusetts: 2004-2005*. Retrieved April 12, 2009, from http://www.mass.gov/Eeops/docs/msp/divisions/investigative_services/crime_reporting_unit/mass_crime_report_2004_2005.pdf
- Commission on Social Determinants of Health. (2005). *Towards a conceptual framework for analysis and action on the social determinants of health*. Retrieved October 24, 2008, from <http://www.naccho.org/topics/justice/resources/upload/WHOCommissionTowardsConceptualFrame.pdf>
- Cooper, L. & Roter, D. (2003). Patient-provider communication: The effect of race and ethnicity on process and outcomes of healthcare. In Smedley, B., Stith, A., & Nelson, A. R. (Eds.). *Unequal treatment confronting racial and ethnic disparities in healthcare (552-593)*. Washington DC: National Academies Press.
- Coté-Arsenault, D. & Morrison-Beedy, D. (1999). Practical advice for planning and conducting focus groups. *Nursing Research*, 48(5), 280-283.
- Creswell, J. (1998). *Qualitative inquiry and research design choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- Curtis, E. A. & Redmond, R. (2007). Focus groups in nursing research. *Nurse Researcher*, 14(2), 25-37.
- Delbanco, S., Parker, M., McIntosh, M., Kannel, S. & Stewart, F. (1998). Missed opportunities teenagers and emergency contraception. *Achieves of Pediatric and Adolescent Medicine*, 152,727-733.
- Denzin, N. K. & Lincoln, Y. S. (2005). The discipline and practice of qualitative research. In N.K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research (3rd Ed.) (pp. 1-32)*. Thousand Oaks, CA: Sage Publications, Inc.
- Dietz, J. (1986). *Economic history of Puerto Rico*. Princeton, NJ: Princeton University Press.
- Donta, A. (2001). The Hispanic population in Massachusetts. *Massachusetts State Data Center Newsletter*, 3(1), 1-2.

- Driscoll, A., Biggs, M., Brindis, C. & Yankah, E. (2001). Adolescent Latino reproductive health: A review of the literature. *Hispanic Journal of Behavioral Health*, 23(3), 255-326.
- Dunlock H. L. & Holzemer, W. L. (1991). Substruction: Improving the linkage from theory to method. *Nursing Science Quarterly*, 4(2), 83-87.
- Estes, L. (August 5, 2003). *Onsite follow-up monitoring report*. Retrieved March 23, 2008, From <http://www.doe.mass.edu/pqa/review/cpr/reports/2003/followup/0137.pdf>
- Farber, N. B. (2009). *Adolescent pregnancy (2nd ed.)*. NY, NY: Springer Publishing Company.
- Finlay, L. (2002). "Outing" the researcher: the provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545.
- Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, 2, 209-230.
- Frith, H. (2000). Focusing on sex: using focus groups in sex research. *Sexualities*, 3(3), 275-297
- Fraser, A.M, Brocket, J.E., & Ward, R.H. (1995). Association of young maternal age with adverse reproductive outcomes. *New England Journal of Medicine*, 332, 1113-1118.
- Frost, J. J.& S. Oslak (1999). *Teenagers' pregnancy intentions and decisions: A study of young women in California choosing to give birth*. New York, NY, Alan Guttmacher Institute.
- Foster, J. (2003). *Masculinity and fatherhood: Stratified reproduction among Puerto Rican partners of adolescent mothers*. Unpublished doctoral dissertation, University of Massachusetts, Amherst.
- Foster, J. (2004). Fatherhood and the meaning of children: An ethnographic study among Puerto Rican partners of adolescent mothers. *Journal of Midwifery and Women's Health*, 49(2), 118-125.
- Gallagher, K., Stanley, A., Shearer, D., & Mosca, C. (2005). Implementation of youth development programs: Promise and challenges. *Journal of Adolescent Health*, 37(3), S3-S10.
- Gallup-Black, A. & Weitzman, B. (2004). Teen pregnancy and urban youth: Competing truths, complacency, and perceptions. *Journal of Adolescent Health*, 34, 366-375.
- Georges, J. (n.d.). *Interstate 91-MA: Historic overview*. Retrieved April 22, 2009, from www.bostonroads.com/roads/I-91_MA/ the construction of interstate 91 in western Massachusetts
- Geronimus, A. T. (2003). Damned if you do: culture, identity, privilege, and teen childbearing in the United States. *Social Science & Medicine*, 57, 881-893.

- Gilbert, W., Jandial, D., Field, N., Bigelow, P., & Danielson, B. (2004). Birth outcomes in teenage pregnancies. *Journal of Maternal-Fetal and Neonatal Medicine*, 16(5), 265-270.
- Girls Incorporated of Holyoke. (nd) Retrieved September 14, 2010, from <http://www.girlsinholyoke.org>
- Glasser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine Publishing Co.
- Government Accountability Office. (October 2006). *Abstinence education: Efforts to assess the accuracy and effectiveness of federally funded programs*. Washington, DC: Government Printing Office. Retrieved November 22, 2007, from <http://www.gao.gov/new.items/d0787.pdf>
- Government Registry (2008). *Crime Records*. Retrieved April 26, 2008, from <http://www.govtregistry.com/lp.php?sk=Crime&tc=mI02I97>
- Green, C. M. (1939). *Holyoke Massachusetts a case history of the industrial revolution in America*. New Haven, CT: Yale University Press.
- Greenbaum, T. (2000). *Moderating focus groups*. Thousand Oaks, CA: Sage Publications.
- Guba, E. G. & Lincoln, Y. S. (1981). *Effective evaluation*. San Francisco, CA: Josey-Bass Publishers.
- Gueorguieva RV, Carter RL, Ariet M, Roth J, Mahan CS, & Resnick MB. (2001). Effect of teenage pregnancy on educational disabilities in kindergarten. *American Journal of epidemiology*, 154(3),212-20.
- Guttmacher Institute. (2006). *U.S. teen pregnancy statistics national and state trends and trends by race and ethnicity*. Retrieved October 30, 2007, from <http://www.guttmacher.org/pubs/2006/09/12/USTPstats.pdf>
- Hamilton, B., Martin, J., & Ventura, S. (2007, December 5). Births: Preliminary data for 2006. *National Vital Statistics Reports*, 56(7). Retrieved December 6, 2007, from www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_07.pdf
- Hamilton, B., Martin, J., & Ventura, S. (2010, April 6). Births: Preliminary data for 2008. *National Vital Statistics Reports*, 58(16). Retrieved October 125, 2010, from http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_12.pdf
- Hamilton, B., Martin, J., & Ventura, S. (2009, March 18). Births: Preliminary data for 2007. *National Vital Statistics Reports*, 57(12). Retrieved April 2, 2009, from
- Hanson, D., Hanson, J., Vardon, P., McFarlane, K., Lloyd, J., Muller, R., et al. (2005). The injury iceberg: an ecological approach to planning sustainable community safety interventions. *Health Promotion Journal of Australia*, 16(1), 94-99.

- Happell, B. (2007). Focus groups in nursing research: An appropriate method of latest fad? *Nurse Researcher*, 14(2), 18-24.
- Hardy-Fanta, C. & Bassols-Matinez, R. (2002). Strategic planning in the community and courts of Holyoke. In Hardy-Fantana, C. & Gerson, J. (Eds.), *Latino Politics in Massachusetts: Struggles, Strategies, Prospects* (pp. 99-125). NY, NY: Rutledge.
- Hartford, W. (1990). *Working people of Holyoke: Class, ethnicity in a Massachusetts mill town*. New Brunswick, NJ: Rutgers University Press.
- Heavey, E., Moysuch, K., Hyland, A., Druschel, C. & Sill, M. (2008). Female adolescents' perceptions of male partners' pregnancy drive. *Journal of Midwifery and Women's Health*, 53(4), 338-344.
- Herman, J. (2008). Adolescent perceptions of teen births. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 37, 42-50.
- Hockenberry, M. & Wilson, D. (2007). *Wong's nursing care of infants and children* (7th ed.). St Louis, MO: Elsevier Mosby
- Hoffman, S. (2006). *By the numbers the public costs of teen childbearing*. Washington, DC: National Campaign to Prevent Teen Pregnancy.
- Hollaway, I. & Wheeler, S. (2002). *Qualitative research in nursing* (2nd Ed). Malden, MA: Blackwell Science, Inc.
- Holyoke High School. (2010). *Course selection guide 2010-2011*. Retrieved March 5, 2011, from http://www.hps.holyoke.ma.us/hhs/pdf/guidance/Course_Selection_Guide_1011.pdf
- Holyoke Public Schools. (2010). *Social and emotional health*. Retrieved April 1, 2011, from http://www.hps.holyoke.ma.us/pdf/curriculum_health/k_12healthall.pdf
- Holyoke Youth Task Force. (nd). *The Holyoke youth commission*. Retrieved march 13, 2011, from <http://www.youthtaskforce.org/HolyokeYouthCommission.html>
- Hofferth, S. L., & Reid, L. (2002). Early childbearing and children's achievement and behavior over time. *Perspectives on Sexual and Reproductive Health*, 34, 41-49.
- Hook, R.A. (1988). *Shifting gears 1920-1980: the changing meaning of work in Massachusetts*. Holyoke, MA: Holyoke Heritage State Park.
- Hoppe, M., Wells, E., Morrison, D., Gilmore, M. & Wilsdon, A. (1995). Using focus groups to discuss sensitive topics with children. *Evaluation Review*, 19(1), 102-114.

- Hyde, A., Howlett, E., Brady, D., & Drennan, J. (2005). The focus group method: Insights from focus group interviews on sexual health with adolescents. *Social Science & Medicine*, 61(12), 2588-2599.
- Hotz, V. J., McElroy, S.W., & Sanders, S.G.(2005). Teenage childbearing and its life cycle consequences: exploiting a natural experiment.” *Journal of Human Resources* 40(3): 683-715.
- Institute of Medicine. (2003a). *The future of the public’s health in the 21st century*. Washington, DC: The National Academies Press.
- Institute of Medicine. (2003b). *Who will keep the public healthy? Educating public health professionals for the 21st century*. Washington, DC: The National Academies Press.
- Ito, K., Gizlice, Z., Owen-O’Dowd, J., Foust, E., Leone, P., & Miller, W. (2006). Parent opinion of sexuality education in a state with mandated abstinence education: Does policy match parental preference? *Journal of Adolescent Health*, 39(5), 634-641.
- Janesick, V. (1998). *Journal writing as a qualitative research technique: History, issues reflection*. Retrieved January 11, 2010 from www.eric.ed.gov/ERICDOCS/data
- Jewel, D., Tacchi, J., & Donovan, J. (2001). Adolescents from different socioeconomic backgrounds had different attitudes about teen pregnancy. *Evidence-Based Nursing*, 4, 125.
- Jones, R., Darroch, J. & Henshaw, S. (2002). Patterns in the socioeconomic characteristics of women obtaining abortions in 2000-2001. *Perspectives on Sexual and Reproductive Health*, 34(5), 226-235.
- Jones, M.E., Kubelka, S., & Bond, M.L. (2001). Acculturation satatus, birth outcomes and family planning compliance among Hispanic teens. *The Journal of School Nursing*, 17(2), 83-89.
- Joyce, T., Kaestner, R., & Koreman, S. (2002). On the validity of retrospective assessments of pregnancy intention. *Demography*, 39(1), 199-213.
- Kamberelis, G. & Dimitriadis, G. (2008). Focus groups strategic articulations of pedagogy, politics, and inquiry. In N. Denzin & Y. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials* (3rd ed., pp. 375-402). Thousand Oaks, CA: Sage Publications.
- Kidd, P. S. & Parshall, M. B. (2000). Getting the focus and the group: Enhancing analytical rigor in focus group research. *Qualitative Health Research*, 19(3), 293-308.

- Kids Count. (1998). *When Teens Have Sex: Issues And Trends. KIDS COUNT Special Report*. Baltimore, MD: Annie E. Casey Foundation. Retrieved November 15, 2007, from http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/17/98/6f.pdf
- Kirby, D. (2001). *Emerging answers: research findings on programs to reduce teen pregnancy*. Washington DC: National Campaign to Prevent Teen Pregnancy.
- Kirby, D. (2002). Antecedents of adolescent initiation of sex, contraceptive use, and pregnancy. *American Journal of Health Behavior*, 26(6), 473-485.
- Kirby, D. (2007). *Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.
- Kirby, D. & Lepore, G. (2007, November). *Sexual risk and protective factors*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy.
- Kim, S., Flaskerud, J., Koniak-Griffin, D., & Dixon, E. (2005). Health disparities research. *Journal of Professional Nursing*, 21(4), 1999-209.
- Kirtland, E. (1889). *The city of Holyoke*. Retrieved March 20, 2008, from <http://www.holyokemass.com/nem/index.html>
- Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health & Illness*, 16(1), 103-121.
- Klein, J. (2005). Adolescent pregnancy: Current trends and issues. *Pediatrics*, 116(1), 281-287.
- Krueger, R. (1994). *Focus groups a practical guide for applied research (2nd Ed)*. Thousand Oaks, CA: Sage Publications.
- Kruger, R. A. (1998a). *Moderating focus groups*. Thousand Oaks, CA: Sage Publications
- Kruger, R. A. (1998b). *Analyzing and reporting focus group results*. Thousand Oaks, CA: Sage Publications
- Krueger, R. & Casey, M. (2000). *Focus groups a practical guide for applied research (3rd Ed)*. Thousand Oaks, CA: Sage Publications.
- Levine, J., Emery, C. & Pollack, H. (2007). The well-being of children born to teen mothers. *Journal of Marriage and Family*, 69 (1), 105-122.
- Lindberg, L.D., Santelli, J. S., & Singh, S. (2006). Changes in formal sex education: 1995-2002. *Perspectives on Sexual and Reproductive Health*, 38(4), 182-189.

- Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.
- Logan, C., Holcombe, E., Manlove, J. & Ryan, S. (May 2007). *The consequences of unintended childbearing: a white paper*. Retrieved January 13, 2009, from www.thenationalcampaign.org/resources/pdf/consequences.pdf
- Mack, N., Woodsong, C., MacQueen, K. M. Guest, G., & Namey, E. (2005). *Qualitative research methods: a data collector's field guide*. Research Triangle Park, NC: Family Health International.
- Madriz, I. (1998). Using focus groups with lower socioeconomic status Latina women. *Qualitative Inquiry*, 4(1), 114-128.
- Martin, J., Hamilton, B., Sutton, P., Ventura, S., Menacker, F., Kimeyer, S. & Munson, M. (December 5, 2007). *Births: final data for 2005*. Hyattsville, MD: National Center for Health Statistics.
- Martin, J., Hamilton, B., Sutton, P., Ventura, S., Menacker, F., Kimeyer, S., et al. (January 7, 2009). *Births: Final data for 2006*. Hyattsville, MD: National Center for Health Statistics.
- Martin, J., Hamilton, B., Sutton, P., Ventura, S., Mathews, T. J., & Osterman, M. (December 2010). *Births: Final data for 2008*. Hyattsville, MD: National Center for Health Statistics.
- MassCHIP. (2007a). *Race/Hispanic Ethnicity Report :Population and Demographic Indicators for Massachusetts Total*. Retrieved January 13, 2009, from <http://masschip.state.ma.us/InstantTopics/three.asp?Rptid=290&Geo=2961&lvl=2>
- MassCHIP. (2008b). *Adolescent health report for Holyoke*. Retrieved March 20, 2008, from <http://masschip.state.ma.us/InstantTopics/three.asp?Rptid=289&Geo=1560&lvl=2>
- Massachusetts Citizens for Children. (2007). *Profile for Holyoke, Massachusetts*. Retrieved March 22, 2008, from http://www.kidscount.org/cgi-bin/cliiks.cgi?action=profile_results&subset=MA&areaid=138
- Massachusetts Department of Education. (2010). *Massachusetts School and District Profiles – School Data Reports*. Retrieved October 25, 2010, from <http://profiles.doe.mass.edu/profiles/student.aspx?orgcode=01370505&orgtypecode=6&>
- Massachusetts Department of Education. (November 25, 2003). *Commissioner's recommendations of four districts referred for determination of under-performance*. Retrieved March 24, 2008, from <http://www.doe.mass.edu/boe/bib/bib03/1125.pdf>
- Massachusetts Fair Housing Center. (September 2006). *Analysis of impediments to fair housing for the city of Holyoke, MA*. Retrieved February 21, 2011, from <http://www.massfairhousing.org/archives/Holyoke%20AI.pdf>

- Massachusetts Office of Public Safety and Security. (2009). Massachusetts Executive Office of Public Safety and Security. (2009). *Crime policy brief*. Retrieved September 22, 2009, from www.mass.gov/Eeops/docs/eops/Publications/082009_property_crime_v6_jul09.pdf
- Massachusetts Department of Public Health. (2007). *Massachusetts birth 2006*. Retrieved October 15, 2008, from http://www.mass.gov/Eeohhs2/docs/dph/research_epi/slides_birth_report_2006.doc.
- Massachusetts Department of Public Health, Center for Health Information, Statistics, Research, and Evaluation. (January 2007). *Massachusetts births 2005 presentation*. Retrieved January 28, 2007, from http://www.mass.gov/?pageID=eohhs2terminal&&L=4&L0=Home&L1=Consumer&L2=Community+Health+and+Safety&L3=Population+Health+Statistics&sid=Eeohhs2&b=terminalcontent&f=dph_research_epi_c_births&csid=Eeohhs2
- Massachusetts Government. (2009). *Workforce Development*. Retrieved September 22, 2009, from http://lmi2.detma.org/lmi/lmi_town.asp
- Maynard, R. (1996). *Kids having kids*. New York, NY: The Robin Hood Foundation.
- McLeroy, K.R., Bibeau, D., Steckler, A. & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351-377.
- McLafferty, I. (2004). Focus group interview as a data collecting strategy. *Journal of Advanced Nursing*, 48(2), 187-194.
- Merton, R. K. (1987). The focused interview and focus groups continuities and discontinuities. *Public Opinion Quarterly*, 51, 550-566.
- Merton, R. K. & Kendall, P. L. (1946). The focused interview. *American Journal of Sociology*, 51, 541-557.
- Merton, R. K., Fiske, M., & Kendal, P. L. (1956). *The focused group interview a manual of problems and procedures*. Glencoe, IL: The Free Press.
- Morales, J. (1986). *Puerto Rican poverty and migration*. NY, NY: Praeger.
- Moore, K. A. (October 2008). *Teen births: Examining the recent increase*. Retrieved October 28, 2008, from http://www.thenationalcampaign.org/resources/pdf/TeenBirths_ExamIncrease.pdf
- Moore, K., Miller, B., Suglans, B., Morrison, D., Gleib, D. & Blumenthal, C. (2). *Beginning too soon: Adolescent sexual behavior, pregnancy and parenthood*. Retrieved March 11, 2009, from <http://aspe.hhs.gov/HSP/cyp/xsteesex.htm>

- Morgan, D. L. (1993). *Successful focus groups: Advancing the state of the art*. Newbury Park, CA: Sage Publishers.
- Morgan, D. L. (1995). Why things (sometimes) go wrong in focus groups. *Qualitative Health Research*, 5(4), 516-523.
- Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology*, 22, 129-132.
- Morgan, D. (1997). *Focus groups as qualitative research (2nd ed.)*. Thousand Oaks, CA: A Sage University Paper.
- Morgan, D. (1998a). *The focus group guidebook*. Thousand Oaks, CA: Sage Publications
- Morgan, D. (1998b). *Planning focus groups*. Thousand Oaks, CA: Sage Publications
- Morrison-Beedy, D., Coté-Arsenault, D., & Feinstein, N. F. (2001). Maximizing results with focus groups: Moderator and analysis issues. *Applied Nursing Research*, 14(1), 48-53.
- Nadeem, E., Romo, L., & Sigman, M. (2006). Knowledge about condoms among low-income Latina adolescents in relation to explicit maternal discussion of contraceptive. *Journal of Adolescent Health*, 3, 119.e9-119.e15.
- National Center for Health Statistics. (2007). *Recent trends in teenage pregnancy in the US*, Retrieved October 30, 2007, from www.cdc.gov/nchs/products/pubs/pubd/hestats/teenpreg1990-2002/teenpreg1990-2002.htm
- National Campaign to Prevent Teen and Unplanned Pregnancy. (November 2006). *By the numbers: The public Costs of teen childbearing in Massachusetts*. Retrieved January 13, 2009, from <http://www.thenationalcampaign.org/costs/pdf/states/massachusetts/factsheet.pdf>
- National Campaign to Prevent Teen and Unplanned Pregnancy. (December 2007). *Teen pregnancy and birth rates in the US*. Retrieved October 15, 2008, from <http://www.thenationalcampaign.org/national-data/pdf/STBYST07.pdf>
- News-Adeyi, G., Helitzer, D. L., Caulfield, L.E., & Bonner, Y. (2000). Theory and practice: Applying the ecological model to formative research for a WIC training program in New York state. *Health Education Research*, 15(3) 283-291.
- Nyamathi, A. & Shuler, P. (1990). Focus group interview: a research technique for informed nursing practice. *Journal of Advanced Nursing*, 15(11), 1281-1288.
- Office for Human Research Protections. (2005). *Special protection for children as research Subjects*. Retrieved May 2, 2008, from http://www.hhs.gov/ohrp/children/guidance_407process.html

- Oetzel, J. G., Ting-Toomey, S., Rinderle, S. (2006). Conflict communication in contexts: A social ecological perspective. In J. G. Oetzel & S. Ting-Toomey (Eds.), *The SAGE handbook of conflict communication*. Thousand Oaks, CA: Sage.
- Ortlipp, M. (2008). *Keeping and using reflective journals in the qualitative research process*. *The Qualitative Report*, 13(4), 695-705.
- Owen, S. (2001). The practical, methodological and ethical dilemmas of conducting focus groups with vulnerable clients. *Journal for Advanced Nursing*, 36(5), 652-658.
- Parsons, M. & Greenwood, J. (2000). A guide to the use of focus groups in health care research: part 1. *Contemporary Nurse*, 9(2), 169-180.
- Patton, M. (2002). *Qualitative research & evaluation methods (3rd Ed)*. Thousand Oaks, CA: Sage Publications.
- Peckman, A. (2007). *The urban dictionary*. Retrieved May 30, from <http://www.urbandictionary.com/define.php?term=jump+off>
- Peterson-Sweeney, K. (2005). The use of focus groups in pediatric and adolescent research. *Journal of Pediatric Health Care*, 19(2), 104-110.
- Pew Hispanic Center. (2009, December 11). *Between two worlds: How young Latinos come of age in America*. *Pew research enter Report*. Retrieved December 15, from pewhispanic.org/reports/report.php?ReportID=117
- Phipps, M., Blume, J., & DeMonner, S. (2002). Young maternal age associated with increased risk of postnatal death. *Obstetrics & Gynecology*, 100(3), 481-486.
- Pieve, L. (2001). *An ethnographic study of the perceptions of Puerto Rican pregnant teens*. Unpublished doctoral dissertation, University of Connecticut, Storrs.
- Pittman, J. (1993). *Promoting youth development: strengthening the role of youth-serving and community organizations*. Washington, DC: Center for Youth Development and Policy Research
- Potter, M. A. & Quill, B.E. (2006). *Demonstrating excellence in practice-based research for public health*. Washington, DC: Association of Schools of Public Health.
- Powell, R.A., Single, H.M., and Lloyd, K. (1996). Focus groups in mental health research. *International Journal of Social Psychiatry*, 42(3), 193-206.
- Presser, S., Couperr, M. P., Lessler, J. H., Martin, E., Martin, J., Rothergeb, J. & Singer, E. (2004). Methods for testing and evaluating survey questions. *Public Opinion Quarterly*, 68(1), 109-130.

- Rabiee, F. (2004). Focus group interview and data analysis. *Proceedings of the Nutrition Society*, 63, 655–660
- Raine, T., Harper, C., Leon, K., & Darney, P. (2000). Emergency contraception: advance provision in a young, high risk clinic population. *Obstetrics & Gynecology*, 96(11), 1-7.
- Resnick, M., Gueorguieva, R., Carter, R., Ariet, M., Sun, Y., Roth, J., et al. (1999). The impact of low birth weight, perinatal conditions, and sociodemographic factors on educational outcome in kindergarten. *Pediatrics*, 104(6), e74-e84.
- Rich-Edwards, J. (2002). Teen pregnancy is not a public health crisis in the United States. It is time we made it one. *International Journal of Epidemiology*, 3, 555-556.
- Richard, L, Gauvin, L & Raine, K. (2011). Ecological models revisited: their uses and evolution in health promotion over two decades. *Annual Review of Public health*, 32, 307-326.
- Richardson, L. & St. Pierre, E. A. (2005). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *the Sage handbook of qualitative research (3rd Ed.)* (pp. 959-978). Thousand Oaks, CA: Sage Publications, Inc.
- Robinson, N. (1999). The use of focus group methodology – with selected samples from sexual health research. *Journal of Advanced Nursing*, 29(4), 905-913.
- Rodriguez, C. (1989). *Puerto Ricans Born in the US*. Boston, MA: Unwin Hyman.
- Rosengard, C., Phipps, M., Adler, N., & Ellen, J. (2004). Adolescent pregnancy intentions and pregnancy outcomes: A longitudinal examination. *Journal of Adolescent Health*, 35(5), 453-461.
- Rosengard, C., Phipps, M., Adler, N., & Ellen, J. (2005). Psychosocial correlates of adolescent males' pregnancy intention. *Pediatrics*, 116(3), 414-419.
- Rosengard, C., Pollock, L., Weitzen, S., Meers, A., & Phipps, M. (2006). Concepts of the advantages and disadvantages of teenage childbearing among pregnant adolescents: A qualitative analysis. *Pediatrics*, 118(2), 503-510.
- Rubin, V., & East, P. (1999). Adolescents' pregnancy intentions. *Journal of Adolescent Health*, 24(5), 313-320.
- Ruff, C. C., Alexander, I. M., & McKie., C. (2005). The use of focus group methodology in health disparities research. *Nursing Outlook*, 53(3), 134-140.
- Salis, J. & Owen, N. (2002). Ecological models of health behavior. In K. Glanz, B. K. Rimer, & F. M. Lewis (Eds.), *Health behavior and health education (pp462-484)*. San Francisco, CA: Jossey-Bass.

- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, 23(4), 334-340.
- Santelli, J.S., Lindberg, L.D, Finer, L. B. , & Singh, S. (2007). Explaining recent declines in adolescent pregnancy in the United States: the contributions of abstinence and improved contraceptive use. *American Journal of Public Health*, 97(1):150–156.
- Satcher, D. (2001, July 9). *The Surgeon General's call to action to promote sexual health and responsible behavior*. Retrieved November 1, 2007, from <http://www.surgeongeneral.gov/library/sexualhealth/call.htm>
- Satin, A., Leveno, K., Sherman, L., Reedy, N., Lowe, T. & McIntire, D. (1994). Maternal youth and pregnancy outcomes: middle school versus high school age groups compared with women beyond teen years. *American Journal of Obstetrics & Gynecology*, 171(1), 184-187.
- Sciarra, D. & Ponterotto, J. (1998). Adolescent motherhood among low-income urban Hispanics: familial considerations of mother-daughter dyads. *Qualitative Health Research*, 8(6), 751-763.
- Sim, J. (1999). Collecting and analyzing qualitative data: Issues raised by focus groups. *Journal of Advanced Nursing*, 28(2), 345-352.
- SmithBattle, L. (2007a). Legacies of advantage and disadvantage: the case of teen mothers. *Public Health Nursing* 24(5), 409–420.
- SmithBattle, L. (2007b). “I wanna have a good future” teen mothers’ rise in educational aspirations, competing demands, and limited school support. *Youth & Society*, 38(3), 348-371.
- Shore, R. (2005, July). *Kids count indicator brief reducing the teen birth rate*. Retrieved January 12, 2007, from <http://www.kidscount.org/datacenter/auxiliary/briefs/teenbirthrateupdated.pdf>
- Sim, J. (1998). Collecting and analyzing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing*, 28(2), 345-352.
- Smedley, B.D., Stith, A.Y., and Nelson, A.R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academies Press.
- SmithBattle, L. (2007). Legacies of advantage and disadvantage: the case of teen mothers. *Public Health Nursing*, 24(5), 409-420.

- SmithBattle, L. (2007). "I wanna have a good future" Teen mothers' rise in educational aspirations, competing demands, and limited school support. *Youth & Society*, 38(3), 348-371.
- Spear, H. & Lock, S. (2003). Qualitative research on adolescent pregnancy: a descriptive review and analysis. *Journal of Pediatric Nursing*, 16(6), 397-408.
- Strauss, L., Gamble, S., Parker, W., Cook, D., Zane, S., Hadam, S., et al. (2007). Abortion surveillance --- United States, 2004. *MMWR Surveillance Summaries*, 56(SS09), 1-33.
- Stewart, D.W. & Shamdasani, P. N. (1990). *Focus groups: theory and research*. Newbury Park, CA: Sage
- Stewart, D.W., Shamdasani, P. N., & Rook, D. W. (2007). Focus groups theory and practice (2nd ed.). *Applied Social Research Methods Series, Volume 20*. Thousand Oaks, CA: Sage Publications.
- Stokols, D. (1996). Translating social ecological theory into guidelines for health promotion. *American Journal of Public Health*, 10, 282-298.
- Talashak, M., Alba, M., & Patel, A. (2005) Untangling the health disparities of teen pregnancy. *Journal for Specialists in Pediatric Nursing*, 11(1), 14-26.
- Terry-Humen, E., Manlove, J., & Moore, K. (2005). *Playing catch-up: How children born to teen mothers fare*. Washington, DC: The National Campaign to Prevent Teen Pregnancy.
- Thomas, P. (1999). *Whaley & Wong's nursing care of infants and children (6th ed.)*. St Louis, MO: Mosby.
- Turley, R. (2003). Are children of young mothers disadvantaged because of their mother's age or family background? *Child Development*, 74(2), 465-474.
- Trenholm, C., Devaney, B., Fortson, K., Quay, L., Wheeler, J., & Clark, M. (April; 2007). *Impacts of four Title V, Section 510 abstinence Education Programs, Final report*. Retrieved October 29, 2007, from <http://aspe.hhs.gov/hsp/abstinence07/index.htm>
- Trent, K. & Crowder, K. (1997). Adolescent birth intentions, social disadvantage, and behaviors outcomes. *Journal of Marriage and Family*, 59, 523-535.
- U.S. Census Bureau. (1990). 1990 *Census of population and housing Public Law 94-171 data (official) age by race and Hispanic origin*. Retrieved October 26, 2007, from <http://www.census.gov/main/www/cen1990.html>

- U.S. Census Bureau. (2000). *Projections of the total resident population by 5-year age groups, race, and Hispanic origin with special age categories: middle series, 1999 to 2100*. Retrieved March 20, 2008, from <http://www.census.gov/population/www/projections/natsum-T3.html>
- U.S. Census Bureau. (2006). *State and county quick facts*. Retrieved March 14, 2008, from <http://quickfacts.census.gov/qfd/states/25000.html>
- US Census Bureau. (2007). *Hispanics in the U.S.* Retrieved March 14, 2008, from www.census.gov/population/www/socdemo/hispanic/hispanic_pop_presentation.html
- US Census Bureau. (August 26, 2008). *Household income rises, poverty rate unchanged number of uninsured down*. Retrieved September 22, 2009, from http://www.census.gov/Press/release/www/releases/archives/income_wealth/012528.html
- US Census Bureau. (2009). *State and county quick facts*. Retrieved September 25, 2009, from <http://quickfacts.census.gov/qfd/states/25/2530840.html>
- USDHHS. (2000). *Healthy people 2010 understanding and improving health(2nd ed.)*. Washington, DC: U.S. Government Printing Office.
- USDHHS. (2010). *Healthy people 2020:healthy people in healthy communities*. Retrieved January 28, 2011, from <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=2>
- US Department of Agriculture. (2009). *Child nutrition programs – income eligibility guidelines*. Retrieved June 20, 2010 from www.fns.usda.gov/cnd/Governance/notices/iegs/IEGs.htm
- US Department of Justice. (2008). *Crime in the United States*. Retrieved September 30, 2009, from http://www.fbi.gov/ucr/cius2008/offenses/property_crime/index.html
- US Office of Management and Budget. (1997). ***Revisions to the standards for the classification of federal data on race and ethnicity***. Retrieved October 15, 2008, from <http://www.whitehouse.gov/omb/fedreg/ombdir15.html>
- Ventura, S. J., Abma, J. C., William D. Mosher, M. D., & Henshaw, S. K. (April 14, 2008). Estimated pregnancy rates by outcome for the United States, 1990–2004. *National Vital Statistics Reports*, 56(15). Retrieved April 22, 2008, from www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_15.pdf
- Vexler, E. (2007). *Voices heard: Latino adults and teens speak up about teen pregnancy*. Washington, DC: the National Campaign to Prevent Teen Pregnancy.

- Vexler, E. & Suellentrop, K. (2007). *How teen pregnancy prevention programs can better serve Latino youth*. Retrieved December 12, 2007, from http://www.teenpregnancy.org/espanol/PDF/voices_final.pdf
- Villarruel, A.M. (1998). Cultural influences on the sexual attitudes, beliefs, and norms of young Latina adolescents. *Journal of the Society of Pediatric Nurses*, 3(2),69-70.
- Waterton, C. & Wynne, B. (1999). Can focus groups access community views?. In R. Barbour & J Kitzinger (Eds.), *Developing Focus Group Research Politics, Theory and Practice* (pp 127-143). London: Sage Publications.
- Waxman, H. (December 2004). *The content of federally funded abstinence-only education programs*. Retrieved November 11, 2007, from <http://oversight.house.gov/documents/20041201102153-50247.pdf>
- Webb, C. & Kevern, J. (2001). Focus groups as a research method: a critiques of some aspects of their use in nursing research. *Journal of Advanced Nursing*, 33(6), 798-805.
- WHO. (1986). *The Ottawa Charter for health promotion*. Retrieved October 19, 2008 from <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>
- Williams, S. (1992). *Seeds of change: Community gardening in South Holyoke Massachusetts*. Amherst, MA: Hampshire College.
- Wolf, Z. R. & Heinzer, M. M. (1999). Substruction: Illustrating the connections from research question to analysis. *Journal of Professional Nursing*, 15(1), 33-37.
- Wong, D. L., Hockenberry-Eaton, M., Wilson, D., Winkelstein, M., Ahmann, E., & Divito-
- World Health Organization. (2001). *Department of reproductive health and research: Technical report*. Retrieved April 5, 2011 from <http://www.who.int/hrp/governance/ATR2000.pdf>