Ambivalent messages: Adolescents' perspectives on pregnancy and birth.

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Abstract:

Purpose

To examine, from a youth's perspective, adolescent pregnancy and parenting in Baltimore, Maryland, a city with high rates of adolescent pregnancy.

Methods

Six gender-stratified focus groups with 13- to 19-year-olds (4 female and 2 male groups; n = 47). We recorded focus groups, transcribed them verbatim, and analyzed them using the constant comparison method. Participants completed questionnaires to collect demographic and behavioral information.

Results

Results fit into a social-ecological framework. Individual (e.g., contraceptive use behaviors, religion), interpersonal (e.g., peer norms, maintaining male partners), and community (e.g., clinic factors, perceptions of community) level influences on adolescent pregnancy emerged. Participants discussed contradictory messages that were often gendered in their expectations; for instance, women were responsible for not getting pregnant and raising children. Adolescents expressed beliefs both against (e.g., challenging to complete school) and supporting early childrearing (e.g., religion). Recommendations for addressing the different influences included mentors, education, and community resources.

Conclusions

Adolescents' perspectives and values regarding pregnancy and parenting may not mirror traditional and expected norms for pregnancy and requirements for raising a child. These findings challenge the framing of existing interventions as they may not accurately reflect adolescents' values regarding pregnancy and parenting, and thus may need to be modified to highlight positive attitudes toward contraception and postponing pregnancy.

Keywords: adolescent pregnancy | urban youth | focus groups | public health | adolescent health | pregnancy | adolescent pregnancy | adolescent parents

Article:

Despite a one-third reduction since 1990, the United States still has the highest rate of adolescent pregnancy among comparable countries (68 pregnancies per 1,000 females) [1] and [2]. Approximately one in three American females becomes pregnant by age 20 years, about half of which result in a live birth [3]. Substantial racial, ethnic, and social disparities exist with disproportionately high pregnancy and birth rates among young women of color [4] and [5], particularly among adolescents living in low-income urban centers such as Baltimore, Maryland. With at least 30% of youth living in poverty [6], Baltimore has one of the nation's highest adolescent birth rates: 66.4 per 1,000 females age 15–19 years and 1.3 per 1,000 females under age 15 years [7]. In 2007, Hispanic/Latino adolescents in Baltimore had the highest rates of adolescent births (95.5 per 1,000 young women) [8]. African American adolescents had the next highest rate (50.8 per 1,000 young women), followed by non-Hispanic white adolescents (19.4 per 1,000 young women) [8].

Adolescent pregnancy is associated with social, economic, and physical consequences. Adolescent mothers are less likely to graduate from high school [9], are at a higher risk of living in poverty and receiving public assistance [10], and are less likely to be married at age 35 years [11]. Babies of adolescent mothers are more likely than infants born to older mothers to be born premature and at low birth weight [12]. Children of adolescent mothers are at increased risk of suffering abuse and neglect [13], are less prepared to enter school, and score lower on assessments of cognition, knowledge, and language development compared with children of older mothers [10]. These children are also more likely to become adolescent parents themselves [14]. Society bears the economic burden associated with adolescent births. In 2008, it was estimated that adolescent pregnancy costs taxpayers $10.9 billion annually, and in Maryland the cost was estimated at $229 million [15].

Lower socioeconomic status, poor school performance and attendance, and race/ethnicity have all been correlated with positive or ambivalent feelings about adolescent parenting [16], [17] and [18]. Adolescents with positive views of adolescent parenting often state that having a baby will

give them purpose in life, someone to love who reciprocates that love, and maturity [19]. They note the disadvantages of adolescent parenting as having insufficient financial resources to support the child, not having their "life together" enough to raise the child, and social isolation [19]. Adolescents' ambivalence toward pregnancy has been shown in several studies [18] and [20] and is often attributed to inconsistent or lack of contraceptive use [21] and [22], even among those who have access to contraception [22]. In two waves of the National Longitudinal Study of Adolescent Health, 22% of the participants were either pro-pregnancy or ambivalent [21]. Among those who were ambivalent and reported being sexually active (53%), there were reduced odds of consistent contraceptive use [21]. However, having a positive attitude toward contraception increased the odds of use [21].

Several risk and protective factors that align with the social-ecological model affect adolescents' decisions and attitudes regarding sexual activity, use of contraception, and adolescent pregnancy. Some of these interconnected factors include sexual values (individual), peer network experiences and acceptance, connection to adults and organizations that encourage safe sexual behaviors (interpersonal), and disadvantage and disorganization in the lives and environments of adolescents (community) [3], [17] and [21]. Given the potential consequences of adolescent pregnancy and childbearing, a better understanding of the influential, multilevel factors among urban youths is essential. Youths, including adolescent parents, are critical yet under-represented [17] in research seeking to elucidate population-specific and culturally relevant insights. Accordingly, this study examined the context of adolescent pregnancy and parenting in Baltimore from youths' perspective.

Methods

Study procedures

We recruited adolescent boys and girls from five geographically representative areas in Baltimore through the use of flyers in English and Spanish posted by staff (e.g., clinic waiting room, outside of classrooms). Eligible participants were between 13 and 19 years of age, spoke English or Spanish, and were residents of Baltimore City. Interested participants received a letter of invitation that described the purpose, procedures, risks, and benefits of participation.

We conducted focus groups to elicit perceptions of adolescent pregnancy and parenting and effective strategies to prevent or reduce adolescent pregnancy in Baltimore. We conducted a total of six gender-stratified focus groups (4 female and 2 male groups; n = 47). Three groups consisted of in-school adolescents (one male and one female African American/Euro-American

and one Latina female group), two groups were with out-of-school boys and girls, and an additional female group consisted of adolescents recruited from a community clinic. The percentage of adolescents in each group who had previous coital experience ranged from 44% to 100%, with higher rates among the male groups. Most reported condoms as the most frequent contraceptive used at last coitus. Of the participants, 11% were parents or expecting, including four adolescent mothers, one adolescent father, and one pregnant participant. Table 1 lists participants' characteristics.

Table 1.

Participant demographics

Characteristics of focus group participants (n = 47)	
Variable	% (n)
Mean age	17
Sex	
Female	63.8 (30)
Male	36.2 (17)
Race/ethnicity	
White	2.1 (1)
Black	70.2 (33)
American Indian or Alaska Native	4.3 (2)
Hispanic/Latino	19.1 (9)
Other	4.3 (2)
School status	
Not enrolled	2.1 (1)
No, I've already graduated from high school (have my Graduate Equivalency Diploma)	2.1 (1)
Yes, I'm in high school	61.7 (29)
Yes, I'm taking Graduate Equivalency Diploma classes	34.0 (16)
Employment status (missing n = 2)	

No.	75.6 (34)
Yes, I work part time	22.2 (10)
Yes, I work full time	2.2 (1)
Sexual activity (missing n = 2)	
Have you ever had sex?	
No	28.9 (13)
Yes	71.1 (32)
Contraceptive method used during last sex (missing n = 8)	
Birth control pills	18.4 (7)
Condoms	52.8 (19)
Depo-Provera	14.3 (5)
Withdrawal	5.7 (2)
Don't remember	11.8 (4)
Other method	4.2 (2)
Parental status (missing n = 4)	
No	79.1 (34)
No, but I am pregnant right now	4.7 (2)
Yes	16.3 (7)
One child	87.5 (6)
Two children	12.5 (1)
Mean age first sex (years)	
Females	13–14
Males	11–12
Mean number of partners in the past 3 months	1

A semistructured interview guide was focused on attitudes and beliefs regarding adolescent pregnancy (e.g., "What do you think about teen pregnancy in Baltimore City?" "Do you know anyone who has been or gotten someone pregnant? How has it affected them?"), knowledge and attitudes about accessing family planning services (e.g., "If you or your friend told you that they didn't want to get pregnant or get someone else pregnant, where would you tell them to go?"), and recommendations for pregnancy prevention programs (e.g., "What is missing from your community that would help teens wait to have sex, have safer sex, and/or prevent pregnancy?").

As most participants self-identified as African American, a qualitatively trained African American woman facilitated the focus groups. The forthright discussions that occurred in each session suggest that a female facilitator did not inhibit discussions in the male groups. An assistant was present at each group to take notes, capture nonverbal communication, and translate if necessary for the Latina group. At the start of each group, the facilitator explained the purpose and procedures, explained that there were no right or wrong answers, and encouraged each participant to express his or her opinions. At the conclusion of each group, the facilitator clarified any misconceptions expressed during the discussion and answered any questions. Participants completed an anonymous survey about demographics, sexual activity, and contraceptive use, and received a $20 gift card. The Chesapeake Institutional Review Board approved the study protocol.

Data analysis

Sessions lasted 90 to 120 minutes and were recorded and transcribed verbatim. We entered transcripts into Atlas.ti 6.2 (Scientific Software Development GmbH, Berlin, Germany) and analyzed them using the constant comparative method [23]. We created a coding dictionary based on literature using a social-ecological framework [24] and preliminary readings of transcripts. A trained researcher coded all transcripts, and analytical memos were written to summarize the codes. We then searched transcripts for negative cases to identify exceptions to the initial themes and modify codes as needed [23]. Coding discrepancies were resolved by discussion. We then selected quotes that best represented the commonalities and variations among the youths, and edited them for readability and clarity. Descriptive statistics summarized the demographic data.

Results

Adolescents discussed different influences on adolescent pregnancy and birth that were consistent with the social-ecological model, including individual, peer, family, and community.

Within each of these categories, adolescents discussed risk and protective factors (Box 1, Box 2 and Box 3) and provided suggestions (Box 4) for addressing adolescent pregnancy.

Box 1.
Self/individual factors: illustrative (and contradictory) participant quotes

Age and timing of pregnancy

"It is out of control and the thing is, they are getting younger. More pregnant girls and they are getting younger." (Female participant)

"It's not having a child as a teenager that is the issue; it is not having the money to take care of the child. If we had money, this wouldn't be an issue." (Male participant)

"I think it's better when you have kids when you're young; you have more energy, more time and can relate to them better. You all, I don't know who is waiting in here to have kids until they are 30 and married. You going to be raising kids at 30 and mine will be grown." (Female participant)

Contraception use

"Condoms, right, you don't feel nothing. Using a condom, you think something is wrong with you. I will wear one but I won't be as strong." (Male participant)

Church and religion

"Jesus' mother, Mary, had Jesus when she was 15 years old, so in biblical ways people were never too young. People our age were having babies and it was normal. … So I think that people put it in your mind that you are too young to have babies. Your mother tells you, 'Oh she is too young.' It's a stigma; I don't think you are ever too young, you just got to be ready." (Female participant)

"My thought about pregnancy is that it is a blessing. It is a blessing to have a child put into your life if you think about it." (Male participant)

"I thought God wanted [the pregnancy] to happen, so I don't go against that." (Male participant)

Box 2.
Interpersonal factors: illustrative (and contradictory) participant quotes

Peer norms and expectations

"The age range is too young because some people just want to do what their home girls are doing. … It's like, if we have had sex, then we go and tell our friend, girl, you got to go do it." (Female participant)

P1: … But listen, it is as simple as not doing it, not giving in to peer pressure. You said your friends are going to be on you, but I can say I can wait. Your heart just says you can wait.

P2: So your girlfriend is pressuring you to have sex and you still will not have sex?

P1: Yeah, I won't do it.

P3: Are you waiting to get married?

P1: We haven't discussed marriage. But if I have to make a choice, I would like to wait until I get to college. (Male participants)

Maintaining male partners

P1: Girls just want to keep having babies because they think it's going to hold the guys. They think it is going to keep the boys.

P2: No. Because my child, I am not with his father. I'm just saying, you were saying that a lot of girls keep having babies so the man can stay. But the men are not going to stay.

P3: But you can be married and have a baby by your husband and he can still leave or cheat on you.

P1: But a lot of girls do crazy stuff so the boy can stay with them. (Female participants)

Gendered poles around pregnancy outcomes

"[Girls] make their own decisions; they make decisions they got to live with. If you have sex and you end up pregnant and you gotta raise your baby, that is something you gotta live with." (Female participant)

Parents (mothers) and caretakers

"I blame teen pregnancy on the parents as much as I blame it on the kids. I'm going to tell you why, because at the same time you know how we call girls dummies, because their mothers haven't talked to them about sex." (Female participant)

"[Having parents watch the kid] makes it easy on them. They get used to someone else taking care of [kids]. Then they pop up with another one. And the parent will start to say, 'I shouldn't help her all the time.' She wanted to lay down and have the babies and she is going to have to stay in and take care of the babies." (Female participant)

Box 3.
Community factors: illustrative participant quotes

Clinic factors

"I go to the school clinic and I went in there after somebody and the nurses were like, Oh my god, these kids have high blood pressure. I feel as though you are letting them down …" (Female participant)

"They don't put your business on the street. Like, you don't want to go to a clinic where they are going to tell everybody and their baby mother that this girl is about to have sex and she needs some birth control over the intercom and embarrass her. They sit you down one on and tell you the steps to prevent pregnancy." (Female participant)

"I think that all of these girls are getting pregnant because they can sneak around and go to the clinic getting protection without their parents' permission. … You can't put a band aid on a bleeding wound. They are just trying to cover it up, so those girls likely will come back pregnant, they will come back with a sexually transmitted disease or STI and then they want an abortion." (Female participant)

Community perceptions

"My community is dead; I don't really care about my community." (Female participant)

"There are more things in the community that wants you to have sex … than stuff that makes you want to wait to have sex." (Female participant)

Box 4.
Recommendations: illustrative participant quotes

Mentors/advocates

"The support groups could be led by teenagers. Maybe someone that has already had a child; someone who can relate to what is going on and can talk about it." (Female participant)

"Somebody that is between the ages of the kids and the parents. Because the kids are too scared to talk to their parents, because their parents are too old, but they talk to their home girls but they [are] too young. So you put someone in between and they get the [best of] both two worlds." (Female participant)

"Someone who can listen; someone we can trust; someone who speaks both English and Spanish." (Female participant)

Education and community resources

"Advertisement about the programs that already exist." (Female participant)

"If everyone was doing something constructive, that would be better. ... You know where you and your friends get together and do something that is going to benefit the community? So it keeps you busy and so you don't think about sex." (Male participant)

Individual influence

Participants' perceptions of adolescent pregnancy and parenting varied (Box 1). Some believed that the age of pregnancy was irrelevant. In all but one group, participants supported adolescent parenting as long as the young woman and man were "ready" and had jobs to pay for the baby;

there was little acknowledgment of a relationship (e.g., marriage) as a helpful component of parenting. Participants also discussed the value of having children earlier in life.

Many participants reported distress about the number of young women having babies. Few participants indicated awareness of the consequences of adolescent pregnancy for high school completion or dropout, employment opportunities, finding child care, and grandparents raising the child. One participant, however, reported: "Pregnancy is a real problem because, for example, you have to find someone to take care of the kid and you can't find a job. It closes opportunities."

Male participants highlighted a gendered experience of pregnancy and contraception. They described condoms as something that frequently inhibited their experience. The focus on their manhood as related to condom nonuse reflected a focus on the immediate pleasure of sex, not the potential consequences. The tactile experience was more salient than safe sex because of the negative meaning (e.g., threat to their masculinity) imbued with condom use.

The way in which participants internalized religious messages was unexpected (Box 1). Church and religion were reported as influencing and rationalizing pregnancy. Some participants expressed the belief that it is God's will to become pregnant and/or have a child. Discussions focused on religious beliefs as a supporting factor, with no comments on the doctrines of abstinence before marriage.

Peer influence

Whereas peer pressure to follow social norms was a strong influence on sexual behaviors and adolescent pregnancy attitudes (Box 2), the discussions of peer influence were gendered. For instance, the only participant to describe a situation of not succumbing to peer pressure was a young man. Young women debated the role of sex and pregnancy in sustaining relationships with male partners: "… Some girls think that when they lay down with a boy, [the boys] are going to love them forever." Young men, on the other hand, rarely discussed sex within a relational context.

Young women further highlighted the gendered experiences of adolescent pregnancy and childrearing. There was a consistent message across groups that taking care of pregnancy outcomes (i.e., children and/or abortions) was the woman's responsibility. One boy corroborated

the gendered experiences of pregnancy outcomes, discussing the discrepancy between his readiness to have a baby and his partner's ultimate choice to abort: "I wanted to have the baby, but she said she wasn't ready to have a baby so she had an abortion. … I was ready."

Family influence

Parents, primarily mothers, were identified as important influences on adolescent pregnancy, with often contradictory and gendered messages. Parents were reported as frequently too permissive and contributing to adolescent pregnancy (Box 2). Having a mother who was an adolescent parent herself served as both a positive and negative influence and created a space in which young women received conflicting messages. Some youths thought that young women were getting pregnant because their mothers modeled this experience, continuing the adolescent pregnancy cycle: "… They are probably taking after their parents. Their parents were probably young when they had them." Furthermore, grandparents taking care of the baby was described as problematic and a contributor to the issue. For example: "Like some girls be like, 'Ma, can you watch my baby?' and the parent won't complain, won't say nothing, especially the grandmothers."

Other youths reported that parents provided assistance in the prevention of adolescent pregnancy. For example, one young woman discussed how her mother's experience served as a motivation for pregnancy prevention and her abortion: "Because my mother had me at 15 and I didn't want to repeat the cycle … and since then I have not become pregnant again." A few young women indicated that they were fearful that their parents would kick them out of the house if they got pregnant, providing them an incentive to practice safe sex.

A male participant described the message that he received about sex: "…You can have sex whenever. Like our fathers say, you can do whatever you want, just don't bring any babies home." These comments highlighted gendered messages toward young women and men. Messages toward young women were more reactive, focused on not having sex and avoiding pregnancy, whereas the messages to young men were more proactive, emphasizing behaviors and pleasure with less attention to their role in potential consequences.

Community factors

Youths described community and contextual factors that affected adolescent pregnancy (Box 3). Participants identified resources in their community that helped prevent adolescent pregnancy,

such as youth-focused clinical services. Many youths depended on and even preferred in-school options for contraceptive and sexually transmitted infections (STIs)/human immunodeficiency virus testing and services. They discussed school based health centers as "real convenient" and appreciated access to birth control and condoms, as well as the fact that "you can get tested for everything." One concern with school based clinics, however, was the perceived lack of confidentiality and not meeting expectations. Conversely, participants appreciated the confidentiality of community health clinics (e.g., "You don't have to tell your parents"). Other than a few organizations located in their neighborhoods or schools, youths lacked knowledge of community resources to obtain contraceptives and access information about sexual and reproductive health. Nevertheless, one participant commented that the availability of clinics and free condoms may not address the root causes of adolescent pregnancy and STIs.

Some participants noted the limitations of resource and support in their communities, suggesting that some issues may be related to contextual forces, such as poverty. As one participant stated, "My community is dead; I don't really care about my community." This provides a challenging environment for young people to make healthy decisions about sexual behaviors and pregnancy prevention. In summarizing their experience, an adolescent observed that "There are more things in the community that want you to have sex … than stuff that makes you want to wait to have sex."

Recommendations

Youths discussed factors to address adolescent pregnancy in Baltimore: mentors and advocates, and education and resources (Box 4). A primary interest was in having a person or people to talk to about sexual health and other concerns. One participant noted that this person should have particular characteristics and skills (i.e., trustworthy, bilingual). Others suggested that such people should function as health educators: "The community needs people to talk to teens about how to overcome peer pressure." Youths also desired to talk to or learn from peers or near-peers who had intimate knowledge of adolescent pregnancy and could empathize with adolescent parents—a person who "… already experienced [pregnancy] because they know about [pregnancy]." Others reported that the ideal person should be a slightly older person who could speak to his or her own experiences and knowledge.

Youths also suggested reducing adolescent pregnancy through education and community resources. Community programs and "sex education classes in school" were considered important but insufficient venues for addressing adolescent pregnancy. Increasing attention on existing programs was discussed as important to increase young people's awareness. Adolescents

also discussed the provision of particular resources in the community to reduce adolescent pregnancy. Participants wanted access to condoms (especially the Trojan Ecstasy); one participant proposed: "Free condoms on every corner. Why do they charge for condoms?" Furthermore, participants suggested opportunities for youth-specific activities that were constructive and meaningful to maintain a connection to their community and give them something to do besides having sex.

Discussion

This study highlights the different social-ecological influences in Baltimore that may encourage or discourage adolescent pregnancy [24], and underscores the importance of understanding the larger social context of adolescents' lives. The participating adolescents described the major challenges in reducing adolescent pregnancy—individual attitudes, peer expectations, parental messages, and limited community resources. The findings emphasize the importance of using multilevel strategies to ensure long-term program sustainability and success [25], [26] and [27].

The views on adolescent pregnancy and parenting varied. In most groups, initial condemnation was challenged by participants who believed that the ability to take care of a baby was sufficient to have a child. Many adolescents presented an ambivalent attitude toward pregnancy and timing—planned (which is rare) and unintended. These expectations reflect distinct challenges for pregnancy prevention efforts and highlight the need to both assess pregnancy intentions in a variety of ways and approach the development of adolescent pregnancy prevention programming differently [28] and [29]. For instance, programs could promote positive contraceptive attitudes instead of focusing on negative outcomes related to early pregnancy [21].

Pregnancy and childbearing readiness were limited to discussions of economics rather than emotional or mental preparation and maturation. Furthermore, parenting was discussed primarily outside the context of a relationship (e.g., marriage), which may reflect these adolescents' realities, in which having a baby is viewed as more likely than getting married. There seemed to be limited recognition of the link between education and economic wellbeing and lack of a well-developed sense of the effect of children on one's life. For example, discussions of the difficulties of finishing school as an adolescent parent were rarely noted [10], [13] and [30].

Participants' application of religious messages often provided a rationalization for pregnancy. In this study, several adolescents provided a sentiment that an unintended pregnancy is "what God wants," which may discourage the use of prevention strategies. This discourse is especially

important because research suggests that religion can be protective, especially for adolescents of color [31] and [32]. Whereas adolescent sexuality can be challenging for faith communities, interventions that incorporate the faith community have implications for supporting comprehensive efforts to reduce adolescent pregnancy [32].

Parents, especially mothers, were described on a continuum from enablers to sex educators, which reflects both their mixed messages about sexual behavior and their important role in pregnancy prevention for adolescents. This is particularly pertinent given the influence that family disorganization can have on adolescents' decisions regarding sexual activity and use of contraception [33]. The findings emphasize the importance of engaging parents to reduce adolescent pregnancy by providing more consistent messages and room for conversations to help counteract some of the peer pressure adolescents receive.

Participants discussed gendered experiences of and messages related to sex, pregnancy, and parenting. Fitting into adolescents' brain development, which is characterized by higher risk taking and difficulty making decisions with considerations of long-term outcomes [34], young men focused on the immediate outcomes (e.g., pleasure) rather than the future consequences of their sexual behavior. Further, young men expressed beliefs about how potential threats to masculinity influenced their use of contraception, particularly condoms [35].

On the other hand, young women noted that the responsibility of pregnancy outcomes was the woman's [36]. Interestingly, one of the male participants described his readiness for parenthood at age 17, although his partner chose to have an abortion. The young woman was the sole decision maker, which demonstrates the inherent limitations of gender stereotypes in which women are often portrayed as powerless [36]. Thus, both men and women may diminish men's role in the pregnancy and birth experience. These gendered expectations require a reconceptualization of adolescent relationships and pregnancy and integration of gender transformative approaches into adolescent pregnancy prevention efforts in which the role of male youths in pregnancy and birth needs more attention [37].

The community context was identified as important in promoting healthy sexual development, addressing adolescent pregnancy, and comprehensively understanding youths' reproductive decisions. Participants identified resources in their community that helped prevent adolescent pregnancy, including school-based health centers and youth-focused community health clinics. Adolescents' suggestions for mentors—both peers and near-peers—highlight the utility of this

approach for supporting healthy sexual development and for exposing young people to potential outcomes and alternatives of early parenting [38]. A mentor approach could be valuable for both adolescents and mentors in developing a stronger connection to their community and promoting sexual and reproductive health. Participants also discussed the resource limitations of communities (e.g., lack of youth organizations), which suggests that some issues may be related to contextual factors such as poverty, and may require structural interventions to address root causes [24].

Access to evidence-based, medically accurate, and comprehensive sex education and confidential contraceptive services have been shown to be essential to decreasing adolescent pregnancies and births [3]. Increased contraceptive use has been correlated with decreases in adolescent pregnancy over the past decade [39]. Some research recommends that rather than change attitudes toward pregnancy, positive attitudes about contraception should be promoted [21]. The need for these services was evident among these youth, because most could not identify sources for contraception beyond their immediate neighborhood or school. Youth with access to a school-based health center reported that this was their preferred source of care for reproductive or pregnancy-related services. However, perceived or real lack of confidentiality has been documented previously as a barrier to adolescents seeking contraceptive services [40]. Adolescents without easy access to services may be less likely to seek and use an effective contraceptive method.

Strengths and limitations

This study incorporated the voices of a variety of youths, including in- and out-of-school youths from a range of geographic areas in Baltimore, using a convenience sample. Despite the diversity of participants, youths in each focus group could discuss only their individual experiences, which may differ from those of other youths. Future studies should work to elucidate understanding of sexual networks and norms and identify strategies to improve reproductive health outcomes among youths in Baltimore and other urban locales.

This study provided a youth perspective on reducing adolescent pregnancy and birth rates. These findings suggest that using a social-ecological framework [28] to develop educational and policy-related programming is essential to address the complex individual, interpersonal, and community-level factors that influence adolescent sexual behaviors and pregnancy. The study underscores the importance of including young men and fathers and gender transformative approaches in adolescent pregnancy prevention efforts. Future studies should also explore how specific and consistent sexual health messages affect adolescents' behaviors in terms of sexual

behaviors and contraceptive and condom use, to see whether less contradictory messages create opportunities for youth to be "safer."

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