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## Distributing Condoms and "Hope": Race, Sex, and Science in Youth Sexual Health Promotion

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**DISTRIBUTING CONDOMS AND HOPE:  
RACE, SEX, AND SCIENCE IN YOUTH SEXUAL HEALTH PROMOTION**

A Dissertation Presented

by

CHRIS A. BARCELOS

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

DOCTOR OF PHILOSOPHY

September 2016

School of Public Health and Health Sciences

Department of Health Promotion and Policy

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David R. Buchanan, Chair of the  
Department of Health Promotion and Policy

For my father, Celso Anthony Barcelos,  
and my son, Clay Anthony Barcelos,  
without whom none of this would have possible.

## ACKNOWLEDGMENTS

Over the years I've heard numerous analogies comparing the process of writing a dissertation to pregnancy and childbirth. Such a comparison seems especially appropriate here, but instead I'll simply say that it takes an awful lot of people to raise a dissertation. This particular one was brought up by a number of mentors, colleagues, family and community members, only a few of whom I have the space to thank here.

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The utmost respect, acknowledgements, and gratitude goes to the people that participated in my research. A sincere thanks to the professional stakeholders interviewed for this project, who face abundant constraints in, as we say in health promotion, "trying to work ourselves out of a job." To the students at The Towne House, for being smart and sexy moms in the face of so much shame and stigma; I wouldn't have done this project were it not for your voices.

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To my family of choice, for supporting me through the precarity of life in countless ways: there are far too many of you to name, but a few people deserve special recognition. Josefa Scherer has stood by me through this entire process, and remains one of the most brilliant scholars I know. I love you to pieces and please don't ever stop fighting the good fight. Davey Shlasko came into my life at the tail end of this process,

but was nonetheless instrumental to making it happen. Davey, words in a dissertation acknowledgment are not sufficient to express how grateful I am to have you as a lover, friend, partner, comrade, and last but not least, dissertation editor. Finally, a special shout out goes to all the teen moms, young moms, slutmoms, queer families, welfare queens, and everyone else out there who dares to live fabulously and authentically in a world where our existence is abject. You all keep doing you.

My father, Celso, who passed away during the first year of my doctoral program, was the first, and for a long time only, person who believed in me. Without his support, I would not be here today, and it makes my heart heavy that he cannot be here to witness this.

Finally, to my son Clay, who thinks that teen pregnancy is bad except for the one that resulted in his birth, thank you so very much for “ruining” my life, because otherwise I never would have finished college, much less a doctorate. This is for you.



## **ABSTRACT**

### **DISTRIBUTING CONDOMS AND HOPE:**

### **RACE, SEX, AND SCIENCE IN YOUTH SEXUAL HEALTH PROMOTION**

SEPTEMBER 2016

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This project uses discursive, visual, and ethnographic approaches situated in a critical feminist methodology to understand how ways of knowing about youth sexuality and reproduction influence community health work. I understand the “problem” in this inquiry as the discursive contexts that limit critical ways of knowing about young people’s sexual subjectivities and practices and about the design of policies and programs. Although race, class, gender, and sexuality are understood in the public health literature as important social determinants of health, there is a lack of research that applies a critical, feminist lens to these constructs. I draw on three years of ethnographic research in a small, northeastern city with a large Puerto Rican population and high rates of teen pregnancy to illustrate how community health workers take up and transform discourses of race, science, and sexuality as well as how teen parents situate their embodied experiences within these discourses. I combine interviews with key informants, participant observation at coalition meetings and community events, and visual analysis of stories produced by pregnant and parenting young women to argue that the production of authoritative racialized, sexual scientific knowledge both obscures and contributes to health and social inequalities. The politics of youth sexuality and reproduction easily reify what everyone “knows to be true” and enable community health workers to naturalize claims about race, culture, sexual health, and causality. I argue that a reproductive justice framework can shift the discursive context of youth sexuality and reproduction in the city to promote racial, economic, and sexual justice.

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## CHAPTER 1

### THIS IS WHAT HAPPENS WHEN YOU GET PREGNANT AS A TEENAGER

#### A Reflexive Entry Point

Driving down Route 41 to Stockton from my apartment in Hatherleigh, a primarily white, middle- to upper-class college town, exemplifies the structural violence that is at the heart of this project, that is, the systematic—yet subtle—ways that individuals are harmed and disadvantaged by the way society is set up. Each time I drove to the small, post-industrial city I call “Stockton” to attend coalition meetings, interview policy makers and health care providers, or work with young parents, I was struck by the degree to which Route 41 provided a near perfect visual illustration of a socioeconomic gradient. It was not simply that Hatherleigh was whiter, richer, and more sexually “progressive” in comparison; the route illustrates the social, economic, racial, and political inequalities between Stockton in relation to the rest of the Algonquin River Valley as well as within the city itself. The drive south enters Stockton in the “Heights” neighborhood, where the population is 89% white, non-Hispanic, median annual income is \$65,000, and the teen birth rate is 34 births per 1,000 young women ages 15-19 each year. As you drive south, suburban style single-family homes and restaurants advertising brunch give way to worn brick tenements, empty lots, and a long-economically depressed downtown area where the major industry is health and human service work, staffed largely by people from outside the community. This area, known as the “Canals,” borders the factories that once made Stockton a vibrant city at the height of manufacturing.

Nowadays, the median income is \$13,230, the population is 90% Latinx,<sup>1</sup> and the teen birth rate is 154 births per 1,000 young women ages 15-19.

I could not help but note the sensations I felt each time I drove this route, the complications of my own social privilege as an academic and non-resident, my complex relationship to the project as a former pregnant teenager, and how the city so drastically turns from nourished homes and lawns to tired multi-family properties and brown lots. Like many other post-industrial cities in the US Northeast, this situation is the result of a intricate history of racial politics, rapidly changing economic structures, urban disinvestment, and the social production and regulation of sexualities and families. In Stockton, this visual socioeconomic gradient provides a backdrop for the ways in which youth sexual health work is understood, deployed, and regulated.

I drove this route one day in December 2013 to attend the quarterly meeting of the Stockton Adolescent Sexual Health Promotion Committee (SASHPC), a group composed of representatives from city government, health clinics, and social service organizations whose mission is to “develop community-based, multi-faceted approaches to decrease teen pregnancy and sexually transmitted infections (STIs) in Stockton.” Throughout my fieldwork, I spent many hours sitting in on meetings such as this, where groups of mostly white, female, middle-class, middle-age professionals lamented the “problem” of teen pregnancy in the city, a problem they saw themselves engaged in a valiant battle against. As I turned down Pear St. to the Stockton Boys & Girls Club, where the meeting was hosted, a blue BMW coupe cut me off and sped ahead. When I pulled up in front of the Club, I discovered that the driver of the vehicle was Hannah McNeil, a white, former

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<sup>1</sup> See page 26 of this chapter for an elaboration of this term.

nurse in her 60s who served as the Commissioner of the Stockton Board of Health and the Chair of SASHPC. Offering to help her unload the car, I found myself carrying in snacks piled into a tote bag from Lululemon, an upscale athletic wear company whose \$100 yoga pants would represent 12.5 hours of labor for a worker making the then \$8 state minimum wage.

Often in these meetings I felt like I was in the Bill Murray movie “Groundhog Day,” where a time warp forces the main characters to relive the same day over and over again. In SASHPC meetings, along with other coalitions and committees I observed during my research, the same issues were discussed, identical complaints were made, and similar strategies were proposed. As I later learned through archival documents, the focus of these efforts has been mostly unchanged since the beginnings of Stockton’s teen pregnancy prevention work in the early 1990s. This particular meeting exemplifies many of the main themes I explore in this dissertation: structural racism and classism, unacknowledged power relations, magical thinking about the causality of teen pregnancy and STIs, uncontested problem constructions, talking about sexuality without ever talking about sex, an unfaltering belief in, but strategic use of, scientific discourses, and the ways of knowing exhibited by professional like Hannah McNeil. However, this dissertation is not a story about “good” professionals trying to do right by young people versus “bad” professionals intent on regulating young people’s sexuality and reproduction. The story is at once both and neither, as it is much more complicated than an easy dichotomy. I have no doubt that these professionals were sincere in their beliefs and work in Stockton. Nevertheless, I aim to call attention to how their work reproduces racist ideologies surrounding certain young people’s bodies, sexualities, and reproductive decisions. Doing



so is not merely an exercise in understanding or eliminating health inequalities, but rather speaking truth to power.

On this particular day, while telling a story about “missed opportunities” to reduce the teen pregnancy rate in Stockton during earlier incarnations of the committee, Hannah shared that the work had always been a “passion” of hers that is “close to the heart.” I scribbled in my fieldnotes, “I don’t even know what to say about that,” noting the contradictions and politics inherent to a white, economically privileged professional woman who saw the prevention of pregnancy among low-income women of color “close to her heart.” This dissertation is one way of not only “saying something about that” but also reimagining what youth sexual health work in Stockton would look like through a reproductive justice framework, or a way of understanding sexuality, families, and reproduction that takes into account power relations. At this meeting, however, a critical lens was absent as committee members failed to acknowledge the impact of racism in the city, talked about youth sexuality in ways that were detached from pleasure, desire, and agency, and devised community health strategies without the input of those most affected by the issues at hand.

### **“How Do You Suppose You’re Going to Do That?”**

It’s difficult to know the precise bounds of an ethnographic research project—where it begins, where it turns, and where it ends. If I’m to trace this project to its origins, I’d have to return to my own unintended pregnancy at age 19. Shortly after I gave birth, a visiting nurse came to my father’s house, where I was living at the time, on a routine post-partum follow-up visit. She asked, the derision in her words all too noticeable, what I planned to do now that I had a baby. I replied that I wanted to go to college. “Well,” she

snorted, “How do you suppose you’re going to do that?” I can’t recall what I said, but whatever it was, it was a lie, because I really had no idea. Now, looking back, it’s almost as if I challenged her assumptions by going to college and then never really leaving, as I’ve been a post-secondary student almost continually since beginning an undergraduate degree. Like many of the young mothers in Stockton, and contrary to the dominant narrative, my “teen pregnancy” was not what ended my life, but what started it. Yet, I would be remiss if I let this anecdote pass without acknowledging the considerable privilege and cultural capital that enabled me to be the person conducting this research rather than being interviewed for it as a respondent. It is neither an accident, luck, nor the result of a meritocratic system that allowed me to follow this path, and it is not one that is equally open to all young people experiencing pregnancy while young, single, and poor.

For now it is sufficient to say that I got pregnant as a teenager and made a career out of it in the form of researching, writing, and teaching about sexuality and reproduction. Teen pregnancy, however, was the *very* last thing I wanted to conduct dissertation research about. In fact, as I finished my comprehensive exams I felt certain that I would rather do anything *but*. Yet, I’m not the first scholar whose dissertation topic chose them: a convergence of external funding and roots in Stockton’s professional public health circles made it a logical choice. Although over the years I have frequently joked, “I got knocked up as a teenager and now I’m stuck talking about teen pregnancy for the rest of my life,” I’ve come to appreciate that although this topic is not news to me, the social and political context of youth sexuality and reproduction is fertile ground for a critical social scientist. While teen pregnancy and the moral panic surrounding it is not a recent development, it remains a timely issue and deeply contested area for communities,

politicians, feminists, health and human service professionals, and cultural observers. Ultimately, this dissertation is not so much a story about teen pregnancy as it is a story about the structural violence that lies at the intersection of race, class, gender, and sexuality. Moreover, as I will illustrate, it is a story about the ways in which youth sexual promotion is always already about teen pregnancy *prevention*, and teen pregnancy prevention is always already about *race*.

### **Situating the Discursive Context**

A November 2014 New York Times op-ed by Nicholas Kristof is a good primer for illustrating the dominant ways of knowing and doing related to teen pregnancy in the United States. Kristof, who has been criticized by feminist journalists and academics (Bhatia, 2013; North, 2012) for his self-fashioning as an emancipator of oppressed women worldwide (Kristof & WuDunn, 2008) greatly over-simplifies the social and political context of youth sexual health by invoking a stalwart discourse on sexuality: responsibility. Kristof, to his credit, attempts to redirect the burden of responsibility toward the state and away from young people themselves, albeit in a manner that elides the racial politics of sexuality, contraception, and family formation (Kristof, 2014):

Here's a story of utter irresponsibility: About one-third of American girls become pregnant as teenagers.<sup>2</sup> But it's not just a story of heedless girls and boys who don't take precautions. This is also a tale of national irresponsibility and political irresponsibility — of us as a country failing our kids by refusing to invest in comprehensive sex education and birth control because we, too, don't plan ahead. I kind of understand how a teenage couple stuffed with hormones and enveloped in each other's arms could get carried away. But I'm just bewildered that

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<sup>2</sup> This widely cited statistic comes from data analyzed by the National Campaign to Prevent Teen and Unplanned Pregnancy (2011) that measures the cumulative risk of pregnancy before the age of 20 by adding together the yearly pregnancy rates of women ages 14–19, a technique that is not the standard epidemiological measure of cumulative risk (Rothman, Greenland, & Lash, 2008).

American politicians, stuffed with sanctimony and enveloped in self-righteousness, don't adequately invest at home or abroad in birth-control programs that would save the government money, chip away at poverty, reduce abortions and empower young people.

By invoking "responsibility," Kristof is using a keyword that signals deeply held American cultural values surrounding individualism, self-sufficiency, and personal responsibility (Fraser & Gordon, 1994). Whether intentional or not, its use also reifies a well-worn trope in American politics: the irresponsible, non-white, promiscuous woman who keeps having babies in order to increase the value of her welfare check.

In his brief piece, Kristof touches on nearly all of the taken-for-granted truths that comprise commonsense understandings about teen pregnancy and parenting. These are assumptions that I encountered over and over again both in my field research and in my analysis of policy documents, committee reports, health promotion campaigns and so on. These "truths" include that teen pregnancy is inherently problematic; having children inside a two-parent heterosexual middle-class marriage is the only legitimate family formation; teens are ignorant about their bodies and unable to make healthy decisions; abortion is undesirable; contraception is apolitical and uncomplicated; and teen pregnancy causes poverty, rather than the other way around. Kristof also deploys another common strategy I encountered in my research, one that is used by academics, activists, and professionals alike. He attempts to reframe the issues at hand from an individual level (blaming teens for being sexually irresponsible) to a structural level (misguided public policies around sex education and contraception are the problem). Like many people involved in this work, Kristof is unsuccessful. By failing to acknowledge the influence of racial and sexual politics, Kristof does little to address the structural

inequalities that might promote sexual and reproductive justice and increase the well being of vulnerable families.

### **Knowing Teen Pregnancy in Research and Policy**

The United States has one of the highest adolescent birth rates in the developed world, at approximately 25 births per 1,000 young women ages 15-19 each year (Hamilton, et al., 2015). In comparison, western European countries such as France and the Netherlands have dramatically lower rates, at 6 and 5 births per 1,000 women under the age of 20, respectively (World Bank, 2015). There is great disagreement on the causal factors related to this discrepancy, with poverty, lack of comprehensive sexuality education, lack of access to contraceptive services, and cultural attitudes about teen sexuality vying for attention in scientific and popular literature (Alford & Hauser, 2011). The problem of teen childbearing in the US is considered pervasive and is simultaneously defined as a public health problem (Rich-Edwards, 2002; Scally, 2002), a medical problem (Klein, 2005), a social problem (Bonell, 2004), and an economic problem (Hoffman, 2008). More recently, teen pregnancy has been characterized as a health disparities problem, with researchers noting the vast differences in teen birth rates by race and socioeconomic status (Kost & Henshaw, 2014; Penman-Aguilar, Carter, Snead, & Kourtis, 2013; Sisson, 2011).

Teen pregnancy, abortion, and birth rates in the United States have been on the decline for several decades. At 24.2 births per 1,000 women ages 15-19, the 2014 teen birth rate represents a 61% decline from its peak in 1991 (61.8 births per 1,000 ages

women 15-19). In 2010, the U.S. teen pregnancy rate<sup>3</sup> reached its lowest point in over 30 years (57.4 per 1,000), a 51% decline from its apex in 1990 (116.9 per 1,000) (Hamilton, et al., 2015). The 2010 teen abortion rate was 14.7 abortions per 1,000 women ages 15-19, the lowest since abortion was legalized (Kost & Henshaw, 2014). The rates for Hispanic/Latino and Black/African American young women remain about twice as high as their white, non-Hispanic counterparts, although they have fallen 51% and 56%, respectively, since their peaks in the early 1990s (Kost & Henshaw, 2014).

Although the adolescent birth rate has declined in the past few decades, the preoccupation with it has not (Wilson & Huntington, 2006). The U.S. Department of Health and Human Services *Healthy People 2020* project, the primary mechanism for planning health promotion activities in the country, includes numerous objectives on reducing adolescent pregnancy and increasing the proportion of adolescents who use contraception and/or receive sexual health education and who have never had sexual intercourse (U.S. Department of Health and Human Services, 2011). Preventing adolescent pregnancy first came under the purview of the US federal government in 1981 with The Adolescent Family Life (AFL) program (Title XX of the Public Health Service Act). This program authorized grants for programming that included prevention (in the form of promoting sexual health education and contraception) and supports for pregnant and parenting teens. However, by the 1996 passage of the Personal Responsibility and Work Opportunity Reconciliation Act (commonly referred to as “welfare reform”), the primary strategy of most federal teen pregnancy prevention efforts was the promotion of

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<sup>3</sup> The teenage pregnancy rate is composed of all pregnancies, including births, abortions and miscarriages. The teen birth rate is the generally used indicator for discussing teen pregnancy in the US and thus I will use it through this dissertation unless otherwise specified.

sexual abstinence. The Obama administration shifted away from the focus on abstinence with the establishment of two programs that provide federal funding for “evidence-based” teen pregnancy prevention initiatives: the Teen Pregnancy Prevention (TPP) and the Personal Responsibility Education Program (PREP). The TPP is a discretionary project that provides competitive grants to both public and private entities to fund “medically accurate and age appropriate” programs to reduce teen pregnancy. PREP created a new state grant initiative that appropriated \$375 million in mandatory spending for broad approach programs to educate young people on both abstinence and contraception in order to prevent pregnancy and sexually transmitted infections (STIs) (Solomon-Fears, 2016). President Obama’s proposed fiscal year 2017 federal budget is the first since 1996 to eliminate all funding for abstinence-focused programs. Other federal programs related to teen pregnancy include the Title X family planning program that provides preventive care and family planning services to low-income and uninsured individuals at sites nation wide (proposed \$300 million for FY17) and various funding streams to support teen pregnancy prevention research (proposed \$17 million for FY17). Teen pregnancy prevention therefore occurs through multiple levels and sites, including clinics, schools, research entities, community-based organizations, and through state and federal funding mechanisms.

The scholarly literature is replete with reports, data, interpretation, and polemics that detail the scope of the teen pregnancy problem from the perspectives noted earlier, namely that teen pregnancy and parenting are dire social, economic, health, and educational problems. For example, the National Campaign to Prevent Teen and Unplanned Pregnancy’s “Counting It Up” project reports that preventing adolescent

childbearing could save American taxpayers \$9.4 billion dollars per year (in terms of public assistance expenditures) (Hoffman, 2008).<sup>4</sup> Their “Why It Matters” series states that the sons of teenage mothers are more than twice as likely to be incarcerated as the sons of older mothers, teenage mothers are significantly more likely than mothers over the age of 20 to be reported for child abuse or neglect, children born to teen parents score significantly lower on measures of reading and math ability, and that teen pregnancy is linked to other “risky behaviors” such as substance abuse; they also emphasize that teen parents are disproportionately likely to not finish high and experience poverty. Language from their websites echoes a common cultural sentiment on teen pregnancy:

By preventing teen and unplanned pregnancy, we can significantly improve other serious social problems including poverty (especially child poverty), child abuse and neglect, father-absence, low birth weight, school failure, and poor preparation for the workforce (NCPTUP, 2016).

Amid such dire predictions on the social, economic, and health outcomes for young mothers and their children, some researchers have called attention to epistemological and methodological issues in constructing the teen pregnancy “problem.” First, as Debbie Lawlor and Mary Shaw (2002) note, defining adolescent childbearing as a problem is a reflection of what is currently considered to be socially, culturally, and economically acceptable. Likewise, Arline Geronimus (2003) posits that “teen pregnancy” is less a valid construct than it is a political tool that signifies “an abruptive shorthand that strikes exposed dominant cultural nerves about race, responsibility, and sexuality” (p. 887). She argues that the sustained social problem construction of early childbearing among low-income women of color serves to reinforce elite cultural interests and allows for the

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<sup>4</sup> The report does not explicitly illustrate its research methods and does not indicate if the results are statistically significant.



reproduction of privilege in advantaged social groups (Geronimus, 1996; Geronimus, 1997; Geronimus, 2003; Geronimus, 2004). These epistemological issues signal the ways in which the problem construction of teen reproduction produces and constrains research and policymaking.

Second, empirical findings on outcomes related to teen pregnancy are equivocal, and some research finds that early childbearing can even have *positive* effects. Scholars criticize research that finds considerable negative outcomes of adolescent childbearing for methodological problems such as confounding factors (Fessler, 2003; Furstenberg, 2003; Lawlor & Shaw, 2002; Rich-Edwards, 2002), selection bias (Geronimus, 2003; Rich-Edwards, 2002), failing to use appropriate comparison groups (Furstenberg, 2003; Geronimus, 2003; Geronimus & Korenman, 1993) and confirmation bias, particularly on the part of national advocacy organizations such as the National Campaign (Geronimus, 2003). To take one example, studies find that when an appropriate comparison group (such as sisters where one is a teen mother and one is not, or comparing young women who had miscarriages as teenagers) is used to assess the consequences of teen childbearing, many of these negative outcomes are minimized or disappear altogether. That is, the social, health, educational, and economic outcomes for teen mothers and their families are equivocal, with negative effects minimal and often short-lived, rather than sustained throughout the life course of the mother and her children (Fessler, 2003; Geronimus, 1996; Geronimus, 1997; Geronimus, 2003; Hotz, McElroy, & Sanders, 2005; Sisson, 2011).

Similarly, growing evidence suggests that poor educational and economic outcomes among young mothers are the result of preexisting poverty, not early

motherhood *per se* (Kearney & Levine, 2012). For example, Hotz et al., (2005) report contradictory findings on the relationship between age at first birth and lifetime earnings. They find that not delaying childbearing results in *increased* earnings over time: teen mothers would have earned an average of 31 percent less per year if they had delayed their childbearing. Finally, in contrast to the common notion that teen births result in adverse health outcomes, most teen births are medically low risk. While there are modest risks of low birth weight and preterm delivery for very young teens (those under 16 years of age) (Cunnington, 2001), the vast majority of teen births in the U.S. occur to older teens (Hamilton, et al., 2015), and some researchers have found young maternal age to be a protective factor against low birth weight and infant mortality in low-income communities (Rich-Edwards, et al. 2003; Geronimus, 1996; Geronimus, et al., 2001). Geronimus (2003) suggests that early childbearing, particularly among urban, African American young women living in poverty, may be an adaptive strategy to alter fertility-timing norms in order to deal with shortened health and life expectancies (known as the “weathering hypothesis”). Despite all this, the moral panic surrounding teen pregnancy and birth remains all pervasive. It is important to note that while this moral panic is directed at teen pregnancy and young mothers in general, it largely works largely through the bodies of poor women of color.

The extant scholarly research on teen pregnancy can be characterized into three broad (though not mutually exclusive or homogenous) approaches: teen pregnancy as a problem (the pathology approach), teen pregnancy as the symptom or outcome of a problem (the reform approach), and teen pregnancy as a discursively constructed problem (the critical approach). First, research in the pathology approach tends to construct

adolescent childbearing as an inexorable social, health, and economic problem and focuses on preventing teen pregnancy in order to alleviate the “costs and consequences” to society (Hoffman, 2008; Hoffman & Maynard, 2008). This body of research uses stigmatizing and pejorative language such as “kids having kids” (Hoffman & Maynard, 2008) and “the devastating consequences of teen pregnancy and parenthood” (Candie’s Foundation, 2015) and promotes a variety of strategies to prevent teen pregnancy. Ranging from the promotion of contraceptive services to restrictions on welfare assistance, these policies and programs view improving the lives of teen mothers and their children in strictly instrumental terms as a means to an end benefiting their children, reducing taxpayer burden, and/or reining in presumed sexual promiscuity. This approach sometimes acknowledges, but does not emphasize, socioeconomic or racial inequalities in the distribution and determinants of teen childbearing and lacks a historicized understanding of sexuality, fertility, race, and adolescence. Research in this approach generally views the determinants of teen pregnancy in terms of individual behaviors and attitudes such as “intentions toward abstinence or condom use” as well as, in the words of one report, “misperceptions, magical thinking, and ambivalence” on the part of teens (Kaye, Suellentrop, & Sloup, 2009), rather than the social structural factors such as racism, classism, and sexism that affect young people’s sexuality and reproduction.

The reform approach also understands teen childbearing as a social problem but differs in its conceptualization of causal mechanisms, consequences, and prevention strategies. Researchers in this group, which includes many feminist and public health researchers, posit poverty as a key determinant of teenage pregnancy and push for structural social change, instead of punitive policies or demonizing teen mothers, as the

primary policy strategy to address early childbearing. This body of research attributes the potential negative outcomes of adolescent childbearing not to the age of the mother *per se*, but instead the underlying socioeconomic inequality that itself results in negative social, economic, and health outcomes (Fessler, 2003; Kearney & Levine, 2012). Here the “problem” is not so much teen childbearing itself, but rather the social conditions that make some young people more likely to be teen parents and create disadvantages for those who do. Correspondingly, the determinants of teen pregnancy are often framed in terms of stratification (low-income and women of color are more like to be teen parents) and consequences are framed in terms of the inequality of outcomes for teen mothers (teen mothers face stigma and a lack of supportive services) (Sisson, 2011). Although the reform approach seeks to address structural issues, it tends to focus on the prevention of adolescent pregnancy through comprehensive sexual health education programs and increased access to contraception (Advocates for Youth, 2008; Kirby, 2007). Advocates of this approach argue that the focus on abstinence-based sex education not only exacerbates teen pregnancy rates but also denies young people a positive and healthy sexuality (Santelli et al., 2006). Key to the reform approach is a notion of “prevention as social justice” and “social change as a means of prevention” (Sisson, 2011); in other words, teen pregnancy is something that ought to be prevented, not because it is inherently pathological but there is a need to reform our frameworks and strategies.

The third approach, which I employ in this project and elsewhere (Barcelos, 2014), uses critical analytic frameworks to deconstruct the problem of adolescent childbearing and imagine radically distinct approaches to programming and policymaking. Central to this approach is an analysis of power that challenges easy

assumptions about the causes and consequences of and responses to teen childbearing. Following Foucault, this approach sees social power as not merely repressive, but also productive of identities, bodies, populations, and practices: power is everywhere (Foucault, 1977). The critical approach no doubt views inequality as problematic, but seeks to not simply remedy social inequality but also call attention to and shift hegemonic discourses on adolescent childbearing. For example, in her study of the politics of inclusive schooling for pregnant and parenting young women, Deidre Kelly (2000) uses a critical, feminist ethnographic approach not as a research for its own sake, but with the goal of challenging and transforming unequal power relations. Similarly, Catriona Macleod and Kevin Durrheim (2002) outline several ways in which a critical analysis can be utilized in feminist projects on teen pregnancy: to deconstruct taken-for-granted assumptions surrounding mothering, pregnancy, adolescence, sexuality, and reproduction; to refuse to represent teen pregnancy and motherhood as pathological; and to locate adolescent sexual and reproductive practices within historical and social specificities (p. 57). Thus, the critical approach does not aim to reform teen pregnancy prevention efforts but instead challenges what is and can be known about teen childbearing, thus illuminating the need to significantly transform policies and programs.

Wanda Pillow's work is an exemplar of the critical approach (Pillow, 2003a; Pillow, 2004; Pillow, 2006a; Pillow, 2006b). She extends her ethnographic work in a school-based teen parent program with a feminist genealogical analysis of how teen mothers are discursively positioned within educational policy. Pillow's method combines a Foucauldian analysis of how the body is used as a site of repressive and productive power with a feminist attention to how bodies are raced, classed, and gendered. Pillow

seeks to “trace not only *what is said* about teen mothers, but how teen mothers *are said* and what this means for the development and implementation of educational policy affecting school-age mothers” (2004, p. 8, emphasis added). Her explicitly feminist approach to Foucauldian genealogy illustrates how policies are aimed at regulating, reproducing, and surveilling young female bodies. Her embodied analysis offers a rich account of the pregnant and parenting body as a site where racialized fears about female sexuality are (re)produced and provides an important lens for my own work.

### **Statement of the Research “Problem”**

My project uses discursive, visual, and ethnographic approaches situated in a critical feminist methodology to understand how ways of knowing about youth sexuality and reproduction influence community health work. In this inquiry, youth sexual health promotion is a lens through which to view our cultural anxieties about unrestrained female sexuality, failure to adhere to white, middle-class childbearing norms, and an out of control welfare state. Because, as I will argue, youth sexual health promotion is always already about teen pregnancy, and teen pregnancy is always already about race, I utilize a case study of a racialized Northeastern city that sustains a long-held reputation as place of hyperfertile young Latinas. I understand the “problem” in this inquiry not as youth sexuality or reproduction itself, but rather the discursive contexts that limit critical ways of knowing, constructing policies, and providing programs and services. This project asks: How are social and public health discourses on youth sexuality and reproduction raced, classed, gendered, and sexualized? How do those working within the parameters of

what I call the “teen pregnancy prevention industrial complex”<sup>5</sup> take up, reproduce, and transform these discourses? How do pregnant and parenting young women situate themselves within the social and public health discourses on adolescent childbearing? What implication does this have for public health and social policy responses? Finally, this project asks how a feminist analysis of youth sexuality and reproduction in the United States informs a critical public health practice that recognizes multiple ways of knowing and plural techniques for inquiry.

### **Significance of the Inquiry**

As a result of widespread taken-for-granted assumptions about teen pregnancy as a social problem there is a dearth of critical inquiry into its social and political construction and, importantly, how young mothers make sense of their lives amid these discourses. While there is an established body of social science research that focuses on teen sexuality and reproduction (Fields, 2008; Fine & McClland, 2006; Fine & McClland, 2007; Garcia, 2012; Mann, 2013; Solinger, 2000; Tolman, 2002) there are relatively few public health scholars using critical epistemologies and methodologies to approach teen pregnancy. Much of the critical, feminist work on youth sexuality and reproduction focuses specifically on education and schooling (Fields, 2008; Fine & McClland, 2006; Kelly, 2000; Luttrell, 2003; Pillow, 2004). Although race, class, gender, and sexuality are understood in the public health literature as important social determinants of health, there is a lack of research that applies a critical, feminist lens to these constructs. Most health promotion scholarship on youth sexuality focuses myopically on promoting contraceptive use and “comprehensive” sexual health education

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<sup>5</sup> See chapter 3 for an elaboration of this concept.

while disregarding how “youth sexual health” is understood, deployed, and represented. My project adds a much needed approach to this literature by illustrating how social and public health discourses on youth sexuality and teen pregnancy are raced, classed, and gendered through both populations and individual bodies. This project contributes to literature in the social and behavioral health sciences by helping to articulate a theory and practice of critical public health and informing policymaking and programming on youth sexuality and reproduction. Additionally, it contributes to a growing body of scholarship that uses a reproductive justice framework by teasing out the forms of power that are implicated in teen pregnancy prevention.

The lack of critical inquiry on teen pregnancy and parenting within the field of community health studies makes this project significant in terms of its contribution to a critical public health. Despite a stated commitment to social justice (American Public Health Association, 2016), dominant approaches to health promotion research and practice in the United States disregard structural analyses in favor of a continued focus on manipulating individual health behaviors, emphasize paternalism, and lack an analysis of power (Buchanan, 2000). Critiques of the dominant (biomedical and positivist) paradigm in health promotion operate at the intersection of the politics of knowledge, an analysis of power, and the goals of social justice; they simultaneously critique the epistemological, ontological, and methodological aspects of the leading paradigm (Buchanan, 2000). First, although the field has acknowledged the explanatory power of social determinants of health (CSDH, 2008; Marmot, 2005; Marmot, 2007), health promotion continues to rely on micro-level behavior change strategies (Glanz, Rimer, & Viswanath, 2008) imposed on the marginalized by those with social, economic, and political power (Thompson &



Kumar, 2011).<sup>6</sup> It is important to consider why we focus on manipulating individual behaviors when we know that population-level changes in health status are best achieved by policy-level changes and large-scale social emancipation (CSDH, 2008; Daniels, Kennedy, & Kawachi, 1999; Hofrichter, 2003; Wilkinson & Marmot, 2003).<sup>7</sup> Second, scholars identify important problems in relying on positivist biomedical and behavioral science to solve health problems that are moral and political in nature (Green & Labonte, 2007; Nettleton & Bunton, 1995; Petersen & Lupton, 1996). This critique argues that there is no “value-free” state of health; indeed, the discipline of public health and the social production of knowledge around health are replete with value making. Similarly, the uncritical adaptation of “evidence-based” public health does not acknowledge its methodological limitations and the contested nature of evidence (Denzin, Lincoln, & Giardina, 2006; Goldenberg, 2006; House, 2008; Raphael, 2000), that is, what counts as evidence in hierarchies of power.

The discursive context of adolescent childbearing is a useful way to understand the possibilities of a critical public health. That teen pregnancy is unquestioningly understood as a significant public health problem limits what is and can be known about youth sexuality and reproduction. Inquiry rarely deviates from attempts to understand why young women become pregnant and how to prevent them from doing so, thus

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<sup>6</sup> For example, the foreword to 4<sup>th</sup> edition of the widely used textbook *Health Behavior and Health Education* states that “Health behavior change is our greatest hope for reducing the burden of preventable disease and death around the world.” This statement is surprising given the large body of literature documenting the degree to which social and economic inequality contributes to and exacerbates poor health.

<sup>7</sup> To take a historical example, dramatic declines in mortality rates during the late 19<sup>th</sup> to early 20<sup>th</sup> centuries are attributed not to individual health behaviors or health education campaign but rather macro-level social changes such as improved sanitation, the enactment of labor laws, and expansion of social programs.

delimiting and constraining the work of youth sexual promotion. Absent from taken-for-granted understandings and inquiries is an analysis of the power relations inherent to the regulation of youth sexuality and reproduction. As a result, the social and health problem construction is seen as neutral and value-free. To view teen childbearing through the lens of a critical public health enables us to critically examine the contested nature of the teen pregnancy “problem.”

This project also offers an important critique of programming and policymaking related to youth sexuality and reproduction and identifies strategies through which to shift health promotion work. Teen pregnancy prevention is considered a key public health issue in the United States (Lawlor & Shaw, 2002; Santelli, Lindberg, Finer, & Singh, 2007; Scally, 2002), and in Stockton, teen pregnancy prevention is seen as crucial to the social and economic revitalization of the city. Limited ways of knowing about adolescent childbearing are closely connected to the kinds of policies and programs that are created in order to prevent teen pregnancy or assist young mothers. For example, the public health literature identifies the need for increasing contraception use (Santelli et al., 2007), preventing sexually transmitted infections (Kershaw, Magriples, Westdahl, Rising, & Ickovics, 2009), and promoting consistent use of condoms (Van Horne, Wiemann, Berenson, Horwitz, & Volk, 2009) among young people. Policies and programs aimed at young mothers are primarily concerned with promoting skills and behaviors based on the image of promiscuous, bad mothers who are a drain on the welfare system and incapable of escaping intergenerational poverty. For example, a meta-analysis of 14 parenting programs for young mothers indicates that such programs focus on outcomes such as reducing the risk of child maltreatment and developmental delay, changing maternal

mealtime behavior, enhancing infants' cognitive development, supporting "parenting skills," and reinforcing the maternal role (Coren, Barlow, & Stewart-Brown, 2003). Yet, as Pillow (2003) asks:

What would happen if [older, middle-class women were]... put under the same scrutiny and regulation as teen mothers? What if our sexual and love lives, our mothering, our relationships, our dietary and health habits, our fiscal responsibility, our familial relationships, our career choices, and moral fortitude were continuously monitored and judged? Who could withstand this type of scrutiny? Would any of us be "good" mothers? (p. 154).

What would policies and programs look like if we began with an understanding of young people as agentic social and sexual subjects embedded in a system of stratified reproduction, that is, a system that values, promotes, and supports the childbearing of some groups (older, white, middle-class, heterosexual) and while condemning and regulating others' (young, poor, of color, queer) (Rapp & Ginsburg, 2001)? What would it look like if we understood the goal of providing services and programs for young people as speaking truth to power, transforming unjust social relations, and recognizing their families as valuable and valued? It is questions such as these that this project will address.

Finally, this project marks an important contribution to the literature on reproductive justice. The concept of reproductive justice (RJ) as a vision, movement, and framework was developed in the mid-1990s through women of color feminist activists in order to refocus individual level debates surrounding reproductive "rights" and "choice" to a broader analysis of racial, economic, cultural, and structural constraints on power (ACRJ, 2005; Luna & Luker, 2013; Ross, 2006; Silliman, Fried, Ross, & Gutiérrez, 2004). The widely cited 2005 report from *Asian Communities for Reproductive Justice* (now *Forward Together*) defines reproductive justice as:

The complete physical, mental, spiritual, political, economic, and social well-being of [all people], and will be achieved when [all people] have the economic, social, and political power and resources to make healthy decisions about [their] bodies, sexuality, and reproduction for [themselves], their families and communities in all areas of [their] lives.<sup>8</sup>

A reproductive justice analysis moves beyond what has historically been an emphasis on white, economically privileged women's access to contraception and safe, legal abortion to include the right to have children and parent them with dignity and support. The limitations of an individual-level, law reform centered approach to "rights" obscures how not all sexual and reproductive actors have the resources to exercise these rights. Likewise, RJ considers sexual and reproductive justice to be integrally linked to other struggles for social justice. For example, Loretta Ross (2006), one of the founders of *Sister Song*, a woman of color reproductive justice organization, emphasizes that an RJ approach works against the problem of isolating sexuality and reproduction from imbricated issues of economic, environmental, immigrant, and disability justice.

According to Zakyia Luna and Kristen Luker (2013), issues of reproductive justice related to the right to parent with dignity include population control, the criminalization of reproduction, the cultural shaming of teen mothers, incarcerated people's loss of reproductive rights, and resistance to expansive definitions of families beyond the nuclear norm. Luna and Luker note that RJ's shift from an activist to an academic concept has not been without complications: some scholars have taken up the RJ term while continuing to focus on narrowly defined reproductive rights, while others utilize an RJ framework but do not identify it as such. They call for a range of best practices in using the approach for academic scholarship, from clearing defining the term

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<sup>8</sup> In keeping with a commitment to a gender inclusive reproductive justice, I have changed the language in this definition to be gender neutral.

to engaging in fully participatory projects that center the most marginalized voices. Luna and Luker also emphasize the importance of research that examines the under-studied aspects of reproductive justice, such as the right to parent with dignity. Through its focus on the discursive practices of teen pregnancy prevention and the use of digital storytelling to highlight the voices of young mothers, my project engages with a number of under-studied reproductive justice issues and provides an empirical account of the importance of integrating the RJ framework in public health practice.

### **A Note on Language and Terminology**

Language is always political and fraught with meaning. Throughout this dissertation I will discuss how the deployment of language is used to serve various discursive projects. Wherever possible I am specific about the choice of words I use to describe participants, places, processes and so on. For now, I want to make clear to the reader some important notes about my general use of language and terminology. First, I subscribe to the belief that gender neutral and inclusive language is an important political choice. In my professional and political work I employ gender neutral language in order to call attention to how language is used in the service of sustaining or dismantling sexism as a system of oppression as well as to avoid making assumptions about a person's gender identity or expression. In this piece of writing, however, I use gendered terminology (in particular "mothers") in an intentional way. Academics and professionals doing teen pregnancy work increasingly use "expectant and parenting teens" to replace "teen mothers" in an attempt to call attention to the role of young men in pregnancy prevention, and, sometimes, as an attempt to avoid the stigmatized term "teen mom." I mainly use "teen mothers" for two reasons: first, because it is more accurate and specific.

Generally, when we are referring to teen *parents*, we are really talking about teen *mothers*, and using a gender neutral term can elide the racially coded and gendered meanings associated with young people who become parents, that is, most of the time we are referring to what is assumed to be a young woman of color. Second, while the reproductive justice movement has made important strides to being more inclusive of trans and gender nonconforming individuals, to the best of my knowledge the participants in this project are most comfortable with the use of language including “mothers” and “women,” and my writing in this dissertation reflects the language they used to describe themselves.

Another language issue concerns the use of the terms “adolescent pregnancy” versus “teen pregnancy” and “teen” versus “young” mom. The youth participants in this study are referred to as “young” or “teen” moms, as these are the terms they most often used to describe themselves. Some strongly identify with “teen mom,” while others distance themselves from it due to its negative connotations. The scholarly literature generally uses both “teen” and “adolescent” pregnancy interchangeably. Public health research usually does not acknowledge that “adolescence” is a relatively recent social construct thought to produce a particular and unique developmental period of the life course (Lesko, 2012). To the contrary, public health literature typically uses “teen” or “adolescence” to refer to anyone under the age of 21.<sup>9</sup> This is not a neutral choice when the majority of “teen” births in the United State occur to women who are 18 or 19 years of age and are thus legal adults. I use “teen” or “adolescent” pregnancy to connote the discursive context of childbearing outside of culturally sanctioned norms, rather than the

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<sup>9</sup> Up until January 25<sup>th</sup>, 2016, the National Institutes of Health considered any person under the age of 21 to be a “child” for the purposes of research protocols.

chronological age of the parent. For example, some of the participants in the study are 22 years of age, but still identify as “teen” or “young” parents, either because they became pregnant as a teenager or because they identify with the construct of “teen parent.” Finally, I distinguish between “youth” and “professional” participants, although some “youth” are over the age of majority. This distinction reflects the ways in which young people are positioned within teen pregnancy discourses, rather than revealing anything absolute about either group of participants.

A related language issue concerns how scholars and activists refer to the colonized peoples of the Caribbean and Latin America without using language that is androcentric or erases gender nonconforming individuals. Important conversations are taking place with regard to the best way to refer to such peoples in writing—using the masculine “Latino” to refer to entire groups of people is problematic, prompting the neologisms “Latin@” and “Latinx.” While imperfect, I use “Latinx” for the following reasons: unlike Latin@, it is inclusive of people with a nonbinary gender and has the benefit of the ability to be spoken aloud (pronounced “La-teen-ex”). Additionally, Latinx is quickly becoming the most common term used by intersectional scholars calling attention to and working against racialized and gendered oppressions (Scharrón-Del Río & Aja, 2015). I use the term “Latinx” to refer to hypothetical or unknown groups of people, whereas I use “Latina” where it is appropriate. When I use the term “Latino,” as in the “Latino culture narrative,” I do so intentionally to signal that I am talking about a discursive construction (one that is not necessarily concerned with addressing gender essentialism or gender-based oppression). Likewise, when referring to data, I use the term in the original interview or text, which is generally “Latino.”

Finally, unlike most of the research conducted in Stockton over the years, including numerous doctoral dissertations, I have chosen to use pseudonyms for the city itself in addition to participants, places, and organizations. This is a complicated choice, as making anonymous a place-based social inquiry is quite difficult. More than once I have presented my research at academic conferences nowhere near Stockton only to have an audience member raise their hand and say, “Oh, you mean [the name of the city]?” Despite the difficulties, I have attempted to protect the privacy of my participants and those associated with the city in general. There are two reasons for this; the first is related to confidentiality and the second is political. As I describe in the next chapter, my very non-random sample of interview respondents were chosen because they are key stakeholders in what I call Stockton’s “teen pregnancy prevention industrial complex.” These participants include the heads of public committees, well-known educators and healthcare providers as well as the mayor and superintendent of schools. Because I was interested in teasing out how these actors understand the social and political context of the work that they do, providing even the smallest degree of confidentiality was important in order for them to be able to speak freely. Thus, this confidentiality helped to promote the quality of my data. With all public figures, I offered to refer to them in the text as an “elected city official,” rather than their actual title, but all gave consent to use their specific position. Most offered to use their real name in the text, but I have chosen to use pseudonyms in an effort to protect the identity of many others who requested confidentiality.<sup>10</sup>

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<sup>10</sup> One of the problems associated with my choice to make Stockton anonymous is that it prevents me from citing data and sources that would reveal its identity. As such, there are many places in this dissertation that should include a citation but do not. Readers with concerns or questions about citations are invited to contact me.



The ethics of visual research are even more multifaceted than those related to traditional ethnographic methods of individual interviews and participant observation (Gubrium, Hill, & Flicker, 2014). Specific to the digital storytelling method I use in this dissertation, in addition to heightened vulnerability and loss of confidentiality, there are fuzzy boundaries with regards to the multiple uses of digital stories as research data, community development materials, and strategic communication products. Questions of ownership and representation, which are germane but often understated in ethnographic research, are especially relevant with visual research. Additionally, an ethical question of anonymity arises when participants in a digital storytelling project actively want their stories and identities to be public. With all of these complexities in mind, I have aimed to make choices surrounding representation and confidentiality that balance the situated needs of all of the people, places, and groups implicated in this research project. To this end, I have used pseudonyms, changed or omitted potentially identifying details, and edited visual imagery to protect the identities of all people and places depicted.

The decision to use pseudonyms is also political, as are many ethical choices in social research. Intervening in something that is already over-determined and over-represented is a complicated negotiation. Taking steps to protect the confidentiality of participants, those directly involved in the research and those simply implicated by it, is a strategy to avoid reifying Stockton as the “place with the teen pregnancy problem.” The story of teen pregnancy in Stockton is not a new story, and it is not a story that “ends.” It is not even really my story to tell, but I have chosen to tell it, and want to do so in a way that is mindful of a wide range of participant needs and desires. I believe that it is an important story to be told, especially in a critical way, despite the complexities and

constraints. I recognize the intricacies of these choices, and I know that “Stockton” will be immediately recognizable to many readers. If you are one of those readers, I encourage you to see Stockton with a beginner’s mind, to set aside what you already know to be true about its teen pregnancy “problem,” and view the city, its people, and its problems in a new way.

### **A Compulsory Caveat**

In her work on the politics of sexuality and reproduction in Puerto Rico, historian Laura Briggs writes: “I do not care how many Puerto Rican infants were born out of wedlock, but I am very interested in what made this such an important question for a such a long period of time, and what it tells us about who asks it” (2002, p. 201). Briggs’s comment echoes my position on teen pregnancy in Stockton and elsewhere: I do not care how many infants are born to mothers less than 20 years of age, but I am very interested in why public health and social policy is so concerned with rates of teen pregnancy and what that tells us about race, science, and sexuality. Invariably, when discussing this project or presenting its findings in settings ranging from academic conferences to casual conversations, I am called on to clarify whether or not I am “promoting” teen pregnancy or to adjudicate as to its status as a “problem.” That I must make this compulsory caveat speaks to how discourses surrounding adolescent childbearing constrain what is and can be known about young people’s sexuality and reproduction. Nonetheless, it is worth stating explicitly: I do not think teen pregnancy is a problem, and not least of all because I refuse to engage in the redemptive narrative that requires me to frame my own teen pregnancy as something pathological that must be prevented. I do think cultural framings of the sexuality and reproduction of low-income and women of color are a problem, as I

believe racism, economic inequality, heterosexism and so on are problems. What I want to “promote” is nothing less than a critical public health theory and practice that trades easy answers and polices for a praxis that re-envision sexual health promotion in terms of social and political transformation.

### **Organization of the Dissertation**

This dissertation is organized as follows: In chapter 2, I describe the methodological approaches and specific methods I utilize in my research. Critical social science research does not separate epistemology from methodology—that is, it does not separate our beliefs about what can known about the world with how we go about studying it. In this chapter I delineate how a feminist research methodology informs the ethnographic, visual, and discursive data collection and analysis. Chapter 3, “What Is It About Stockton?” situates my place-based inquiry in both historical and contemporary context through archival sources as well as through my own interview and participant observation data. I explore how politics of race, class, and gender structure narratives surrounding teen pregnancy in the city and the implications they have for youth sexual health work. Chapters 4, 5, and 6 constitute the substantive findings of the project. Chapter 4, “Bodies That Tell,” presents a narrative analysis of digital stories produced by pregnant and parenting young women in Stockton to argue for the importance of an embodied approach to representation and practice. Chapter 5, “‘It’s Their Culture’: Teen Pregnancy Prevention as Racial Project,” argues that a racial project of essentializing “Latino culture” works to obscure structural racism and inequalities in the city. I discuss how the conflation of race and culture enables a homogenous and deterministic Latinx culture that essentializes Latinx sexualities and positions young women as in need of

saving by benevolent outsiders. Chapter 6, “Sex, Science, and What Teens Do When It’s Dark Outside,” explores how sexual scientific discourses surrounding sexuality are taken up and deployed in Stockton. I describe how professional stakeholders engage in causal fantasies about teen pregnancy that conveniently ignore science while at the same time relying on it to legitimize particular truth claims. Finally, Chapter 7 concludes by considering how moving toward a reproductive justice framework can shift the discursive context of youth sexuality and reproduction in Stockton. I describe how reframing community health work in the city with a vision of reproductive justice enables new ways of knowing and doing that account for multiple and intersecting systems of oppression and envisions new forms of agency for marginalized sexual subjects.

## CHAPTER 2

### KNOWING ABOUT AND DOING SEXUALITY IN STOCKTON

#### Methodological Approach

Before describing the specific methods used in this inquiry, it is first necessary to delineate the methodological approaches in which they are grounded. Three interrelated issues inform the methodological approach and specific methods of this project. First, there is a lack of qualitative inquiry on teen pregnancy and parenting in the United States, particularly within the field of public health. Wilson and Huntington (2006) suggest that qualitative research on this topic is inhibited by the dominance of economic- and population-based studies on teen pregnancy and parenting for two reasons: qualitative findings are generally more positive (which present a challenge to dominant ways of knowing about adolescent childbearing) and the notion that qualitative inquiry is not really “research.” Moreover, Wilson and Huntington consider whether the reliance on scientific discourse—and its attendant assumptions of value-neutrality and truth-telling—limits *what is* and *can be known* about teen pregnancy. Undoubtedly, a lack of rich, “thick” description of youth sexuality and reproduction contributes to hegemonic discourses.

Second, and related, my methodological approach speaks to Michelle Fine and Sara McCelland’s (2006) call for a “critical sexuality science” that interrogates “that which is outside the already assumed.” As I discussed in the previous chapter, there is a lack of critical, feminist inquiry that challenges commonsense notions about youth sexuality and reproduction. For the most part, feminist research and theorizing does not challenge the social problem construction of teen pregnancy but rather focuses on calling

attention to inequalities in its distribution and determinants or proposing different approaches to prevention. Kelly (2000) presciently notes that even feminist and progressive researchers have a tendency to demonize teen pregnancy and “sometimes participate in discourses and institutional practices that construct teen mothers unacceptably different, as the Other” (p. 185). By failing to question taken-for-granted assumptions about teen pregnancy and parenting, many feminist researchers with good intentions nonetheless reproduce the pathology of early childbearing and reify stratified reproduction.

A third, closely related, issue concerns voice, representation, and embodiment. In both popular and scientific discourse youth sexual actors are rendered “unspeakable” and “knowable”—their voices and knowledges are generally not part of the public discourse (Gubrium, Krause & Jernigan, 2014). As Pillow (2004) notes, pregnant and parenting young women are both silenced *and* hyper-represented by discourses on adolescent childbearing in the United States. Despite the fact that the pregnant young woman is ubiquitous in public health discourse, there is very limited opportunity for teen mothers to voice their perspectives on the social dynamics and institutions that deeply affect their lives. More often, teens are compelled to participate in “rites of redemption” or serve as warning labels to other young women (Barcelos & Gubrium, 2014; Kelly, 2000).

Pillow obviates the issue of (hyper)representation by focusing exclusively on the discursive context of adolescent childbearing as it plays out in educational policy and practice, instead of focusing on the stories told by her ethnographic participants. I take a mixed approach that centers on illustrating and interrogating the public health discourses related to youth sexuality and reproduction while also including the stories produced by

pregnant and parenting teens in a digital storytelling workshop. This approach both works against dominant ways of knowing and doing about sexuality and reproduction and presents epistemological and methodological challenges for a critical social scientist, particularly around power and voice. My project does not attempt to “give voice” to marginalized young people, nor to expose any particular “truth” about their lives. The notion that researchers can “give” voice to research participants should be complicated, as Joey Sprague (2005) notes, as such a position problematically assumes that researchers have power, research participants do not, and that voice is something that is given downward in relations of power.

With these considerations in mind, my project uses discursive, visual, and ethnographic approaches situated in a critical feminist research methodology to understand how ways of knowing related to youth sexuality and reproduction affect health promotion policy and practice. Wanda Pillow and Cris Mayo (2007) argue that feminist ethnography begins from a different place than traditional ethnographic approaches, “a place that questions the power, authority, and subjectivity of the researcher as it questions the purposes of the research.” Although there is neither a unitary understanding of “feminism,” nor feminist research methods, there are some common elements germane to my project. Feminist *methodology* is a particular theory and analysis of how research does or should proceed (Harding as cited in Hesse-Biber & Leckenby, 2004), while *methods* are the specific strategies used to produce knowledge (i.e., surveys, interviews, etc). According to Sharlene Nagy Hesse-Biber and Denise Leckenby, “the process of interlocking epistemology, methodology, and method in feminist research shapes a synergistic perspective of research” (2004, p. 210). They also

note several other characteristics of feminist research: fluidity of research questions, conducting research *for* (not *on*) women<sup>1</sup>, tending to issues of difference, focusing on lived experiences, a commitment to reflexivity, and the goal of social transformation and emancipation. As Pillow and Mayo (2007) suggest, a key part of feminist research is looking at what is missing, what is passed over, and what is avoided. Likewise, Marjorie DeVault (1999) calls for research as an “excavation” that “pays attention to what is missing” (p. 208). Importantly, my project speaks to Pillow’s (2004, p. 8) call to analyze not only what *is said* about teen mothers, but *how teen mothers are said* and what this means for policy development and implementation. The lack of critical inquiry on teen pregnancy means that much is missing, passed over, and avoided in examining why young women become pregnant, who teen mothers are and how they make sense of their lives, and how to best improve the health of young people and their communities.

An important component of “critical” social science research is that it does not separate epistemology from methodology; that is, it does not decouple what we believe can be known about the world (and who knows it) with the strategies we use to study it. Sprague (2005) argues that what differentiates critical research from “uncritical” research is not the particular methods used (e.g., statistical modeling or participant observation), but rather how the methods are used, both technically and politically. Therefore, we must pay attention to the kinds of questions we ask, the analytic frames we use to interpret findings, and the ways we communicate the results of research (Sprague, 2005, p. 6). At the heart of critical research is a commitment to uncovering the reproduction of

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<sup>1</sup> Like other critical social scientists, I expand this to include subordinated or marginalized social groups, based on intersections of gender, social class, race/ethnicity, sexual orientation, citizenship status, ability, age, etc.



inequality and working toward social transformation and emancipation, a commitment that is at the heart of my inquiry.

### **Ethical Considerations**

In the tradition of feminist research, the ethical issues in this project extend beyond traditional social science and biomedical concerns of a favorable risk-benefit ratio and informed consent as understood through institutional review boards. Rather, my project understands research ethics as situated in a field of power relations that structure the selection of research topics and participants, the research interactions and encounters, and the practices of writing representation, and dissemination (Gubrium, Hill & Flicker, 2014). That I share positions in a matrix of domination (Collins, 2000) with *both* the professionals and young people in this study further complicates issues of power and representation. However, as Nancy Naples (2004) reminds us, “insider and outsidership are not fixed or static positions, rather, they are ever-shifting and permeable social locations that are differently experienced and expressed by community members” (p. 373). Assuming that there is an “insider” perspective to be gained by conducting research with members of your own community masks intersecting relations of power. Because in most cases the researcher maintains control over the interpretation of results and responsibility for the task of representation, power is always present (Hesse-Biber, 2007). This power is not a responsibility I take lightly.

A key component of my ethical approach is a reflexive commitment to interrogating the power relations inherent to the project. “Reflexivity” refers to the process of critically reflecting on how one’s own social identities and locations affect the

research process. Hesse-Biber and Piatelli (2006) argue that reflexivity can uncover new angles of vision, reveal invisible barriers of power or ethical concerns, and lead to greater understandings, less hierarchical relationships, and more authentic research. However, Pillow (2003b) asks us to reexamine the turn to reflexivity in qualitative research by acknowledging the limitations of the practice. She highlights the problems of confessional tales and “knowable” subjects, the desire to represent marginalized groups, complex power relationships, and the idea of reflexivity as transcending (mis)representation. Pillow doesn’t think we should abandon entirely the project of naming our positions and critically reflecting on how they affect the research process, but rather pay better attention to *how* to practice reflexivity and how these practices “impact, open up, or limit the possibilities for critical representations” (2003, p. 177). She calls for an “uncomfortable reflexivity” that “seeks to know while at the same time situates this knowing as tenuous” (Pillow, 2003b, p. 188). Throughout the process of conceptualizing my project, devising research questions, collecting and analyzing data, and writing this text, I have aimed for this sort of discomfort by engaging with the “messiness” of knowledge production in qualitative inquiry. In particular, I have tried to engage with the messiness of my status as a non-resident with race and class privilege who is also situated within hegemonic teen pregnancy discourses and works as an outsider in academia. These reflections on knowledge and power relationships inform the research decisions I describe below.

Despite the issues of representation and potential exploitation that ethnographic work including marginalized young people might entail, this project seeks to facilitate a space where the embodied knowledges of young mothers can begin to emerge, partial and

multiple though they are. The stories of young people, however, are not the main focus of this dissertation. I have chosen to focus primarily on how professional stakeholders take up and transform youth sexual health promotion discourses related to race, sex, and science for two main reasons. First, I have sought to simultaneously create a space for young people's voices while decentering them in an attempt to avoid so-called "poverty porn" and the duty of marginalized subjects to constantly "confess." In other words, there is an emancipatory potential in *not* always being the focus of research and policy interventions and a privilege in *not* having to tell your story (Zussman, 2012). Second, and related, the decision to emphasize professionals' discursive constructions is part of a strategy in "studying up" (Nader, 1972). Focusing on those in power, rather than, as is often the default in the social sciences, studying oppressed and marginalized social groups, is one strategy to "shift the way we see who is 'the problem' from those who are the victims of power to those who wield it disproportionately" (Sprague, 2005, p. 186). Studying up is a method of working toward redressing power imbalances by researching those who have the power to affect the lives of disadvantaged peoples. However, like "insider" or "outsider" research positions, studying "up" or "down" is a false dichotomy, and this dissertation might best be thought of as an attempt to study up, down, sideways, and all around.

### **Setting and Sites**

#### **Inequalities in Stockton**

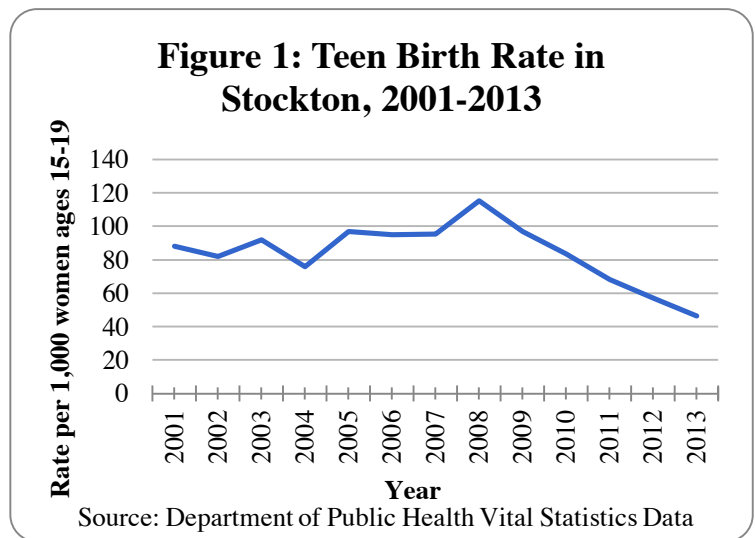
The place I call "Stockton" is a post-industrial Northeast city that sustains a long held reputation as a place with high levels of poverty, high school dropout, unemployment, substance abuse, and violence. It is recognized throughout the region as

the city with the state's highest rate of teen births. A former mill town known for its textile and paper factories, the city is among many in the U.S. that experienced considerable economic depression following the decline of manufacturing. After experiencing several waves of immigration throughout the 19th and 20th centuries, today nearly half of the population in the city is Latinx; the majority of whom are Puerto Rican, with many speaking Spanish as a first language. Stockton consistently ranks poorly in term of socioeconomic and educational indicators. The median annual household income in Stockton is \$35,550, compared to \$67,846 for the state. The U.S. Census estimates that 27% of all families in Stockton live below the federal poverty level compared to 8.3% statewide. Forty-two percent of families with children under 18 years of age in the city live below the federal poverty level, compared to 12% statewide. Fourteen percent of residents over the age of 25 have not completed high school or an equivalency, compared to 6% in the state as a whole. Whereas 40% of people in the state overall hold a bachelor's degree or higher, in Stockton that figure is only 23%. As I described in Chapter 1, there are significant socioeconomic inequalities both within Stockton and in relation to rest of the Algonquin River Valley region. Additionally, Stockton's close proximity to a number of colleges and universities, including a large, public, research university, means that it has long been the subject of academic scrutiny. I do not purport to stand outside this power dynamic; rather, I intend to call attention to how these power dynamics produce and exacerbate inequalities, particularly within community health work.

Stockton also fares poorly across numerous health status indicators. The city's rate of overall age-adjusted mortality, cancer mortality, and cardiovascular-related

mortality are all higher than the state as a whole. The rate of admission to state-funded substance abuse treatment facilities is 1.6 times higher than the state overall and the rate for injection drug use in particular is 1.75 times higher. In terms of sexual health indicators, the HIV/AIDS prevalence rate in the city is nearly three times higher than the state (705.8 cases per 100,000 versus 261 per 100,000). The rate of Gonorrhea infection among persons 15-19 years of age is 2.5 times higher than the state rate (193.4 per 100,000 versus 76.6 per 100,000) and the rate of Chlamydia infection in that age group is 3.5 times higher (4,771 per 100,000 versus 1,310 per 100,000).

The city is also well known for having the highest rate of births to women ages 15-19 in the state, a position it has held since 2002.<sup>2</sup> When I began fieldwork in Stockton 2011, the teen birth rate for the most recent year available (2009) was 96.8 births per 1,000 women ages 15-19, compared to 19.5 per 1,000 for the state as a whole. As in the United States



overall, the teen birth rate is on the decline in both the state and the project city.

The state has the second lowest teen birth rate in the nation, a rate 50% lower than the US rate (Ventura, et al., 2014). Racial differences in teen birth rates in Stockton and the state mirror those nationally. In 2010, the state birth rate among Hispanic<sup>3</sup> women ages 15-19

<sup>2</sup> Prior to 2002 Stockton had vacillated between the first and second spot since the late 1980s.

<sup>3</sup> The state department of public health data does not disaggregate Black, non-Hispanic and white, non-Hispanic.

was five times higher than the rate for whites (49.3 per 1,000 versus 10.4 per 1,000). In Stockton, the rate among Hispanic teens was three times higher than whites (99.3 per 1,000 versus 36 per 1,000). Chapter 3, “What Is It About Stockton?” considers these issues in depth and argues that the history of racial politics in the city is key to understanding the contemporary teen pregnancy prevention industrial complex.

### **Studying Teen Sexuality and Reproduction in Stockton: People and Places**

Stockton is an exemplar setting for studying sexual and reproductive politics. In particular, it is a useful site to explore sexual health and teen parenting in a population characterized as hyperfertile that has been subjected to a long history of reproductive control (Briggs, 2002; Chavez, 2008; Lopez, 2008). Given current fears among some white politicians regarding the “browning of America” and the rapid growth in the Latinx population, the U.S. panic surrounding immigration, and the history of regulating Latina reproductive bodies, the politics of sexuality in Stockton are all the more timely and relevant. Indeed, scholars and activists have noted a definitive shift toward the control of Latina reproduction in contemporary political structures: the specter of the Black “welfare queen” is being replaced by the hyperfertile, opportunistic Latina (Garcia, 2012; Mann, 2013). Although this study is not intended to be generalized to other communities or settings, the power dynamics I describe in this dissertation are certainly germane to locations beyond Stockton. Because growing wealth inequality has troubled deeply held beliefs in the American dream, particularly following the 2008 financial collapse, and because racial justice movements have gained increasing visibility in the mainstream culture, specifically around mass incarceration, police brutality, and health inequalities, Stockton is all the more relevant as site for researching health politics. Thus, while the

findings in this study may not be generalizable, they are undoubtedly transferrable to other settings in which reproductive politics play out in complex power dynamics. There are many Stocktons.

Stockton is a place of a great deal of social, health, and educational programming surrounding adolescent health, both in terms of pregnancy prevention and services for parenting young women; the following sections provide an overview of this work. After considerable public debate, in 2010 the Stockton school committee voted in favor of implementing a “comprehensive, scientifically-based” sexual health curriculum in the city’s public schools. Additional sexual health programming occurs through clinics, including the Stockton Community Health Center, and community-based organizations, including Girls Inc. and the Boys & Girls Club.

A major player in the area’s youth sexual health work, The PASH Network (Promoting Adolescent Sexual Health), serves as a visible organizing presence in the area with the goal of using “research, advocacy, and community education and collaboration to influence policy and practice in adolescent sexual health.” Malta Brigado, a physician with a master’s degree in public health, formed the PASH Network in 2006 and served as executive director until 2015. PASH is not a service-providing agency, but instead consists of, in their words, “diverse community stakeholders who work together to create a proactive, comprehensive response to adverse adolescent sexual health and adolescent sexuality.” In addition to serving as a stakeholder umbrella, PASH provides technical assistance and holds an annual community-based conference on youth sexual health.

In partnership with the Statewide Organization on Adolescent Pregnancy (SOAP), a statewide capacity-building organization, in 2010 the PASH Network was awarded \$1.1

million from the Centers for Disease Control and Prevention for the *Teens Count* initiative, a “multi-component, community-wide” effort to reduce teen pregnancy and STIs in Stockton and the neighboring city of Carlsborough, a larger, more racially mixed community that ranks 4<sup>th</sup> in the state for teen births. The goal of *Teens Count* was to reduce teen birth rates in these cities by 10% in five years through community mobilization, clinical coordination, evidence-based programming, and stakeholder education. *Teens Count* project activities that took place during my fieldwork included the formation of a “Clinic Collaborative” for medical providers to share information and resources about best practices, including the promotion of long-acting reversible contraceptives (LARC, see Chapter 5); the promotion of evidence-based comprehensive sexual health curricula in area schools and community organizations; and the establishment of a “youth leadership team”<sup>4</sup> and a “Collective Impact” process to bolster the work in Stockton and Carlsborough (see Chapter 6).

SOAP works on issues related to both teen pregnancy prevention and support services for pregnant and parenting teens by administering grants, providing technical assistance and provider training, advocating for youth-friendly state policies, and organizing young parents to reframe the stigma around teen childbearing. The organization is one of few that simultaneously engages in disparate activities such as training providers to implement teen pregnancy prevention curricula and organizing the annual Teen Parent Lobby Day, when providers and teen parents from across the state converge at the state house to advocate for policies that meet their needs. SOAP also organizes an annual conference, though unlike the PASH conference theirs draws service

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<sup>4</sup> Youth were not involved in a significant or meaningful role in project activities and were mainly solicited for feedback on existing strategies and programs.



providers from across the state that work in both prevention and support. Staff from SOAP also collaborated with students at The Towne House to identify and communicate findings from the digital storytelling project that forms part of my dissertation project (see below). Amy Lexington, the grants manager at SOAP who wrote the proposal that funded the *Teens Count* Initiative, and Amanda Church, SOAP's policy director and legislative advocate, were both interviewed for my research.

The Stockton Adolescent Sexual Health Promotion Committee (SASHPC), mentioned in Chapter 1, was formed in 2010 through a request by the then mayor in order to formalize collaborative teen pregnancy prevention efforts between the city health department, the public school system, and the high school teen clinics. The group, officially a committee of the Stockton Board of Health, meets approximately quarterly and is attended by a rotating group of staff from area health and human service organizations, clinics, schools, city government, and occasionally a few academics. One long-time, active regular member, Beth Emmerson, a white former nurse in her 60s, was not affiliated with an organization in Stockton, but had conducted research in the city. There are no official criteria for membership, and the committee has a high rate of turnover and a small core group of regular attendees. Throughout the two years that I observed the SASHPC meetings, about one-quarter to one-third of the attendees on any given day were women of color. There is considerable overlap between those who are involved with the PASH Network, the *Teens Count* initiative, and SASHPC, making it often difficult to tease out precisely the role of each. SASHPC runs three subcommittees, Access to Comprehensive Reproductive Health Services, Community Engagement, and Education, which meet independently of the larger committee and issue periodic reports.

In addition to providing recommendations and reports to the Mayor, SASHPC is responsible for organizing the annual National Day to Prevent Teen Pregnancy events in Stockton.

In addition to The Towne House, described below, there are numerous programs that provide services to pregnant and parenting young people in Stockton (generally specifically geared toward teen mothers). The Young Parents GED Program is funded through the state Office of Welfare Assistance (OWA) and is implemented through a variety of community-based organizations (including The Towne House). In addition to GED preparation and testing, this program provides job skills training, job placement assistance, parenting classes, and case management; it also fulfills the education requirement to receive benefits under the rules of the federal TANF (Temporary Assistance to Needy Families) or “welfare” program. Young mothers eligible for welfare benefits who are homeless are also eligible for the teen parent shelter system; in Stockton, Patina Peron managed this program (see Appendix A). Other state-funded programs provide childcare assistance, case management, and/or parenting classes to young parents to help them “meet their responsibilities as parents, students and employees.” Finally, under a federal grant from the Department of Health and Human Services Office of Adolescent Health, community-based organizations in Stockton and Carlsborough administered the State Pregnant and Parenting Teen Program, whose goals are to “provide pregnant and parenting teens with wrap-around services to promote graduation from high school or GED attainment, delay second pregnancy, and ensure teen parents’ children are on track for healthy development.” Through her work at a large, multi-site health and human services provider organization, Emily Lambert

managed both this program and the aforementioned case management and parenting class program. In sum, services for pregnant and parenting youth in Stockton are geared mainly toward teen mothers, there is a great deal of overlap and redundancy among programs, and existing programs emphasize preparing young parents for the low-wage labor market, preventing secondary teen pregnancies, and begin from an assumption that young people need to be taught to be “good” parents.

My first introduction to community health work in Stockton was in 2006, when I began working at the city’s clinic of the regional sexual and reproductive healthcare provider I call Continuum Health Services (CHS). I had recently enrolled in a Masters of Public Policy program at the university and received a fellowship through the Department of Housing and Urban Development to fund low-income students interested in public service. CHS is the area’s major Title X family planning provider and also offers a range of HIV/AIDS programs, including case management and needle exchange. The Stockton clinic was located at the very edge of the Canals neighborhood I described in Chapter 1, the most economically depressed area of the city where we were one of the only occupied storefronts on the street. CHS was my first fellowship placement site, and while I was originally meant to conduct outreach on implementing the then state policy allowing pharmacy access to emergency contraception, changes in federal Food and Drug Administration policy enabling nation-wide pharmacy access made the project moot. As a result, I mostly languished in the clinic, occasionally clearing expired condoms out of the storeroom closet or fielding phone calls from people with anxious questions. During the time of my fieldwork, CHS was part of the PASH Network and the *Teens Count* project’s clinic collaboration; Elizabeth Randolph, the manger of CHS’s Stockton clinic,

regularly participated in SASHPC meetings. CHS employed many people from the community, including Latina family planning counselors at their Stockton site, although the senior and middle management staff at the regional office in Hatherleigh was almost entirely white.

I eventually transferred to CHS's regional office but continued to work with staff and projects at the Stockton clinic as well as other sites. The next year I was placed at the Stockton Community Health Center (SCHC), the city's federally qualified community health center. Located on a main intersection just above the canal, SCHC is one of the main clinical providers in the area, serving over 24,000 patients per year with primary care, urgent care, dental, behavioral health, pharmacy, and a variety of community health education programs, including youth sexual health promotion. I wore a variety of hats at SCHC, including writing federal, state, and private grants to fund health education programming, coordinating campus-community programs, developing and distributing outreach materials, and conducting internal health service outcomes research related to issues ranging from pediatric dental access to food and fitness policy. Since my main position was in organizational and community development, I became well acquainted with the politics of health in Stockton as well as the community players.

Working at the Stockton Community Health Center provided a significant part of the impetus to continue on to a PhD following my master's degree. I recall sitting at my cubicle one day, staring at my computer screen, thinking that if I had to write one more grant describing how "Latino cultural food practices" contributed to the obesity rate in the city, I might just explode. As with teen pregnancy more generally, there were myriad unexamined power relations and racial discourses operating at SCHC. Although we

always included a statement in our grant proposals that over half our staff were “bilingual and bicultural members of the community,” these were mostly low-level and low-wage positions such as medical assistants and administrative assistants. Approximately 10% of the medical providers (MDs and Nurse Practitioners) and 12% of senior management staff were Latinx. Similar to CHS, at the time of my fieldwork, SCHC was a member of PASH and a clinic collaborator in the *Teens Count* initiative; SCHS’s youth health coordinator, Clarisa Ortiz, regularly attended SASHPC meetings.

I continued to work at SCHC during the first year of my doctoral coursework and maintained connections in the Stockton community throughout the next couple of years, officially returning to the city in 2012 as a research assistant for a foundation-funded project administered through my university. The project consisted of a variety of research strategies, including digital storytelling workshops, participant observation, individual interviews, and strategic communication to explore how pregnant and parenting young Latinas experience and negotiate sexual health. This project was based at The Towne House, a community-based, alternative education high school equivalency program for pregnant and parenting young women. The Towne House is unique in that it enables students to complete their GED within a college-preparatory curriculum that emphasizes the arts, humanities, and athletics. The program also provides wrap-around services, including transportation, childcare, and college and career counseling. According to The Towne House, approximately 70 to 85 percent of graduates go on to college, a figure higher than in the city’s public school system. It is an open enrollment program that serves about 100 young women per year, most of who were pushed out of public school before becoming pregnant and came to The Towne House as the result the welfare

assistance school attendance requirement (Ruglis & Fine, 2009). Most students were Latinas from the Stockton and Carlsborough area.

The Town House is an atypical program for pregnant and parenting young women and is not representative of the educational system and social services experienced by many young people living in the city; in fact, the school has received national recognition for its excellence in the arts and humanities. As an unusually comprehensive and supportive program for young mothers, The Towne House is an important site for inquiry, as it gives us a lens through which to see what services for this population *might* be like. I describe the digital storytelling project in detail in the next section.

### **Data Collection**

I collected data in multiple, overlapping ways: participant observation at committee meetings, conferences, and community events; key informant interviews with professional stakeholders in Stockton; digital storytelling workshops, interviews, and co-facilitation of a youth engagement group with students at The Towne House; and collection of a wide range of documents, both archival and current.

### **Participant Observation**

Although I had been an informal participant observer in Stockton for several years, I conducted formal participant observation from approximately May 2012 to August 2014. During this time period I attended the quarterly meetings of the Stockton Adolescent Sexual Health Promotion Committee (SASHPC), Stockton's events for the National Day to Prevent Teen Pregnancy, and events organized through the PASH Network and the *Teens Count* initiative, such as community conferences, provider

trainings, and “Collective Impact” meetings (see Chapter 6). I also conducted participant observation during the digital storytelling project at The Towne House, which included a series of community-based story screenings and talk back sessions, and co-facilitated the youth engagement group MAMA (Mothers Are Majorly Awesome). Finally, I participated in policy meetings, the Teen Parent Statewide Lobby day, and provider trainings with SOAP.

During these observations I took handwritten field notes following the guidelines described by Emerson, Fretz, and Shaw (2011). In writing these fieldnotes I focused on a variety of elements, including initial impressions, a sense of what seemed significant or unexpected, what those in the setting experienced as significant or important, how routine actions in the settings took place, and sensory details including visual, oral, aural, and spatial observations. I aimed to “show” rather than simply “tell” what was happening in interactions. Depending on the setting, my balance of “participant” versus “observer” dictated the level of detail I was able to capture. For example, in SASHPC meetings, I sat in mainly as an observer, whereas at conferences or story screenings, where I might also be presenting or facilitating, I took as detailed notes as was possible. I would often audio-record oral notes as I drove home from an event and later type notes from those recordings. I believe that fieldworkers are never detached, neutral observers and I took care to make notes on my own positionality and interactions within the setting. At the end of the day, I would type my handwritten notes with the perspective that writing fieldnotes is a construction, a filter rather than a mirror of reality. As Emerson, Fretz, and Shaw (2011) note, “‘Doing’ and ‘writing’ should not be seen as separate and distinct activities, but, rather, as dialectically related, interdependent, and mutually constitutive activities”

(p. 19). Thus, my in-process analytic writing not only described the people and places I observed but also asked questions, made comparisons, noted what was present and what was missing, made connections to the research questions, and noted any emergent findings.

### **Key Informant Interviews**

I conducted 15 in-depth, semi-structured interviews with professional stakeholders whose work relates to sexual health and teen pregnancy in Stockton. Rather than a “sample,” these interviews are best conceived of as a selection of key informants. I aimed to conduct interviews with key players in the “teen pregnancy prevention industrial complex,” stakeholders whose insights would be important to understanding the discursive context of youth sexual health work in the city. I sought to have a balance of stakeholders working in clinical, educational, administrative, and policy domains (see Appendix A for a description of interview respondents). Because I had worked in community health settings in Stockton for some years, had been conducting participant observation at meetings and events, and was known in the community as a doctoral student engaged in dissertation research, I had developed a network of potential interviewees. I contacted most participants directly to ask for an interview; occasionally participants would refer me to a colleague for an interview. Interviews took place wherever it was most convenient for the respondent, and most interviewees chose to conduct the interview at their place of employment.

I informed participants that the purpose of my study was to gain a better understanding of how public health and social policy stakeholders in the greater Stockton area make sense of teen pregnancy and parenting and how to best develop programs and



policies related to youth sexuality. I was careful to explain that I was interested in hearing *their* beliefs about what was happening in Stockton and what to do about it, as opposed to commonsense understandings and/or positions articulated by their organizations.

Interviews began by inviting the participant to tell me about the work that they do in the community, how they came to do it, and what they liked and disliked about it. I asked what they believed to be the most important issues facing Stockton and then asked specific questions related to teen pregnancy that sought to elucidate their views on problem constructions, race, class and gender, the sexual health needs of young people, and the best way to approach policy and practice (see Appendix B for interview guide). I audio recorded all interviews with a digital recording device and wrote up brief fieldnotes after each interview that focused on contextual information, initial impressions, ideas for future interviews, and emergent findings. A paid research assistant transcribed all interviews verbatim. Although I subscribe to the school of thought that views transcription as an important part of the analytic process and believes that the interviewer is the ideal person to do the transcription, repetitive strain injuries in my hands and wrists prevented me from doing the transcription myself. To compensate for this, I read and re-read the transcripts several times over in order to familiarize myself with the data.

### **Digital Storytelling Workshops**

As part of a research assistant position, I co-facilitated a digital storytelling workshop with nine pregnant and/or parenting young women who attended The Towne House. Digital stories are short, first person, video narratives created and edited by research participants during a multi-day workshop process that combine recorded voice, still and moving images, and music or other sounds to represent and communicate

experience (Gubrium, 2009). As a group process, digital storytelling allows for the co-construction of knowledge, a shift from textual to multi-sensory ways of knowing, and enables novel ways of engaging stakeholders in the research process. Often utilized in community organizing settings, digital stories can be used and disseminated for strategic purposes, such as documenting health issues, connecting stakeholders to community issues, or facilitating the emergence of previously subjugated knowledges (Gubrium, Hill, & Flicker, 2014). Particularly relevant for youth sexuality research, the process and products can provide a source of information not readily offered or fully articulated by others, such as professionals, policymakers, and the media.

The workshop I participated in was one of four completed by the project team. A total of thirty-one students participated in the digital storytelling project (participant demographics are described in greater detail in Chapter 3; see also Appendix A). Each workshop was co-facilitated by trained staff from two professional digital storytelling organizations, at least one project principal investigator, one graduate research assistant, and a graduate student intern. The Towne House's Director of Education, Lourdes Navarro, who visited classrooms and reviewed the project purpose and activities with students, recruited workshop participants. We followed a codified digital storytelling workshop format (Lambert, 2012). Following the completion of all four workshops, students were invited to participate in a 9-week elective course based at The Towne House in which storytellers worked in collaboration with me, another facilitator from the university research project, and staff from SOAP to develop digital stories into strategic communication materials. In this course, called MAMA, we engaged in discussion about the representation of young mothers in the media and in public policy, reflected on the

digital storytelling process, analyzed teen pregnancy prevention materials, viewed and analyzed digital stories produced in the project, strategized about how to present the stories to the public, and prepared for community screenings.

I wrote fieldnotes during each of the four days of the workshop I co-facilitated and conducted follow-up interviews with each participant. The workshop generated a considerable amount of data of various types: drafts of participant stories, field notes on the workshop process, transcripts of the various parts of the workshop, follow-up interviews, fieldnotes from the MAMA group, and the digital stories themselves. I transcribed interview and workshop audio recordings verbatim. As part of my research assistantship, I transcribed all 31 digital stories produced in the project using an intertextual transcription method. Chapter 4, “Bodies That Tell,” describes the digital storytelling process and intertextual transcription methods in greater depth and presents an analysis using the digital stories as multi-sensory data.

### **Document/Archival Data Collection**

According to Adele Clarke (2004), using extant visual and textual materials is one strategy to move beyond the “knowing subject” of the qualitative interview and “be fully on the situation of inquiry broadly conceived, including the turn to discourse” (p. xxviii). I collected a wide range of documents and archival documents that provided historicity and context to my interview and participant observation. First, I located all of the sexual health curricula in use in the Stockton public schools and obtained as much information from the material as possible. Because these are proprietary curricula costing hundreds of dollars, I often did not have access to the entire curriculum but was able to view learning objectives, tables of contents, and sample lessons. I also collected print, web, and audio-

visual sexual health education materials in use in Stockton. Audio-visual materials were transcribed into text and web sources were printed by page. In addition, I collected documents from the *Teens Count* initiative, such as progress reports and data briefs, policy reports from SOAP, and reports and meeting minutes from SASHPC. I also monitored the local newspaper for articles on youth sexual health in Stockton.

Second, I conducted archival research through the database of the “Algonquin Valley News” for the years 1950-2015 using keywords to locate articles from three time periods: the mid 20<sup>th</sup> century influx of Puerto Ricans to Stockton, the beginning of organized efforts around teen pregnancy prevention in the early 1990s, and the time of my fieldwork in the 2010s. In addition, I utilized two collections in the archives of the Bougainvillea Estate, a historic house museum in Stockton. The “Stockton Collection” is a massive archive of industry, government, civic, and personal materials. I accessed the part of the collection titled “Puerto Rican Migration to Stockton,” which consists mainly of newspaper clippings and a few Census reports and maps. Although there are several published manuscripts related to European immigration to Stockton, the history of Puerto Ricans is more difficult to discern; therefore, this collection was integral to teasing out the history of racial politics in the city I describe in Chapter 3. The “Pablo Rivera Collection of Latino History in Stockton, 1958-2012” consists of materials donated by the estate of a long-time civic leader in the city and includes administrative files, electoral and legal documents, scholarly works, memorabilia, and news clippings related to Latinxs in the city. Of particular use to my research were the minutes, budgets, memoranda, and reports related to a variety of community health task forces and projects

in Stockton, most notably the Stockton Infant Mortality Task Force, which later morphed into the first organized teen pregnancy prevention efforts in the city.

### **Data Analysis**

Data analysis proceeded iteratively and inductively. Fieldwork and analysis were not distinct and separate processes but rather overlapped and informed one another. Indeed, writing fieldnotes, pouring over archival materials, or conducting interviews were all interpretive tasks. During active data collection, I kept notes and wrote brief memos on emergent themes and ideas. Sometimes this occurred by sitting down at the computer to type while I thought in a stream-of-consciousness fashion, other times I would jot down notes to myself on post-its and type them up later. Concurrent data collection and analysis enabled me to pursue new lines of inquiry through theoretical sampling, and seek out additional interview participants, observation settings, or archival documents that would inform emergent ideas (Clarke, 2005). Prior to formal analysis, I organized all of my data into a series of 3-ring binders, one each for interview transcripts, participant observation notes, inter-textual transcripts of digital stories, and archival documents (including health education materials).

The analysis procedure I used for my interviews, participant observations, and archival materials was guided by a constructivist grounded theory approach to coding and was followed by situational analysis mapping. According to Kathy Charmaz (2006), a constructivist approach to grounded theory assumes that neither data nor theories are separate from the observer. Rather, researchers construct theories grounded in data “through our past and present involvements and interactions with people, perspectives,

and research practices” (p. 10). I open coded all interviews and participant observation notes and most of the archival materials (where it made sense to do so). Following Charmaz (2006), I highlighted processes in the data using gerunds and looked for in vivo codes that represented respondents’ understanding of situations and processes; generally these were in the form of quotes. I developed codes inductively from the data while keeping in mind my research questions, existing theories on race, sexuality, risk, and the body, and emerging theories and ideas. Codes were developed with an eye to making them fit the data, rather than making the data fit the codes. After open coding all materials, I began focused coding by going back through the materials and selecting codes with the most relevance to my research questions. I typed up all of these codes, copied them onto post-it notes, used large sheets of butcher paper to organize the post-its, and then codified focused codes and sub-codes by moving the post-its around. I compared codes against one another to identify both similarities and differences in the data while also keeping in mind the importance of what did not appear in the data—what was silenced or missing. Next, I wrote a codebook where each code and sub-code was described in narrative format (Bernard & Ryan, 2009). The main codes included: Race and Racism; Conceptualizing Stockton; Telling Social and Political Stories; Public Health Discourses and Epistemologies; Sex and Sexuality; and Doing the Work (see Appendix C for a list of codes and sub-codes). Once the codebook was refined, I imported the text of the interviews and fieldnotes into MAXQDA version 11. Finally, once the materials were coded in the software program, I ran reports on individual codes in order to collate excerpts and prepare for situational mapping exercises.

Clarke's "situational analysis" extends traditional grounded theory strategies in qualitative inquiry by "pulling" them around the postmodern turn (Clarke, 2005). In this approach, interview and ethnographic data are analyzed alongside existing narrative, visual, and historical discourse materials to comprise the "situation *per se* as the ultimate unit of analysis" (p. xxii). In my case, the "situation" is that of youth sexual health promotion in Stockton. Clarke argues that situational analysis can "deeply situate research projects individually, collectively, organizationally, institutionally, temporally, geographically, materially, discursively, culturally, symbolically, visually, and historically" by understanding the elements and relations of the situation (p. xxii). According to Clarke (2005, p. 155), situational analysis is valuable for examining how identities and subjectivities, power/knowledge, ideologies, and control are produced through discourses. Situational analysis can make possible a more complete construction of the situation, including how discourses are created and legitimated through the situation of inquiry (Perez & Cannella, 2011). The approach is useful in that it addresses multiple discourses related to the situation of inquiry, not merely the master discourses at work, thereby allowing the analyst to "turn up the volume" on lesser but still present discourses, less but still present participants, the quiet, the silent, and the silenced (Clarke, 2005, p. 175).

Practically speaking, situational analysis was significant to my project in that it allowed me to analyze a large volume of data from a variety of sources simultaneously. Theoretically, situational analysis was an ideal choice for an analytic strategy in that it acknowledges that research and interpretation are always already political (Clarke, 2005, p. xxvii) and that analysts must move beyond the knowing subject to analyze salient

discourses within the situation of inquiry (p. xxix). As I discussed in the beginning of this chapter, although I do not discount the importance of “voice” in social science research, particularly among historically marginalized groups, I also want to complicate the notion of “giving voice” and the possibility of a pre-social knower divorced from their discursive context. Additionally, Clarke argues that the objective of situational analysis is to “capture complexities,” rather than aim for simplifications, which is key to my critical inquiry into teen pregnancy. Youth sexuality research suffers over-simplification from scholars across the political and ideological spectrum, and my project is an attempt to capture the messiness inherent to how we make sense of the discursive productions of reproduction, sexuality, politics, and health promotion.

Situational analysis uses analytic mapping exercises as a ways of “moving in and around the data.” The resulting maps are not intended as final analytic products but rather are used to “open up” the data. Clarke (2005) suggests, as visual representations of data, maps “help to rupture some of our normal ways of working and allow us to see things fresh” (p. 30). Additionally, maps work as discursive devices to make assemblages and connections, illustrate spatial and temporal narratives, and allow for unmapping and remapping ideas. Mapping exercises proceeded as follows. After spending time with my data through constructing the codebook, reviewing emergent findings memos, and studying my code reports, I descriptively laid out the most important *human and nonhuman, material, and symbolic/discursive* elements in the situation of concern of the research (Clarke, 2005, p. 87). Clarke advises that the elements are to be understood as broadly conceived and framed by the analyst, who inquires: *Who and what are in the broader situation? Who and what matters in this situation? What elements “make a*



*difference*” in this situation? I laid out these elements into a “messy map,” which simply consists of a large sheet of paper with these elements arranged in no particular fashion (see Figure 2).

After examining the messy map, the identified elements are then organized into an “ordered/working map” according to their discursive domain, including individual and collective elements/actors, political, economic, temporal, symbolic, and spatial elements, and related visual, historical, and narrative discourses (see Figure 3). Reviewing the “ordered/working map” allowed me to identify how elements of the situation work within and through various discourses. In particular, situational analysis highlighted the ways in which youth sexual health promotion is always already about teen pregnancy prevention and teen pregnancy is always already about race; the silence and invisibility of teen parents; how race and sexuality were continuously invoked without ever naming racism or sex; and how the selective uptake of scientific discourses affected both knowledge and practice. Significantly, situational analysis made visible the workings of the teen pregnancy prevention industrial complex (described in the next chapter) and allowed me to analyze simultaneously the overall discourses and effects of the situation alongside the individual actors within it.

### **Overview of Analytic Chapters**

Of the many acts of interpretation that occur during a research project, decisions about what to include in a final written project are but one. Practical constraints limit the inclusion of every pertinent or even interesting finding in one document. Chapters 3, 5, and 6 comprise the analytic chapters of the dissertation based on situational mapping. The topics of these chapters are historical contexts, racial projects, and scientific discourses,

respectively. These topics were selected, based on the work of the situational mapping, because they are illustrative and representative of the overarching situation of inquiry: the discursive production of race, sex, and science in Stockton's health promotion work related to youth sexuality and reproduction. Chapter 4, "Bodies That Tell," is an interlude that departs slightly from this focus by presenting an analysis of embodied knowledge through the digital stories produced by students at The Towne House. The experiences, knowledges, and bodies of pregnant and parenting young women in Stockton are obscured by the dominant discourses at work in the city, and this chapter is one small attempt at helping them emerge. Through telescoping back and forth between the history of teen pregnancy prevention in Stockton, pregnant and parenting young women's stories, and discourses of race, sex, and science, I am able to capture the intricacies of health promotion work in the city while highlighting the missing, absent, and unnamed.

Figure 2: Situational Analysis Messy Map



**Figure 3: Situational Analysis Ordered Map**

**Individual human elements/actors**

Benevolent emancipators  
 Pregnant and parenting teens  
 Teens who are not pregnant or parenting  
 Clinicians  
 Teachers and health educators  
 Social workers  
 Policymakers

**Collective human elements/actors**

SOAP  
 SASHPC  
 Community based organizations  
 The Towne House  
 PASH  
 Teens Count

**Discursive constructions of individual and/or collective human actors**

Moral panic?  
 “We’re just trying to help this population”  
 Youth as lacking hope  
 What everyone already knows  
 “We just don’t want to be #1”  
 The “problem”  
 Funding money

**Political/economic elements**

Neoliberalism  
 City government  
 Institutional racism  
 Structural violence  
 Catholicism

**Temporal elements**

Declining TBR in US and Stockton  
 “Back in the 90s”  
 Changing norms around age at first birth  
 Decline in manufacturing/economic changes in city  
 Post-Fordist economies  
 Migration (forced and economic, Operation Bootstrap and Operation Pressure Point)

**Major issues/debates (usually contested)**

Contraceptive access in schools  
 Prevention strategies and tactics  
 Nature of the problem

**Nonhuman elements/actants**

“Safe(r) sex”  
 LARC  
 Evidence-based curricula  
 Condoms  
 Abortion

Health education materials  
 Media center film  
 Funding and grants

**Implicated/silent actors/actants**

Pregnant and parenting teens  
 LGBTQ youth  
 To some extent all teens are silent, esp the “bad ones”

**Discursive constructions of non-human actants**

Abortion as a sin  
 Contraception as easy/safe/compulsory  
 Health education as “comprehensive” and “scientifically-based”  
 Contraception and sex ed curricula as apolitical

**Sociocultural elements/symbolic elements**

Young women as sexual gatekeepers  
 Actual fucking  
 Race and racism  
 Latino/a “culture”  
 Heteronormative, phallogocentric sexuality  
 Causal fantasies  
 Youth sexual health promotion as always already about teen pregnancy  
 Teen pregnancy as always already about race  
 Talking about sexuality without ever actually talking about sex  
 Talking about race w/o ever actually talking about race  
 National Day to Prevent Teen Pregnancy

**Spatial elements**

Stockton neighborhoods (Heights, Canals, etc.)  
 Two Stocktons  
 Two Valleys  
 Puerto Rican migration  
 Daily migration to work in city

**Related discourses (historical, visual, and/or narrative)**

Latino family/culture narrative  
 Health disparities  
 Opportunity/hope/progress  
 Headless pregnant teens

**Other key elements**

(Lack of) reproductive justice framework  
 Sexuality and families as sites for the reproduction of empire

(adapted from Clarke, 2005)

## CHAPTER 3

### WHAT IS IT ABOUT STOCKTON?

Throughout both my research fieldwork and employment in community-based health organizations, I repeatedly heard the sentiment that there was just “something about Stockton” that resulted in, among other problems, the city’s high teen birth rate. For some, such as health and human service providers, this “something” was related to city policies or health disparities. Lourdes Navarro, a 40-something Latina who grew up in Puerto Rico and served as the Educational Director at The Towne House, described it as “the problem of poverty, and not having services, and poor communities, and [being] welfare dependent, all of those criteria that created this system in which communities felt entitled to be dependent to the system instead of being educated and being offered, um, access to being self-sufficient.” Similarly, Patina Peron, a Latina in her late 20s who worked as the director of Stockton’s transitional living program for homeless teen mothers, described the stigma she saw in the general public’s perception of the city:

I think it's just a lack of resources and not knowing that there is more out there to life than this little city. I think it just becomes a cycle, and I think that just the repetitiveness of things...I do think, especially, this is the stigma in the city. You live in Stockton, you're a parent, you're just fast and you have kids, everyone in Stockton's infested with STIs, [but] that could be the issue with every other city.

For others, including young people, teen pregnancy and Stockton were synonymous.

Amanda, a 21-year-old Towne House student who lived in the city desired to move elsewhere because, as she put it, “everywhere you look there are girls with babies.” When I asked Ana Gutiérrez, a Latina in her early 20s who grew up in Stockton and conducted teen pregnancy prevention programs in youth residential homes, about the first thing that came to her mind about Stockton she replied: “A lot of babies.” In addition, community

outsiders often spoke about Stockton as if there was something in the water or the air that made young people pregnant or families poor. If you live in the college towns surrounding Stockton, it is not unusual to hear people refer to the city as a “joke,” a place where go you to work in a non-profit organization, buy drugs, or because you got priced out of the rental market in Hatherleigh.

Understanding the historical and contemporary contexts of Stockton’s racial, political, and economic structures is central to understanding how discourses surrounding youth sexuality and reproduction play out today. Ultimately, the “something” about Stockton is discursive constructions of race and sexuality. In this chapter, I situate my place-based inquiry through the use of primary and secondary sources as well as my own data. I begin by providing a history of the city that focuses on industry, migration patterns, and shifting racial composition. Next, I trace how historical discourses of sexuality in the US colony of Puerto Rico inform present day understandings in Stockton. Finally, I sketch a portrait of the “teen pregnancy prevention industrial complex,” the term I use to frame the webs and relationships of service providers, organizations, coalitions, programs, and funding at work in Stockton. Understanding teen pregnancy’s effect on Stockton cannot be over-emphasized, and I outline how both young parents and professional stakeholders make sense of the “problem.” Considering “what it is” about Stockton sets the stage for the analytic chapters that follow.

## **Historical Contexts of Labor, Migration, and Race in Stockton**

The city of Stockton is nestled between the Algonquin River and a small mountain range.<sup>1</sup> Prior to European arrival, the Algonquin was a dividing line between two tribes of the Algonquin Nation. White people began colonizing the Algonquin River Valley in 1633, when Englishmen established a post down the river in what is now the southern part of New England. Three years later, colonists established the town of Carlsborough as a settlement valued for its rich soil and proximity for trading with other New England colonies. The city that would become Stockton was originally part of this settlement; at the time it was known as the “Ireland Parish.” First settled in 1745, it was not incorporated until 1850, when the population numbered 3,713. Stockton was one of the first planned industrial cities in the US, founded by a group of venture capitalists who selected the city for its geography ideal for building a canal system and harnessing the power of the Algonquin River. The first workers hired to dig the canal system arrived from Ireland seeking relief from the religious oppression and economic exploitation of British rule and its resulting potato famine. Soon thereafter, the canals begot multiple cotton mills, a machine shop, and several textile and paper factories. By 1855, the city’s population surpassed 4,600 residents and by 1883 the canal stretched four and half miles long to its current capacity.

Stockton has long been a city of migrants and immigrants. The English colonized the river valley and drove out the indigenous population; the Irish fled persecution and famine to become the city’s first migrant labor force; they were followed by French

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<sup>1</sup> The material in this section comes from a 2006 book produced by a curator at the Bougainvillea Estate Museum in conjunction with an exhibit about the history of immigration and migration to Stockton.

Canadians and then Europeans seeking factory work. When the Polish arrived in the late 1800s, Stockton's population was over 50% foreign-born. The factories, and by extension the city's residential patterns, were ethnically segregated, with textile mills largely French Canadian and the paper mills Irish. Churches were also linguistically, ethnically, and socioeconomically divided, an arrangement that remains today. At this time, labor organizing was hindered by conflict among Irish, French Canadian, and Polish workers. "Irish Need Not Apply" signs in Stockton's mills appeared as French Canadians were willing to work longer hours for less pay and were considered less likely to unionize. At this time, other ethnic groups in Stockton regarded the Irish as an "inferior race," and business owners and residents in the city deemed them "stupid, superstitious and untrustworthy, diseased, and dirty."

### **Race, Reproduction, and Modernity Converge in Stockton**

Stockton's most recent wave of newcomers began arriving in the late 1950s, when Puerto Ricans began to constitute an increasing percentage of Stockton's population. By 1980, 13% of the city's population was born in Puerto Rico; in 1990 that figure rose to 31% and by 2000 was 41%. Today almost half the population claims Puerto Rican descent. Like their predecessors, Puerto Ricans initially came to Stockton seeking employment opportunities and housing. What sets apart Puerto Ricans from other racially or ethnically marked groups in Stockton's history, however, relates to a complex web of US imperialism, racialization, economic exploitation, geographical displacement, and gendered ideologies. Teasing out these complexities allows us to more clearly understand how sexuality and reproduction, and in particular teen pregnancy, become emblematic of this racialized post-industrial small city.



A series of legislative maneuvers in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries slowed immigrant flows to the United States, notably the Chinese Exclusion Act of 1882 and the Quota Act of 1921. Both Acts were based in a xenophobic reaction to the perceived threat of outsiders, a reaction that continues to structure immigration responses today. These restrictions decreased the availability of immigrant labor, creating a demand that Puerto Rican migrants eventually filled. Migration to the mainland United States was precipitated by a convergence of economic and political factors (described in depth below) that prompted several waves of Puerto Rican migration from the island to New York and other parts of the Northeast; Puerto Rican migrants to Stockton variously arrived, and continue to arrive, directly from the island but also by way of New York City and other major US cities in the Northeast.

Migration to the Algonquin River Valley area also intensified between 1948 and 1982 as increasing numbers of farmworkers sought work in the tobacco fields. During this time period the Puerto Rican Department of Labor and Human Resources helped arrange contracts for more than 400,000 seasonal workers in the region. Simultaneously, the demolition of housing in Carlsborough's north end as part of Johnson administration urban renewal programs prompted relocation to Stockton, where people settled into the former tenement row houses built at the height of Stockton's industrial economy. Unlike earlier groups, Puerto Ricans came to Stockton at a time of significantly changed economic structures and declining population in the city. The paper and textile industries had declined throughout the 20<sup>th</sup> century as manufacturing all but disappeared in the Northeast. Newer techniques for producing paper and fabric, in addition to the growth of

outsourcing labor, decimated Stockton's industries. Remarkably, the last paper company held on until 2004, when operations were moved to Mexico.

The particular historical moment when Puerto Ricans arrived in Stockton greatly influenced the trajectory of racialization that sets up the discursive context of youth sexuality and reproduction today. Although the Irish were once a racialized ethnic other, they arrived at a time of economic growth and prosperity. In particular, as fair-skinned, Anglophone Europeans, the Irish were able access to whiteness in ways that Puerto Ricans, as Spanish-speaking, diasporic Caribbeans, did not. Moreover, although the Irish came to Stockton as a racialized class of workers, their labor was valued in the construction of the canal system. Conversely, despite the pull of seasonal migrant farmworker jobs in the region, Puerto Ricans came to Stockton at time when the city's overall economy was declining. Stockton didn't need Puerto Rican workers in the way they needed the Irish, but other places needed to "get rid of" Puerto Ricans: initial migration to the mainland was a strategy to address poverty on the island, and later organized political resistance among Puerto Ricans in New York prompted government efforts to disperse them to other mainland cities. As I describe in the next section, the convergence of US colonialist development policy and eugenic ideology helped push migration from the island to the mainland and eventually to Stockton.

### **From the Rich Island to the Canal City**

The "persistent colonial status" of Puerto Rico (Duany, 2000) not only structures the economic and political events that prompted mass migration to the mainland but is also implicated in longstanding discourses surrounding sexuality and reproduction that manifest themselves today in Stockton. In 1898 the United States acquired the island of

Puerto Rico from Spain as part of the treaty that ended the Spanish-American War. Twenty years later, Puerto Ricans gained US citizenship through the Jones–Shafroth Act, conveniently in time to be drafted into the military at the outset of the First World War. Laura Briggs (2002) argues that sexuality and reproduction are key to organizing colonialism and racial projects, particularly in Puerto Rico, which has long served as a literal and metaphorical “test tube” for the US to produce knowledge about women’s lives and bodies. Emergent social scientific knowledge about Puerto Rican “difference” justified interventions into the sexuality and reproduction of Puerto Rican women through two great modernist narratives: women’s rights and scientific progress (Briggs, 2002, p. 197). Briggs argues “forms of sexuality are crucial to colonialism, from imperialism to development, from US involvement overseas to the migration of refugees of these processes to the mainland” (2002, p. 4). Similarly, Gina Pérez (2004) explicates how the history of Puerto Rican migration and displacement is a story about gender that is embedded in “development ideologies, labor history, place-making, and ethnic identity construction in a transnational context” (p. 7). Tracing these histories enables us to more fully understand how youth sexuality and teen pregnancy in Stockton is constructed specifically as a *Puerto Rican* problem, and the ways in which that construction elides the history of racism, economic exploitation, and the production of Latina sexual deviance.

Mainland US interests prompted the implementation of sweeping economic policy changes beginning with the 1898 occupation of the island.<sup>2</sup> At that time, the

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<sup>2</sup> As I was writing this chapter in late 2015 and early 2016, Puerto Rico defaulted on portions of its \$72 million in debt. The island’s commonwealth status disallows it to file for bankruptcy in the way that major US cities have in order to deal with a debt crisis. In early 2016 Congress was drafting legislation titled the “Puerto Rico Oversight, Management, and Economic Stability Act” (PROMESA, Spanish for “promise”) that would create a financial control board without including any elected Puerto Rican officials with voting rights.

island's agricultural economy was balanced among coffee, tobacco, and sugar production, but by the 1930s sugar production grew by over 250% and mainland corporations controlled two-thirds of the sugar industry. Being forced into a mono-crop economy had significant effects on unemployment and poverty on the island, which transmogrified into concerns about "overpopulation" on the island. Initially this referred to the idea that the working class was reproducing "too much," and later became a way to describe the condition of Puerto Rico as a whole. Excessive sexuality and fertility were to blame for the poverty of the island, which almost perfectly parallels understandings of teen pregnancy in Stockton today. Then as now, hyperbolic panic about excess brown and black babies were discursive productions rather than statistical facts. Briggs notes that although population increased on the island during the 1940s and 50s, so did per capita income. Population growth was not a sufficient explanation for island poverty, yet the "argument that uncontrolled Puerto Rican sexuality and reproduction were dangerous had sufficient force that it persisted even in the face of evidence that flatly contradicted it" (Briggs, 2002, p. 85). Similarly, in Stockton in the 1990s, 2000s, and 2010s, the teen birth rate rapidly declined in a state with one of the nation's lowest rates, yet it is considered a significant social, health, and economic issue with grave consequences for the well being of the city.

By the mid-20<sup>th</sup> century, mainland migration and contraception were seen as solutions for island poverty and overpopulation. Addressing the perceived problems of overpopulation on the island through reforming Puerto Rican sexualities and families was key to becoming a "modern" nation. In 1947 the US government set into motion "Operation Bootstrap," a series of policies and programs aimed at transforming Puerto

Rico's economy through attracting foreign investment and promoting export-oriented industrialization. Although ostensibly neutral with regards to the need for migration, the Bureau of Employment and Migration opened its first mainland office in New York City in 1948 and "actively encouraged migration to the mainland by facilitating settlement and employment, thus laying the groundwork for subsequent chain migration" (Peréz, 2004, p. 46). Simultaneously, as Iris Lopez (2008) notes, "the application of neo-Malthusian and eugenic approaches to population and development within the colonial relationship between Puerto Rico and the US played a critical role in the development of the island's birth control movement" (p. 13). Puerto Rico served as a site for early clinical trials of hormonal contraceptives—in what we now know were deleteriously high doses of estrogen and progesterone—in part because the dangers of overpopulation were believed to outweigh the potential risks of the medications. Puerto Rico also became entangled in the politics of population control through the ubiquity of surgical sterilization. Although there is evidence against widespread forced sterilization campaigns (Briggs, 2002), by 1968 approximately one-third of childbearing aged women on the island were sterilized (Wilcox, 2002). Indeed, sterilization was so common among Puerto Rican women both on the island and the mainland that it was, and still is, referred to as *la operación*, needing no distinction from other kinds of operations. Nonetheless, Lopez (2008) posits that sterilization is best thought of on a continuum from freely chosen to fully coerced, and that most Puerto Rican women, then and now, make sterilization decisions under a situation best described as "constrained choice."

## **Puerto Ricans in Stockton**

This history provides an important backdrop for making sense of “what it is about Stockton.”<sup>3</sup> When Puerto Ricans displaced from Carlsborough’s North End relocated to Stockton, the local press helpfully tried to suggest that these “problem families” wouldn’t pull down neighborhood standards in their new home. A 1959 article in the Algonquin Valley News details a police officer who took it upon himself to befriend the Puerto Ricans and “point out to them the necessity of education and the adjustments they must make if there were to continue to live in the United States.” Then as now, the fact that Puerto Ricans are US citizens seemed lost on many observers of the demographic shift happening in Stockton; Puerto Rican identity and culture is always already constructed as fundamentally “other.” In 1962, the same newspaper referred to the city’s new arrivals as “immigrants” who were “lured” to Stockton by cheaper rents and the lesser degree of residential segregation than Carlsborough residents experienced. The article positions Puerto Rican migrants to Stockton in familiar terms. Using the language of “invasion” the author notes that the population was increasing by three Puerto Rican families per week and that whereas these newcomers had been “very hard at work all week” in Carlsborough, upon arrival in Stockton they were putting in a lazy “2 to 3 day work week.”

By the late 1960s, Puerto Ricans in Stockton became implicated in a discourse of public assistance-hungry over-reproducers. In the fall of 1969 the state dispatched their “special assistant for Spanish affairs” to the city to “investigate the reported mass

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<sup>3</sup> The historical discussion in this section is based on my archival research through the Bougainvillea Estate Museum collections “Puerto Rican Migration to Stockton” and the “Pablo Rivera Collection of Latino History in Stockton, 1958-2012” in addition to the database of the “Algonquin Valley News.”

recruitment of Puerto Ricans to fly to [Stockton] and collect state welfare benefits.” Concerned about welfare coyotes that were offering charter trips from Puerto Rico to New England and bus rides up to Stockton to collect on the “nation’s most liberal welfare benefits,” officials quoted in the Algonquin Valley News were quick to foreground families with twelve children who were making a dubious \$750 per month (the equivalent of \$4,800 in 2015 dollars) in welfare benefits without working. Headlines that proclaimed “Out-of-State Arrivals Jam Welfare Office” could easily be written today: the women are always pregnant, living with their dead-beat boyfriends, and mired in inter-generational poverty exacerbated by over-generous welfare benefits.

Stockton’s complicated relationship to and thinly veiled racism toward its Puerto Rican residents continued through the 1970s and 80s. In the early 1970s, what the newspaper called “civil unrest” in the city’s Canal neighborhood prompted mass arrests and a citywide curfew. Subsequent police brutality directed at Puerto Ricans in the community prompted further organizing and public protest. In 1981, the city implemented a busing program in order to desegregate the public school system. By the mid 1980s, Stockton garnered a national reputation for its growing arson problem. Although the Puerto Rican community was blamed for each spate of fires, many residents thought the true origin of the fires could be attributed to absentee landlords trying to cash in on insurance money. Around this time, a white op-ed writer in the Algonquin Valley News called attention to the sentiment of some whites in the city that Stockton’s problems wouldn’t exist without its Puerto Rican population, or at least wouldn’t exist if they conducted themselves the way that other migrant groups did when they first arrived in the city. While the author made the unusual move of explicitly naming racism as one

of these problems, he let whiteness remain invisible, partially blamed city tensions on a lack of Puerto Rican leadership, and admonished that “a solution will require an understanding on the part of the Puerto Rican community of the feelings of some of Stockton’s non-Puerto Ricans about the habits of some members of the Puerto Rican community in such matters as litter in the streets, idleness, and noise.” The article represents an apparently widely held view that the problem was not so much racism, economic exploitation of migrants, or inequitable distribution of resources as it was that the Puerto Ricans are dirty, lazy, and loud.

Today it is not uncommon to hear similar statements expressed by white residents of the city and the greater region. Whereas most people will talk around the notion that Puerto Ricans are responsible for the city’s problems using racially coded language, such as “inner-city poverty” or “Spanish speakers,” Hannah McNeil, the Commissioner of the Stockton Board of Health and Chair of the Stockton Adolescent Sexual Health Promotion Committee (SASHPC) was uncharacteristically explicit about it. “See,” she told me, “I grew up here, so it’s—I *know* what the city once was. And I know how, um, the city can function, and it is going to have a different face, because it has a different population. But I would love to see the present face become the *past* face, the way it was when I grew up.” When I pressed her to explain what she meant by the “face when she was growing up,” she replied that it was a time when there was a high percentage of Irish Catholics in the city, something that was unifying (though ostensibly not exclusionary to other ethnic or religious groups). Hannah continued:

Well, it was a—it was a safe city, where you could, um, be outside and go downtown and walk anywhere. Um, your schools were ranked as one of the top in the state. Education was superb. People didn’t need to go to private schools. They were in the public school system. Um, teaching, teachers were state-of-the-art,



literally. And, um, then, when people came out of the schools, they went on to further themselves. Not only with education, but with job opportunities. We had a lot of unity in the city.

Hannah explained that although the city's annual St. Patrick's Day parade was a point of pride for the city that brought people together, "divisions" in the community meant that the same was not true for the annual Puerto Rican Pride Parade. When asked why she thought this division existed, Hannah framed it this way:

Well, I think it's because the city—I think the city deteriorated too quickly. There were no controls in the housing. So there was so much inexpensive housing that it drew in, um, people that were, you know, dependent on, um, on welfare is what it was back then. So, when you have people that aren't working and aren't contributing to the city—as it was, everyone contributed—there were divisions in the city. You know, you had the Heights and the Canals neighborhoods. But all those people still worked together within their own, um, section of the city. And then there was, you know, integration, which then hit the schools. Whereas now there's just too much division.

Despite her racialized understanding of Stockton's divisions, Hannah was quick to tell me that she had an "open mind" and was welcoming of the changes in her city. "But there are of course," she said, "those who aren't as positive about, you know, um, the changes in the...in the culture. So, I find that unfortunate." When pressed, she identified these "changes" as the presence of more Latinos in the city.

### **"The Two Stocktons"**

Shortly after I began working in Stockton in 2006, an article in a statewide magazine on politics and civic life posed the question: "Can Stockton 'tap into' the prosperity of its college town neighbors?" Comparing the small mountain range that separates Stockton from the rest of the Algonquin River Valley to the Berlin Wall, the article reified long-held tropes of the city as "dangerous" or "dirty," a place where the health and human service workers who drive up the highway from the wealthy, white

college towns are afraid to be after dark. The article detailed the city's attempts at "revitalization" in language that can easily be read as "gentrification" to make Stockton more like the neighboring college towns. Put another way, "revitalization" is an attempt to make Stockton more white by inviting artists (who, according to the article, are used to cities and aren't afraid of Stockton) to set up studios in the city's abandoned factories, attract tech industries to the city, and promote commerce in the form of places to see live music and consume lattes. To quote a white resident who owned successful businesses in one of the nearby college towns: "Stockton is in the business of being poor."

This notion of the "Two Valleys," one white, educated, middle-class, and sexually "progressive" (but with low teen birth rates) and the other non-white, uneducated, poor and hyperfertile, mirrors local understandings of the "Two Stocktons." In the most basic sense, the difference between the Two Stocktons is a difference in the race and social class composition of various neighborhoods. This simplification, however, obscures how the "something" that divides the city is not merely "difference" but is comprised of marked and sustained power asymmetries. Ana Gutierrez held an unusually trenchant perspective on this asymmetry. Ana grew up in Stockton, attended one of the nearby liberal arts colleges and returned to the city after graduating. She explained the Two Stocktons:

Ana: I don't know if you've seen this yet—but there's two Stocktons.

Chris: Sure. Yes. Everyone talks about the two Stocktons.

Ana: Yeah. So, the people that are making decisions about Stockton, and the people that are in power, are not the ones that are...getting pregnant...So I think that a lot of it has to do with the problem that the people that are working in Stockton—they're trying to fix these problems, or have these ideas, but are not realistic, and they're not really fitting into the lives of the people that are affected by this.

Ana articulated clearly the politics of representation and leadership that plagued the city. She noted the phenomenon of community outsiders moving to and purchasing property in the predominately white, middle-class Heights neighborhood of the city, who were then called upon to serve as representatives of Stockton. She illustrated this phenomenon by describing how one of her college professors bought a house in the Heights and subsequently became the person newspaper reporters quoted whenever they wrote a story about Stockton's problems. Similarly, Ana recalled the 2011 campaign of the city's mayor, Ryan Brown, which drew on his insider status as a person who grew up in the city in an attempt to bridge the gap between the two Stocktons. "I remember, it was sort of like, 'I'm from Stockton, I'm white but I speak Spanish and I went to the Stockton public system like you and I was successful.' And it's like, you are a white man! The system is made for you to succeed."

In addition to calling out the limitations of a bootstraps mentality that disregards intersecting systems of oppression, Ana clarifies how one of the Stocktons has decision-making power, the ability to escape stigma, and the privilege of being ignored in discussion about youth sexual health "problems." The other Stockton holds far less political power and is saturated with stigma and assumptions connected to race, class, sexuality, and reproduction. Those in power, including many community health workers and city policymakers, tend to see the distinction between the Two Stocktons as, in the words of a speaker at the high school's National Day to Prevent Teen Pregnancy rally (described in Chapter 6), the "choices you make," and thus unrelated to socioeconomic and racial inequalities. The specter of race was ever-present, though almost never specifically invoked. Instead, politely colorblind racist ideology was masked by

discourses of “culture” and the mythically innate “something about Stockton” (see chapter 5 for a discussion of racial projects in Stockton).

### **Teen Pregnancy’s Effect on Stockton**

When I asked interview participants about the first thing that comes to mind when they think of teen pregnancy in Stockton, they gave responses such as, “That there’s a lot of it,” “We are number one in the state,” and “A lot of babies.” Farrah Silecio, a nurse practitioner at the Stockton High teen clinic, answered the question simply with a long “sigh.” Indeed, that Stockton was widely known for its tenure as the city with the state’s highest teen birth rate escaped almost no one. As Greta McNally, the coordinator of the Stockton public schools’ science and health curricula, blurted at a SASHPC meeting: “We’re number one for something *really bad!*” During a National Day to Prevent Teen Pregnancy rally at the high school, the invited “inspirational speaker” asked the crowd of students, “Let’s turn Stockton around. That number one spot? We don’t want that. We’re gonna turn that around. Are you guys with me?” The crowd cheered (the only response that could have been allowed) and the speaker continued, “Stockton doesn’t want to be number one for teen pregnancy. We don’t want that. We’re gonna try to get to the bottom of that list.” Notwithstanding the fact that “getting to the bottom of the list” may not be possible or even desirable, the speaker’s comments indicate how Stockton is synonymous with being “number one” for teen pregnancy.

### **The Teen Pregnancy Prevention Industrial Complex**

That Stockton is synonymous with teen pregnancy makes it difficult to tease out the specific historical processes that contributed to the ways in which the city makes

sense of and addresses teen pregnancy today. A frequently heard sentiment lamented that the city “had a chance” to address teen pregnancy back in the 90s and was unsuccessful; project partners were steadfast in their desire to succeed in having the impact they wished had occurred during earlier funding streams. Teen pregnancy itself first emerged as a health concern and policy target in the United States during the late 1970s with the Guttmacher Institute’s report “11 Million and Counting: What Can be Done About the Epidemic of Adolescent Pregnancies in the United States” (Lincoln, Jaffe, & Ambrose, 1976). Indeed, this report was instrumental in producing teen pregnancy and birth as particular objects of concern and scientific inquiry, despite the fact that, as the report notes, adolescent fertility had declined since the 1960s. The report accomplishes a major discursive move by conflating sex and pregnancy (11 million teenagers were reportedly having sex, not necessarily getting pregnant or having babies) and identifying teen pregnancy as a problem because it was affecting “our girls.” Whereas previously early childbearing was seen as affecting primarily racial minorities and the poor, data indicating that young white women were having sex outside of marriage ignited moral panic (Pillow, 2004). As the face of racialized teen pregnancy at the time, Black teenagers having black babies were seen as morally unsalvageable, but something needed to be done to help “our girls” (Kunzel, 1993; Pillow, 2004; Solinger, 2005).

The current teen pregnancy prevention work in Stockton grew out of infant mortality prevention efforts that began in the 1980s. A series of archival documents<sup>4</sup> provide clues to the origins of how infant mortality prevention work in Stockton morphed

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<sup>4</sup> The historical discussion in this section is based on my archival research through the Bougainvillea Estate Museum collection the “Pablo Rivera Collection of Latino History in Stockton, 1958-2012.”

into the teen pregnancy prevention work that continues today. By positing teen pregnancy among Blacks and Hispanics as causally related to high infant mortality rates, public health workers were able to construct the prevention of teen pregnancies as key to preventing infant death. This claim is grounded more in a racialized definition of poor women's reproduction than it is epidemiological "fact." A 1983 "Community Study Project" about health issues in the city stated that the "poorer areas are taken over by the Hispanic population," who were generally "young and unemployed." The report also noted a \$1,200 program of sex education in schools and stated, "therefore it is inferred that teenage pregnancy may be a problem," though the correlation is unclear. In 1985, a report titled "Health Issues and Concerns of Hispanics: Preliminary Findings" argued that the relationship between teenage pregnancy and infant mortality was being ignored and that "The city of Stockton, followed by Carlsborough, has the highest infant mortality rate statewide, yet regional studies show an acute lack of prenatal care and/or services for Hispanic women." Similarly, the report stated, "Selected physical and mental health problems, e.g. substance abuse, teen pregnancy, and infant mortality occur at alarming levels among Hispanics." In addition, documents from the Stockton Primary Care Coalition of the early 1980s state, "Stockton has the state's highest teen pregnancy rate and proportion of births to Hispanic women, and its second highest neonatal mortality rate. Births to unmarried women are 2.5 times the state rate. All these women are at increased risk for poor perinatal outcomes."

A 1984 Statewide Task Force on the Prevention of Low Birth weight and Infant Mortality identified Black/white infant mortality disparities as a key problem in cities including Stockton (vital statistics data collection at the time included only "White,"

“Black,” and “other”). A major programmatic outcome of this task force was the creation of funding to serve as a payor of last resort to ensure prenatal care for uninsured women. While state data indicated lower infant mortality rates among participants, the task force reconvened in late 1989 to address persistent gaps in Black/White disparities and broadened it to “include representatives of diverse communities across the state.” In January 1989, the Algonquin Valley News reported on the reconvening of the task force with the headline, “Stockton has highest rate of teen pregnancy in the state.” They quoted a member of a task force, a Latino man who lived in Stockton, on the data showing that Stockton had the state’s highest rate of teen births, about half of whom were unmarried and most of whom were Hispanic: “They’re all extraordinary figures. They represent a serious threat to the future of the Puerto Rican and Hispanic community.” The same article quoted Pablo Rivera, the civic leader whose papers comprised the archive utilized in my research, using the language of choice and hope that mirrors that of present day stakeholders in the city. “People who are economically more well off have more options and are able to make choices,” Rivera said. “One way of getting to the problem is by providing more choices—educational choices, independent living choices, and employment and career choices.” In 1990 the renewed infant mortality prevention task force released a final report titled “Unfinished Business: Poverty, Race, and Infant Survival in the State.” The report included recommendations to implement new and expand existing public health programs to provide low-income women with perinatal services and supports. Although the report does not explicitly discuss teen pregnancy, it does include a recommendation for school-based education on sexuality and reproduction

as a “critical means for reaching young women prior to pregnancy with information and services.”

This collection of documents from the mid 1980s to early 1990s frames the problem of infant mortality in Stockton in a way that sets up later teen pregnancy prevention efforts. Newspaper accounts, health reports, and task force meeting minutes tended to frame the problem as too many young and unmarried “Hispanic” women having babies. Inherent to this problem construction is not only that smaller families are healthier and more desirable, but also that Latinx babies are dying not because of racism, but because Latinas are having the wrong kind of family (Briggs, 2002). This connection between infant mortality and teen pregnancy enables the discursive production of teen pregnancy prevention as a major objective of policy and practice. Population data consistently shows that women of color have higher rates of inadequate prenatal care, preterm birth, low birth weight, and infant mortality than white women (Matthews, MacDorman, & Thomas, 2005). Without a doubt, these are undesirable (and preventable) outcomes, but we ought not let them obscure implications of the discursive work that establishes a causal link between teen pregnancy and infant mortality. Adverse perinatal outcomes across all racial groups have been consistently declining since the 1960s, and the infant mortality rate for teenage mothers declined 34% between 1986 and 2006 (Singh & van Dyck, 2010). In the 1980s, fueled by growing acceptance of teenage pregnancy and parenting as significant social, economic, and health problems, public health workers both nationally and in Stockton conflated lowering teen pregnancy rates with preventing infant deaths, despite a lack of causal evidence suggesting that changes in the teen pregnancy rate would have measurable effects on the infant mortality rate. As



epidemiologist Arline Geronimus presciently noted in 1987, “If environmentally induced risk factors are the primary explanation of the association between early fertility and excess infant mortality, then policy initiatives focusing directly on altering the childbearing behavior of teenagers will not reduce infant mortality (p. 245).”

In December 1995, the state released their annual vital statistics report, which indicated that Stockton had the 2<sup>nd</sup> highest infant mortality rate in the state as well as the highest teen birth rate. This report prompted the convening of a task force that formally merged earlier efforts to prevent infant mortality with teen pregnancy prevention. As the final report of the “Stockton Infant Mortality and Teen Pregnancy Prevention Task Force” later read, the group was formed in response to the “distressing figures” of teen pregnancy and infant mortality with the goal of developing a set of recommendations to “reduce the tragic toll.” The report made a total of 41 recommendations and 22 additional sub-recommendations organized into five categories: readiness to learn, excellence in education (including health education), school-to-community linkages, community-to-school linkages, and readiness to earn. A July 1999 implementation report indicated that 24 recommendations were completed, 21 were in process, 12 were not addressed, and 7 were of an unknown status. In 2007 the Stockton City Council Redevelopment Committee took up the issue of teen pregnancy (but not infant mortality) and high rates of STIs in the city; in 2009 they released a set of recommendations calling for the city to “become unified in proclaiming that education on reproductive health and sexuality is vital to the prevention of high rates of teen pregnancy and sexually transmitted diseases.” These recommendations were followed by the 7-3 school committee vote in March 2010 that enabled scientifically-based comprehensive sex education for ninth graders; the

recommendations also initiated the formation of the Stockton Adolescent Sexual Health Promotion Committee (SASHPC). In that same year, SASHPC members collaborated with other PASH Network members and the Statewide Alliance on Teen Pregnancy (SOAP) to apply for federal funding under the Presidential Teen Pregnancy Prevention program (TPP, see Chapter 1). They were awarded \$1,177,051 over five years (2010-2015) for the *Teens Count* initiative, described in Chapter 2.

Today the association with infant mortality has disappeared from teen pregnancy prevention work in Stockton. The work continues under the rubric of “youth sexual health promotion,” but preventing teen pregnancies remains the primary focus. Although Stockton ranks much higher than the state in terms of STI infections and HIV/AIDS, and project and organization mission statements reflect these disparities, youth sexual health promotion is *always already* about teen pregnancy prevention, which is manifested through funding streams, coalition partners, local media, and professional discourse. Teen pregnancy prevention is the singular focus of the work, with other sexual and reproductive health indicators taking a backseat. Indeed, a veritable “teen pregnancy prevention industrial complex” (TPPIC) operates in the city. Although “industrial complex,” as both neologism and concept, has proliferated to the point of over use (Gilson, 2011), it is nonetheless a useful way of framing the web of service providers, community-based organizations, committees, coalitions, research projects, programs, and grants in Stockton. The teen pregnancy prevention industrial complex in Stockton consists of the relationships, policies, money, and professional identities associated with this web of individual and collective actors. My use of this term is intentionally political and intended to draw attention to the possibilities for social transformation that are

foreclosed by a myopic focus on preventing teen pregnancies in the context of a broadly conceived “youth sexual health promotion.” Despite the many issues Stockton faces, young Latinas pushing strollers are at the center of the discursive understandings and practical workings of sexual health promotion in the city.

In conceptualizing the teen pregnancy prevention industrial complex, I draw on critical scholars who, despite its limitations, utilize the concept of “industrial complex” to reveal how power is consolidated in our current neoliberal landscape. Dean Spade (2015) suggests that when “intellectuals use various terms that end in ‘industrial complex,’ [they] are pointing to a multivector analysis of law, power, knowledge, and norms” (p. 3). Naming and elucidating the workings of the TPPIC allows me to illustrate the discourses and effects that cohere in and through it, rather than through specific stakeholders. Specifically, I draw on scholarship that interrogates the “non-profit industrial complex,” or the professionalization of social movements that has the effect of dampening political dissent and serving the interests of government and private industry (Gilmore, 2007; Rodríguez, 2007). Dylan Rodríguez (2007) defines the non-profit industrial complex as “a set of symbiotic relationships that link political and financial technologies of state and owning class control with surveillance over public political ideology, including and especially emergent progressive and leftist social movements” (p. 21). Mananzala and Spade (2008) highlight key concerns with the non-profit industrial complex: it separates survival services from political organizing, undermines the radical potential of social justice work, and reproduces racism, classism, and colonialism within non-profit organizations because the direction of the work and decisions about its implementation are made by elites, rather than by people directly affected by the issues at hand. The

notion of a non-profit industrial complex draws on that of the “prison industrial complex,” or a way of understanding mass incarceration not only in term of the material buildings of prisons, jails, and detention centers, but also as a “set of relations [that] makes visible the connections among capitalism, globalization, and corporations” and “the practices of surveillance, policing, screening, profiling, and other technologies to partition people and produce ‘populations,’” (Stanley, 2011, p. 6).

Like the non-profit industrial complex or the prison-industrial complex, the teen pregnancy prevention industrial complex delimits what can be known about its object, that is, youth sexuality and reproduction in Stockton. Understanding youth sexual health promotion in the city as a set of relationships, practices, and technologies that constrain liberatory possibilities allows us to see how health promotion can reify inequalities and serve the interests of those in power, rather than those targeted by its apparatus. The TPPIC eclipses other concerns in the city, including the needs that young people define for themselves, and most importantly, obviates the possibility that sexual and reproductive health could be integrated with movements for social and political justice. In many ways, the work of the TPPIC benefits those in power more so than those marginalized by interlocking systems of oppression such as racism, sexism, and classism. Indeed, teen pregnancy prevention can be said to have replaced textile and paper manufacturing as the main industry in Stockton.

### **Constructing the Problem**

Integral to sustaining the teen pregnancy prevention industrial complex are the stories that circulate to make sense of the teen pregnancy/youth sexual health “problem” in the city. Participants varied in their construction of the “something about Stockton” as

well as how to identify the “real problem.” This variation should not be mistaken for a lack of nuance. Whereas some people I interviewed easily reproduced well-worn narratives of teen pregnancy as a threat to the very social fabric of the community, most worked to tease out the complexities of the issues at hand. Like teen parents themselves, professionals charged with promoting youth sexual health cannot completely step outside of the discourses that produce meanings, practices, and identities related to their work; they must negotiate and work within them.

Students at The Towne House struggled to reconcile dominant understandings of teen pregnancy as a social problem with their own identities and experiences as teen mothers. This process occurred through a “strategic negotiation” (Barcelos & Gubrium, 2014) in which young mothers worked to set themselves apart from stigmatizing discourses of teen motherhood without challenging its construction as a problem. For example, during a brainstorm on how teen moms are portrayed in the media, participants in the MAMA group, the strategic communication component of the digital storytelling project, pointed out that teen childbearing is considered a “big deal” nowadays but was not a generation ago. Noting that older women in their families had had children in their teens but weren’t excoriated as “teen moms,” the participants drew attention to the fairly recent construction of “teen” motherhood. Another strategy young mothers utilized was to set themselves apart from “bad” teen moms: those who were very young, didn’t take good care of their children, or were complacently reliant on welfare assistance. After showing her digital story at the SOAP annual conference, Vienna, a 19-year-old mother of a toddler, emphasized that the stories illustrate how teen moms can be good moms and insisted, “I’m almost done my GED, I’m getting off welfare.” Vienna strategically

positioned herself as distinct not only from the bad teen moms, but also perhaps the discursive category of teen moms altogether. Other participants worked to set themselves apart from very young teen moms, as Catherine said in her digital story, “Girls like her at 14 or 13 thinking about having kids when they can’t even shower themselves? This is what I heard all the time.” Catherine, and many others were quick to point out that they were 18 or 19 when they had their first children, putting them in the liminal category of legal adults who are counted as “pregnant teenagers.” Towne House students did not identify access to contraception or sexual health education as key issues that they faced. As I illustrate in Chapter 4, young parents were more concerned with having access to safe, affordable housing, facing intimate partner violence, and bearing the burden of stigma around teen pregnancy. Likewise, youth who participated in a community needs assessment conducted by the *Teens Count* initiative emphasized the problems of violence, drugs, school quality, jobs, and homelessness.

Professional stakeholders also struggled to make sense of multiple circulating discourses about teen pregnancy as a problem; they both reproduced and reshaped common discourses, often contradicting themselves. The major contradiction, discussed in more depth in subsequent chapters, concerns a disconnect between arguing for a structural understanding of the causes and consequences of teen pregnancy but proposing and utilizing individual level strategies that cannot possibly address these larger issues. While participants were aware of and drew from the framework of “social determinants of health,” most did not name racism or the distribution of wealth and power in society as key to addressing the issues they encountered in their professional work. Many stakeholders quixotically spoke of needing to foster “hope” and “opportunity” in young

people as a strategy to prevent unintended pregnancy but failed to connect this to a lack of social, economic, and political power among marginalized peoples. Professional stakeholders' views on teen pregnancy in Stockton fell along two interconnected axes. One axis concerns the type of problem (socioeconomic to health) and the other the level of the problem (individual to structural). Amanda Church, the policy director at SOAP, illustrated these axes, though with more of a social justice framework than most professionals who worked day-to-day on the ground in Stockton:

[The problem is] the circumstance or circumstances and factors that lead to things such as teen pregnancy. I think of teen pregnancy as a consequence of, um, mostly environmental factors that impact individual young people, and some individual behavior choice factors. And I actually think that one of the biggest environmental factors is really about [pause] the lack of systemic supports for certain people when they get—when they're pregnant. And specifically, low-income people of color, people in certain communities, those who have less access to resources to begin with, who experience, you know, racism and oppression to begin with.

Amanda's statewide policy focus likely impacted her nuanced understanding of the “problem.” For the most part, however, professionals did not question the problem construction of teen pregnancy childbearing.

Participants tended to frame the “type” of the problem concomitant to their particular work within it, for example, clinical providers often spoke about the health aspects, but many positioned it as exemplified by the way Mayor Brown described it during our interview: “It's a very complicated topic [with] so many different variables.” For these participants it was difficult to tease out whether teen pregnancy was a health problem, a social problem, an economic problem, a political problem, and/or an educational problem—generally it was thought to be all of the above. For example, Farrah Silecio said, “It's, it's all of them. It's no brainer—I think teen pregnancy in

Stockton is a very complex problem. That's why you can't solve it all. If you get enough approaches, sooner or later you'll, you know, you'll [reach] more and more people, but it is a poverty problem." Farrah went on to say that teen pregnancy was also a "school problem," a "family problem," and a problem that Stockton had long ignored. Emily Lambert, who coordinated a number of primary and secondary teen pregnancy prevention programs through a large health and human service provider, also saw teen pregnancy in Stockton as a multifaceted issue. "I wouldn't say it's the largest problem in Stockton," she said, "I think it's the largest *result* of problems in Stockton... You know, there's a drug issue, there's a violence issue, there's a lack of supervision issue, a boredom issue, and there's a lot of adolescents in this town, so if you put all of those together, somebody's gonna get pregnant." She laughed, "Right?"

Malta Brigado, an obstetrician-gynecologist, founder of the Promoting Sexual Health Network (PASH), and a widely recognized leader in the area's teen pregnancy prevention industrial complex, surprised me by beginning our interview by referring to teen pregnancy as a "quote unquote" problem. She told me that "problem" was not a word she would like to use, but often defaults to it in her work and public presentations. "You know," she said, "I even kick myself when the word problem comes out of my mouth because I'm like, that's not really what I want to say." Malta went on to cast an ostensibly neutral position on teen pregnancy and parenting quite divergent from the rhetoric she used in committee and coalition settings:

The reason I struggle and you hear me hesitate is because on one end, and I still haven't figured this part out, we need to be able to help those that are most impacted by the situation [of teen pregnancy] just to give them resources...I'm not passing judgment but, 'Hey, if you want to be a teen parent, let me give you everything you might need to succeed because I want you to.' Or if you're not a



teen parent but hope to [be a parent later in life], let me help you be the best youth you can so that you develop the skills to be the best parent you want to become.

Using the word “situation” to stand in for “problem,” overall Malta framed the issue in terms of the racial and socioeconomic disparities in the antecedents and outcomes of teen pregnancy and parenting, but stopped short of naming racial justice as a solution. Similar tensions were also evident in her position as an insider/outsider to the issues and the community: although she was quick to note that she was Latina (though never mentioned, as I later learned, that she was Dominican, not Puerto Rican), as far as I knew she never publicly acknowledged her class privilege as a physician who lived in a wealthy white suburb of Carlsborough.

Malta’s framing was common among participants who acknowledged teen pregnancy as problematic, but named something else as the “real problem.” In her case, the real problem was racial and socioeconomic disparities in teen birth rates. Here participants struggled with the question of multi-directional causality: was teen pregnancy a problem in and of itself or the *symptom* of a much larger problem? For Patina Peron, the director of Stockton’s homeless shelter for teen mothers, teen pregnancy was not an individual problem but rather a “society problem.” In her view, teen parents were not to be blamed, but social factors were. A few participants, such as Kristina Myers, a white nurse-midwife who served as a clinician in the high school’s teen health clinic, articulated the complexities of their work within a larger analysis of structural constraints on power. Kristina did not mince words when she told me, “You know, I mean, Puerto Rico is our colony, and the sort of social economic injustice that plays out in that kind of relationship is happening in Stockton.”

Only one participant, Amy Lexington, the grants manager at the Statewide Organization on Adolescent Pregnancy (SOAP), named reproductive justice as a vision for rearticulating the youth sexual health work happening in Stockton: “If we had real reproductive justice, young people would be fully empowered in whatever decision they would want to make and adults would support their right to do so.” This vision was far from being articulated in Stockton, where the range of acceptable decisions regarding sexuality and reproduction are limited by structural inequalities. Delaying pregnancy until one graduates high school (let alone college) and has a middle-class income is a situation that, given the socioeconomic realities of life in Stockton, few are able to realize despite how persistently service providers try to instill “hope” in them.

Finally, in a slightly different and important frame on the teen pregnancy problem in Stockton, Ana Gutierrez called attention to the limitations of a binary construction of teen pregnancy as either wholly problematic or empowering. Here Ana is referencing a trend in academic and activist framings of teen pregnancy that attempt to mitigate stigma by pointing to the empowering aspects of the experience, such as a renewed motivation to finish school, start a career, or leave an abusive relationship (Schultz, 2001; Silver, 2000). When completing her undergraduate thesis on the implications of sterilization abuse among different generations of Puerto Rican women (described in Chapter 5), Ana encountered this shift away from stigma and to empowerment as a romanticization: “I don’t think [teen pregnancy] is a problem, but I also don’t think the flip side to it is too accurate either...I think in Stockton we’re still looking at it as a problem. And we haven’t shifted to romanticizing it yet. But I’m afraid that that’s going to be the shift.”

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When I interviewed Mayor Brown in his city hall office, he asked me if part of my research was to quantify attitudes surrounding teen pregnancy in Stockton, for example, how religious beliefs influenced whether young women in the city were less likely to have an abortion. I explained that my work was interpretive, that I was interested in how people made sense of teen pregnancy in the city particularly how it related to race, class, and gender. As a way of illustrating that my research was qualitative, not based on frequencies or distributions, I joked that I wasn't looking to quantify how many people in the city think there's something in the water making all the teens get pregnant. The joke seemed to be lost on the Mayor, who told me, deadpan and with a corrective urgency, "Yeah, there's nothing in the water, obviously." Nonetheless, while there may not be anything in the canal water, raced and classed understandings of sexuality and reproduction no doubt saturated the "something" that I repeatedly heard about Stockton.

## CHAPTER 4

### BODIES THAT TELL

#### **Dangerous Representations: Visually Telling Pregnant and Parenting Teen Bodies**

Mapping out the teen pregnancy prevention industrial complex (TPPIC) through situational analysis exercises reveals pregnant and parenting teens as an implicated, yet mostly silent, presence in the situation. Despite the fact that their sexuality and reproduction are at the center of the work conducted by the TPPIC, pregnant and parenting teens are largely absent. This chapter focuses its analysis on their lives in order to paint a more complete and complex portrait of teen childbearing in Stockton. In aiming an analytic lens at the stories of pregnant and parenting young women, this chapter takes the focus off the TPPIC in order to “trouble the consensus that can be heard between dominant discourses and those who speak about them” (McClelland & Fine, 2008, p. 255).

Reductive and prescriptive portrayals of pregnant and parenting teens are routine. A teen pregnancy prevention video produced by the Stockton Public High School media center is illustrative of the narrow range of ways in which young parents are allowed to be visible and is a common portrayal of the kinds of acceptable stories they are permitted to tell. As the opening credits proclaim, this video was created to “shine a light on the issue of teen pregnancy.” The film begins with two Latinx teens, Miguel and Kati, both juniors, who awkwardly and without much facial expression introduce the video in front of a plain black backdrop. Miguel’s body faces the camera directly, his hands shoved in his pockets. Kati’s body is turned toward his, but her face looks at the camera. They are clearly reading off a prompter, and after introducing themselves, Kati states, “we’re here

to introduce a really important topic, teen pregnancy.” They take turns reading their lines to say the following:

The teen pregnancy rate in Stockton is dropping but everyone agrees that it is still much too high. In this report, you will hear about what students at Stockton High School think about this issue and how it is implemented in the curriculum. You’ll also hear from the public officials and agencies in Stockton about the work they are doing to help decrease the teen pregnancy rate. You’ll view some of the public service announcements that students have created to help prevent teen pregnancy. And finally, you’ll hear from students like us, who are teen parents. We are in a way, “experts on the subject.”

The first half of the 30-minute film focuses on sexual health education at Stockton High School. Students are interviewed in front of a row of red lockers, sharing insights that fit within a stigma-as-prevention discourse: “It’s about your future first, you know, like have a steady home and job before you start a family cause it’s much easier once you have it all set,” “It could ruin your life,” and “Have a life, like, enjoy your life, it’s no shame to be a virgin, there’s no shame in being that.”

Next, melodramatic soft piano music plays in the background as several of the professional stakeholders interviewed for my project make appearances to talk about their work. Shots from inside Stockton High’s sexual health classes are mixed with montages of high school graduation ceremonies to convey the linear progress narrative inherent to the TPPIC: if you don’t get pregnant, you will graduate high school. Hannah McNeil offers, “through education, the youth will, um, gain the knowledge they need to prevent getting pregnant,” and Mayor Brown reiterates what might be seen as the city’s “official line” on teen pregnancy: “It’s important to acknowledge that we have the number one highest, you know, teen pregnancy rate in the entire state and it’s a big issue, it has big economic implications for our community and for our schools. So we have to address the

problem head on by providing contraception, by providing an education about sexual health.”<sup>1</sup>

The second half of the film begins with the title “Teenage Parents” and Kati and Miguel return to tell the viewer “Yes, it is a blessing to have a child and not impossible for a teenager to raise one, but it is a very difficult task. It is better to wait until you’re ready for the challenge.” Three sets of teen parents—the “experts”—are profiled: Patricia, a young woman from Ghana who had moved to Stockton from the New York City area; Mary, a white woman who lives with her grandmother; and finally Kati and Miguel. All are introduced while the words “Teen Mom” appear on the screen, and all are positioned with their babies on their laps. The video emphasizes the difficulties of carrying on with life after a baby and the individual self-sacrifice involved and aims to show conversion through participation in intensive mothering norms (Barcelos & Gubrium, 2014; Kelly, 2000). Although all the young women (Kati holds the baby during most of her and Miguel’s interview) adeptly manage to sooth, feed, burp, and respond to their babies while talking to the interviewer, the message is nonetheless clear: life as a teen parent is impossibly difficult. Their stories serve mainly as a “warning” to others about the shame, stigma, and burdens of teen parenting. Moreover, the video illustrates how teen parents are very rarely invited to speak about their lives outside of the context of pregnancy prevention. All of the teens in the video are asked to speak about what they think should be done to prevent teen pregnancy in Stockton, which include “providing resources for birth control” and a “program that educates young girls to not need a guy to

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<sup>1</sup> Though as I describe elsewhere, this statement differed from those he used at Towne House events.

make them happy.” They are not asked about what types of services or supports teen parents need, nor are they asked about any other aspects of their lives.

The young parents repeatedly emphasize the difficulties of raising babies, though not in ways specific or limited to *teen* parents. Mary says, “Going to school is hard. I don’t get much sleep a lot. I have to go out on appointments a lot because he was 8 weeks early. It’s harder than it looks [sits up baby to burp him]. You can get help while you’re in school, but when you’re home you have him constantly.” The stresses they describe are germane to *all* new parents: waking up in the middle of night, managing “second shift” responsibilities, paying for daycare and having less time for friends or personal leisure. These stressors are framed as individual problems rather than linked to, for example, the gendered division of parenting labor, family unfriendly workplaces, the high cost of quality childcare, the failure of schools to implement equitable services under Title IX, or the lack of supportive community available to new parents.

In addition, the young parents in the video do not say anything positive about their lives, children, or experiences with parenthood, and their stories frame sexuality as dangerous, non-agentic, and disembodied. For example, Patricia reproduces an out-of-control “bad girl” narrative (Garcia, 2012) when she tells the viewer, “[My father] grounded me, and I escaped from home, and that’s how I got pregnant.” Although Kati giggles and says about Miguel, “He was really cute, and he caught my attention,” there is otherwise a complete denial of the possibility that young women have bodies capable of desire or pleasure. Similarly, the young parents engage in evasive talk about pregnancy and abortion. Miguel says, “We felt we were ready to move our relationship a little bit more, and then our son appeared...It was already there and there was nothing we could

do.” Mary states, “I asked my grandma for birth control and she said no, cause she felt like that was a ‘yes’ for me having sex...but it happens anyways.” Finally, Patricia says, “It just happened, which isn’t what I was planning for...I had no choice but to keep it.” Decisions about sexual and reproductive bodies—enjoying sex, taking birth control, having an abortion—are not theirs to make. Much is glossed over—not only in the messy, complex process of having sex, discovering unintended pregnancy, and making decisions about abortion, adoption, and raising children—but also the inequalities that structure heterosexual dating norms, contraception, and reproductive decision-making (Mann, Cardona, & Gomez, 2015).

The representation of young parents in the Stockton High video is neither new nor surprising. Representations of pregnant and parenting teen bodies are everywhere, from prevention campaigns and MTV to clinics and high schools; the vast majority represent bodies as abject, as sites of fear and disgust. Much more than simply stigmatized, pregnant teen bodies (re)produce particular “truths” about race, poverty, sexuality, motherhood, and inequality. For example, in 2001, the National Campaign to Prevent Teen and Unplanned Pregnancy’s (NCPTUP) first “National Day to Prevent Teen Pregnancy” included a series of posters depicting young women of color along with large print including the words “CHEAP” and “DIRTY.” The text below reads: “Condoms are CHEAP. If we’d used one, I wouldn’t have to tell my parents I’m pregnant” and “I want to be out with my friends. Instead I’m changing DIRTY diapers at home” (See Pillow, 2004). Likewise, MTV’s reality series *16 and Pregnant* and *Teen Mom* have been both lauded as effective prevention programming (Kearney & Levine, 2014) and derided for “glamorizing” teen pregnancy (Guglielmo, 2013). Produced with funding from the



NCPTUP and intended to “motivate teenagers to practice abstinence or use birth control” and “encourage these behaviors by modeling the disruptive consequences of unintended pregnancy” (Guglielmo, 2013) these shows exhibit many of the same themes as the Stockton High video: teen sexuality is dangerous, young women are passive sexual actors, and teen moms are to be pitied, feared, or made into examples. As Caryn Murphy (2013) argues, a major aspect of the show’s message is that the female teen body is a commodity that is devalued by pregnancy. She writes that the series construct a “postfeminist neoliberal subject through discourses of individual choice and personal responsibility” in a way that negates the existence and impact of socioeconomic and racial inequalities. As one final example, New York City’s 2013 teen pregnancy prevention campaign—consisting of visual depictions of sad toddlers with messages including “Honestly Mom...chances are he won’t stay with you. What happens to me?” and “I’m twice as likely to not graduate high school because you had me as a teen”—drew considerable backlash for its over-the-top shaming messages and inspired a reproductive justice inspired counter-campaign (Pérez, 2013).

This brief summary helps to illustrate how the bodies of pregnant and parenting young women are at once made hypervisible *and* silenced through prevailing modes of representation, in particular, teen pregnancy prevention campaigns, reality television, news media, and academic and policy discourses. Wanda Pillow suggests that pregnant and parenting teen bodies both represent and are represented (2003a, p. 148). Pregnant and parenting teen bodies are a convenient tool through which to police the boundaries of socially sanctioned sexuality and reproduction, reify race and class inequalities, and symbolize the sexual and reproductive excess that must be mobilized in the service of

prevention; that is, stigmatizing pregnant and parenting teen bodies enables certain deployments of policy and programming under which only particular narratives are allowed. In her work on educational discourses related to teen pregnancy, Pillow (2006) asks, “How does paying attention to bodies change what we look at, how we look, what we ask, and what we choose to represent?” To this I would add: What might we learn by placing pregnant and parenting teens and their bodies at the center of research and policy work? How can their bodies and stories “talk back” to the stock of (almost entirely negative and disempowering) existing narratives about adolescent childbearing? These questions highlight how failing to attend to the messy complexities of teen bodies enables the reproduction of the TPPIC through stigma and fails to actually meet their needs. In this chapter, I use digital storytelling to facilitate the emergence of embodied knowledges related to young pregnancy and parenting. In doing so, I emphasize bodies and embodiment as a way to center the lived experiences, material realities, and embodied needs of marginalized young mothers.

### **Bringing Bodies In**

A key tension in feminist theorizing of the body has involved disentangling the extent to which we understand bodies as part of a lived reality or as produced, inscribed upon, and disciplined by discourse (Bordo, 1993; Butler, 1999; Grosz, 1995). Western thought on the body has long been dominated by tensions over binaries, such as mind/body, subject/object, and man/woman (Grosz, 1995). Historically, female-assigned bodies have been characterized as “natural,” irrational, uncontainable, or extra corporeal, making their materiality a cautious terrain for feminist theorizing and research.

Moreover, bodies are not just gendered, but also raced, classed, and sexualized.

Following Grosz, Budgeon (2003) argues that:

[T]he body serves not simply as a natural foundation or passive surface upon which meanings are inscribed by systems of signification, but there is an irreducibility between the subject and object such that, in order to understand the ways in which young women actively live their embodied identities, we need to develop an approach which can envision a body beyond the binary of materiality and representation – the body not as an *object* but as an *event* (emphasis original, p. 36).

Understanding the body as a non-static, ever-evolving event opens up possibilities for considering how “subjects are neither wholly governed by discourse nor fully capable of stepping out of discourse” (Lupton, 1995, p. 137). Pregnant and parenting young women are not merely passive bodies that are discursively inscribed upon; they exhibit resistance at the same time as they are disciplined in particular ways. According to Grosz (1995), “If bodies are traversed and infiltrated by knowledges, meanings, and power, they can also, under certain circumstances, become sites of struggle and resistance, actively inscribing themselves on social practices” (p. 36). Additionally, as Lupton (1995) notes, bodily practices and sources of subjectivity are not available to all people equally and are stratified along race, class, gender, sexuality, age, and so on. Focusing on body-as-process can highlight these practices and subjectivities through attention to their intersections. The digital storytelling method is useful in highlighting these tensions as storytellers access resistance through “sensuous subjectivity,” a process in which they claim embodied knowledges and practices at the same time as they are constrained by them. Digital storytelling facilitates paying attention to the lived realities of pregnant and parenting teen bodies while simultaneously conceiving of them as both *produced by* and *resistant to* social and cultural inscriptions of the body.

The body is considered a primary site where disciplinary power is exercised (Foucault, 1977/1995; Lupton, 1995; Pillow, 2003a), and this discipline takes on particular forms in relation to early childbearing. With regards to teen pregnancy prevention, and sexual health more generally, the consequences of sexual behavior are presented not as a range of potential outcomes, but rather inevitabilities. Discipline is enacted through fear by producing the body as a site of toxicity, contamination, and catastrophe (Lupton, 1995). The adolescent female body is produced and regulated through the surveillance of the potentially pregnant body, the discipline of the pregnant body itself, and the representation of the teenage mother's body (Barcelos, 2014). Lupton (1995) reminds us that discourses act to shape bodies, and the experiences of bodies, in ways that individuals cannot totally control. Likewise, the social and public health discourses of teenage pregnancy as pathology shape the young female body in important ways. Constructions of risk produce young women in a subjective state that envisions their bodies in a position of "pre-pregnancy" that must be regulated (through abstinence or compulsory contraceptive use) and monitored (through expert authorities such as health professionals) (Barcelos, 2014).

When a teen body does become pregnant, it is represented as uncontrolled and uncontrollable, visibly swollen with evidence of a lack of sexual restraint and adherence to normative understandings of appropriate fertility. When a body is understood to be uncontrolled, the self is revealed as undisciplined, whereas "the civilized body is controlled, rationalized, and individualized, subject to conscious restraint of impulses, bodily process, urges, and desires" (Lupton, 1995, p. 8). Pillow (2003a) illustrates this point succinctly: "The teen pregnant body is a site of state regulation and control not only

of the teen mother, but also a site for the regulation and reassertion of societal norms, morals, and values on issues such as female sexuality, single parenting, welfare, birth control, and abortion” (p. 149). She argues that the pregnant teen body is seen as “dangerous” and as such public policies are focused on controlling, regulating, shaping, and (re)producing bodies (Pillow, 2003a).

In both popular and scientific discourse young mothers are largely rendered “unspeakable” and “unknowable”; to speak of them requires a very particular narrative, namely, that teen pregnancy and parenting are social pathologies we must remedy. As Pillow (2004) notes, pregnant and parenting young women are both silenced *and* hyper-represented by the discourses on adolescent childbearing in the United States. Despite the fact that the pregnant young woman is ubiquitous in public health and social policy discourse, there is very limited opportunity for teen mothers to voice their perspectives on the institutions that deeply affect their lives. More often, as in the video described at the beginning of this chapter, teens are compelled to participate in “rites of redemption” or serve as warning labels to other young women (Kelly, 1997; Kelly, 2000).

In the teen pregnancy prevention industrial complex, pregnant and parenting teens exist in two ways: as a warning label and as part of “secondary prevention programs,” which focus on preventing subsequent teen pregnancies. In bringing attention to embodied storytelling through emergent visual research strategies, I aim to “bring in” pregnant and parenting teens while being mindful of how representations of teen moms too often must include the duty to confess the abjection of their lives. Like race (as I describe in Chapter 5) and sex (Chapter 6), the bodies of pregnant and parenting teens in Stockton are everywhere and nowhere at once. In a way, the stories in this chapter are a

sort of interlude that draws our attention to McClelland and Fine's (2008) call for feminist researchers to "theorize the sexual imaginary for young women, even when it is denied or stuttered" and to "design research that troubles the consensus that can be heard between dominant discourses and those who speak about them" (p. 255). When storytellers produce their own truths and embodied knowledges, we must work to hear what they say, what they not do say, and how they negotiate the tension that lies between marginalized young mothers and the discourses that produce them. In particular, focusing on *embodied* storytelling is one way to center the needs young parents define for themselves, rather than what policymakers, educators, clinicians, and pundits perceive them to be.

The digital storytelling approach can reveal the unspoken insights and "poetic, embodied, or visually articulated moments of sexual subjectivity" not easily captured through traditional research strategies (McClelland & Fine, 2008). The digital storytelling method helps us to turn around disciplinary gazes and consider how bodies "talk back" to policies of regulation and surveillance. First, I detail the digital storytelling process and describe the analytic strategies I employed in using the stories as data. Next, I describe three key themes from the set of digital stories, which are informed by participant observation conducted during the workshops and follow up interviews with participants. I analyze exemplar stories using "intertextual transcription," an emergent method for analyzing digital stories. Through this analysis I aim to "gain a deeper understanding of narrative constraints placed on meaning-making in relation to structures of power, such as race, class, and gender, by looking at the language used in a digital story, the ways that the narrator chooses to situate herself within her story, and reflecting upon what is

<b>Figure 4: Digital Storytelling Participant Demographics</b>		
	<b>Count</b>	<b>Percent*</b>
<b>Participant age at time of workshop</b>		
17	3	10%
18	4	13%
19	7	22%
20	6	29%
21	8	26%
22	2	6%
Did not report	1	3%
<b>Marital Status</b>		
Married	4	13%
Never married	27	87%
<b>Highest level of education completed</b>		
8 <sup>th</sup> grade	6	20%
Some high school, but did not graduate	23	74%
High school graduate/GED	2	6%
<b>Identifies as Latina</b>		
Yes	29	93%
No	2	7%
<b>Place of Birth</b>		
Puerto Rican	20	65%
Dominican	1	3%
Mexican	1	3%
Not Specified	7	22%
<b>Number of children</b>		
1 child (or pregnant)	25	80%
2 children	6	19%
<i>Participant n= 31</i>		
* may not equal 100% due to rounding		

possibly left *unsaid* in a digital story” (Gubrium & Turner, 2011, p. 478).

### **The Digital Storytelling Process**

A total of 31 Towne House students participated in the digital storytelling workshops. They ranged in age from 17 to 22, with an average age of 19.6. All but two participants identified as Latina (mostly Puerto Rican); one identified as Middle-Eastern and another Haitian. Participants were either pregnant or parenting at the time of the workshops; six had more than one child. Seventy-four percent of participants had completed some high school before coming to The Towne House; 20% had completed up to the 8<sup>th</sup> grade, and 6% had recently obtained their GED from the program. About one third of participants lived with an intimate partner. Others lived with their parents, extended family members or friends; four participants

lived in a teen parent shelter. See Figure 4 for participant demographic information.

The research team followed the general Center for Digital Storytelling ([www.storycenter.org](http://www.storycenter.org)) workshop format with a few adjustments to accommodate the length of time that participants had childcare through the Towne House's daycare program. Catered breakfast and lunch from local restaurants were provided each day. The first day of the workshop included icebreaker activities, an overview of the project, a discussion of informed consent, group agreements, and writing activities. Students were offered a list of potential writing prompts related to the project's research questions but were encouraged to write about anything that resonated with them. We presented the following prompts:

Write about a time when...

- You learned about sex and desire.
- You understood what love is all about.
- You felt like a bad mom or a good mom.
- You felt like you were (or were not) part of a family.
- You realized what home means to you.
- You felt really strong or really helpless.

After participants prepared a draft of their story, each took a turn reading it aloud to the group as part of a "story circle," which was audio recorded and later transcribed. The story circle is an opportunity to give and receive feedback from the group and is often the first time that stories are heard. It is also a safe space in which to build trust and allow for stories to emerge and take shape.



During the second and third days of the workshop, participants refined their stories with the assistance of facilitators, eventually audio recording their narration in a portable sound studio. Participants brought print and digital images from home (generally on their cell phones or from their Facebook pages) and spent time during the workshop taking still images and videos with project staff. Facilitators gave a brief introduction to video editing software and worked closely with participants to piece together their story, including editing and adding transitions, credits, text and/or sound. On the fourth and final day of the workshop we held a story screening where we showed the final edit of each story. This discussion was also audio recorded and later transcribed. Graduate research assistants, of whom I was one, took participant observation notes during the workshops and conducted follow-up interviews with the participants from their respective workshops. Participants were given a DVD of their finished story and invited to participate in an elective class—subsequently named MAMA (Mothers Are Majorly Awesome)—at The Towne House where we would work together on next steps for disseminating messages from the digital stories in community settings. Over the next twelve months storytellers presented their stories at several community-based conferences aimed at service providers, including the annual meetings of the Statewide Alliance on Adolescent Pregnancy (SOAP) and the Promoting Adolescent Sexual Health (PASH) Network. Two community forums were held, one in Stockton and one in the state’s capital city, where storytellers talked about the process and screened stories. I took participant observation notes at each of these conferences and community forums.

The workshops therefore generated a considerable amount of data of various types: textual drafts of participant stories, participant observation notes on the workshop

process, transcripts of the storycircles and screenings, follow-up interviews, and the digital stories themselves. As noted, the analysis in this chapter focuses on the digital stories and is informed by participant observation and follow-up interviews. Because digital storytelling is an emergent method in social research, analytic procedures are emergent and flexible as well. Following Riessman (2008) and Rose (2012), digital stories can be analyzed by focusing on both process and outcome. Analysis can focus simultaneously on what participants say in their stories (textuality), the process of making the stories (production), and how audiences respond to the presentation of finished stories (performance). This chapter focuses on the textuality of stories and is informed by the process of the workshops and the reaction from audiences at community presentations.

Analysis of digital stories proceeded in two steps. First, I watched all stories and took notes on generative themes, use of imagery, text, and sound, and references to dominant representations of pregnant and parenting young women. Often I would pause, re-watch or slow down the video to make closer observations. I grouped these themes both by storyteller, in order to narratively analyze individual stories, and thematically to consider how knowledges and representations intersected across the group of stories as a whole. Next, I transcribed all 31 stories using Gubrium and Turner's (2011) intertextual transcription method (p. 478). This method combines still images from digital stories along with transcription of narration, notes on emotion, features of visual objects, text on screen, music, and special effects to "begin to understand how people make meaning across the different modalities of visual, chronological, aural and oral, emotional, gestural, and textual elements found in a digital story" (p. 478). (See Figures 9, 10, and 11 for examples of a completed intertextual transcription).

Moving through the storytelling process was at once emotionally challenging, nourishing, and cathartic for the storytellers. As each participant took their turn reading the first draft of their story during the storycircle, nervousness, fear, and shyness slowly shifted into mutual support and solidarity. One storyteller, Marianne, a 21-year-old mother of a toddler who grew up in Carlsborough, encouraged other students as they nervously began to read their first drafts during the storycircle: “You got this,” she said. Likewise, many participants reported that the workshop was the first time they had been able to tell their particular story without having to work within the limits of the stories they were “allowed” to tell.<sup>2</sup> Marianne shared during the final day story screening, “We expressed ourselves in ways that we never got to before.” The process of taking pictures and videos prompted rich dialogue among participants about the experience of pregnancy and birth, homelessness, food insecurity, and intimate partner violence. During formal workshop activities, in one-on-one consultations, and over *empanadillas* in the lunch room, participants related knowledge of the declining teen birth rate in Stockton and the lack of a cohesive definition of “teen mom” along with quotidian talk of pregnancy discomforts and potty training struggles.

Within the stories, the body emerged in several contexts and spaces, including the hospital, the shelter system, and the family home. Storytellers positioned themselves in ways both similar and distinct from most other visual imagery surrounding young mothers—while at times stories used ubiquitous images of pregnant teen bodies without faces or heads, in others they presented sexually actualized young women who took pride

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<sup>2</sup> As one example, participants reported that in The Towne House’s long-running and highly lauded poetry program, they were encouraged, and often required, to produce upbeat poems that highlighted their successes while downplaying the struggles or ambivalences about their lives.

in their motherhood. Across the imagery, their bodies were not pathological, not the “target” of policy interventions, but rather sites of pleasure, pride, and resistance. These qualities were referenced in narratives that centered the storytellers’ knowledge through embodied experiences. At the same time, although the disciplinary work of teen pregnancy discourses is often hidden or unacknowledged, the stories made it subtly visible through reference to stigma and shame. The stories also signaled several unmet needs among pregnant and parenting young women, in particular, inadequate housing, freedom from both intimate partner and structural violence, and the need for support in diverse aspects of mothering. While the affectivity of many stories was intense, and at times quite somber, I resist a reading of these stories as “trafficking in tragedy” (see page 137), or an exploitative duty to confess. Rather, I analyze the stories’ sadness, regret, and ambivalence alongside—and as integral to—their potential to serve as sites of resistance.

### **Embodying Teen Pregnancy Through Digital Storytelling**

I identified three key themes from the thematic analysis of the set of digital stories as a whole: ways of (re)presenting the self, knowing bodies, and embodied trauma. The themes represent not only elements common to the stories, but also a theoretical basis from which to conceptualize the body as a process of sensual subjectivity. Storytellers make and re-make their bodies at the same time that they negotiate the dominant cultural stories surrounding pregnant and parenting teen bodies. It is important to analyze how storytellers both resist and reproduce dominant beliefs about and visual representations of teen pregnancy and parenting: at the same time that their bodies are inscribed upon by pathological discourses surrounding teen childbearing, storytellers find resistance by

claiming knowledge of their own bodies, calling attention to stigma and shame, and re-envisioning the meanings of young motherhood. This process can be thought of as making claims to a sensuous subjectivity, or a strategy of rejecting the knowing body as a disembodied rational actor and evoking the messy complexity of bodies. In the sections that follow, I describe each of the three key themes using examples from across the set of digital stories. For each theme I highlight one story as an exemplar and consider how it illustrates the breadth and depth of the theme.

### Ways of (Re)presenting The Self

Storytellers draw on and transform available narratives and visual culture in their representation of bodies and presentation of the self. While they utilize narratives of progress through personal responsibility and depict their bodies in gendered, classed, and sexualized ways, they also mobilize narrative, visuality, and affect to strategic ends. “Bodies” are at once literal and metaphorical, active and passive; stories are at once linear and messy. The set of digital stories as a whole contain numerous examples of dominant visual culture, both in general and particular to the representation of pregnant and parenting teen bodies. Half of all stories contained “selfies,” or photographs taken of oneself using a phone or a webcam. All but one story included images of the storyteller and/or her child(ren). Selfies are variously seen as, on the one hand, a narcissistic,



**Figure 5: Teen Pregnancy in a Stockton Spanish Language Newspaper**

inauthentic consequence of a youth and social media obsessed culture, and on the other, a strategy for turning the “gaze” around on oneself in a way that retains agency. Selfies both produce and are a product of our current visual culture: the ubiquity of mobile devices facilitates self-photography and changes the way we see and think about ourselves. In part, the participants use selfies in their digital stories because they are easily accessible to take and share electronically. But selfies also help to shift the way we think about ourselves in relation to the broader cultural imagery surrounding marginalized bodies. One way to read the “artificialness” of selfies is to state that they are not “real” representations of ourselves because of the ways they are staged. Another is to acknowledge that we are always performing various selves (Goffman, 1959) and that there are implications to being in control, of producing images of ourselves.

There are 14 shots in the set of stories that feature images of pregnant bellies in profile with the woman’s head cropped out of the frame (see Figures 6, 7, and 8), a ubiquitous visual referent for the shame and danger that pregnant teen bellies represent (see Figure 5) (Vinson, 2012). It is unclear whether participants composed their heads out of photos because of the positioning of the cell phone/camera during taking the selfie, for reasons of anonymity, or as a manifestation of internalized notions of the shamefulness surrounding teen pregnancy; it seems likely that all of these factors existed simultaneously. It is also possible that participants took selfies because they had few others to celebrate (and thus photograph) their pregnant bodies.

The stories frequently use shots of gendered and



**Figure 6: Vienna's Belly Selfie**

classed imagery such as hands with engagement/wedding rings, ultrasound pictures, and



**Figure 7: Magda's Belly Selfies**

family portraits. Inez, a 20-year-old mother of two who grew up in Puerto Rico, used stock photos of fetal ultrasounds and bride and groom hands in her story about discovering she was pregnant despite using birth control—much to the disbelief of her

mother, who insists “*La única manera que yo lo voy creer es por ultrasound!*” (“The only way I’m going to believe it is by ultrasound!”). As she shows us the wedding ring shot, Inez’s steady voice narration tells us what her boyfriend told her mother upon confirmation of her pregnancy, “I promise I will be there for her and my baby.” This shot directly fades into the final shot of the story, a photo studio image of Inez, her now husband, and their two small children in front of a pale blue backdrop. With a sense of fulfillment she tells us, “And he has been,” and the image fades to black. In the same way, Catherine, a 20-year-old mother of one who was pregnant with her second at the time of the workshop, titled her story “A Mom Can Be Anyone.” The story, which discusses the stigmatization of young mothers as irresponsible parents, includes a shot of her belly when her tone switches from indignant to affectionate as she says, “Bringing a baby into this world isn’t about age or money. It’s about love. It’s about being the best mommy.” Like Inez, Catherine ends her story with a family photo including her husband and first baby. Shot in a living room with flowers and household plants in the background, the final frame transposes the text “FAMILY = LOVE” in pink letters across the upper left side of the frame.

As with selfies, the excessive use of belly profiles, wedding rings, ultrasounds, and family portraits are simultaneously a product of a normative visual culture and productive of a sensuous subjectivity that stakes a claim for the legitimacy of abjected teen bodies. These images might be read as reproducing intensive mothering norms, medicalized pregnancy, and compulsory heterosexuality; they can also be read as acts of resistance significant in a culture where pregnant teen bodies symbolize danger, excess, disgust, and fear. By choosing to repeatedly show their bellies and families—although often in low quality images that distract from the narrative<sup>3</sup>—storytellers demand recognition and respect for their experiences, bodies, and families. By reproducing visual culture in this way, storytellers access the celebration of their bodies, pregnancies, babies, and families that is generally denied to them.

The narratives told in the digital stories feature a number of variations within the broad prompts that facilitators provided storytellers during the first day of the workshops.



**Figure 8: Amal's Belly Selfie**

Although many of the digital stories exhibit a linear narrative of progress that speaks to Murphy's (2003) characterization of the young women in MTV's *Teen Mom* as "post-feminist neoliberal subjects," they also help to complicate that narrative through attention to the nuances of their lives. This nuance is significant

given the static and homogenous ways that we typically

understand teen mothers' lives: you were bad, you ruined your life, and that's the end of

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<sup>3</sup> Although sometimes a point of contention, most digital storytelling facilitators emphasize the use of photos that convey meaning important to the storyteller, rather than adhere to prescriptions about artistic merit.



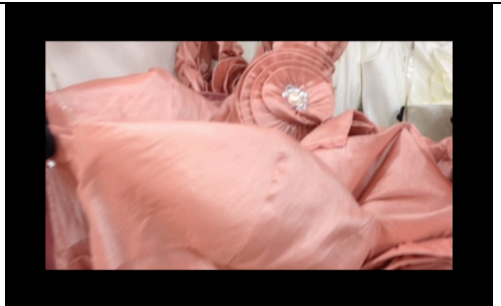


the story. Likewise, scholars point to the limited and limiting available narratives about teen pregnancy and parenting. Deirdre Kelly (2000) describes four common “stigma stories” found in media and popular discourse. These stories stigmatize teen pregnancy and parenting by focusing on where to place “blame” for the transgression of unintended pregnancy. Kelly’s research participants, however, identify a “stigma is wrong” story that shifts the “problem” of teen pregnancy to the stigma that they endure. Similarly, Chris Barcelos and Aline Gubrium (2014) illustrate how young mothers strategically negotiate dominant cultural narratives on teen pregnancy through both reproduction and reinterpretation of these narratives. Through their strategic negotiations with available circulating stories, including pathology and redemption narratives, the participants in Barcelos and Gubrium’s research work to assuage stigma and construct unproblematic identities.

Angela’s story illustrates how storytellers reproduce a dominant narrative of personal responsibility and progress at the same time as they highlight the importance of understanding nuance in the lives of marginalized young mothers. Angela, a 17-year-old mother of one, grew up migrating back and forth between Puerto Rico and the greater Stockton area. Her voice is hesitant and somewhat unsure as she opens her story with a moving image that pans across a rack of formal wear dresses in pinks and whites (see Figure 9). The shot is shaky from a handheld camera as Angela tells us, her voice becoming perceptibly hurt, “One day my mom asked me what color I wanted for my sweet 15. I stayed quiet and didn’t say anything because I knew what she was going to say to me: “*¡Tu eres una puerca, preñada esta edad! ¡Toda la familia va a ser avergonzado por usted!*” (“You’re a pig, pregnant at this age! The whole family is going

to be embarrassed by you!”). The combination of the glamorous visuals and the tentative audio narration communicate a sense of longing. We first see Angela herself in the next shot, a selfie taken in a mirror, in which she smiles cautiously with a crib visible in the background. She continues, “But I didn’t care, so I left Puerto Rico and came to the USA at 6 months [pregnant], going on 7.” In this turn of talk there is a sense of confidence in her act of self-care by leaving a place where she had no support.

Angela’s selfie fades directly into a photo of a white crib in a white room, empty and sterile. The shot pans in toward the center of the crib as she continues, “I imagined having her at 9 months, holding her, breastfeeding her, spending time with her.” This image fades to black and is replaced with a black and white video of bird origami hanging from strings reminiscent of a baby mobile. The lack of color and gentle shaking of the birds give it a tenuous feel as Angela says, “When I was 7 months, I had a beautiful baby girl.” A baby scale is superimposed over this image as we learn the size of her tiny newborn: 3 pounds, 11 ounces, 12 inches long. The next few frames alternate between the mobile and colorless photos of the neonatal intensive care unit (NICU): “I didn’t get to hold her. They took her upstairs to the NICU. I stood downstairs waiting with my dad. After an hour, they finally called me. I went and all I seen was little tiny babies. I started crying, cause it hurts, seeing babies like that. She had an IV through her head and legs, and a tube going down her nose. I can still hear the sounds of the machines. They put stickers on their chests to see if their heartbeats are staying steady or going down.” The cold, impersonal black and white frames convey alienation, distance, and chaos but then shift to color images of Angela, both with and without her baby. “I walked till I got to my baby. She was so little, I didn’t even know how to hold her. I

cried, but of joy. I knew I never leave her alone, not for one minute. She was everything I had. She was the only thing that kept me alive. I held her on my bare chest, holding her close to keep her warm.”

<b>Figure 9: Intertextual Transcript Excerpt from Angela's Story</b>			
<b>Image</b>			
<b>Time (sec)</b>	5-8	9-11	12-14
<b>Location represented</b>	Clothing store	Clothing store	Clothing store
<b>Script</b>	I stayed quiet and didn't say anything,	because I knew what she was going to say to me:	<i>¡Tu eres una puerca, preñada esta edad!</i>
<b>Emotion conveyed from script</b>	Apprehension, silence	Shame, fear	Shame, pain, hurt
<b>Features of visual objects</b>	Camera turns to focus on flower on shoulder of pink dress	Camera continues on down the racks of dresses. Shot is shaky from hand held camera.	Movement continues, extra light enters camera lens and highlights gray dress
<b>Emotion conveyed from visual</b>	Glamour, longing	Abundance, longing, that which is unattainable	Change, complication
<b>Voice quality</b>	Perhaps timid	Hurt in voice becomes perceptible	Continues to sound hurt
<b>Special effects</b>	Fade	Fade	Fade
<b>Text on Screen</b>	[None]	[None]	<i>You're a pig, pregnant at this age!</i>

Angela's baby stayed in the hospital for 27 days. "When I took her home," she says, "I was happy, but I was sad too." An image of the baby fades directly into a picture of a toddler in a frilly pink dress, followed by a shot of a young woman in a pink dress dancing with who the viewer presumes is her mother, *quinceañera* guests looking on in the background. Angela continues, "Every girl dreams that dream, of having a *quinceañera*. I saw the other girls having their sweet 15, they were happy. They enjoyed their bonding time with their moms, being loved by them." The final shot depicts Angela and her baby as she says, sadness palpable in her voice, "I never got to pick a color."

Although her daughter gives her strength in the face of family rejection, premature birth, and uncertainty, Angela must navigate the complicated and conflicting emotions of separation from her own mother and missing out on an important adolescent cultural ritual. This speaks to a complex, nonbinary way of thinking about teen pregnancy: it is neither wholly pathological, redemptive, nor empowering. While Angela's story reinforces individualistic tropes of personal transformation through perseverance (I didn't care what my mother said, I moved on/My daughter was everything I had and the only thing that kept me alive), it also creates space for her to mourn the loss of her *quinceañera*. The dissonance of finding "everything" she needs in motherhood while still desiring a *quince* is important in a context where young mothers are denied the right to simultaneously take pride in motherhood and grieve what they lost. While older, middle-class parents are typically given space to lament how becoming new parents limits their ability to socialize with childless peers, low-income racialized teen mothers must repent and are not afforded such a luxury. As such, Angela's story exemplifies the messy, complex realities inherent to many young mothers' lives, where

redemptive progress narratives collide with longing for that which they are not supposed to want.

### **Knowing Bodies**

Storytellers conveyed an embodied knowledge that challenges common understandings of young mothers as ignorant and immature, not knowing how to take care of themselves and their children. Through knowledge produced in and through bodies—theirs’ and those of their children—they worked against the abjection and pathologization of the pregnant and parenting teen body. At the same time that they reified gender norms around mothering, the storytellers’ depiction of embodied knowledges provides an important contrast to how research and policy discourses construct their needs. While storytellers did not specifically articulate what they needed from providers and policymakers (and this was not one of the prompts the research team provided) they did provide insights about their needs and how they have come to know them through embodied experiences. Policies and programs aimed at young mothers are largely concerned with promoting skills and behaviors based on the image of promiscuous, bad mothers who are a drain on the welfare system and incapable of escaping intergenerational poverty; such programs include preventing secondary pregnancies (Coren, Barlow, & Stewart-Brown, 2003), welfare-to work-programs, and remedial secondary education (Pillow, 2004). With the exception of The Towne House, this description is illustrative of the services and programs available to young mothers in Stockton. Paying attention to the sensual subjectivity of these digital stories is one way to shift policy and practice to focus on the issues that young parents identify for themselves.

Embodied knowing emerged as an instinctual knowledge of how to care for one's own body and those of others (children and other family members). In her digital, which calls attention to teen parent stigmatization, Catherine mocked the voices that doubt young mothers' ability to care for their children. "Don't hold her legs like that when changing her diaper! Oh my god, hold up her head!" she says chidingly along pictures of her newborn baby on the screen. Here the shame is turned back to the viewer, who is made to feel complicit in this commonplace denial of agency. Through textual, visual, and affective means, Catherine and many other storytellers described a way of knowing that came with becoming pregnant and having a child. Marianne, whose mother struggled with drug addiction, grew up being bounced back and forth between extended family members and foster homes. Many of the visuals in her story are abstract images of paper art (rather than photographs). Her doubtful tone of voice tells us that when she found out she was pregnant, she immediately thought she was not "mother material." She self-deprecatingly recounts the lack of supportive mothering she received as a child—not having manners or learning how to cook or clean—eventually finding strength within herself and confidently declaring: "My son will have his family with him on every birthday, first day of school, and for every play or recital. Now I know that I am not only mother material, I am a great mother."

Storytellers often unequivocally knew what they needed in terms of support, whether it was rides to the NICU to visit a sick baby, something to eat, a shoulder to cry on, a safe neighborhood to raise their children in, freedom from shame and stigma, or instrumental and affective support from community and family members. In contrast to how health and human service providers tend to understand young mothers' needs (e.g.,

contraception, parenting skills), storytellers showed a much broader array of concerns. Zemora's story is significant in that it talks back to a common social policy concern surrounding teen childbearing, what public health professionals call "secondary prevention" (Asheer, et al., 2014): having a second teen pregnancy. Recall from Chapter 2 that most educational and social programs aimed at teen mothers include a secondary prevention component. Whereas for women in a higher position in the hierarchy of stratified reproduction a second pregnancy is often cause for celebration and support, for young mothers it is condemned as a second failure. Zemora, 21, grew up in Stockton and dropped out of school at age 15 after an extended period of sporadic attendance. The next year, while living out of state, she conceived her first child with a then long-term boyfriend. The couple broke up a few years later; shortly thereafter Zemora discovered she was pregnant with her second child. Knowing that she would soon be a single mother to two young children, Zemora decided to move back to Stockton in order to be closer to family and have a better environment in which to raise her children. At the time of the digital storytelling workshop, Zemora had been a student at The Towne House for about two weeks; she passed her GED test later that fall.

The first word that comes to mind in describing Zemora is "sweet." Looking through my field notes about interactions with her, I note several times where I comment about her cheery exuberance and positive outlook on life—the kind of thing you wish you could bottle up. The digital story Zemora produced in the workshop also exhibits these qualities, and as a result positions the experience of having her second child in direct contrast to the existing supply of stories related to second births among teen mothers. She described her intention in choosing this story as a way to support other young women



having their second baby (two of the participants in her workshop were pregnant with their second). Zemora framed it in terms of worrying about having enough love for all of your children and introducing older children to a new sibling—issues commonly discussed among women having their second child, but unheard of in the context of teen pregnancy. Her narration speaks nothing of her age, marital status, level of education, contraceptive intentions, or any of the other many issues that are generally positioned as young mothers’ “needs.” Whereas welfare policy institutes “family caps” for subsequent children and public health programs focus almost obsessively on “not making the same mistake twice,” Zemora is concerned instead with finding enough love in her heart and strength in her body for both of her children.

Zemora’s digital story evokes feelings of hope, reassurance, joy, and familial love. Her upbeat and cheerful voice conveys a sense of normalcy about her experiences and signals an important departure from the intense pathology of secondary teen pregnancies. As Zemora’s story begins, the words “It’s going to be ok...” scroll across the screen and fade into a selfie of her pregnant belly. “Three and half years after having my son,” she narrates over a picture of her and her son riding a red toy car, “I was pregnant again. All I could think was, ‘how is my son going to feel?’” These emotions and visual representations signal the joy she finds in mothering and the reassurance that everything will work out. Note that “all she could think” was how her son would feel, not “how could I let this happen?” Zemora then appears with her son at an amusement park—perhaps a classed performance of parenting—and tries to make sense of the implications of her expanding body and family. Her son, too, tries to understand the changes happening. As we see him touching his mother’s pregnant belly and looking up

at her with a smile, Zemora tells us that he thought he was also pregnant and had a baby growing inside him “I thought, ‘Maybe this means he’s making sense of everything.’”

When Zemora went into labor with her second child, she felt excited for her children to meet. Her family brought her son to see her in the hospital post-partum; he ran up to the bed and exclaimed, “That’s my sister, she’s so pretty!” This moment triggers what Zemora names her “mother’s instinct,” an embodied knowledge that she has the emotional resources to sustain her family. The physical experience of holding both her children in arms enables her to say, “I knew everything was going to be ok.” A selfie in the mirror presents her round belly on her petite frame; in other pictures we see her interacting with her children, holding their bodies and symbolizing the growth of her family and her love as a mother. She first shows us her two children with her on the day of her daughter’s birth and then at home several months later where she holds her infant on one knee and hugs her son with her left arm.

Watching Zemora’s story again and again, I am struck by the absence of pathology in relating an experience generally seen as the ultimate failure: unable to redeem themselves through individual hard work and resilience, young mothers having their second child have failed *twice*. Some policy makers and service providers might frame this in terms of the system having failed them—this baby could have been prevented through promoting long-lasting, provider controlled contraceptives or giving Zemora a “sense of hope” to discourage her from having children again “too soon.” She shifts our attention away from this common narrative and abjection of repeat unintentional pregnancies without even acknowledging it. Zemora places herself outside of this narrative by connecting her experience to deeply felt bodily and affective senses, a

form of sensuous subjectivity. Zemora knows what is important to her, what her needs are, and she claims access to a common yet intense physical and emotional transition to being the mother of more than one child.

### **Embodied Trauma**

The most prevalent theme that the stories generated was an embodied trauma that highlights the need for a shift to “bearing witness” to suffering (Farmer, 1996) and addressing structural inequalities rather than looking to prescriptive, individualized solutions to young mothers’ needs. While some storytellers focused explicitly on the judgment and trauma that they experienced, this topic was implicitly woven throughout many: stories of teachers who told them they had ruined their lives, the parents who rejected them, the baby daddies who refused paternity. Storytellers described embodied trauma including family abuse, neglect, and rejection, depression and other mental health issues, housing and food insecurity, and intimate partner violence. Although some of the professionals who worked at The Towne House preferred to emphasize happy, redemptive student narratives in their public relations materials, the young mothers used the digital storytelling workshop as a space to make visible and validate the very real yet often unspoken traumas they experienced. In the concluding section of this chapter, “Sensuous Subjectivity in Digital Storytelling,” I detail how, in addition to bearing witness to suffering, acknowledging both the struggles and resiliencies of young mothers’ lives is integral to centering their needs to improve policy and practice.

As I discuss in Chapter 5, a well-worn trope favored by health and human service providers is that Latinas have higher rates of teen pregnancy because of cultural norms among Latinx families. The logic of this argument is that Latinas are more likely to have

children young because they know they will be welcomed and supported by their families, due to the ostensible high value Latinx families place on family. Although some stories did illustrate support from extended families, many other storytellers spoke of deep family traumas both surrounding and preceding their pregnancies, ranging from indifference and rejection to abuse and neglect. For example, Angela feared responding to her mother's request about a color for a *quinceañera* dress, knowing that her mother would likely shame and reject her. Similar accounts of the trauma of revealing pregnancies appear throughout the stories. In disbelief that she was really pregnant, Inez took two pregnancy tests at home and three more with the school nurse. She describes the sensations of disclosing the pregnancy to her mother. Her hands were hot and sweaty as she lifts up her mattress to reveal all five pregnancy tests underneath her bed. Still, in her anger and disbelief, Inez's mother refused to acknowledge the pregnancy until Inez had an ultrasound.

Several participants who did not have strong families to support or reject them in the first place illustrate a notable fault in the "supportive Latino family trope." In many cases due to factors exacerbated by structural inequality, families were already not a part of storytellers' lives because of substance abuse, incarceration, and engagements with the child welfare system; for instance, Marianne's story focuses on her childhood as the daughter of a substance dependent mother. Likewise, Flor, 18, describes how her mother was initially angry with her for becoming pregnant when she was 15 years old, but soon came around: "I'm her *princesa*, she had no choice but to be there through it all." Flor's mom agreed to accompany her to all of her prenatal appointments, but this promise went unfulfilled as her mother was incarcerated shortly after Flor learned that her baby was a

girl. As a result, Flor and her baby were put into the foster care system together and “moved from house to house.”

Traumatic rejections from fathers of their children were also common and linked to intimate partner violence. For example, Amanda, a 21-year-old mother of a 5-month-old who also had custody of her 15-year-old sister, was rejected by her baby’s father, who became abusive at the announcement of her pregnancy. “The day that I spoke to him,” Amanda recalls with a down tone of voice that contrasts with a photo of her pregnant and smiling in her living room, “his words were: ‘Get an abortion, you’re young. You’re going to ruin your life.’” The next frame zooms into an image of a pane of broken glass and Amanda continues, “His sweet words I was used to changed into verbal abuse. He wasn’t there throughout the pregnancy. I became homeless and sometimes went days without eating. I went from house to house [and] I couldn’t take it anymore.” Similarly, in her emotionally intense story that uses a soundtrack of a heartbeat, Tamara, 19 and a mother of two boys, describes how she intentionally got pregnant at age 14 as a strategy to get away from her mother’s repeated relationships with abusive men. “It started when I was four,” she tells us, “I still remember, my mom on her knees, my dad standing over her, with the gun pointing at her head.” Tamara’s own boyfriend turned out to be violent and abusive; as the audio of the heartbeat grows faster and a photo of her children playing becomes blurry she says, “He pushed the door, grabbed me, and started pulling my hair. I tried to defend myself, and he choked me. The kids cried and screamed. He let go of my throat because of them. My 3-year old kept saying, “Mommy, don’t cry....After the police told me it wasn’t safe for us, we left.” Later on, Tamara shared that she learned via Facebook that her son’s father had begun dating her mother; both had left

the country. Clearly, these examples cast doubt on the legitimacy of the homogenous “supportive Latino family” that encourage and support their daughters’ pregnancy and childrearing.




Vienna, a 19-year-old Haitian mother of one who landed in Stockton while being shuffled around the state’s system of teen parent homeless shelters, experienced intimate partner abuse, family rejection, housing insecurity, and a lack of food during her pregnancy. Vienna’s story is one that I returned to again and again. It is not simply that her video is skillfully executed; the visceral urgency and intense transfer of feeling to the viewer prompted its use in numerous community forums, research presentations, and provider trainings. Working with her during the workshop and throughout the next several months as a participant in MAMA, it was clear that Vienna’s complicated portrayal of herself as a proud and strong, yet also vulnerable and angry, young woman carried over into her public presentations of her story. During the question and answer portion of our session at the annual SOAP conference, in which several storytellers screened their stories and discussed their experiences, Vienna asked the audience to not look at her as she read from her prepared remarks. As she spoke, her voice trembling and tears gently forming in her eyes, she emerged from her discomfort and looked fiercely toward the audience. Speaking pointedly about a recent racial micro-aggression she had experienced in a shopping mall, she stated without ambivalence: “My daughter is not a mistake.”

Vienna’s digital story sensually conveys this dance of vulnerability, anger, and strength. The title frame reveals a single word, “Hurt,” in white font centered in a black screen. An initial selfie of Vienna smiling into a mirror quickly shifts to a headless selfie

of her pregnant belly as she tells us, “My baby daddy didn’t believe [I was pregnant] until I was five months along. That’s when he started hitting me.” As she continues she invites the viewer to feel the multiple forms of hurt embodied in intimate partner violence: the lack of phone calls, refusal to accompany her to prenatal appointments, ignoring her need for food and nourishment, posting pictures of his other children on Facebook and not hers. Vienna recalls particular coercive attempts to her body, “I remember when I wanted him to come to my house, I’d have to tell him I’d have sex with him.” On screen, she features a photo of him holding their baby, which is quickly followed by a scrawled word in red—“sex”—featured with an explosive background of red and black to convey the violence of this suggestion (see Figure 10). The tone of Vienna’s voice expresses her hurt feelings, but her follow-up response includes a haughty laugh and demonstrates her challenge to his violence. She literally laughs at her daughter’s father not once but twice, again when he says, “Don’t worry, I’ll be there for the birth.” “Yeah, right,” she challenges.

Throughout the story, multiple sensory and embodied elements represent Vienna as far from passive. In a video clip shot in profile, she actively engages her whole body to “talk back” to her daughter’s father on the phone. Vienna’s pink cell phone, stickered with photos of her daughter, foregrounds the frame as she angrily talks into the device not only with her voice, but with her whole body. While only her voiceover is audible, we can both hear and experience the resistance and strength that she relates toward someone who has caused her so much pain.

**Figure 10: Vienna's Intertextual Transcript Excerpt**

<b>Image</b>			
<b>Time (sec)</b>	22-30	31-37	38-43
<b>Soundtrack</b>	[None]	[None]	[None]
<b>Script</b>	and he wouldn't come to the doctor's with me. He'll say, "No, I'm too busy, I gotta play soccer." He said, "Don't worry, I'm gonna be there for the birth." [Laughs haughtily] Yeah, right.	He changed his number and I couldn't get in touch with him. I remember when I wanted him to come to my house, I'd have to tell him, I'd have sex with him.	But I didn't, and it made him mad. [Laughs wryly]
<b>Location represented</b>	Bottom of a stairwell	n/a	n/a
<b>Emotion</b>	Resistance and strength. You don't mess with me.	Hurt, plain and simple	Vienna's laugh invokes a quality of resistance. Shock.
<b>Features of visual objects</b>	Video of Vienna on her phone. Shot from behind, we can see her earrings and photos of her daughter taped to the back of her phone.	iPhone with picture of the baby's father and Vienna's child as background.	White piece of paper with SEX written in large, quick, red letters. Black and red explosive background painted behind the word.
<b>Special effects</b>	Vienna's head and body moves as she "talks" on the phone. Dramatic, realistic effect of cussing out her child's father as she talks with her hands.	Slow pan up	Direct fade from previous shot
<b>Text on screen</b>	[None]	"Slide to unlock" on iPhone	"Sex"



Remembering her own father's active role in her childhood, Vienna laments that her daughter will not have the same father in her life. Yet, she vehemently asserts that her daughter has everything she needs from her. Vienna uses still images, including a large photo of her embracing her small daughter on a sunny day, and a series of smaller photos to illustrate the material and emotional needs that she fulfills for her daughter. Vienna ends by saying: "I realized she's smart because of me. She walks because of me. She eats because of me. Everything she's got is because of me." The last frame of the story returns to an earlier shot of a black and white video of a leaky kitchen faucet, used to represent the tears she has shed over these experiences. The hope and abundance signaled in the preceding words returns to the deeply felt trauma hinted at in the beginning of the story as Vienna tells us: "But I'm still hurt."

Amethyst's story, "Unexpected," references trauma by focusing on her birth experience. A 20-year-old mother of one, her story describes not infrequent experiences of new parents: unexpected complications during childbirth, a newborn who requires treatment in the NICU, and post-partum depression. Similar to Zemora's concern over introducing her son to his baby sister, telling this particular story gives Amethyst access to the empathy and support that normative new mothers often experience. Like Zemora and most of the storytellers, Amethyst does not situate her experience in terms of being a young mother. Still, it is clear that the early days of her motherhood were difficult in distinct ways. Her baby's father was incarcerated at the time of the birth, and with no other familial support or transportation to the hospital, Amethyst must deal with the unexpected alone. Her story is slowly paced, visually dark, her voice strong but her pain audible as she speaks. Beginning the story with shots of a hospital-like ceiling from a first

person point of view invites us to feel and see her experiences from her vantage point (see Figure 11). The low light and shaky camera work evokes an ominous, lonely, fearful sense of despair. Shots fade to black before transitioning into the next image, contributing to a feeling of not knowing what will happen, how the story will end.


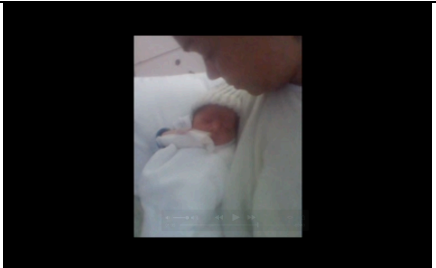

The imagery remains abstract until nearly a minute into her story, when we see a baby adorned with medical equipment. We don't see Amethyst herself until more than a minute into the story and we only ever see her face in profile. Her body is only partially present—she stares out a window in a colorless shot or nervously rotates baby blocks in her hands. Color returns when the frame suggests hope and resilience, but reverts to black and white when she speaks of loneliness, sadness, and depression. Her voice tells us about the physicality of her experience: fatigue, hair loss, constant crying, and loss of appetite. While we do not *see* this embodied trauma, we *feel* it through the use of imagery, sounds, pace, and special effects. The ceiling shots bring the viewer into Amethyst's sensory experience: we are lying in a stiff hospital bed, alone with nothing to look at but white ceiling tiles and nothing to hear but the beeps of machines. The lack of color in the imagery conveys a sense of coolness and a lack of familiarity or intimacy with one's sensory environment. Apprehension builds through these lengthy sequences, and the story again fades to black before we get to see her son in the NICU. The image of her baby fades in and the camera pans out as Amethyst tells us about her seeing her son for the first time: "Staring at all of them...not knowing which was mine. It didn't feel real at the time; I just couldn't believe he came out of me." Amethyst experiences a sense of disembodiment through the experience of visiting her newborn in the NICU. For the viewer as for Amethyst, we feel this ethereal sense of contradiction, struggle, fear, and

loneliness. The shot of her baby fades to black for several seconds before we finally see Amethyst holding him with skin-to-skin contact. Here is where she begins to tell us her story of embodied trauma: “I was lonely. I wasn’t producing milk, my hair started falling out, I kept crying. The nurse asked, ‘Are you alright?’ ‘I don’t know, I can’t stop crying.’” As the colorless video of Amethyst rotating a baby block in her hands plays, she tells us that although the nurse explained the medical term for what was happening, she still didn’t explain why she was “feeling so down.”

Experiencing a difficult birth and a fragile newborn is certainly enough to cause trauma in any parent. Amethyst’s story allows us to feel this experience as someone who lacks the material resources and support to cope. Having no transportation to the hospital to visit her baby, she begged for rides although she didn’t want to “bother anyone.” Her post-partum depression is exacerbated by her lack of resources and support. She is tired, her hair is falling out, she can’t eat and can’t stop crying. Eventually we see a selfie of Amethyst at home with her baby exhibiting a sense of perseverance and survival, yet as she tells us, “I did it all by myself. No support when there was people around who could help me. It still hits me really hard.”

Bearing witness to these various embodied traumas is important for several reasons. First, it calls attention to the ways that our bodies experience, feel, and internalize trauma, which has implications for physical and emotional well being (Burstow, 2003; Sotero, 2006; Van der Kolk, 1994). Second, it illustrates that although young mothers are strong and resilient, we need to shift our focus away from individual-level explanations for and solutions to trauma in favor of a structural approach. This shift connects back to my earlier point regarding the disjuncture between what public health

professionals and social policy makers understand the needs of these young women to be. If pregnant and parenting young women are experiencing and suffering from a lack of housing and food, violence, and rejection from families, is greater contraceptive access the best policy strategy? Perhaps instead they need transportation, nonjudgmental emotional and instrumental support, and freedom from violence?

<b>Figure 11: Amethyst's Intertextual Transcript Excerpt</b>			
<b>Image</b>			
<b>Time (sec)</b>	1:28-1:32	1:33-1:40	1:41-1:53
<b>Soundtrack</b>	[None]	[None]	[None]
<b>Script</b>	She told me the medical term, but didn't explain why I was feeling so down.	I begged for rides to the hospital, but I didn't want to bother anyone. I stayed until late at night, without eating,	I still felt depressed. I'm not used to this life, taking care of another person. The pregnancy triggered something in me. I feel tired, no appetite, no support at all.
<b>Location represented</b>	n/a	Hospital	From the inside looking out a window
<b>Emotion</b>	Apathy, depression	Empathy, compassion	Apathy, depression
<b>Features of visual objects</b>	Still black and white, torn jeans, jean jacket, moving the baby blocks through her hands	Back to color, but mostly white, mom wearing protective gown	Loss of color, only the side of the face, blinds drawn, other buildings visible through the blinds
<b>Special effects</b>	Fade in, movement of hands, fade to black	Fade in, fade out to black	Fade in , pan right
<b>Text on screen</b>	[None]	[None]	[None]

## Sensuous Subjectivity in Digital Storytelling

In one session of MAMA, the group of Towne House students focused on devising strategic uses for the digital stories, I solicited participants' opinions on the Stockton Public High teen pregnancy prevention video that opens this chapter. Zemora's comments are indicative of the general reaction to the video: "I'm upset by everything in this video. It uses pictures of cute babies to distract viewers from the fact that they're talking shit about teen parents. I'm mad that teen moms participated in this film. They're idiots! They're trying to say good things, but they don't know what they're doing. Mind you, I was in [sex ed] for four years. I learned all about prevention! I still had sex and kids!" In addition to noting the assumptions that teen moms are unable to care for themselves or their children, participants called out several of the professionals in the film for their complicity in the injustices faced by marginalized people. This MAMA session took place in the fall of 2013, when young moms acutely felt the federal government shutdown because the local WIC offices were running out of food. Zemora reacted to imagery of the mayor in his elegant city hall office: "I'm pissed! He has an Apple computer in the background—and he's talking shit about *us*! We have all this economic shit going down, and he's saying this!"

I asked the students how the video differed from the digital stories they had produced in the workshops. A young woman named Yara offered, "It's contradictory. Calling a baby 'a mistake' is wrong...They didn't talk at all about the positives—what can be beneficial from having a child," and Zemora asked, "What happens when [our] kids see this later on?!" Amethyst questioned why they focused so intensely on lowering the teen pregnancy rate when all around her she saw young mothers struggling without

receiving any assistance from those same professionals. By the end of the session, Zemora could no longer contain her anger at the portrayal of young mothers in the video. “I can’t think straight,” she said, “I want to punch everyone in that video.”

The community forum event we held in Stockton that next spring ironically coincided with the city’s events celebrating National Teen Pregnancy Prevention Month. As attendees settled into their seats, I was struck by the infrequency with which such a wide range of constituents come together in the same room. In addition to Towne House staff, along with many past and present students, staff from SOAP joined the crowd, as did Malta Brigado, the leader of the PASH Network. As a slideshow of still photos from our workshops played in the background, the executive director of The Towne House—a white woman from outside the community who was fiercely committed to the students—emphasized that the digital stories were a “snapshot in time” and that participants had “grown in the eight months since they made the stories.” In a private setting, she spoke of the the stories as “trafficking in tragedy.” Put another way, the digital stories were not in line with the redemptive narrative that The Towne House worked so hard to promote. This narrative was no doubt important to the organization, whose funding was constantly being cut and who relied heavily on fundraising and grant seeking to keep the doors open. Melissa Campbell, the director of young parenting services at the YWCA, acknowledged the importance of utilizing teen parent success stories but also highlighted a tension in the strategy. “Something tells me,” she said, “that we have to do much more than that though, that that's not enough. And so sometimes when we put on a newsletter or if we have to go to an event and they want us to bring a young parent, it's like we bring the most successful young parent. ‘Look here, see...’ Um, that's great, and that's great for that

young parent, but that doesn't mean that that's going to happen for every parent or that that is what success is for all, you know, young parents. So that can be dangerous too.”

While the stories might sully the Towne House’s strategic narrative of personal responsibility and individual success, their raw realness exhibits these young mothers’ own truths, messy, complicated, and “tragic” though they may be. The range of these stories is vital: sugar-coating lives and struggles only serves to reinforce a dichotomy of prevention and redemption. As the first video, a story about the inadequacies of the teen parent shelter system, played and the narrator’s voice filled the room, speaking her truth to power, I reflected on how what really is tragic is that stories like these are silenced just about everywhere. As was often the case, service providers in the audience reacted positively and many were overcome with complicated emotions. One woman, a staff member at SOAP, stood up during the Q & A and shared, her voice trembling and her eyes teary, “As someone who works with providers, these stories illustrate how much more work there is to be done to prevent young moms from being treated with shame and stigma.”

The messy complexities of these stories highlight the need for nonbinary ways of thinking about teen pregnancy and parenting as neither wholly emancipatory nor tragic. The stories also exemplify the importance of bringing bodies into conversation— theoretically and practically— with policies and programs centered on the real needs of young people, especially those who are pregnant and parenting. The sensuous subjectivity of representing and creating knowledge of and through pregnant and parenting teen bodies can help us understand how the body is both resistant to and inscribed upon by discourse. At the same time as storytellers must work within the



confines of discourses that position their bodies, their families, and their very existence as abject, as social problems to be solved, they manage to position their bodies and embodied knowledges with agency. Their bare, pregnant bellies are beautiful, as are the images of their babies and families. They articulate the vast gap between their needs and what service providers and the teen pregnancy prevention industrial complex declare their needs to be.

Acknowledging that bodies are at once produced by and working against discourse, the bodies in these stories are best understood as “process.” The idea of bodies-as-process recognizes that pregnant and parenting young women are neither fully produced by discourses of pathology, risk, and abjection, nor fully capable of resisting these discourses. The embodied processes of sensual subjectivity—taking belly selfies in the bedroom mirror, claiming a right to their maternal instincts, and demanding access to safe housing and freedom from violence and stigma—is one way to think of their bodies as malleable, ongoing projects open to transformation and emancipation. Pregnant and parenting teen bodies undoubtedly remain the site of a great deal of regulation and surveillance. The digital stories produced in this project highlight many ways that storytellers mediate the construction of “dangerous” bodies. Most importantly, by inviting the public to engage with their bodies through image, sound, affect, and text, storytellers shift the hypervisibility and pathology of teen pregnancy to a visibility of the body as agentic and knowledgeable, yet situated in a hierarchy of stratified reproduction. With these stories in mind, I now turn the lens to zoom back out to the TPPIC itself.

## CHAPTER 5

### **“IT’S THEIR CULTURE”: TEEN PREGNANCY PREVENTION AS RACIAL PROJECT**

Early on in my fieldwork I attended a Towne House fundraising event at an elaborate banquet hall in Stockton’s Heights neighborhood. Like many such events, the people and community that the organization served were largely absent, save for a few token success stories. Attendees were primarily representatives from local non-profit organizations, faculty from the nearby colleges and universities and, as a colleague put it, “a few independently rich folks.” Artwork from Towne House students was prominently displayed as the almost entirely white audience took their seats at white-clothed tables pre-set with elaborately decorated cupcakes. Mayor Ryan Brown delivered brief, although carefully planned, introductory remarks. He stated that The Towne House is part of the “great city of Stockton” and went on to say that while politicians have historically “put people in boxes based on race, family formation, and sexual orientation,” people have children in all different stages of life. As he often did while speaking at Towne House events, Mayor Brown shared that he was the son of a teen mom, a revelation I never once heard him say in prevention-focused meetings. His whiteness, like white teen pregnancy and whiteness in Stockton more generally, went unremarked.

The well-known Latino author Junot Diaz was the event’s keynote speaker, and along with the three Towne House students who introduced him, was one of the few people of color in attendance. The students nervously took turns reading their introductions off note cards; one shared that she liked how Diaz uses Spanglish in his writing, which she noted Towne House teachers did not allow. In contrast to the room full of suits and at least one tuxedo, Diaz took the stage wearing jeans, t-shirt, and an

athletic jacket. He began his keynote address by saying, “next time you should structure it so the young sisters speak more,” and that we often center the voices of those with power, rather than those most affected by the issues at hand. He could not recall the first time he visited The Towne House, and chalked it up to “typical male privilege memory loss.” The majority of Diaz’s remarks were focused on stories about his family and his sister, who became pregnant at age 15. Their parents kicked her out of the house, but nevertheless it was his sister who was the rock of the family, who took him to the library after school and helped incite his love of reading and storytelling. Of all the speakers that evening, Diaz was the only one to explicitly name racism. In a city where racial meaning was implicated in a host of discourses, practices, and identities, Diaz’s presence and remarks at the fundraiser were illustrative of the simultaneous ubiquity and silence of race and racism in Stockton.

As I’ve stated before, youth sexual health promotion in Stockton is always already about teen pregnancy *prevention*, and teen pregnancy prevention is always already about *race*. Although the projects, funding, coalitions, and committees in the city include the prevention of pregnancies *and* STIs in their mission statements, the work focuses almost entirely on preventing pregnancies—rates of STIs, consequences of STIs, and strategies to prevent STIs are mentioned infrequently. Teen pregnancy itself is deeply racialized, and teen pregnancy prevention work is often targeted specifically toward racial minorities. Despite the centrality of race to the teen pregnancy prevention industrial complex in Stockton, situational mapping exercises revealed it to be an often absent—but often implicated—element of the situation of inquiry. While race was an ever-present specter that haunted committee meetings, local media, and participant interviews, it was

rarely actually named (much less racism as a *system* of oppression). Race was everywhere and nowhere at once. This chapter uses theories of race and racism to accomplish that naming, to bring to the fore the ways in which race operates as a key organizing principle of youth sexual promotion in Stockton. I begin by discussing the racialization of teen pregnancy and describing how race is “seen” and known in the city. Next, I describe the components of teen pregnancy prevention as a racial project. I discuss how the conflation of race and culture enables a story about a homogenous and deterministic “Latino culture” that essentializes Latinx sexualities and positions young women in need of saving through benevolent outsiders. I then analyze how the notion of a post-racial, colorblind society works to obscure the history of reproductive oppression experienced by women of color. This obscuring is part of a larger issue of promoting individual behaviors in a way that abdicates responsibility for structural inequalities. I conclude on a more hopeful note by commenting on how the seeds of racial justice may be planted in Stockton.

### **Racializing Teen Pregnancy**

Teen pregnancy has always been raced and classed in particular ways (Pillow, 2004; Roberts, 1997; Solinger, 2005). Paying attention the ways in which teen pregnancy and teen parents are racialized, or how their existence, identities, and practices take on racial meanings, is important to understanding how health and human service professionals construct the “problem” and structure appropriate responses. Social epidemiologist Arline Geronimus (2003) argues that the sustained social problem construction of early childbearing among low-income women of color serves to reinforce elite cultural interests and allows for the reproduction of privilege in advantaged social

groups. In addition to her large body of research establishing that the outcomes of teen childbearing are not as dire as they are generally understood to be, Geronimus suggests that early childbearing is in part an adaptive response to shortened life spans resulting from racial health disparities. Further, she posits that acknowledging the benefits that teen childbearing may have for some racial, ethnic, and cultural groups requires an acknowledgement of the structural inequalities that account for these norms. In other words, “promoting delayed childbearing norms helps socioeconomically advantaged teens maintain their privilege while the social control messages against teenage childbearing contribute to maintaining the marginal status of African Americans” (Geronimus, 2003, p. 888). Racializing teen childbearing thus helps to sustain a hierarchy of stratified reproduction in which some people’s reproduction is supported and celebrated and others’ is condemned and regulated.

“Teen pregnancy” as a discursive construct and an object of social policy concern has a relatively short history, though a deeply racialized one. Initially, the “problem” centered on unmarried, rather than teen, pregnancy. For example, historian Rickie Solinger (2000) details the divergent race-based approaches to single, pregnant women in the post World War II era preceding the 1973 *Roe v. Wade* decision legalizing abortion. Whereas white, single pregnant women were seen as becoming pregnant through a curable form of neurosis and as possessing a marketable product—a white infant to place in the adoption market—Black, single pregnancy was seen as the consequence of an uncontrollable, racially motivated hypersexuality and did not result in a marketable product. These racialized understandings of single and unmarried childbearing laid the groundwork for future disciplinary public policy in which Black women were seen as

getting something (welfare) for nothing (another black baby) (Mink, 1998; Roberts, 1997; Solinger, 2005). Similarly, historian Regina Kunzel (1993) details how the maternity home movement of the postwar era—in which unmarried, often young, usually white, women were confined to institutions to carry out their pregnancies away from the watchful eyes of the public—contributed to the professionalization of social work as a gendered and racialized practice. In 1965, the release of the now-infamous Moynihan Report helped usher in an era of constructing policy around the notion that Black single mothers were caught in a “tangle of pathology.” Such “culture of poverty” arguments individualized the causes of poverty and implicitly assigned responsibility for social inequalities to Black women’s reproduction.

The initial moral panic around specifically *teen* pregnancy that emerged in the late 1960s came with increasing rates of unmarried sexual activity, pregnancies, and births among white, middle-class young women. The emergence of teen pregnancy as an “epidemic” coincided with it being seen as something affecting “our girls,” that is, white young women (Lincoln, Jaffe, & Ambrose, 1976; Pillow, 2004). In other words, teenage pregnancy initially emerged as a public policy issue in part to morally redeem white young women. This framing supported rights-based claims to enable funding and programs to help young mothers, including little-known Title IX provisions that protect the rights of pregnant and parenting teens in schools (Pillow, 2004). However, the panic over white teen and unmarried childbearing shifted quickly. By the mid-1990s, pregnant and parenting young women entered as subjects of policy debate surrounding welfare reform, with (particularly African American) teen mothers becoming virtually

synonymous with “welfare mothers.”<sup>1</sup> With its racialized rhetoric, the 1996 welfare reform law sought to curb the reproduction of poor, single women, and included specific provisions to prevent teen childbearing (namely, abstinence-only until marriage sex education) and regulate the lives of teen mothers (through stipulations on living situations and schooling). Pregnant adolescents thus came to be seen as a group of undeserving, highly sexualized and racialized young women who were a drain on taxpayer dollars. Young mothers were and continue to be produced as social and economic burdens, rather than a vulnerable group deserving of resources (Hoffman, 2008).

Fears regarding the rapid growth in the Latinx population and the U.S. panic surrounding immigration have helped shape current teen pregnancy discourses in terms of “hypersexual” and “hyperfertile” Latinas. As anthropologist Leo Chavez (2008) argues:

“Latinas” exist and “reproduction” exists, but “Latina reproduction” as an object of a discourse produces a limited range of meanings, often focusing on their supposedly excessive reproduction, seemingly abundant or limitless fertility, and hypersexuality, all of which are seen as “out of control” in relation to the supposed social norm (p. 72).

Chavez argues that the pathologization of Latina sexuality and reproductive behavior is key to the “Latino Threat Narrative,” or the idea that the shifting demographic make up of the United States represents a threat to the “American way of life.” Likewise, scholars and activists have noted the growing incorporation of Latina teens in pregnancy prevention discourses (Fuentes, Bayetti Flores, & Gonzalez-Rojas, 2010; Garcia, 2012;

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<sup>1</sup> This is not to say that white teen mothers were ignored in the political discourse. Conservative pundit Charles Murphy famously stated in a 1993 op-ed that economic support for single mothers should be eliminated altogether, that the children of unmarried women should be placed in orphanages, and advised a re-stigmatizing of childbearing out of marriage in order to curb the “brutal truth” of the coming “white illegitimacy epidemic.” Nevertheless, the “face” of teen pregnancy in the public and political imagination was, and continues to be, non-white.

Mann, 2013). In Stockton, the teen pregnancy problem is framed as a distinctively *Latina* problem. Although the teen birth rate among whites in the city is three times the state rate (36 births per 1,000 women ages 15-19 in Stockton compared to 10.4 births per 1,000 statewide), whiteness is invisible and distinguished in opposition to a distinct Puerto Rican “culture.” Health and human service providers, politicians, the media, and community outsiders frame culture as something non-white people have, and it causes them to have high birth rates. This framing, as I will discuss, allows professional stakeholders to emphasize the importance of the social determinants of health while focusing on promoting individual behavior change and evading responsibility for their collusion in maintaining systems of racial oppression.

The racialization of teen pregnancy and parenting can be thought of as part of a “racial project,” Michael Omi and Howard Winant’s (2015, p. 13) term to describe “efforts to shape the ways in which human identities and social structures are racially signified, and the reciprocal ways that racial meaning becomes embedded in social structure.” Racial projects link signification and structure not only to shape policy or exercise political influence but also to organize everyday understandings about race, or to confirm “what everyone already knows” (2015, p. 126). According to Omi and Winant, “Racial projects connect the meaning of race in particular discursive or ideological contexts and ways that social structures and everyday experiences are racially organized based upon that meaning” (2015, p. 125). Racial projects in Stockton consist of conflating the socially constructed political concept of “race” with an essentialized Latinx culture, reproducing colorblind ideology in the service of the “new racism,” and making invisible histories of reproductive oppression experienced by women of color. Racial



projects confirm *what everybody already knows* to be true about race and teen pregnancy in Stockton.

### **Seeing and Knowing Race and Racism in Stockton**

The ways in which race and racism are (not) talked about and (not) seen in Stockton are a good starting point for clarifying the parameters of teen pregnancy prevention as a racial project. Race is not absent from discourse and practice in the city but it is full of silences, constraints, and, notably, lacks an acknowledgement of white privilege. Most often race is talked about without actually talking about race. Recall my exchange with Hannah McNeil (described in Chapter 3) in which she dances around the word “race” in attempting to describe the “deterioration” of her city. Hannah used code words such “welfare” and “drug problems” to avoid ever actually naming race, much less racism. In doing so, she engaged in what legal scholar Ian Haney López (2014) calls “dog whistle politics,” or how racial code words like “inner city” or “at-risk” are “inaudible and easily denied in one range, yet stimulate strong reactions in another” (p. 3). López is writing about politicians, specifically Republican Party legislators and candidates, but his insights are germane for ways that race is (not) talked about in Stockton. According to Omi and Winant (2015, p. 218), “Code words like ‘get tough on crime’ and ‘welfare handouts’ reassert racist tropes of black violence and laziness *without having to refer to race at all*” (emphasis added). Through racial code words, without ever explicitly invoking race, health and human service providers, clinicians, and policy makers are able attribute racial meaning to youth sexuality and (potentially) pregnant teen bodies. Indeed, “teen pregnancy” itself is a racial code word; its racial meaning is inaudible in that it literally refers to human reproduction at a certain age, but it stimulates strong reactions

through signifying a particular kind of pregnant teenager: black or brown, poor, single, uneducated, probably not fit to parent.

Stakeholders' race talk often refers to racial health disparities, specifically racial differences in teen birth rates. At the PASH Network annual community conference in May 2013, Malta Brigado delivered opening remarks that discussed how politics, race, and class "tie in" with health. She framed these in terms of "difficult conversations" that would lead to a "better understanding of the issues" and thus "better solutions." Later on that day, during a Q & A following another speech by Malta in which she emphasized the high rates of teen birth among youth of color in Stockton and Carlsborough, an audience member challenged her on the use of "race" as a "risk factor" for teen pregnancy. The audience member, a Latina staff person at a provider training organization, began by emphasizing that the work was about "changing paradigms" and said, "We are talking about racial/ethnic health disparities, but race and ethnicity are not risk factors. We have these disparities because young people do not have opportunity or hope." Malta responded to her comment by noting that in clinical medicine, "race" is seen as a risk factor and that she realized that she, as a Latina, shared that risk factor. "My ultimate goal," Malta said, "is to get race off that list of risk factors. It doesn't matter you're purple, green, or blue, if you live in poverty."

This exchange illustrates a number of issues related to how racial meaning operates in Stockton. First, Malta engages in talk indicative of the colorblind approach that obscures racism through reducing racial inequality to economic inequality and homogenizing racial groups (race doesn't matter, poverty is the main problem). Second, race is understood in biological and individual terms, rather than a socially constructed,

political category used in the service of maintaining white supremacy (Roberts, 2011). Note that Malta does not challenge the understanding of race as a *biological* determinant of inequality, but instead advocates making race not matter anymore by equalizing access to “hope and opportunity.” Racism as a systemic and systematic form of oppression is not the issue at hand, as it becomes subsumed under economic inequality (though of course, racial and economic inequality are deeply intertwined). Structural racism was briefly mentioned at the next year’s PASH Network conference when a white physician raised his hand in a Q&A session to smugly tell a Black woman to expand her definition of racism to include internalized and institutionalized forms. He acknowledged that we all participate in structural racism, but that was the end of the conversation. Although some stakeholders I interviewed for this dissertation did present a structural analysis in their work, their voices were the minority (see page 179).

Sometimes the mere existence of racism was acknowledged; more often it was *almost* actually mentioned. Mayor Brown utilized this latter approach in a SASHPC meeting when discussing the high rates of suspension at Stockton High School. “You have a Puerto Rican kid and a white kid,” he said, “who do the same minor infraction, and only the Puerto Rican kid gets suspended.” While racial disparities in suspension rates signal a form of institutionalized racism, Brown fell short of actually naming racism as the cause. Several months later during our interview, I asked the mayor about his thoughts on the racial politics of teen pregnancy in his city. He responded that it was a “heavy question,” and that talking about race in the city was “loaded.” “When people hear teen pregnancy,” he said, “they assume it’s happening in the Puerto Rican population...I mean, I’m paraphrasing what other folks’ perceptions are, mostly white

folks, you know? And then you even hear it within the Puerto Rican population too that, you know, um, that points to a certain segment of the Puerto Rican community that's not caring and um, and, I mean I do think that there are some family behavior differences between, I mean I'm making a generalizations..." Brown went on to summarize some of the elements of the Latino culture narrative, but abruptly switched gears to highlight economic structures:

Just look at it like economics, like income and property among these families as well, and the impact that that has on it. And there's economic opportunity again. So, you know, I think one of the best ways to prevent teen pregnancy is like, getting a good education and getting a good job.

Note the absence of an acknowledgment of racial discrimination in employment, schooling, housing and other administrative systems govern life chances: teen pregnancy prevention is equated with getting a good education and a good job, both of which are in short supply in Stockton. To use Brown's wording, when you've got a Puerto Rican kid and white kid, and only the Puerto Rican kid is barred from fully benefitting from educational and occupational systems, something else is at issue; that is, unnamed racial oppression.

Racial stratification was endemic to Stockton's main industry (health and human service work), as well as city government, the educational system, and the business sector. In Chapter 2, I noted the disproportionate number of white people (often from outside the community) who worked in health and human service positions in Stockton, including Continuum Health Services and the Stockton Community Health Center. Attendance at SASHPC meetings was also majority white, while *Teens Counts* events tended to be about one-third to one-half people of color, as those events also drew participants from the more racially diverse city of Carlsborough. These inequalities were

also reflected in the composition of the Stockton public school system: approximately 78% of the district's student body is Latinx, while Latinxs comprise only 25% of the teaching staff. Additionally, in a city where nearly half of the population is Latinx, white residents generally hold about 80% of the city council seats and the majority of the school committee seats in any given year.

Stockton's residential areas have been racially segregated since the city's early days as a mill town. As I described in Chapter 1, this segregation ranges from an extreme of 89% Latinx residents in the Canals neighborhood and 10% Latinx residents in the Heights neighborhood. Professional stakeholders invoke the specter of race without naming residential segregation by continually highlighting that "health disparities" are concentrated into the "lower wards" of the city (where the population is more densely Puerto Rican) without acknowledging the correlating racial inequalities in employment, housing, and political power. As a result, public health problems are understood in spatial and racial terms, that is, teen pregnancy is not a "problem" in the Heights neighborhood (though of course, there are teenagers in that neighborhood who do become pregnant, albeit at lower rates) and teen pregnancy among low-income whites in the city is not the focus of the TPPIC (although the teen birth rate for white women in Stockton is three times the state rate).

"Seeing" race extends throughout the city in multiple ways. For example, Hannah McNeil characterized the city's annual St. Patrick's Day parade as a unifying event for the city, while viewing the annual Puerto Rican pride parade as *disunifying*. More than one participant visualized Stockton as a place with lots of young Puerto Rican women pushing strollers; Ana Gutierrez noted that you can tell at the spring Puerto Rican pride

parade whether it's "been a busy winter" by the number of strollers, and Clarisa Ortiz shared that her guy friends call downtown Stockton "stroller patrol." In the fall of 2014, as part of a community revitalization public art project, a mural depicting a Puerto Rican flag with the word STOCKTON on it—described by the artist as a "celebration of the Puerto Rican diaspora in Stockton"—was scheduled for installation on a downtown building. At the last minute, under pressure from nearby business owners, the property owner refused to allow the mural to be installed and stated that the "piece would do more harm than good to Stockton's Hispanic community, and that in order to display it I would have to change it to make it 'more diverse.'" In one interview, the artist pointed out the irony that city streets along the St. Patrick's Day parade route have giant green shamrocks painted on them year round. The controversy over the mural prompted the revitalization project to cancel their opening event; the mayor later issued a statement that "the story of Stockton is one of diverse people sharing a common dwelling and striving to forge a common purpose" and had the mural installed outside City Hall until a permanent location could be found.

Having sketched out the precarious dance around race in Stockton, I now turn to expand on three elements of teen pregnancy prevention as a racial project: conflating race with culture, reproducing colorblind ideology, and erasing the history of reproductive oppression.

## The Latino<sup>2</sup> Culture Narrative

Elizabeth Randolph, a white woman in her late 50s, grew up in Carlsborough and began working for Continuum Health Services (CHS) as a college intern in the late 1970s. She now manages all of the organization's reproductive health clinics in the county that encompasses Stockton. Because of her work, Elizabeth saw teen pregnancy mainly as a health problem, but thought that there was a "cultural aspect" to it as well. "Not to sound racist at all," she told me, "but it really is a Latino cultural issue. It just is not a, um, it's not a bad thing if a kid gets pregnant. It's just much more socially acceptable within that community. Right or wrong, I don't know." Similarly, Clarisa Ortiz, a Latina who grew up in Stockton and coordinated the teen health programs at the Stockton Community Health Center, used the phrase "it's a cultural thing" to explain the higher rates of teen pregnancy among Latinas in Stockton:

I think because [the rate] is just so high here, and then when you look at the numbers, and the highest numbers are the Latino, I have no choice but to make it more of a cultural thing. And not only that—not only like, traditional Latino culture but also like, a Stockton culture, and when you walk around the streets of Stockton and you see that there's plenty of people, you know, saying that they're getting [welfare] assistance, and there are plenty of people who are kind of like, sometimes even gypping the system.

In this quote Clarisa connects high rates of teen birth among Latinas in Stockton to culture by virtue of the fact that the rates of both are "so high." In addition to a "traditional Latino culture," she extends this correlation to a "Stockton culture" in which there is a visible culture of dependency on welfare assistance that ostensibly fuels the teen pregnancy rate. Hannah McNeil also connected high rates of teen pregnancy in

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<sup>2</sup> In referencing this narrative I specifically use the word "Latino," rather than "Latinx," as the narrative I'm describing is not gender inclusive and anti-oppression focused, as the latter term implies, but deterministic and homogenous, as the former implies.

Stockton to Latino culture and emphasized the role of familial norms around early childbearing:

I think [teen pregnancy is] a cultural issue that is perpetuated, and because of the lack of education, I think that that definitely has contributed to young people not having the understanding of what becoming a teen parent involves. And, unfortunately, because there is not that educational component in, as part of their, uh, their upbringing, then they tend to gravitate towards what they feel is the right thing to do. And because they have seen it, it's intergenerational. In order to, um, change an intergenerational pattern, you have to be aware that there's a problem. And you have to *want* to change it. And I don't think that awareness, until now, has been there. So that's where we are helping. But without that awareness, I don't think that we, they will ever, that it could ever change.

Here the culture of teen childbearing is identified as a deeply ingrained problem affecting generations of families. Although some of these families did not see it as a problem, Hannah saw a role for herself and other cultural outsiders to intervene and bring awareness. In this case, “awareness” is predicated on an individual behavior change model that fails to account for structural inequalities.

According to Omi and Winant (2015, p. 22), to treat race as a matter of ethnicity is to understand it in terms of culture. In this way, race is reduced to almost a preference, which in turn reduces the importance of *racism*. This reductionism was ever-present in Stockton; while “race” or “racism” was seldom mentioned during the course of my fieldwork, “culture” was part of a regularly invoked story told during individual interviews and committee meetings as well as through health promotion materials and news media. This narrative equates race with an essential, homogenous, and deterministic Latino culture. “Latinos” are normalized as a singular group rather than a large and heterogeneous group of people with disparate histories of (de)colonization and a range of geographic, linguistic, demographic, and cultural origins, not to mention sexual and reproductive practices. The narrative is not entirely uncontested—some professional



stakeholders did call into question the correlation between culture and teen birth rates — but its ubiquity and embeddedness is notable. The Latino culture narrative is remarkable for its breadth, its depth, and its power. “It’s their culture,” and “I have no choice but to make it a cultural thing,” are used to explain why Latinas “don’t have abortions,” that contraception is considered a sin, how Latino parents don’t talk about sex with their children (implying that non-Latino parents do), that Latino culture in general is sex-negative or silent about sex, that Latinas are hypersexual and hyperfertile, and that Latino families encourage, condone, and/or accept teen pregnancy. In the following critique of the Latino culture narrative I do not mean to imply that culture has no bearing on fertility practices or health behaviors; rather, I aim to call attention to the problems inherent to producing culture in an essentialized way that enables intervention. Even if there *were* a Latino culture in Stockton that rigidly dictated sexuality and reproduction, it would not justify the essentialization of this culture and building health promotion policy and practice around it in a way that masks racial, economic, and gender inequalities.

The Latino culture narrative in Stockton bears resemblance to Chavez’s (2008) “Latino Threat Narrative.” Chavez charts how media pundits, politicians, and the general public produce and reproduce a discourse of Latinos and Latinas as unable or unwilling to learn English, unable or unwilling to integrate into the larger society, unassimilable, and ahistorical. Notably, the Latino Threat Narrative posits that Latinas are a *reproductive* threat altering the demographic make up of the nation. Chavez argues that Latina bodies symbolize key aspects of the narrative: they are considered “hot” and “spicy,” overly sexual and hyperfertile while simultaneously pure and virginal, constrained by conservative religious values. During our interview, Patina Peron echoed

this sentiment about how Latinas are sexually constructed, “You're spicy. And you're hot. And you're just sexy. And that's all you're good for.” As Chavez (2008, p. 75) explains:

The hypersexuality of the hot Latina combines with the abundant fertility and uncontrolled reproduction of the Mariana mother to produce the Latino threat. In other words, sexuality, especially the image of the sexually “hot” Latina, supposedly combines with the pronatalist cultural and religious values (that are static and immutable because of their lack of social integration, assimilation, and acculturation) to produce high fertility rates.

Similarly, in her ethnographic work with young Puerto Ricans and Mexicans in Chicago, Lorena Garcia (2012) describes how young Latinas are positioned as “bad girls,” always already pregnant or promiscuous, their bodies excessively reproductive. Garcia shows how these young Latinas negotiate a precarious terrain of sexual respectability in which their attempts to push back against homogenization inadvertently reinforce justification for the “gendered sexual and racialized stigmatization of Latina girls.”

In Stockton, a series of similar essential “truths” about young Latina’s reproduction are embedded in the Latino culture narrative utilized by stakeholders in the teen pregnancy prevention industrial complex. It’s important to note that, for the most part, stakeholders understood these truths to be particularly germane to Stockton, echoing the notion that there’s “just something about Stockton.” Stakeholders frequently noted that the teen pregnancy rates for Latinas in Stockton were higher than those in Puerto Rico<sup>3</sup>, pointing to there being something particular about Stockton, but nonetheless attributed Stockton’s high rates to residents’ Puerto Ricanness. The following sections examine these presumed truths: an assumed silence around sexuality, constraint on reproductive agency, and the supportive Latino family trope. I discuss how each of these

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<sup>3</sup> During the majority of time I conducted fieldwork in Stockton, the overall teen birth rate in the city was 83.6 births per 1,000 women ages 15-19 and for Stockton Latinas the rate was 99.3/1,000, whereas in Puerto Rico the overall rate was 51.4/1,000.

truths are understood in Stockton and offer evidence to illustrate some of the gaps between the narrative and the social science literature on Latinx sexual and reproductive beliefs and practices. In an advancing an argument for a more nuanced understanding of how Latinx people experience and negotiate sexuality and reproduction, I am not arguing that their experiences are unconstrained by power relations. Nor am I arguing that culture and family are irrelevant to sexual and reproductive beliefs and behaviors. Instead, I am calling attention to the ways in which the discourse is raced, classed, and gendered, the ways in which it works through the bodies of young Latinas in Stockton, and how it enables certain forms of health promotion while precluding others.

### **“Latinos Don’t Talk about Sex”**

Health educators and policy makers frequently posit that communication about sex and sexuality is integral to alleviating barriers to preventing STIs and unintended pregnancies. Jessica Fields (2008) notes that proponents of both abstinence and comprehensive sexual health education utilize this “prophylactic of talk” as key to their objectives. Yet, neither group adequately accounts for the gender and sexual social inequalities that compromise both youth and adults’ abilities to engage in effective communication about sexuality. Bolstering the importance of the prophylactic of talk in Stockton was a widespread agreement that Latinxs simply don’t talk about sex. Because sexual silence was presumed to be an essential part of Latino culture, teen pregnancy prevention industrial complex stakeholders viewed increasing parental communication as an important part of their work. Clarisa Ortiz suggested that, “rarely in a Latino family will you hear them talking to their kids about, you know, how to use a condom, why they should wait. It’s more like, ‘Don’t have sex. Why? Because I said so.’” Indeed, belief in

the sexual silence of Puerto Rican families was so endemic that SASHPC members organized a series of “parent education” forums in the community with the goal of encouraging Latinx parents to talk to their children about sex. These forums were sparsely attended, which members attributed to poor timing, bad weather, and distraction from a recent school bus shooting in the community. While all of these factors were likely at play, stakeholders failed to understand that families likely had needs that took precedence over attending a school-sponsored function in which a group of mostly white strangers wanted to help them parent differently.

Additionally, stakeholders failed to problematize the notion that there is something particular to Latinx families that prevents them from having productive conversations about sexuality with their children. As Lourdes Navarro, the educational director at The Towne House, put it: “As a Latino person...the subliminal message that I've gotten from the dominant culture is, the reason why you're in this predicament [having a pregnant child] is because you don't talk about sexuality with your kids. And so, the innuendo there is *that the dominant culture does.*” Lourdes calls attention to an implicit assumption about the narrative’s element of cultural silence: if Latinxs have difficulty talking about sexuality (theirs or their children’s), non-Latinx people and non-Latinx families do not. As sexualities scholars Gloria González-López and Salvador Vidal-Ortiz (2007) argue, in addition to reinscribing an essential Latinx sexual culture and an absence of sexual silence among non-Latinxs “sexual silence is not absolute but highly selective and that selectivity is not shaped by a so-called ‘Latino culture’ but by multiple forms of social inequality affecting other cultural groups as well” (p. 313). In other words, sexual silence is about power and inequality rather than “culture.” In fact,

empirical evidence suggests that Latinxs *do* value and practice communication about sexuality in their families: in a random sample survey of adult Latinxs in California, California Latinas for Reproductive Justice found that 8 out of 10 respondents stated it is “extremely important” that parents talk to their children about sexuality related issues, including continuing or terminating a pregnancy, sexual health and sexuality, and contraception (Suseth Valladares & Franco, 2010). Similarly, in her ethnographic study of how Latina girls experience their sexual subjectivities and negotiate safer sex, Lorena Garcia (2012) interviewed a series of mother/daughter pairs that problematized an easy characterization of Latinx families as unwilling to talk about sex. Garcia challenges the notion that Latinas are “culturally silent” about sexuality with their daughters, arguing instead that their interactions are structured by broader discourses about adolescent sexuality, racial formations, and gender and sexual ideologies. Again, the issue is not so much that Latinx families are consistently unable or unwilling to discuss sexuality within their families, but rather they are embedded in racialized discursive contexts that shape and limit their ability to do so.

### **“Latinas Don’t Have Abortions/Use Contraception”**

A second element of the Latino cultural narrative involves the belief that Latinxs are adverse to using contraception and do not terminate pregnancies. Although she saw “the tide starting to turn in the population,” Elizabeth Randolph believed that, in general, Latinas didn’t “contracept because that was like a sin, because you know, you're Catholic” (she did not share her thoughts about whether the large Irish Catholic community in Stockton shared this sentiment). Similarly, Clarisa Ortiz recounted:

It's a cultural thing. You know, for a white female, um, the mothers are more— like for me growing up [in the 90s], for me it was like, only white people do that. Like white parents will get their child put on a birth control. We won't do that. But we're okay with them having kids at an early age.

Similarly, Mayor Brown wondered if the higher rates of teen birth among Latinas in Stockton were related to poverty or to “religious values within a certain community.” “Anecdotally,” he told me, “talking with families who are religious, obviously they don't believe in abortion. Many of the families I speak to, when a young woman gets pregnant, that's not a choice.” Beth Emmerson, a former nurse and regular SASHPC member who had conducted research on non-parenting young Puerto Ricans' perceptions of teen pregnancy in Stockton, stated it plainly: “In Stockton if you're Latina and you get pregnant, you are not going to have an abortion.”

Analogous to the part of the narrative in which Latinxs don't talk about sex, survey data suggests that the misconception that Latinxs are less likely to use contraception or have abortions doesn't hold up. Latina women who are at risk of unintended pregnancy (defined as heterosexual intercourse within the last 3 months) use contraception in numbers similar to their white counterparts (Jones, Mosher, & Daniels, 2012). According to the National Latina Institute for Reproductive Health (2012), the overwhelming majority of Latinas, including Catholic Latinas, use contraception at some point their lives: 97% of Latinas who have ever had (heterosexual) sex have used contraception and 96% of sexually active Catholic Latinas have used a contraceptive banned by the Vatican. The Latina Institute emphasizes that the issue is not that Latinas do not “believe in” contraception but that they often lack access to affordable contraceptive services due to factors including health insurance coverage, immigration

status, and the availability of clinics and competent providers, factors that are germane in Stockton.

Likewise, California Latinas for Reproductive Justice found that female respondents highly ranked “access to contraception and birth control services” as an important service to have available in their communities. This report also found that 52% of respondents personally knew someone who had an abortion and over 8 in 10 “strongly agreed” that every woman should have a right to decide for herself the number and spacing of her children. Moreover, “religion” ranked below “don’t want a child” and “financial situation” as factors that most influence a woman’s decision whether to terminate a pregnancy (Suseth Valladares & Franco, 2010). In direct contradiction to elements of the Latino Threat Narrative promulgated by media and policy discourse, and replicated in the Stockton Latino culture narrative, Chavez (2004) found most Latinas use contraception at some point in their lives, and that age, marital status, education, and language acculturation better account for variability in fertility rates than does ethnicity.

Similarly, the notion that Latinas “don’t have a abortions” is much more complex than stakeholders in Stockton understand it to be.<sup>4</sup> “Hispanic”<sup>5</sup> women accounted for 25% of the abortions that occurred in the US in 2008 (Jones, Finer, & Singh, 2010). Hispanic women in the United States have abortions at twice the rate of white, non-Hispanic women: in 2012 the abortion rate for Hispanics was 15.3 per 1,000 women whereas for white, non-Hispanic women it was 7.6 per 1,000 (Pazol, Creanga, & Jamieson, 2015). The abortion rate among Hispanic teenagers is similar, with a rate of 15.3 per 1,000

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<sup>4</sup> Further, as I discuss in the next chapter, there was a great deal of silence around abortion in Stockton on the part of youth sexual health promoters themselves.

<sup>5</sup> Abortion data collected by the CDC uses US Census Bureau race/ethnicity categories.

women ages 15-19 compared to 8.5 per 1,000 white women ages 15-19 (Kost & Henshaw, 2014).<sup>6</sup> Research indicates that some Latinas are more likely than others to have an abortion, with Puerto Rican women more likely than Mexican- and Cuban-American women (Erickson & Kaplan, 1998). Additionally, Latinxs hold a range of beliefs regarding the acceptability and legality of abortion. A 2011 national poll of registered Latino voters found that 74% of respondents agree “a woman has a right to make her own personal, private decisions about abortions without politicians interfering” (Lake Research Associates, 2011). Three out of four respondents (73%) agreed “we should not judge someone who feels they are not ready to be a parent,” and about 2/3 (61%) agreed “the amount of money a woman has or does not have should not determine whether she can have an abortion when she needs one.” Additionally, as Mann, Cardona, and Gomez (2015) illustrate, young Latinas’ decision-making around unintended pregnancy, like all people’s, is more complicated than binary ways of thinking about it suggest. Although some of their respondents expressed unambiguous opinions about abortion, others wrestled with the choices of abortion, adoption, and parenting constrained by stigma, pressure from male partners, and access to services. In working with young Latinas at The Towne House, I frequently heard similar examples of constrained choice and complicated decision-making around abortion; it was not uncommon to hear a young woman rant about how abortion was evil and then admit that she’d had multiple abortions, but insist “that was different.”

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<sup>6</sup> The rate of abortion among Black women is higher than both Hispanic and non-Hispanic white women, with a 2012 rate of 28.6 per 1,000.



### **“Latino Families Promote Teen Pregnancy”**

The third element of the Latino culture narrative in Stockton posits that Latinas are more likely to be teen parents because Latino families promote teen pregnancy by failing to stigmatize early childbearing and supporting their pregnant daughters. This element of the Latino culture narrative derives from the Latinx cultural value of *familismo*, or the strong identification with, respect, and loyalty to the nuclear and extended family. Clarisa Ortiz connected this phenomenon to rigid gender norms in her community:

I mean, in the cultural standing point, like, if you come to really look at the Latina culture, I think we're brought up in a way where we're brought up to be mature at an early age. You know? Having a child at a young age is not a bad thing. You know, it's kind of like our way to go on to the next step of being an adult and a woman...My mom had me at nineteen. It wasn't frowned upon, you know? It was like her mom basically groomed her to be, like, a housewife...So my mom was married at eighteen, she had me at nineteen; that's what you do.

For Clarisa, the expectation that women follow a particular gendered life course contributed to a normalization, or even expectation, of early childbearing. Hannah McNeil likewise saw family as playing a role in the high number of teen births in Stockton. She attributed it not to Puerto Rican culture in particular, but rather a Stockton Latino culture that she was knowledgeable about through her focus group research:

It's not, say, because you're Hispanic. Because there it's totally different. Like, in Puerto Rico, they don't have the problems that we have, as far as teen pregnancy. It's handled totally different within the family. In this particular Hispanic culture [in Stockton], it's, it's not rewarded, but it's condoned. And, I mean, I don't think I'm generalizing, because I've been, like...Well, I don't know. I've had enough focus groups. I've worked enough with focus groups with kids that have said their parents had them at 15...So it's one of those kinds of things. And I think it only becomes part of the family, that it's an extended family, and it gives them support. And it's not like, you know, it's not looked upon in any way that it's going to prevent them from having goals.

In Hannah's estimation, the support that families in Stockton give their pregnant

daughters serves to “condone” teen pregnancy. Beth Emmerson contradicted herself by invoking the cultural value of Latino family as a casual factor in high birth rates among young Latinas after declaring that the cultural explanation was “hogwash”:

I even brought this up at the meeting this week at the Stockton Technical High School when the nurse there said, like, "Well, it's their culture. It's their culture to have babies." Come on. Whose culture is it to have babies?<sup>7</sup> It's not their culture to have babies. It just is an easy way to put it. It's their culture not to have an abortion. It's a culture for them to value family. When you talk about a Puerto Rican family, it's not the little nuclear family, it's blood relatives and it's also emotional relatives. So family, *familia*, is so much different to a Puerto Rican than to us white people. Um, it's their culture—they're not going to put up their babies for adoption. If they can't take care of their baby, they're going to give it to an aunt.

Thus, although she discounted the validity of culture as a causal factor in teen pregnancy, Beth nonetheless saw culture and the presence of extended family as an explanation for why Latinas don't have abortions or place their children for adoption.

Certainly, Puerto Ricans may value family and consider it an important cultural value and practice. Assuming that valuing family, however, is a causal factor in Latina teen pregnancy requires essentialist thinking that disregards the complexities of the meaning of family, the role of gendered ideologies, and the persistence of social inequalities. The internal logic to this part of the narrative assumes that 1) white parents uniformly condemn teen pregnancies in their families; 2) family stigma is a desirable teen pregnancy prevention strategy; and 3) there is something wrong or bad about families that nurture and support their children through challenging life experiences like early pregnancies. Moreover, as storytellers' narratives highlighted in Chapter 4, the assumption that Latinx families in Stockton are naturally supportive of their daughters'

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<sup>7</sup> I feel the need here to point out the obvious: having babies is part of every human culture, otherwise the species would cease to exist.

pregnancies obscures the variation in family response and the structural inequalities that render extended families unable to provide financial or emotional support. Amy Lexington, the grants manager at SOAP, called out the problems with these assumptions by noting that “when you talk to teen parents who are Latino, they’re like, ‘My parents were so mad!’ ...Everyone has this weird idea that white parents are really mad about teen pregnancy, but Latinos aren’t. Families are all over the place, and it’s this lack of respect and really othering Latinos in this area. I mean, it’s just stupid.”

### **The Work of the Latino Culture Narrative**

Because data on contraceptive use and abortion is not collected and reported at the city level, and because my research cannot speak to family and youth attitudes in Stockton regarding these matters, I can’t unequivocally state that the elements of the Latino cultural narrative are completely unfounded. Yet, the extent to which the narrative reflects whether young Puerto Rican women in Stockton do or not use contraception, have abortions, talk about sex with their families, or receive support in the event of an unplanned pregnancy, doesn’t actually matter. Either way, the Latino culture narrative works to sustain the racial project of teen pregnancy prevention in Stockton. Conflating race with culture permits stakeholders to deploy a “culture of poverty” argument, which enables outsider intervention into the sexual and reproductive lives of racialized young women in the form of promoting individual behavior change. This conflation also works to obscure the intersections of racism, classism, and sexism that configure sexuality and reproduction among young people in Stockton. The narrative allows professional stakeholders to escape responsibility for attending to these systemic and systematic forms of oppression. Amy Lexington trenchantly called attention to this issue when she told me:

This concept that, and I've heard even [health and human service] providers say this, the concept that it's a cultural thing, that it's something wrong with their culture. And this is something that I hear from Latino providers as well—this idea that it's something about the culture that makes Latinos more susceptible to early parenthood....[But] it's not a problem among Latino culture. Um, although there are cultural elements that, I think, contribute to early pregnancy and parenthood, but it's not, like, a problem with the culture. And what happens is people say this, or they kind of hint at it, and what happens is it lets people off the hook because it becomes this kind of normalized, naturalized thing. That's, like, "Well, that's just the way they are, so we can't do anything about it." Which is absolutely not the way it is.

Amy conceded that there were cultural elements that contribute to early parenthood, but she took to task health and human services providers—including Latino providers—for relying on the culture narrative to “let them off the hook” for their responsibility in naturalizing inequalities. I now turn to a specific component of the youth sexual health promotion strategy in the city—long acting reversible contraception—to illustrate how ideologies of colorblindness are implicated in these racial projects.

### **Colorblind Ideology: What's Not to LARC?**

Scholars of race and racism point to the shifting forms of racial domination in the United States that are indicative of a so-called “post-racial” era (Alexander, 2012; Bonilla-Silva, 2014; Omi & Winant, 2015; Roberts, 2011). This “new racism” is a set of social arrangements and practices that (re)produce a racial order distinct from older forms of the Jim Crow era (Bonilla-Silva, 2011). In his widely read text, “Racism Without Racists,” sociologist of race Eduardo Bonilla-Silva (2014) details the elements of this subtler racism and illustrates how it is just as pernicious as its more recognizable predecessor: the nature of racial discourses and practices are increasingly covert, racial terminology is avoided as whites invoke claims of “reverse racism,” most mechanisms that reproduce racial inequality have become invisible, and Jim Crow era practices, such

as housing segregation, have not disappeared but have merely been rearticulated. Central to the “new” racism is an ideology of colorblindness, or a repudiation of the concept of “race” itself in the service of arguing against the existence of racism as a systemic and systematic form of oppression (Bonilla-Silva, 2014, p. 26). According to Omi and Winant, (2014, p. 257):

Those advocating a colorblind view of race assert that the goals of the civil rights movement have been substantially achieved, that overt forms of racial discrimination are a thing of the past, and that the US is in the midst of a successful transition to a “post-racial” society. From a colorblind standpoint, any hints of race consciousness are tainted by racism. Thus it is suggested that the most effective anti-racist gesture, policy, or practice is simply to ignore race.

The 2008 election of president Barack Obama help to herald in this colorblind, post-racial order and enabled the pronouncement that, now that a highly educated, economically privileged African American man was elected president, racism was a thing of the past.

Colorblind racism obscures and naturalizes the persistence of racial inequalities in the US, including Stockton. Colorblindness performs a sort of “hat trick” by distracting us with the notion that “we’re all the same” while institutional and structural inequalities are reproduced and become harder to recognize. Michelle Alexander (2012) deftly illustrates this distraction by illuminating the ways in which the war on drugs and mass incarceration have become a “New Jim Crow” that disenfranchises Black men.

Colorblindness enables the masking of racial inequalities in access and outcomes related to a host of social factors, including but not limited to housing, employment, education, healthcare, and politics. If race doesn’t matter anymore, than something else must be at play, a notion that also enables the Latino cultural narrative: if race and thus racism is not real, then surely something else—cultural or economic factors—produces racial inequalities. Moreover, as part of the colorblind ideology, to even acknowledge race is to

be racist. In Stockton, teen pregnancy prevention stakeholders are careful to avoid being seen as racist by employing a “polite” racism that is woven throughout interactions in which they state things such as “I’m not racist, but...” “Not wanting to sound racist or anything,” “I hate having to use vaguely racist language, but...”

One prominent way that colorblindness is produced in Stockton is through the widespread, uncritical promotion of long-acting reversible contraception, or LARC. LARC includes methods such as Depo Provera (“the shot”), intrauterine devices (IUDs), and subdermal contraceptive implants (Implanon/Nexplanon). These methods are extremely effective in preventing pregnancies, with efficacy rates the same as surgical sterilization (less than 1 out of 100 users each year will experience a pregnancy). Efficacy rates for contraceptive technologies are expressed in terms of “perfect use” and “typical use,” but since LARC are “set it and forget it” methods, there is little room for user error (as there might be with forgetting to take a pill each day). Significantly, these are provider-controlled methods that cannot easily be stopped by the user, as one could do with a contraceptive pill, meaning that discontinuation is more difficult to achieve in the face of undesirable side effects, health complications, the desire to switch methods or to become pregnant. When I first started doing reproductive justice work in the early 2000s, I recall a robust discussion about the historical legacy of coerced sterilization among low-income and women of color on the part of medical and government authorities and its present-day implications for contraceptive promotion; this discussion has all but disappeared as LARC is now touted as the ideal contraception for young women and is marketed as promoting “freedom” for the user by borrowing the discourse of “choice.” The enthusiasm for LARC is illustrated by the significant increase in funding, community

health projects, and professional guidelines that promote the methods. The “Contraceptive Choice Project,” a \$20 million demonstration project through the Washington University School of Medicine that began in 2007 and enrolled nearly 10,000 women, is the most notable of such projects (Secura, et al., 2014; Weise, 2015). In 2014 the American Academy of Pediatrics revised their policy statement on contraception for adolescents to promote LARC as a first line contraceptive choice for young people (Ott, et al., 2014), and the CDC reports that LARC use among teens ages 15-19 years old at Title IX family planning clinics increased 1,500% from 2005 to 2013, from 0.4% to 7.1% (Romero, et al., 2015).

The enthusiasm over LARC stems from its stated potential to reduce unintended and teen pregnancies, framed in terms of “reducing the burden” to taxpayers. The neoliberal logic that underlies this framing shifts the burden for reducing poverty from the state to the bodies of individual women. Scholarly and news media accounts of the promise of LARC foreground its potential to reduce teen births and thus public assistance expenditures (McClain, 2015; Secura, et al, 2014; Trussell, et al, 2013). A growing number of reproductive justice scholars call attention to the lack of a race and class analysis that contributes to an uncritical promotion of LARC and inhibits reproductive autonomy by promoting “LARC first” to “risky” women (Gold, 2014; Gomez, Fuentes, & Allina, 2014; Gubrium, et al., 2015; Higgins, 2014). As Gomez, Fuentes, and Allina (2014, p. 173) explain:

LARC promotion must expand—not restrict—contraceptive options for all women, particularly for women whose racial, ethnic, or class identities have made them targets of forced sterilization and of policies aiming to restrict their fertility. Efforts to increase LARC use have historically been mired in racial and class biases about who is capable of managing the “hazard” of fertility and who is valued as a mother in American society.

These scholars emphasize that no particular contraceptive method is necessarily oppressive or emancipatory and argue that people should have access to LARC methods if they desire them. To be sure, there are barriers to obtaining LARC methods, such as cost and availability, which produce socioeconomic disparities in a potential user's ability to elect them as their contraceptive method. People at risk for pregnancy may desire long-acting reversible methods for a variety of reasons, including efficacy and convenience. Nonetheless, similar to how professional stakeholders in Stockton use the Latino culture narrative to evade responsibility for structural racism and economic inequality in the city, Gomez, Fuenes, and Allina (2014, p. 171) argue that "narrowing the scope of possibilities for family planning innovation to promote a particular class of technologies allows the widespread social inequalities that underlie unintended pregnancy to be invisible."

As these scholars emphasize, the history of reproductive coercion aimed at low-income women and women of color is well documented, ranging from coerced or forced sterilizations to coerced or forced acceptance of LARC methods. These practices include sterilization abuse of low-income and disabled women through state eugenics boards in the early 20<sup>th</sup> century (Schoen, 2005; Stern, 2005) to more recent legislative actions and state programs that predicate receipt of public assistance on accepting LARC or judicial actions to require sterilization or LARC as a condition of a reduced prison sentence (Flavin, 2008; Gold, 2014; Roberts, 1997; Solinger, 2005). Coercive contraception practices have a long history among Puerto Rican women on both the island and the mainland (Briggs, 2002; Lopez, 2008), a situation, as I will discuss later, that has important implications for teen pregnancy prevention in Stockton. While few people



today are outright sterilized against their will<sup>8</sup>, like the “new” racism, recent forms of contraceptive coercion are much more subtle, though just as severe. For example, researchers find evidence of racial discrimination in family planning settings, including that Black and Latina women are more likely than their white counterparts to be counseled to restrict their childbearing (Downing, LaVeist, & Bullock, 2007) and experience intimidating recommendation for sterilization and LARC methods (Yee & Simon, 2011).

Enthusiasm for LARC in Stockton mirrors trends nationally, with training for clinical providers on IUD and Implanon/Nexplanon insertion and increasing the number of teens using LARC methods part as of the overall teen pregnancy prevention strategy that takes place through the *Teens Count* clinic collaborative. In her role coordinating teen health promotion at the Stockton Community Health Center, Clarisa Ortiz administered a special grant project from the CDC that sought to accomplish both of these objectives. Clarisa explained to me how she saw the evolution and purpose of this new initiative:

Clarisa: I guess there were these conversations happening amongst the bigwigs, that you know, if clinics were able to have more LARC available, there would be a higher rate of less pregnancies amongst adolescents, amongst young adults, yada yada. So they wanted to put this theory to the test.

Chris: Okay.

Clarisa: So, we are a pilot clinic that was chosen for this grant to see if we have more doctors trained in LARC insertion, and more LARC available, instead of having patients come in, set up an appointment, and have to wait till their first period, you use the quick start method and all this other crap, and have it just—less barriers and more education and more doctors

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<sup>8</sup> There is however, evidence that inmates in California state prisons have been unlawfully sterilized as recently as 2013 (California State Auditor, 2014).

available, and more youth put on LARCs, then you would see a decrease in the pregnancy rates.

Chris: So is part of it also promoting certain types of contraceptives, or just training the providers on how to use them?

Clarisa: Yeah. Promoting and training both. So we're going to get doctors trained, having just more staff ready to do the work, instead of just relying on one or two individuals.

Although Clarisa could not provide process or outcome data on her clinic's initiative, the *Teens Count* project boasted that the project's clinic partners had implemented 29 out of 37 of the CDC's best practices for working with youth, including "quick start" insertion of IUDs. Additionally, *Teens Count* reported that from 2010-2012 the percentage of females ages 12-19 in the area using LARC increased from 2% to 7%, and believed that this number might be underestimated since they didn't collect data on the number of clients who reported being sexually active. When this finding was announced during a presentation at a partner organization "Collective Impact" meeting in winter 2014, attendees from health and human service organization across Stockton literally cheered at the news using the provided noisemakers and kazoos imprinted with the project's logo. Echoing my reaction to wealthy white women declaring that preventing teen pregnancies among low-income women of color is an issue "close to the heart" (described in Chapter 1), it was disconcerting to witness a group of majority white, middle-aged and class privileged service providers from outside the community literally "cheer" at a practice that has historically been used to limit the childbearing of marginalized peoples based on their perceived lack of fitness as reproducers.

The most notable way that colorblindness works to uncritically promote LARC in Stockton is through its obscuring of the history of coercive sterilization directed at Puerto

Rican women and the use of Puerto Rico as a site to develop modern contraceptive technologies. In her longitudinal ethnographic work on sterilization among Puerto Rican women in Brooklyn, Iris Lopez (2008) illustrates the nuances of this history and argues that it is a mistake to assume that Puerto Rican women, then or now, are either passive victims of contraceptive coercion or completely autonomous actors in their reproductive decisions. Rather, a complex interplay of historical, political, and economic factors structure their relationship to and high rates of sterilization and LARC, including migration experiences, economic changes on the island, their social support systems or lack thereof, their relationships to their husbands and children, their awareness of gender inequalities, and their lack of access to quality housing, jobs, education, and good health care services (Lopez, 2008, p. xv). The lack of acknowledgement of this interplay reproduces colorblind ideology in Stockton, as providers fail to consider how the history of reproductive coercion and constrained choice might affect the contraceptive decisions of young Latinas in Stockton.

Ana Gutierrez became interested in this topic while being raised by her grandmother, who never talked to her about sex and sexuality. “For a long time,” Ana said, “I thought it was maybe because my mom had me at such a young age, and she was afraid if she talked to me about sex I would end up pregnant.” Yet, as Ana grew older, she realized her grandmother’s “sexual silence” was due to her experience of coercive contraception:

My aunt actually explained that my grandmother had an IUD put in around the time that birth controls were being tested in Puerto Rico. And she didn't really understand. She did want to have some form of birth control, but she didn't understand how long the IUD was going to work, and how it actually worked. Um, so, after that I became really interested in the testing—the birth control testing in Puerto Rico—and then I thought, I never asked her, but then I thought,

like maybe it has to do something with that, that's why she doesn't talk about sex and birth control.

This realization prompted Ana to become interested in her family's experience with sex, birth control, and pregnancy; she eventually completed an undergraduate senior thesis on the topic. One of her findings points to an important implication of how Puerto Rican women in Stockton negotiate the legacy of coercive contraceptive practices. Her aunt, who had her first child at 17 while still living on the island, was later pressed into having a tubal ligation and eventually a hysterectomy, as Ana explained: "In her interview she explains that having her kids at an early age was a blessing, in her eyes, because if she would have waited, till like a 30, 35-year-old age, she wouldn't have been able to have kids, because by 30 she already had a hysterectomy." Ana's research thus complicates the elements of the Latino culture narrative that see Latinas' reluctance to use contraception or have abortions as the result of religious or cultural values.

The issues surrounding coercive fertility practices were discussed, very briefly, at the annual PASH network conference in the spring of 2013 (the same at which Malta Brigado was called out on her use of "race" as a risk factor), which included a screening of the controversial documentary, "La Operacion," which has been criticized for its reductionist depiction of sterilization coercion (Briggs, 2002).<sup>9</sup> Malta Brigado interrupted the keynote speaker, an original member of the Our Bodies, Ourselves collective that brought us the book of the same name, to share an anecdote from when she was in medical school and attended a young patient who didn't know that she had been sterilized. Malta stated that having babies young becomes a norm when women

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<sup>9</sup> According to Briggs (2002, p. 145), "The women in the film who have been sterilized tell a story of decisions they made based on health, family economics, or beliefs about modernity, while the voice-over inscribes a narrative of the state and social control."

know sterilization is a possible part of their future and added that it is important to “have this conversation about what has happened to mothers, grandmothers, and how it affects the young women we serve.” Aside from this brief mention, conversations about the history and implications of coercive contraceptive and sterilization practices or the social and political inequalities that affect birth control choices were absent from youth sexual health promotion in Stockton.

As the director of the PASH Network and heavily involved with the *Teens Count* initiative, Malta indirectly promoted LARC use but was equivocal about its use in our individual interview, much like she was about whether teen pregnancy was a “problem.” At times, Malta and other professional stakeholders in Stockton struggled with the tension between freedom and control inherent to LARC methods. Emily Lambert shared a story about a woman in one of her organization’s teen parent support programs who she characterized as lacking a sense of self-responsibility:

She has three kids, she’s 24, she’s pregnant with her fourth and talking to her about birth control, [she says she] doesn’t need it [and] doesn’t want it, but she doesn’t want any more kids, because her hands are full, and she doesn’t have a job. Sooooo work with me here because I’m thinking if you use birth control then you wouldn’t have that other child that you’re saying you don’t want, but you don’t want to use birth control...so this whole how do I understand that kind of thought process and get through to you is very frustrating....There’s all these reasons they don’t want something inserted into their body they don’t want to gain weight [sarcastically], there’s all these things, but in my head those are just excuses, right, I mean you’re going to gain weight if you get pregnant so what’s an extra ten pounds if you gain weight this way? It’s not like you’re an exercise freak anyway, you know, it’s just I think they’re just excuses.

Despite her belief that this young client was “just making excuses” for “not wanting something in her body,” Emily did acknowledge “really having to take a step back and being like, ‘ok, what is her perspective, where is she coming from, that whole thing.’”

Emily's minimization of the side effects of contraception is interesting given the evidence that side effects have considerable social weight and meaning to women and are often a key reason for discontinuance (Littlejohn, 2012; Littlejohn, 2013; Westhoff et al., 2007).

Clarisa Ortiz shared a similar story that she described more than once as "crazy":

We had an adolescent who got the [IUD] inserted, didn't like it, went to the emergency department [at] the hospital, told the people, "Take it out!" Instead of them conferring with her PCP [primary care provider], or telling her to go back to the PCP to have that done, because we did the procedure, they took it out. And then, the patient came back, and she was like, "I want it back. Cause, you know, I don't want to get pregnant."

Clarisa's remarks illustrate the inability to view contraception as a negotiated, embodied practice situated in a social context. No one, especially young, low-income women of color, utilize contraceptive technologies outside of a social context that dictates norms surrounding female bodies and sexualities. Like users of all kind of medications, contraceptive users must balance the risk of pregnancy with a host of potential side effects, long term health implications, cost, ease of use and discontinuance, their partners' expectations, and the social meanings attached to their methods. Is it really so "crazy" to be ambivalent about such a complicated healthcare decision?

Other stakeholders I interviewed did call more attention to the conflicts and complexities of contraception. Kristina Myers, a white nurse midwife serving as a nurse practitioner at Stockton High's teen clinic, was an outspoken advocate of having contraceptive access through the school clinic, a proposition that the school administration was vocal in opposing. In one tense SASHPC meeting, Kristina addressed Genario Santos Cruz, the Stockton superintendent of schools, by stating, "I'm not allowed to do what I've been doing for 25 years, which is to help women have babies and not have babies [when they want to]." During our one-on-one interview she told me:

I'm not saying that if a girl came into my office and I could put in, you know, a long-acting reversible method of contraception that would give her three years of not having a baby, that that's how you solve teen pregnancy. I mean I think it's—you have to um, help with kid's self-esteem, and you have to offer them opportunities, and they have to go to a school where there isn't like a policeman sort of, you know, standing guard.

Kristina was clear that although she saw contraceptive access as an important part of women's reproductive autonomy (even proclaiming in the SASHPC meeting that it was an important part of her identity as a feminist, the only time I heard that word in all of my years working in Stockton), she did not see LARC as a magic bullet to solving teen pregnancy, but instead named surveillance and militarization at schools with a large population of students of color as important issues. Similarly, as a grant writer and project manager, Amy Lexington dealt closely with funding agencies and acknowledged that the “power structure in Puerto Rico, you know, colluding with the US government to sterilize women” had an effect on the field's work that had not been adequately dealt with. As she stated, “The CDC is very much promoting IUDs and the contraceptive implants... and we really have been doing some soul searching about what does this mean...there's a real push to get more IUDs and implants in young people and it can be really sticky.”

Although some stakeholders engaged with these tensions, for the most part the colorblind racism that enables uncritical promotion of LARC allowed youth sexual health promoters to minimize the side effects of these technologies, elide racial discrimination in healthcare, and ignore the history of reproductive control aimed at women of color. If overt racism is a thing of the past and we are really “all the same,” as the colorblind perspective purports, then the promotion of particular contraceptive technologies can be

seen as race-neutral and thus disregard the implications of historical and current coercive practices. Moreover, as Omi and Winant (2014, pg. 256) argue, neoliberalism has both “overlapped with and required colorblindness.” Because teen pregnancy is intimately understood to be “burden” on taxpayers (Hoffman, 2008) (ignoring the fact that social welfare programs comprise a much smaller proportion of an individual’s tax bill than spending for military, federal prisons, and corporate subsidies)<sup>10</sup> neoliberal logic allows health promoters to privatize the burden of inequality onto the bodies of young, low-income women of color through LARC. This is the fallacy of LARC: the notion that increasing the use of a particular contraceptive method could single-handedly end unintended pregnancies and their associations with poverty omits that poverty creates unintended pregnancies, rather than the other way around (Higgins, 2014; Kearney & Levine, 2012). This notion is an example of what I call “causal fantasies,” which is the subject of the next chapter.

### **The Implications of Stockton’s Racial Project**

The racial project of teen pregnancy prevention in Stockton organizes everyday understandings of race in the city, understood as an essentialized and deterministic “Latino culture,” and structures health promotion efforts accordingly. The culture narrative both produces and constrains the sexual subjectivity of young people in Stockton, which enables the erasure of reproductive oppression and the uncritical promotion of LARC. Simultaneously, the reciprocal relationship of colorblindness and neoliberalism permits the teen pregnancy prevention industrial complex to reduce the importance of racial inequality and obscure how the conditions of poverty affect people

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<sup>10</sup> See [www.nationalprioritiesproject.com](http://www.nationalprioritiesproject.com).



differently based on race. Stakeholders are thus able to collapse inequality to “culture,” as Amy Lexington put it, in order to “get themselves off the hook.” Put another way, what the Latino culture narrative and the ideology of colorblindness do is to allow stakeholders and the TPPIC to abdicate responsibility for structural inequality. Focusing on individual health promotion strategies, such as acceptance of long-acting provider controlled contraception, cannot possibly account for the racial and economic inequalities that contribute to higher rates of unintended pregnancies among low-income women of color. Moreover, by individualizing and privatizing sexual health, stakeholders are able to reproduce the institutionalization of health promotion. As Briggs argues (2002, p. 14), “If Puerto Rican folks are poor, it can’t have anything to do with the United States or colonialism. If Puerto Rican poverty is caused by something about Puerto Ricans themselves, then they need the United States to help them.” The same is true in Stockton: arguing that young people just need hope, opportunity, and an IUD to escape the effects of a race, class, and gender stratified society means that there is always a role for benevolent outsiders. The TPPIC, as it is currently constituted, cannot eliminate the effects of colonialism and reproductive oppression nor provide adequate education and employment opportunities for people in a racist society under late capitalism, but it can provide lessons on how Latinos can talk to their kids about sex and encourage young women to elect birth control methods that cannot be easily stopped without a healthcare provider.

To conclude on a more hopeful note, I’ll end by offering that there are seeds of racial justice happening in Stockton and youth sexual health work more generally. Key to planting these seeds includes engaging with the raced intersections with class, gender,

and sexuality as well as naming the history of reproductive control of women of color with an eye towards developing a reproductive justice framework. Shifting youth sexual health promotion to incorporate a reproductive justice framework means moving from a focus on distributing condoms and “hope” to a broader analysis of racial, economic, cultural, and structural constraints on power. Organizations such as *Forward Together*, described in Chapter 7, are utilizing this approach. Though disparate and nascent, there are also voices calling for a reproductive justice framework in Stockton. Kristina Myers named our colonialist relationship to Puerto Rico and argued that a racial justice lens was important to her work, as did Amanda Church, SOAP’s policy director. Amy Lexington critiqued the CDC’s (and Stockton’s) promotion of LARC methods above all others. Malta Brigado acknowledged, albeit briefly, that the history of reproductive oppression aimed at women of color mattered in youth sexual health promotion work. Lourdes Navarro named it well when she told me, “I think that racism is a powerful tool against poor and marginalized people—that the seeds of racism have been planted so, so well that it’s been internalized in poor communities and we have begun to believe that the stereotypical comments, views, and attitudes are real.” In Chapter 7, I discuss strategies that youth sexual health promotion in Stockton and elsewhere might employ to move toward a reproductive justice framework and better integrate a racial justice perspective in their work. First, I turn to an examination of how stakeholders in the teen pregnancy prevention industrial complex take up and deploy sexual scientific discourses.

## CHAPTER 6

### SEX, SCIENCE, AND WHAT TEENS DO WHEN IT'S DARK OUTSIDE

At a particularly memorable SASHPC meeting in late 2013, Stockton's superintendent of schools Genario Santos Cruz and assistant superintendent Mark Rowan joined the regular crowd of all female health and human service providers crowded into the computer lab of the Stockton Boys & Girls Club. This is the meeting I've described elsewhere that began by SASHPC chair Hannah McNeil cutting me off in her BMW coupe and included nurse midwife Kristina Myers directly confronting the superintendent about the administration's reluctance to allow contraceptive access in the school's teen clinic. The meeting was especially tense and confrontational, with a lot of big personalities grappling for floor time. It was also a meeting that well illustrates how stakeholders understood and negotiated scientific meaning in relation to youth sexuality in Stockton.

As we waited for the guests of honor to arrive, Malta Brigado apologized that she was going to show a powerpoint that most of the attendees had already seen multiple times. This slideshow consisted mainly of graphics depicting the teen birth rates in Stockton over time along with a description of the work that occurred under the auspices of the PASH Network, the *Teens Count* initiative, and SASPHC. Malta shared that she recently attended a meeting with the two superintendents where she felt like she was part of an inspirational movie similar to *Lean On Me*, in which a fictional urban failing high school is turned around through the work of a maverick principal. "I'd never left a meeting feeling like that," she said. When the guests arrived, as she often did during her presentations, Malta acted as a "cheerleader" for the group and emphasized how all the

hard work they were doing to transform youth sexual health in Stockton was paying off. “You guys made that 14% drop in the teen birth rate happen in Stockton!” she told the group, in part for the benefit of our special guests. I sarcastically wrote in my fieldnotes about this piece of data, noting that Malta is an academic physician who received a master’s degree in public health at an Ivy League university: “It appears she was absent the day they learned about causality. It is unlikely that the work of this committee *caused* the drop in teen birth rates—there are too many confounders to make that connection, and if it were true, it would be almost impossible to measure. To state this with such bravado is interesting.”

Malta continued on to say, “We want the teen birth rate to go down for the next year, the next 5 years, and forever after that.” This statement was at odds with the speech she made at the previous year’s PASH Network conference where she acknowledged that teen pregnancy was simply part of our social world, or how she shared in our one-on-one interview that she believed teen pregnancy in and of itself was not a problem. I noted how her presentation to the superintendents used epidemic and eradication language to talk about teen pregnancy as if it were polio or the guinea worm, something we should (and could) eliminate altogether. Dr. Cruz, the head superintendent, spoke up at this point to offer that he didn’t think comprehensive sex education in the schools was doing what it was supposed to, and might even be doing the opposite. “We are focused on results and we are not seeing them,” he said, “Kids are having kids and they are leaving the schools.” He went on to say that “kids having kids is a tragedy” and that “education is the future of the community.” I noted this statement too in my fieldnotes, wondering how, with a doctorate in education, Cruz could be ignorant of the established body of literature

showing that most teen parents drop out of school *before* having children and that teens who leave school after having a baby do so because of the school's inability or refusal to meet their needs (Fershee, 2009; Manlove, 1998; MATP, 2010; Pillow, 2004; Zachry, 2005), findings consistent with the experiences of young women at The Towne House.

The belief that teen pregnancy was a main contributor to the high drop out rate in Stockton was one of many taken-for-granted truths that directly contradicted social science research, and is a prime example of how stakeholders conveniently ignore science while at the same time relying on discourses of science to legitimize particular truth claims. To be clear, I am not arguing that Malta, Genario, or any of the stakeholders in Stockton were purposefully disregarding evidence in order to further some sort of hidden agenda. I am certain that Malta does in fact understand epidemiological theory and that Genario is familiar with the literature on school dropout. What is notable, and what I explore in this chapter in relation to how we do youth sexual health promotion work, are the ways they utilize or neglect certain scientific knowledges in particular contexts for strategic ends.

As tensions over the relative merits of contraception and sex education (the most common strategies of the TPPIC) arose between the regular SASHPC members and the superintendent, Malta struggled to gain control of the discussion. "The fundamental change you're talking about," she said, "is a landscape of opportunity," and asserted that young people will use birth control if they know they have a good job in the future. Beth Emmerson used the tension in the room to redirect conversation, as she often did, to her dissertation research in which she conducted a series of focus groups with non-parenting teens in Stockton about their perceptions of teen pregnancy in the community. She

emphasized that her participants had goals for themselves and thus didn't allow themselves to be home without parental supervision for more than 20 minutes. It was early December, and daylight savings time had recently begun, meaning that the sun set in the Northeast as early as 4pm. Beth practically shouted, "What are you going to do when it's 5 o'clock and it's dark out?!" There were nods and murmurs of agreement around the table in apparent unanimity that the lack of daylight in the winter months was a factor in teens having unprotected sex, and thus babies. I found myself increasingly confused at the self-evident belief that an early sunset was making young people have sex (not because sex is pleasurable or has important social meanings attached to it) and that all teen sex inevitably led to pregnancy and thus babies (because teens are irresponsible with contraception and Latinas don't have abortions). I scribbled in my notes, only half joking: "I'm confused about this daylight savings time need to have unprotected sex thing, and I'm wondering if I can round up a date before the end of today!"

Two other jottings that show up frequently in my field notes are indicative of my arguments in this chapter: "talking about sex without ever actually talking about sex," and "Foucault would not be surprised." At a certain point in my fieldwork I began to realize that I had spent a considerable amount of time in meetings, conference rooms, community events, car rides, classrooms, clinics, and living rooms listening to people discuss "sexual health" and "sexuality" without ever actually talking about *sex*. Similar to how stakeholders in the teen pregnancy prevention industrial complex talk about race but rarely actually name it, they also continually talk about sexuality without ever acknowledging the material realities of sex or the bodies of sexual actors. The preoccupation with young people's sexual activity in Stockton was almost entirely

divorced from the fact of sex itself. While there was ample talk of condoms and birth control and pregnancy, there was almost no discussion of desire, pleasure, or consent, not to mention how gender and sexuality are key sites in which inequalities are maintained and reproduced. Likewise, while there was ample talk of and belief in science, imagined as value-free and apolitical, there was almost no discussion of how science itself constructs sexuality, and teen sexuality in particular, as an object of scientific scrutiny.

This chapter explores how scientific discourses surrounding sexuality are taken up and deployed in Stockton. I begin by exploring how sex and sexuality are understood and talked about in Stockton and compare this to the extant literature on youth sexuality. Attempts to “tell the truth” about youth sexuality in Stockton “make up” teens as particular kinds of (hetero)sexual subjects (Hacking, 1986/2002) while embracing a reductive understanding of sexuality that disregards pleasure and desire and promotes a particular kind of sexual responsibility. All the while, sex is everywhere and nowhere at once. Next, I describe how discourses of sexuality in Stockton are implicated in the uptake, reproduction, and deployment of scientific discourses of progress and modernity. In particular, magical thinking about the causes of teen pregnancy opportunely ignores science (through failure to acknowledge the heterogeneity of research on the outcomes and predictors of teen pregnancy) while at the same time relying on it to legitimize particular truth claims (through a myopic focus on “evidence-based comprehensive sex education”). Stakeholders utilize causal fantasies that permit them to devise community health strategies based on magical thinking, such as the ideas that school suspension or daylight savings time produces an increased risk of unprotected sex. Simultaneously, stakeholders’ selective use of scientific knowledge permits them to confirm and

legitimize taken for granted assumptions and reproduce the work of the teen pregnancy prevention industrial complex. I conclude by considering how notions of progress are integral to the relationship of sex and science in Stockton.

### **Producing Youth Sexuality in Stockton**

Social science scholarship on sexualities has shaped our understanding of “sex” and “sexuality” as not merely as natural, biological processes or categories but as ways of knowing that are socially and politically produced. This work illustrates how "sexual meanings, identities, and categories [are] intersubjectively negotiated social and historical products—that sexuality [is], in a word, constructed" (Epstein, 1994, p. 145). Thus, in the social science literature, “sexuality” includes but it is not reduced to a range of behaviors, identities, and discourses. Sexual subjectivity, as Deborah Tolman (2002) defines it, is “a person’s experience of [themselves] as a sexual being, who feels entitled to sexual pleasure and sexual safety, who makes active sexual choices, and who has an identity as a sexual being” (p. 6). Additionally, scholars of sexualities have directed our attention to the ways in which sexuality is not merely an individual private act or identity but also a form of social power that creates meaning and is organized by its intersections with race, class, gender, ability, nation and so on (Bailey, 2013; Carpenter & Epstein, 2012; Carillo, 2002; Fields, 2008; Fine, 1988; Fine & McClelland, 2006; Gamson & Moon, 2004; Gill, 2015; Irvine, 2004; Pascoe, 2012; Schalet, 2011). As Carole Vance (1995) argues, “Sexuality is an actively contested political and symbolic terrain in which groups struggle to implement sexual programs and alter sexual arrangements and ideologies” (p. 41). Moreover, sexuality has a significant relationship to a range of institutions including schools, government, healthcare, and so on. These institutions both produce sexual



meanings and act as sites where sexuality is regulated. Indeed, as Vance notes, state intervention and regulation of sexuality has historically been a way to legitimize professional practices and identities, including those of sexologists, sex educators, physicians, and psychologists, a phenomenon that is seen in the maintenance of Stockton's teen pregnancy prevention industrial complex.

The notion of sexuality as a discourse that produces individuals, populations, bodies, and fields of study is, of course, indebted to Foucault (1978/1900), who marks the “incitement to discourse” that produces a “multiplication of discourses concerning sex in the field of exercise of power itself: an institutional incitement to speak about it, and to do so more and more; a determination on the part of the agencies of power to hear it spoken about, and to cause *it* to speak through explicit articulation and endless accumulated detail” (emphasis original, p. 18). Foucault's “repressive hypothesis” is useful for understanding our fascination with demonizing and pathologizing youth sexuality and teen pregnancy in public health discourses. Foucault (1978/1990) identifies a paradox in the notion that, particularly since the nineteenth century, society has repressed sexuality while simultaneously producing it as a core feature of human identity and the subject of proliferating discourses. Today we see this manifested in Stockton and elsewhere, as adolescents are told to avoid sexual activity while we valorize motherhood, assume heteronormative relationships, and sexualize young girls. As Epstein (2003) notes, “power does not so much negate sex as organize it through the proliferation of discourses about it,” and “sexual meanings are orchestrated through an injunction that we speak about sex.” In other words, power does not ignore sexuality but rather creates social and political meanings about bodies, identities, behaviors, and populations through

an incitement to speak about them. In Stockton, as I will illustrate, this power produces a limited way of understanding sexuality that involves both silence and constant talk about youth sexual behavior.

Foucault (1977/1995) locates the productive power of discourses in the body—the uses and usefulness of bodies as well as their distribution in space and time. Power becomes biopower when it is situated and exercised at the level of life. Foucault marks the historical and discursive shift toward biopower by noting “an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (1978/1990, p. 140). Biopower is organized along two linked poles; at one end, the “anatomy-politics” of the body seeks to make the individual body and its forces more efficient. Anatomy-political forces discipline the body while optimizing its capabilities and exhorting its forces, for example by encouraging individuals to adapt certain sexual health behaviors. At the other end, “regulatory controls” work to enact a biopolitics of the population. Regulatory controls are concerned with the population body “imbued with the mechanics of life [that serve] as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary” (Foucault, 1978, p. 139). Biopolitical regulatory controls work to construct and delimit how we define, measure, and control to health of populations.

In the case of US teen pregnancy prevention, a variety of biopolitical techniques have emerged, including abstinence-only and comprehensive sexual health education, the pathologization of pregnant teen bodies, an admonishment to engage in contraceptive use, the promotion of the two-parent, heterosexual, middle-class family, restrictions on

welfare assistance, and the creation of multi-sector coalitions to reduce teen childbearing (Pillow, 2004). Indeed, as Rabinow and Rose (2006) argue, sexuality is key to biopower because it links biopolitics at the individual level to the population level. Biopower not only constructs truth discourses about the “vital” characteristics of human sexuality and produces authorities empowered to speak about them, it also enables certain modes of subjugation

through which individuals are brought to work on themselves, under certain forms of authority, in relation to truth discourses, by means of practices of the self, in the name of their own life or health, that of their family or some other collectivity, or indeed in the name of the life or health of the population as a whole (Rabinow & Rose, 2006, p. 197).

The “vital truth” of early pregnancy and parenting in Stockton produces teens as particular kinds of sexual subjects: always already “at risk,” devoid of pleasure and desire, lacking agency but at the same time unconstrained by gender inequalities.

Although teen sexual subjectivity is produced as non-agentic, teens are called upon to engage in practices of the self, such as abstinence from (presumed heterosexual) sexual activity or compulsory contraceptive use in the name of decreasing teen pregnancy rates, bolstering the neoliberal state, and creating normative families.

Stockton’s participation in activities for the National Day to Prevent Teen Pregnancy illustrate how sexuality is understood, deployed, and regulated in the city. The National Day occurs every year in May during national teen pregnancy prevention month. Activities take place across the US and are coordinated by the national, non-governmental organization The National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP). The National Campaign is funded through a variety of private and public sources and is the most visible and influential teen pregnancy NGO in the nation,

with its apparatus extending from MTV programming to the sex lives of legal adults.<sup>1</sup> The National Campaign produces a variety of fact sheets and data briefs about the “costs and consequences” of teenage childbearing, and offers educational resources to teens, parents, and policymakers, among other activities. As I describe elsewhere (Barcelos, 2014), the National Campaign is an exemplar for understanding the biopolitics of teen pregnancy prevention in the United States. In particular, the National Day events are demonstrative of governmentality, Foucault’s term for the dispersed form of power that emerges through all aspects of social life and enforces an individual and population level duty to participate in self-governance (Foucault, 1991).

Each year Stockton participates in National Day activities through a series of events sponsored by city government and community-based organizations. They also hang a banner from city hall to a building across the street proclaiming that May is the national month to prevent teen pregnancy. In 2012, the first year I attended the National Day events as part of my fieldwork, a community health fair intended to be held on the lawn outside city hall was forced inside due to rain. As it is each year, the event was titled “*You Have Choices;/Tienes Opciones!*” Area agencies including the Boys & Girls Club, Girls Inc., Continuum Health Services, the Stockton Community Health Center, and the PASH Network crowded their displays and tables into the building’s basement. The tables were staffed primarily by white women from these area organizations, though the youth in attendance were almost entirely Latinx; both youth and adults sported t-shirts and buttons with the *You Have Choices;/Tienes Opciones!* logo. The walls were lined

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<sup>1</sup> In 2005, the National Campaign expanded its mission to include the prevention of unplanned pregnancies among adults ages 18– 29 in order “to help ensure that children are born into stable, two-parent families who are committed to and ready for the demanding task of raising the next generation.”

with youth-produced teen pregnancy prevention posters that included slogans such as “Stay a teen,” “Avoid crotch rot,” “You’ll have no freedom as a teen parent,” “No more parties, no more movies,” and “Would you rather buy condoms or diapers?” Mayor Ryan Brown began the speakers’ portion of the event by saying that he “wants a healthy future for the city of Stockton” and that “the future of Stockton depends on resolving this issue.” “As all of you know,” he said, “teen pregnancy does have an economic and social impact on our city.” He continued on, expressing his desire for all city youth to go to college, have a nice house and a good job. The next speaker was a Latina woman who was now in her mid-30s but had her first child at 17. She was the only self-identified teen parent in attendance<sup>2</sup>, and became noticeably teary-eyed as she told the audience the only narrative that could be allowed in that space: “Getting pregnant young meant I couldn’t do everything I wanted to. Having a child at a young age can drastically change your life, and not always for the best.”

I was unable to attend the 2013 National Day event, but news media coverage indicated a sunny day for the activities to be held on the lawn outside city hall. Colorful lawn signs emblazoned with *You Have Choices!/Tienes Opciones!* decorated the area, leading the Algonquin Valley News to caption their photo: “The message to young people about having sex and getting pregnant or making a smart decision was clear on a sign outside Stockton City Hall on Wednesday.” Referring to the teen birth rate, Hannah

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<sup>2</sup> Confessing that you are or were a teen parent, or the child of one, was a precarious endeavor in Stockton, as it was likely to elicit any number of potentially uncomfortable responses. It was rare that anyone would disclose their teen parent status in prevention-focused spaces; for example, Mayor Brown only ever acknowledged that he was the son of a teen parent at Towne House events. I admitted to having been a pregnant teenager only once or twice during my fieldwork. As part of the redemption narrative, revealing so usually communicated that I was interested in this work in order to prevent other young people from “doing what I had done.” Conversely, due to my “success” story as an academic, I would often become implicated in a progress narrative and used as an example of what teen parents can do if they “work hard enough.”

McNeil was quoted as saying that “we may be number one in the state, but our rates are dropping and continue to drop.” A young woman, identified as a freshman at Stockton High, told the reporter that a lot of pregnancies happen because guys talk insecure girls into having sex. “Guys can say anything to girls these days to get what they want,” she said.

In the lead up to the 2014 National Day, SASHPC members lobbied hard to have the event held at the city’s two high schools in order to “reach the youth where they are” with their message of hope and opportunity. When Hannah McNeil announced that the superintendent had given them permission to hold the event as an assembly at both Stockton High and the Stockton Technical High School, Clara Ortiz pumped her fist in the air. The events were mostly similar, although the Stockton High event was larger, and so I describe them here as amalgam to illustrate discourses of sexuality in Stockton.<sup>3</sup>

The high school gymnasiums were filled with students, who were required to be there as part of the regular school day. Adults and some students wore *You Have Choices!/Tienes Opciones!* t-shirts, and the banner from city hall was displayed behind a makeshift podium. A health teacher introduced the events by thanking Hannah McNeil and the members of SASHPC, who she described as a group of people “who care about you guys,” “work to increase options for you,” and “help you make correct choices.” Genario Santos Cruz spoke first, and was likewise introduced as someone who cares about the students. He began by stating that the statistics on teen pregnancy in Stockton

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<sup>3</sup> Despite repeated requests to the organizers, I was unable to attend either of these events in person (they were not open to the public). However, the high school’s media center video recorded both assemblies and posted them on their websites. These videos were unedited and used a birds-eye view of the gymnasiums in which they took place. While this is not the ideal way to conduct participation observation, and no doubt missed some importance nuances, the unedited video production and clear audio enabled me to transcribe the videos verbatim.

were “very concerning” to him: “We are number one in the state on teen pregnancy, which is not a good statistic.” He noted that “choices have consequences,” and that while not studying for a test may result in a poor grade, “today we are talking about choices that have life-long consequences. This is about your own life, your own future. Making good choices is very, very important.” Genario continued on to say that he does not want to be number one in the state anymore: “I don’t think we are making the right choices at this point. So I want you to you to be thinking about the serious message, that it’s not a good idea to engage in irresponsible sex without having thought out ‘what is the consequence of that?’” Next, assistant superintendent Mark Rowan awarded students for the best essay response to the prompts: “Think from the perspective of a baby; to think how your chances and your life would be affected if you’re the baby of a teen parent,” and “What is the journey of becoming a teen parent and what are the effects of becoming a young mother or father and how does it influence the rest of your life?”<sup>4</sup> He announced the winners and awarded prizes such as candy, movie tickets, and amusement park season passes.

Next up was the “inspirational speaker” Hannah McNeil had invited. A black man in his 30s wearing an oversized tracksuit, he did a nice job drumming up excitement in the otherwise disinterested group of students. He showed the students a short film, which was projected onto the far wall of the gymnasium and is worth describing at length: A white teen boy and girl are making out on a couch, and the boy pressures the girl to “bring it to the next level.” She says she’s not ready and the next scene shows her crying outside a large suburban house while melodramatic music plays. “One week later,” we

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<sup>4</sup> Kristina Myers shared with me that she thought these prompts were “dissing” the students, as many of them were raised by teen parents themselves.

see the boy walking down the hallway at school with a new girl, who brushes by the first girlfriend. Cutting back to the couch, the new girlfriend tells the boy “it’s amazing how comfortable I am with you, I feel like I could do anything with you.” They start to kiss and the shot fades, leading us to believe they had sex. “Four weeks later” we see a shot of a pregnancy test, and the girl pulls out her cell phone to call the boyfriend, who is sleeping. She tells him she has “bad news”—she’s pregnant. “What?!” he replies, as if he had never considered this possibility. He says he “has to go” and hangs up on her. The melodramatic music continues to play as she encounters him at school, two weeks later. She asks to talk about it, but he says it’s not a good time. “You don’t understand,” she says, “we have to talk about it.” “No, you don’t understand!” he replies, “I had a life, I had dreams, that’s all gone now. I wanted to go to college, I wanted a good career—you ruined that.” He points his finger in her face and begins to walk away. She retorts, “I ruined your life!? You’re not the one who has to carry a baby for nine months. Are you gonna be sick for half that time? Are your friends and family gonna talk about you every time you turn your back? At least you get to finish high school—I won’t get to finish my senior year!” He just walks away and she calls after him: “what about our baby!?” Solemnly he replies, “I just wish we would have waited.” “Yeah,” she says, “Me too.” The screen turns to black and white and then reveals the text “Nearly one million young girls become pregnant each year.”

After the video finished playing, the inspirational speaker told the students, “A lot of times, we go out and have sex and don’t think about the consequences. I’m not here to tell you not to have sex. I’m telling you about the consequences of your actions. If you choose to have sex unprotected: disease, babies, etc. I know myself, personally, I’m a



single father, I don't like it, because I'm raising children by myself." Then, with a flourish, he tore off his tracksuit to reveal a nice suit and tie underneath, "I made some bad choices, but I was able to turn it around." He shared some other "success stories" of other young black men he knew who had made the correct choices and now had jobs as a chef or a DJ. The speaker then invited some students down from the bleachers and engaged them in awkward and forced conversations about "the choices they want to make in their lives." Then, without commentary, he blasted music from the gym's sound system to play a clip from Beyoncé's then popular song "Partition." The event wrapped up by distributing *You Have Choices! / Tienes Opciones!* buttons, bracelets, and cards with links to "You Have Choices" website<sup>5</sup>, and the health teacher delivered preplanned remarks: "A very powerful message for us here at Stockton High today. The choices we make lead us into our future, each one of us, the many choices we have in our lives, the decisions that we make, makes us the people that we are today and leads us to the people we're going to be in the future."

### **Reductive Ways of Understanding Sexuality**

These National Day events are reflective of how youth sexuality is deployed in Stockton. Of course, they do not represent the totality of sexual discourses but rather offer us a window into viewing how reductive ways of understanding sexuality function

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<sup>5</sup> This website had been in development for the duration of my fieldwork. It consisted of a page with the SASHPC's mission statement, a page listing contact info for all of the health and human service organizations in Stockton, links to external youth sexual health websites, an empty events calendar, a story from a teen mom who refers to herself "just another teenager who threw her life away by getting pregnant at seventeen," and links to the *You Have Choices!* Facebook and Twitter pages. There was no user-generated content. By the time I completed fieldwork, the Twitter had zero tweets and the Facebook page featured quarterly posts about contraception or HIV testing awareness month, and was "liked" primarily by other service providers in the city.

in the city. First, in the events, and the sexual health discourses in the teen pregnancy prevention industrial complex more generally, “sex” is reduced to a very specific behavior with presumed inevitable consequences that occurs between certain bodies and identities. It would be easy to write off the video shown during the assemblies as melodramatic and hyperbolic, but to do so would be to overlook how it represents the dominant, disciplining, and productive understanding of youth sexuality in the United States. In line with existing studies of youth sexuality, boys are as positioned as sexual aggressors with girls as defenders of their pure sexuality and bodies (Fields, 2008; Garcia, 2012; Pascoe, 2012; Tolman, 2002). In this view of sexuality, female pleasure does not exist—for example, it’s not even considered that the girl in the story might experience desire or pleasure from her relationship. Moreover, since sex is unfathomable outside of heterosexual, procreative sex there are no sexual practices that young people may engage in that have a lower (or nonexistent) risk of pregnancy. Sex is inevitably dangerous and guaranteed to end badly: in the story, contraception was not part of the picture, as the young woman in the video had sex once and became pregnant. Carrying the pregnancy to term and raising the baby is the only option available in this scenario—abortion and adoption do not exist. Likewise, dropping out of school is inevitable. The intensely gendered messages are not challenged: If you don’t give in to sex you’ll be publicly ostracized, if you do have sex your life is over. Boys are jerks who cannot take responsibility for their actions and girls “ruin” boys’ lives by getting themselves pregnant. In addition, the middle-class setting and white protagonists in the film speak little to the material realities of young people in Stockton.

While encouraging youth to “make the right choices,” there is an assumption about what that “right” choice is: presumably abstinence, and if not then “sex”—which is always already presumed but not explicitly stated to be a heterosexual, penetrative, procreative behavior—should occur in a committed, monogamous relationship with the female partner using appropriate contraception, preferably a LARC method. All sex is understood as inevitably leading to pregnancy and all sex is potentially dangerous. The “consequences” of sexual activity are framed with a neoliberal logic that privatizes responsibility for social inequalities and the gendered power relations in safer sex negotiations and their social meanings remained unaccounted for.

### **Sex Talk and Silences**

As part of the production of authoritative sexual knowledge in Stockton, sex is everywhere and nowhere at once (Foucault would not be surprised). Adults speak of value-neutral “facts” of sex as if it were any other subject (Fields, 2008). Malta Brigado put it like this: “I’m just saying, ‘This is how your body works. I believe this is based on biology.’” In the Stockton High teen pregnancy prevention video described in the beginning of Chapter 4, one health teacher discussed the comprehensive sex education curricula in the school: “They can ask questions, some of the things they may have heard from peers, or you know, out on the street [smiles] could be wrong, so, I’m trying to get the facts across.” Greta McNally, the district’s health and science curriculum coordinator, offered: “We basically teach them all the facts and information they should know about...sex and how it could lead to teenage pregnancy and sexually transmitted diseases.” In Stockton, sexuality is ostensibly always at the table, though actual sex is almost *never* mentioned—it is glossed over, absent, assumed. This silence is significant

given the element of the Latino culture narrative that assumes sexual silence on the part of Latinx families contributes to teen pregnancy. Silences (some full, others partial) are particularly notable around abortion, LGBTQ youth, desire, pleasure, and consent. The silence surrounding abortion is not merely an assumption on the part of white providers that “Latinas don’t have abortions,” it is also the pervasive stigma attached to abortion (Kumar, Hessini, & Mitchell, 2009) and its construction as something that should be “safe, legal, and rare” (Thorne-Thomsen, 2010). The fact that legislative restrictions on abortion services, especially for minors, have increased exponentially in recent years is implicated in this silence.

Similarly, LGBTQ youth were almost entirely absent from youth sexual health promotion efforts in Stockton: the comprehensive curricula in use in the public schools did not include content for queer or trans youth, *Teens Count* project activities did not collect data on them, and the mission statements of TPPIC organizations did not identify them as a target population. LGBTQ youth were rarely mentioned in stakeholder interviews, although Melissa Campbell, the director of Youth and Young Parent Services at the YWCA, was the one exception. Melissa was the only interview participant to disclose not being straight and referenced research showing that queer youth actually have *higher* rates of unintended pregnancy than their heterosexual counterparts (Lindley & Walsemann, 2015; Tornello, Riskind, & Patterson, 2014). Yet, for all the talk of lowering high rates of teen pregnancy and STIs in the city, there was seldom mention of the sexual health of queer or transgender youth in Stockton.<sup>6</sup> This absence is curious

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<sup>6</sup> In one *Teens Count* Collective Impact meeting, a member of the project’s external evaluation team read statistics on the 928 youth served by project activities, noting 32% male, 68% female, and 1% transgender. It was not clear if this 1% consisted of transmasculine and/or transfeminine

given that LGBTQ youth are generally positioned as an “at-risk” population with regards to sexual health behaviors and outcomes (Coker, Austin, & Schuster, 2010).

Discussions of pleasure, desire, and consent were missing not only in National Day events but in youth sexual promotion work in the city overall, including comprehensive sex education curricula, committee meetings, project and organizational mission statements, and stakeholder interviews. As other scholars have documented, these discussions are not just missing, but are missing in specific ways that conceal race, gender, and class inequalities and make their absence appear to be an individual level problem (Fields, 2008; Fine & McClelland, 2006; Tolman, 2002). According to psychologist Deborah Tolman, adolescent girls face a “dilemma of desire” that structures their sexual subjectivities. Understood as a choice between safety and enjoying their sexual feelings, the dilemma is framed “as *if* it were an individual rather than a social problem—if a girl has desire, she is vulnerable to personal physical, social, material, or relational consequences—it is in a way not especially surprising that girls would experience their desire and these resulting difficulties as their own personal problem” (Tolman, 2002, p. 44). Further, the lack of pleasure and desire in sexual health education is well documented (Allen, 2004; Fine, 1988; Fine & McClelland, 2006; Gubrium & Shafer, 2014), and functions to reproduce social and sexual inequalities through its lack of “thick desire,” Michelle Fine and Sara McClelland’s (2006) term for a framework arguing that

young people are entitled to a broad range of desires for meaningful intellectual, political, and social engagement, the possibility of financial independence, sexual

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youth, and the presenter stumbled over the word “transgender” as if she’d never seen it before, referring to it as “1%...gender served.”

and reproductive freedom, protection from racialized and sexualized violence, and way to imagine living in a future tense (p. 300).

It was rare to hear professional stakeholders in Stockton talk about young women owning desire and pleasure, acknowledge that sex can be enjoyable, or name the missing component of desire in sex education; when this did occur, it was only during one-on-one interviews. For example, Ana Guterrez critiqued her work delivering evidence-based curricula in Stockton: “is it really sex ed if we’re not talking about pleasure?” That teens, and girls in particular, might desire sex and experience pleasure from it while also doing it “safely” (defined narrowly as not becoming pregnant) was not part of the conversation at the National Day events or the TPPIC more generally. The inclusion of Beyoncé’s song “Partition” at the assembly is an interesting example of the erasure of pleasure and desire that illustrates how sex was everywhere and nowhere at once in Stockton. In contrast to how the event framed sex as dangerous and did not acknowledge how it could be pleasurable or fun, the song from Beyoncé’s eponymously titled 2013 album positions female sexuality as agentic,<sup>7</sup> explicitly refers to sexual acts, and takes enjoyment in them:

Driver roll up the partition please  
I don't need you seeing 'yonce on her knees  
Took 45 minutes to get all dressed up  
We ain't even gonna make it to this club  
Now my mascara running, red lipstick smudged  
Oh he so horny, he want to fuck  
He bucked all my buttons, he ripped my blouse  
He Monica Lewinski all on my gown...

Take all of me  
I just wanna be the girl you like, girl you like  
The kind of girl you like, girl you like...

Driver roll up the partition fast

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<sup>7</sup> There is, however, considerable debate over Beyoncé’s sexual subjectivity in the album, including whether or not her reputation as a feminist is misplaced (McKenzie, 2014).

Over there I swear I saw them cameras flash  
Handprints and footprints on my glass  
Handprints and good grips all on my ass  
Private show with the music blasting  
He like to call me Peaches when we get this nasty  
Red wine drip, talk that trash  
Chauffer eavesdropping trying not to crash

While the inspirational speaker did not play the song in its entirety, given the album's immense popularity at time, especially among youth of color, the students undoubtedly knew what "Partition" was about. Again, Foucault would not be surprised: an event whose purpose was to warn young people of the dangers of sex and admonish them to make the "correct" choices also included music describing oral sex, ejaculation, ripped blouses, smudged lipstick, ass-grabbing, and dirty talk. Sex is everywhere and nowhere at once.

### **Responsibility and Sexual Values**

Ideas about "responsible" sexuality and sexual values were evident in the National Day events and were also woven into policies, processes, and interactions throughout the city. With titles like "Becoming a Responsible Teen" and "Making Proud Choices," the comprehensive sexual health curricula used in Stockton reference responsibility and choice by valuing particular sexual and reproductive behaviors. Stakeholders likewise placed a high value on an amorphous "sexual responsibility," which translates to heterosexual intercourse in a monogamous, amorous relationship in which contraception is always practiced. Tropes of slut shaming, stud/slut dichotomies, the sexually out of control bad girl narrative, and women as defenders of sexual purity are all present in the city's health sexual health promotion work. Recall how the superintendent told the crowd that "we" are not making the right choices and that it's not

a good idea to engage in irresponsible sex — does he include himself in that? The city of Stockton? What does “irresponsible sex” even mean? Is it irresponsible to choose to have a baby when you’re young, poor, or single? Is it irresponsible to enjoy and want sex? In our individual interview Genario emphasized the importance of “protected sex,” but it is unclear from his National Day remarks if he understands responsible sex to include negotiating consent, respecting boundaries, honestly communicating about risk factors and so on. Emphasizing a word such as “responsibility” is not a neutral choice given that it has long been used as a code word to police the boundaries of socially sanctioned behaviors (Fraser & Gordon, 1994).

Likewise, stakeholders emphasized the notion of “choice” through their framing of health issues in the city and in the specific messages they imparted to youth, most notably in the *You Have Choices!* materials. When I interviewed Elizabeth Randolph at Stockton’s branch of Continuum Health Services she told me, “Our mantra’s always been around choice and your choice.” I asked if she meant that was her mantra or the organization’s, and she replied, “Both, I mean, people who work for us generally have a—you know—certainly we’re not advocates of teen pregnancy. We want to make people aware of their choices and make educated decisions for themselves.” Here Elizabeth is likely referencing that many of her staff would consider themselves “pro-choice” in the liberal feminist notion of the freedom to choose abortion, but she also feels compelled to point out that they were “certainly not” supportive of the choice to become pregnant at a young age.

My interview with Mayor Brown exemplified a different—but similarly ironic— notion of choice rhetoric. As I set up my recorder in his handsome, wood-paneled office



at City Hall, I noticed Elaine Brown's memoir "A Taste of Power" on the shelf along with what I presumed to be books from his undergraduate studies. While discussing inequalities in the city, I mentioned the emphasis of "choice" at the recent National Day rally and asked Brown his thoughts on promoting choice in a situation of marked socioeconomic inequalities. In a sudden shift, he responded, "I mean, I wouldn't completely agree with your assessment, but I think they do have choices. You can be poor and you can be going to the public schools and you can do well in your pathway out of poverty for your family or for yourself. Obviously, it's to finish school and hopefully go onto college." Later on, I reflected on the dissonance between this Horatio Alger-style notion of social and economic progress and the Black Panther Party's anti-capitalist, anti-racist, and anti-imperialist philosophy. Despite acknowledging that myriad social and economic inequalities affected city residents, Brown framed solutions in terms of individual personal responsibility rather than political transformation and redistribution of social goods. Additionally, as Ana Gutierrez pointed out in Chapter 3, there is a certain irony in Brown's own success story as a white man who grew up poor in Stockton.

The appropriation of "choice" rhetoric in this context is noteworthy for two reasons. First, youth sexual promoters are not promoting increased access to *all* sexual and reproductive choices; only certain choices are valid and acceptable. The choices to intentionally parent young, not use contraception, and/or engage in "promiscuous" sex are not among the choices they promote. Neither is the choice to have an abortion, which, ironically, is the most common usage of choice rhetoric surrounding sexual and reproductive health (Luna & Luker, 2013). Second, the ubiquitous *You Have Choices/Tienes Opciones!* slogan is contradictory given that not all young people—

especially low-income youth of color—have “choices” in a city replete with structural violence. Many youth in Stockton and elsewhere do not have access to quality healthcare, freedom from violence, good schools, meaningful employment opportunities, and so on. The rhetoric of “choice” appeals to neoliberal logic—we are, ostensibly, freely choosing autonomous actors in the private marketplace of choices—and conceals the fact that many young people in communities like Stockton don’t have such choices. This rhetoric shifts the responsibility away from the state to the self-governing neoliberal actor who is invited to make (particular, acceptable) choices. Telling youth that they have choices does not make it so. The inspirational speaker at the National Day rally illustrated this shift—and it’s raced and classed meanings—when he asked the students, referring to the more white, wealthy “Heights” neighborhood of the city, “I understand that uptown is where the people that got money live? You know what separates y’all from uptown, right? The choices you make. That’s it.” Thus, race and class inequalities, along with early childbearing, are reduced to a result of “the choices you make.”

### **Producing Science in Stockton**

#### **Particular and Authoritative Ways of Knowing**

This discussion of how youth sexuality is produced in Stockton offers a useful backdrop for understanding how sexuality is implicated in the uptake, reproduction, and deployment of scientific discourses. As with sexuality, sociologists and historians of science point to the ways in which “science” is not merely an apolitical, value-free process of “discovery,” but rather is imbricated in the production of particular knowledges, truths, and bodies (Harding, 1986; Guba, 1990; Oakley, 2000; Sprague, 2005). As with sexuality, I want to emphasize the ways in which scientific discourses can

redirect attention away from structural violence and reduce “sexual health” to an individual matter. Scientific discourses primarily emerged through the constellation of work comprised by the PASH Network, *Teens Count* initiative, and the SASHPC. In the fall of 2013, this work coalesced into a series of “Collective Impact” meetings populated by numerous stakeholders in the city. The email invitation to the first of these meetings addressed the invitee as a “community champion in adolescent sexual health” and asked them to participate in a “high impact collaboration to improve the sexual health of youth.” It noted that determined community partners were already taking “bold steps to begin to develop a high impact sustainability plan to fundamentally change how our communities address the high rates of teen births and sexually transmitted infections among youth.” The invitation went on to state that this new collaboration would include “community partners from diverse sectors” including youth leaders, PASH Network members, SASHPC, and federal/state teen pregnancy prevention initiatives to “merge their collective strength into one highly disciplined, coordinated, collaborative group” and concluded by proclaiming that “by addressing teen pregnancy and other adverse sexual health outcomes, we will help eliminate barriers so that youth can reach their full potential.”

As I entered the corporate meeting space to attend the first of these meetings, Malta Brigado’s cheery assistant greeted me and gave me a nametag that said “sexual health superhero” under my name. The meeting room was set up with chairs in an oval shape and featured side tables set up with refreshments including cheese, crackers, fruit, coffee, and water bottles. Under each seat was a “goody bag” containing noisemakers, candies, and a mug with the PASH Network logo on it. The walls were covered in posters

from various PASH Network events and included foam core standouts of slides from Malta's ubiquitous power point. As participants milled about, some in scrubs, some in jeans, others in suits, smooth blues music could be heard from the overhead speakers. I could not discern the objective of the elaborate set up. Was it an attempt to make yet another meeting at the end of a long workday more pleasant for the participants? Was it part of the "cheerleading" strategy Malta often employed, a sort of reward for all the "sexual health superheroes" who were engaged in valiant battle against teen pregnancies and sexuality transmitted infections?

Several months later, when analyzing my fieldnotes, I wrote about this day: "this was truly the weirdest meeting I've ever been to." A peculiar blend of management science lingo and vague social justice talk mixed with cheering and using cheap plastic noisemakers at any mention of decreasing teen birth rates. A large group of professionals working in youth sexual health promotion giggled when a participant described a "success story" in which after completing a comprehensive sexual health curriculum, youth in the community were now able to say the words "penis" and "vagina" aloud without laughing. Stakeholders lauded the importance of recognizing the structural factors, and poverty in particular, that contribute to problems in the community, but discussed only individual level solutions. Numerous data points were shared without context or elaboration of their significance, statistical or otherwise. At one point, the external facilitator from a consulting firm made all of the participants get out of their seats and dance to Teddy Pendergrass's song, "Wake Up Everybody" while he shouted, "Say hello to the new collective impact team!!" All the while, a narrative of progress

wove together seamlessly with a narrative of science to prompt continual cheerleading of the work.

All of this combines to illustrate how knowledge of youth sexual promotion in Stockton is produced in particular, authoritative ways. As I've highlighted in previous chapters, "what everyone agrees" to be true about youth sexuality in the city ranges from the pathology of teen pregnancy to the essential elements of the Latino culture narrative. Taken for granted beliefs surrounding disease, risk, gender, identity, and community norms become certain facts. Who is qualified to produce authoritative knowledge is intimately connected to social power. For example, "storytelling" from young people is distinguished from "facts" from service providers. Circuits of knowledge flow in particular ways: the connection between the teen birth rate and poverty was thought to "speak for itself," Stockton youth were produced as unquestionably "at risk" (which is also a racial code), and the focus on health disparities began to shift from a structural to a *cellular* level in the form of a growing interest in epigenetics, the subject of a well-attended session at the PASH Network conference. The particular and authoritative knowledge of the science of youth sexual promotion is prominent in the circulation of the "causal fantasies" in Stockton, to which I now turn.

### **Causal Fantasies**

As Norman Denzin (2008) suggests, the politics of research evidence are a question of "who has the power to control the definition of evidence, who defines the kinds of materials that count as evidence, who determines what methods best produce the best forms of evidence, and whose criteria and standards are used to evaluate quality evidence" (p. 62). In Stockton, stakeholders utilize what I term "causal fantasies" to

validate certain kinds of knowledge and forms of evidence while ignoring others. This is both a discursive and strategic move, as it enables the TPPIC to codify taken for granted truths while reproducing the structure of its own internal coherence. For example, stakeholders overlook the equivocal data on outcomes of teen childbearing (and certainly the evidence showing *better* outcomes) as well as research showing that most teen parents drop out of school before becoming pregnant (rather than the widespread belief that teen pregnancy causes school drop out). At the same time, professionals employ causal fantasies that enable them to naturalize claims about causality and youth sexual health. The most prominent of these are stories in which taken for granted truths and assumptions are made into undisputed *facts*. This sort of magical thinking about the causes of teen pregnancy conveniently ignores science *while at the same time* relying on it to legitimize particular truths. For example, teen pregnancy is caused by daylight savings time, not having a movie theater in town, experiencing a lack of love, school suspensions, and not going on LARC—all causal stories I heard during my fieldwork.

The magic recipe of comprehensive sex education, contraception, and “hope” is key to causal fantasies in that it is the primary policy and practice strategy in the city, despite the large body of research suggesting that structural factors have much stronger explanatory power for teen births (Crosby, 2006; Kearney & Levine, 2012; Penman-Aguilar, et al., 2013). Even though most stakeholders acknowledged, or at least alluded to, the social and economic inequalities that affected teen pregnancy in Stockton, they nonetheless focused their efforts (and their self-congratulations) on strategies such as increasing the uptake of comprehensive sex education curricula in the public schools and community-based organizations and increasing the number of teen on LARC. For

example, the invitation to the Collective Impact meetings proposing a “high impact collaboration to improve the sexual health of youth” framed teen pregnancy and “other adverse sexual health outcomes” as barriers to eliminate in order for youth to reach their full potential. Similarly, SASHPC’s vision statement includes “developing a citywide system that gives our youth hope for the future and opportunity to reach their goals.” Yet, strategies such as those in the umbrella Collective Impact group’s “common agenda,” included decreasing the incidence of teen births, STIs, and HIV infections; enhancing health promoting knowledge, attitudes, behaviors and intentions; and increasing access to sexual health services, the high school graduation rate, and the number of youth reached by evidence-based programs—all of which may be related to inequality, but do not address the structural issues that create inequalities in the first place.

A session at the 2013 PASH Network annual conference titled “Exploring an Ecological Model Approach to Teen Pregnancy Prevention” illustrates the causal fantasy that focuses on individual level solutions to structural level problems. The facilitators stressed that teen pregnancy was the “symptom of a larger problem” and that macro-level solutions, such as factors the policy environment, “protect” youth from teen pregnancy. In a brainstorm on structural factors to address teen pregnancy in the community, the audience offered “inspire hope,” “mentoring,” “show youth other options,” “good experiences,” “college tours,” “believe in young people,” “be part of the process of change,” and “provide parameters and expectations,” which the facilitators pointed out were all individual level strategies. This session is demonstrative of how stakeholders in Stockton spoke quixotically about “giving” the young people in Stockton “access to hope and opportunity,” but failed to translate this into actionable policies or programming. In

this way, causal fantasies disregard structural oppression—you can't "create" hope and opportunity, especially in a neoliberal era of immense wealth disparities, a disappearing (or already disappeared) social safety net, and vastly changed economic structures. Sitting through lessons on recognizing the symptoms of Chlamydia and Gonorrhea or having an IUD inserted cannot create opportunities for meaningful employment, access to quality, affordable education or healthcare, or freedom from interpersonal and state violence.

Consider the following examples of causal fantasies I encountered during my fieldwork: "Young people will use birth control if they know they have a good job in the future," "Parents should say to their children, 'don't have sex so that you can graduate from high school,'" "Students in band and chorus don't have to take health class so they might get pregnant," "We need community members to say to their kids 'you're not going to have sex, you're going to go to school!,'" and "Young people in gangs have babies." In the SASHPC conversation I recounted in Chapter 5, in which Mayor Brown alluded to racial disparities in high school suspension rates, the discussion came back around to what stakeholders saw as a correlation between high suspension rates and high teen pregnancy rates. Beth Emmerson rhetorically asked, "What are they doing in those 25 days of suspension!?" and at once I heard responses such as, "Having sex!" and "Making babies!" This notion seemed to be a general consensus among the group: similar to daylight savings time, when students are suspended, not only are they missing out on the magic bullet of comprehensive sex education but ostensibly have more free time for promiscuous sex. However, since research suggests that boys account for the majority of students who are suspended from schools on any given day (Skiba, et al., 2002; Wallace,



et al., 2008) it is unclear how suspension rates could so directly result in increased pregnancies—obviously, the boys are not getting each other pregnant, and LGBTQ youth were specifically not included in TPPIC youth sexual health promotion efforts. Again, this causal fantasy disregards that teens may have sex because sex is fun and pleasurable (not simply because they are bored) while assuming that all sex has procreative potential, inevitably resulting in pregnancies and births. There are many opportunities here for a conversation about the effects of structural violence (racism in schools, policing of different bodies/genders, the poor quality of the educational system) but the discussion is reduced to individual behaviors, that is, if you must have sex, don't get yourself or anyone else pregnant.

Stakeholders perceived themselves as engaged in a bold battle against teen pregnancy and STIs in the form of a causal fantasy that attributed the decline in teen birth rates in Stockton directly to their work. After a long delay in releasing data for the years 2011 and 2012, in the fall of 2014 the state department of public health finally released vital statistics data showing that the teen birth rate in Stockton had fallen from 83.6 births per 1,000 women ages 15-19 in 2010, to 68.3 per 1,000 in 2011, and to 57.1 per 1,000 in 2012, representing a 32% drop from 2010 to 2012. At the December 2014 SASHPC meeting, which also served as a good bye party for Hannah McNeil, who was stepping down from her role as commission of the Stockton board of health, stakeholders celebrated the 32% decrease as a direct result of not just the work of the committee but specifically Hannah's leadership, prompting the city to proclaim December 2<sup>nd</sup> "Hannah McNeil Day" in Stockton. While the activities of SASHPC and the partners of the *Teens Count* initiative likely had some degree of impact on teen pregnancy in the city, there is

no way to establish a direct causal effect, much less the *magnitude* of that effect. Teen birth rates have been on the decline in Stockton, the state, and the country for many years. In the same period as the acclaimed 32% drop in Stockton, teen births fell 18% in the state overall and 14% in the United States as a whole (Ventura, et al., 2014). In fact, during this period the rate dropped in all but two of the top 25 ranked cities in the state, none of which had the same large federal grant that Stockton and Carlsborough did. Moreover, the rate decreased 28% from the years 2008 to 2010, *preceding* the Teens Count initiative, and thus was similar to the 2010-2012 decrease attributed to stakeholders' work.

A number of factors influence teen birth rates at the population level, including shifting fertility patterns more generally: the age at first birth has steadily increased for women in all racial and ethnic groups (Hamilton, et al., 2015). Additionally, teen birth rates are influenced by a variety of changes such as increased healthcare access under the Affordable Care Act, changes in the economy, changes in norms around condom use and safer sex, and easy access to information via the Internet (Boonstra, 2014). The lack of research at the city level to explain teen birth rate decreases allows stakeholders to create stories that fit their narrative of progress—that is, to imagine a direct causation between their work and the changing rates. The work of the *Teens Count* initiative may very well be correlated with this decline, but is not a necessary or sufficient causal explanation for the 32% drop in the teen birth rate. To fully explain the drop we would need to look at other intervening variables that affect the teen birth rate, data that does not exist at the city level.

Data is, of course, integral to public health practice. Data is also implicated in how scientific discourses “make up” individuals and populations (Hacking, 1986/2002), thus influencing the strategies that health promoters employ to achieve their objectives. Alan Petersen and Deborah Lupton (1996) describe the biopolitical workings of epidemiology as a process of “governing by numbers.” The construction of epidemiological “facts” produce the “normal” subject; that is, those who fall within the normal distribution of health determinants or status (Petersen and Lupton, 1996). For example, how one comes to be “made up” as a teen parent through epidemiological surveillance is historically and culturally variable, which current and former teen parents readily acknowledge. For example, Lourdes Navarro, the Educational Director at the Towne House, who had her first child at age 18, shared how she did not know she was a “teen” parent until her children were adults! In the same way, students at The Towne House questioned why they were still considered “teen” moms as 18 or 19-year-old adults. Shifting fertility patterns and norms contribute to the process of making up pregnant teens, and these patterns also take on raced and classed meanings; that is, white middle-class or married teens often escape the label of “teen mother.” Although the majority of teen births occur to women aged 18 and 19 (who are therefore legal adults) (Ventura, et al., 2014), data on teen birth rates, nationally and in Stockton, is generally aggregated as rates among young women aged 15-19, thus inflating the rate and the governance it enables.

While stakeholders tout the importance of “being grounded in the data” and largely believe, as the *Teens Count* external consultant put it, “if it can’t be measured, it’s not on the agenda,” they fail to recognize how data constructs what is and can be known

about youth sexuality and teen pregnancy in Stockton. For example, in TPPIC reports, presentations, and individual interviews there is a constant conflation of and slippage between “teen birth” and “teen pregnancy” rates. These slippages work as a tactic of data massaging that makes invisible abortion and the complicated social experience of resolving an unintended pregnancy (Mann, et al., 2015). Even Malta Brigado, who clearly valued data and often spoke in numbers, frequently exhibited this slippage, as she did when describing the *Teens Count* project at the first Collective Impact meeting: “the purpose of the initiative is to reduce teen birth—er, um—teen pregnancy.” That teen pregnancy and teen birth are frequently conflated in Stockton is indicative of the silence surrounding abortion among policymakers and service providers: abortion access is not seen as part of a strategy to reduce the teen birth rate. In addition, although stakeholders spoke almost constantly about the declining rates in Stockton, they were always careful to note that there was still a problem in the city, that is, racial disparities. While I do not disagree that racial and ethnic disparities in teen births rates exist and are meaningful, the emphasis on racial disparities is in part a discursive move: the teen pregnancy industrial complex needs a problem to fix in order to sustain itself. As a teen parent said in the Stockton High-produced teen pregnancy prevention video, “The teen pregnancy rate in Stockton is decreasing, but everyone agrees that it is still much too high.” However, absent from the focus on racial disparities in teen pregnancy rates was any discussion of or action plan to address the structural causes of racism that exacerbated these disparate rates.

Additionally, despite equivocal research on the outcomes of teen parenting, stakeholders cling to a view of teen parenting as always already bad for the parents, their

children, the community, and the city itself.<sup>8</sup> As I discussed in Chapter 1, the commonly held belief that teen pregnancy and parenting are wholly detrimental does not hold up under scrutiny. In addition to reversing the causal relationship of teen pregnancy and school drop out—stakeholders presume that pregnancy causes students to drop out, whereas as research illustrates how stigma and insufficient school resources push pregnant and parenting teens out of school (MATP, 2010; Pillow, 2004)—the relationship between poverty, inequality, and teen pregnancy was frequently muddled. Whereas a growing body of research indicates that poverty and inequality are key contributors to teen pregnancy rates (Kearney & Levine, 2012; Penman-Aguilar, et al., 2013), stakeholders largely saw it as the other way around. The inequalities in employment, income, and opportunity facing Stockton were often attributed to the rates of teen pregnancy and parenting in the city; as Clarisa Ortiz put it, teen pregnancy was “obviously expensive” and “really downgrading our city.” Even young mothers themselves tried to distance themselves from this stigma, as when a Towne House student shared during a digital storytelling workshop that she wanted to move out of Stockton due to its association with teen pregnancy. During the course of my fieldwork, I heard teen moms blamed for practically all of what ailed the city; at times it seemed like pregnant teenagers were to blame for the decline of manufacturing itself. Not only are the negative effects of teen childbearing amplified or distorted, the discussion also ignores qualitative research with young parents, which often paints a very different picture (Wilson & Huntington, 2006). Notably, with the exception of Malta Brigado, who was

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<sup>8</sup> As one example, Beth Emmerson’s dissertation research omitted citations that complicate the unequivocal pathology of teen pregnancy.

quite moved by the event, no TPPIC stakeholders attended the Stockton community forum where we showed digital stories and teen mothers spoke to service providers on their own terms. While we should caution against, as Ana Gutierrez noted in Chapter 3, a romanticization of teen parenting as necessarily empowering or emancipatory, we should also notice the downplaying of its rewarding and positive aspects as part of the stigma that surrounds prevention efforts, from national campaigns to the Stockton High teen pregnancy prevention video described in Chapter 4. Although teen parents have a complicated relationship to the stigmatizing discourses of teen childbearing (Barcelos & Gubrium, 2014), for the most part they understand having children young as what “saved” their life, rather than the commonly held assumption that it “ruined” it. Yet, in the causal fantasies of the teen pregnancy prevention industrial complex, teen pregnancy and parenting is always already, and must forever be, entirely bad.

### **Making Proud Science**

Although stakeholders disregard the evidence on equivocal outcomes of teen pregnancy and parenting, they highly value and promote “scientifically” or “evidence based” comprehensive sexual health education (CSE). In 2010, a 7-3 vote among members of the school committee approved an expanded sexual health education curriculum allowing for the implementation of CSE in the Stockton public schools. Stakeholders regarded this move as one of the major victories for “sexual health superheroes” in the city, as CSE was seen as a key factor to reduce teen pregnancy in the city; increasing CSE in Stockton was included in the mission statements of SASHPC, *Teens Count*, and the PASH Network. Proponents of “scientifically based” or “comprehensive” sex education position the superiority of this approach in contrast to its

much-maligned (in public health circles, at least) predecessor “abstinence-only until marriage” (AOUM) instruction. As a policy strategy, AOUM was birthed by the 1996 welfare reform act that decimated the safety net for poor women and their children and appropriated billions of dollars into programs that taught young people that “abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems” and that “a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexuality activity” (SEICUS, 2015a). Conversely, comprehensive sex education is comprised of programs that “include age-appropriate, medically accurate information on a broad set of topics related to sexuality including human development, relationships, decision-making, abstinence, contraception, and disease prevention” (SEICUS, 2015b). “Scientifically-based” refers to curricula that have undergone rigorous evaluation and been found to have statistically relevant outcomes on metrics such as delaying the onset of intercourse, reducing the frequency of intercourse, reducing the number of sexual partners, and increasing condom or contraceptive use (Kirby, 2007; Kirby, 2008; SEICUS, 2015b). The various initiatives created by the changes in federal funding for sex education made under the Obama administration make receipt of funds predicated on the use of these externally evaluated, replicable curricula (SEICUS, 2015c).

As Jessica Fields (2008) so eloquently argues in her ethnography about sexual health education in schools, the fight between “abstinence only” and “comprehensive” approaches to school-based sex education works to both elide and reproduce social inequalities. The parents, educators, and committee members Fields interviewed who advocated for comprehensive approaches utilized similar rhetoric to stakeholders in

Stockton in that they framed the sexuality of young women of color as risky and dangerous to themselves, their potential children, and the community at large. Positioning young people this way enables the promotion of CSE through a savior mentality—they need science to liberate them from the dangers of sexual activity. Fields notes that advocates for comprehensive approaches used raced, classed, and gendered rhetoric that replaced conventional social policy stories about the welfare queen with stories about girls whose parents failed in their job of educating them about sex, therefore requiring the school to step in. The racialized rhetoric of “children having children”—which Superintendent Cruz used in his National Day remarks—even convinced some abstinence-only advocates in Fields’ research to switch their minds in favor of a comprehensive approach to order to “save” these kids. Fields (2008) deftly illustrates how the emphasis on the merits of abstinence versus comprehensive approaches “constrains the possibilities that educators, policymakers, students, families and researchers imagine” (p. 166). This focus obscures the ways that both approaches reflect and reinforce social inequalities. As she writes:

An exclusive concern with school system policies obscures several more complicated issues: the silence regarding gay, lesbian, and bisexuality; the affirmation of conventional gender roles and hierarchies in teachers’ and students’ sexual lives; the assertion of bodily norms that marginalize people of color and people with disabilities; the frequent harassment of women and girls; and the absence of a consistent discourse of agentic sexual subjectivity in young people’s lives (Fields, 2008, p. 167).

That stakeholders in Stockton attributed such importance to CSE is indicative of a selective view of which sexual scientific knowledges and outcomes matter. For example, in the Stockton High teen pregnancy prevention video I described in Chapter 4, Hannah McNeil told the viewers:



It's so important because knowledge is power. And without the knowledge about sexual health, they *are* apt to make poor choices. By undergoing these science, evidenced-based programs which are proven to reduce, um, the incidence of teen pregnancy, then I think that there's no question as to the benefit of students being exposed to it.

Here, science is knowledge and knowledge is power, teens are the passive recipients of public health programming, and without the knowledge bestowed upon them, they will make the “wrong” choices. In arguing for CSE, McNeil and other stakeholders in the video, including Beth Emmerson and Greta McNally, position AOUM as unscientific and “backwards,” out of line with the scientific progress narrative. As Fields (2008) reminds us, however, there is much to critique about comprehensive approaches as well—simply because they are based in “science” does not mean that they avoid reproducing ideas about sex as inevitably risky and dangerous, disregard pleasure and desire, position young women as defenders of sexual purity, erase queer and gender-nonconforming youth, and avoid reproducing racist tropes about the pathological nature of reproduction among women of color. In addition to reducing the incidence of teen pregnancies and STIs, outcomes measured by CSE experimental or quasi-experimental evaluations prioritize behavioral outcomes such as “reducing the frequency of sex,” “reducing the number of sexual partners,” and “using condoms or birth control,” as well as attitudinal outcomes such as “perceived efficacy of condoms in preventing pregnancy,” “condom hedonistic beliefs,” and “perception of severity of pregnancy and childbearing” (Kirby, 2007).

The science of CSE thus includes only certain types of research and particular ways of knowing about the world. Qualitative methods or non-positivistic epistemologies

are not part of these government-sponsored hierarchies of evidence<sup>9</sup> (Denzin, 2008; Raphael, 2000). Philosopher of science Maya Goldenberg (2006) argues that the elimination of certain types of research is a political move that makes power relationships seemingly disappear. She suggests that because scientific theories are underdetermined by data, scientists must assume “extraempirical” criteria for evaluating evidence—criteria that are “subject to the whims, preferences, biases, and social agendas” of researchers (Goldenberg, 2006). Moreover, the narrow prescription of what constitutes evidence negates lay knowledge (Popay & Williams, 1996) and the socially embedded ways in which most community health practitioners conduct their work (Labonte and Robertson, 1996). Policy and practice in public health is inescapably tied to morality and values in a way that belies the notion of apolitical evidence-based policymaking and practice (Buchanan, 2000). “Science engages with busy minds that have strong views about how things are and ought to be” (Marmot, 2004, p. 906). Health promotion does not occur in a vacuum; it is greatly influenced by the norms and values held by various constituencies and not solely by “factual” evidence. Policies and programs are developed and implemented in disparate ways depending on social constructions of target populations as deserving or undeserving, good or bad, and strong or weak (Fraser & Gordon, 1994; Schneider & Ingram, 1993). Such examples of “embedded science” (McClelland & Fine, 2008) do not evaluate objective knowledge but rather produce and legitimate what must be known in order to effectively manage the population.

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<sup>9</sup> Here Denzin is referring to the federally funded National Research Council evidence-based movement, which argues that, “educational, health care, and other social problems can be better addressed if we borrow from medical science and upgrade our methods and create new gold standards for evaluating evidence.” See Denzin, 2008, p. 63.

Two of the scientifically based comprehensive curricula in use in Stockton public schools, “Making Proud Choices” and “*¡Cuidate!*,” reveal their value-laden assumptions even in their names. “Making Proud Choices,” a program designed for urban African American youth ages 11-13, acknowledges that abstinence is the “best choice,” but also “emphasizes the importance of condoms to reduce the risk of pregnancy and STIs, including HIV, if participants choose to have sex” (Advocates for Youth, 2008). Notwithstanding the fact that, as a small city in a semi-rural part of the state with a population that’s roughly half Latinx, Stockton does not at all match the target population for this intervention, the curriculum continues the trope of proper choices in an environment full of unacknowledged constraints. Sex is positioned as risky and dangerous: the first half of the 14-week curriculum focuses on the “consequences of sex,” framed as disease and pregnancy. The latter half focuses on strategies to prevent STDs and pregnancy through “refusal and negotiation skills.” “Making Proud Choices” also includes a theme of “protecting the family and community” as a motivation for having safer sex. The creators position this theme as a way to shift the “traditional exclusive focus on individualistic HIV/AIDS knowledge and individualistic attitudes toward risky behavior” (Advocates for Youth, 2008). Yet, the burden for protecting the family and community falls on the individual teens themselves, without an acknowledgement of the myriad structural factors, such as poverty, racism, homophobia, and sexism, that contribute to HIV transmission (Farmer, 1996; Holtgrave & Crosby, 2003; Jeffries, et al., 2013). The curriculum positions high rates of STIs and teen pregnancy as a result of young people’s inability to “express their sexual feelings in a responsible or accountable way.” Similar to the rhetoric of *You Have Choices/¡Tienes Opciones*, “Making Proud

Choices” frames “sexual responsibility” solely in terms of choosing abstinence or using condoms.

Stakeholders loved “*¡Cuídate!*,” or “Take Care of Yourself!,” for its specifically Latino-focused approach, although since most of them did not speak Spanish, they often had a difficult time pronouncing it. According to its creators, “*¡Cuídate!*” is a “cultural and theory based HIV sexual risk-reduction program designed specifically for Latino youth” (Villarruel & Eakin, 2008, p. 3). Similar to “Making Proud Choices,” the curriculum stresses abstinence and condom use; among the goals of the program are to “highlight cultural values that support safer sex practices and reframe cultural values that are perceived as barriers to safer sex,” including *familismo*, *respeto*, and *personalismo* (family, respect, and interpersonal relationships) (Villarruel & Eakin, 2008, p. 5). The Latino cultural value of *machismo*, or as the creators define it, an emphasis on men’s power through strength and control in decision-making, is reframed as the values of caring and taking responsibility for yourself and others. Put another way, the curriculum tells men that they can refocus hegemonic masculinity into appropriate caretaking behaviors. Similarly, the cultural value of *marianismo*, which the creators state expects women to stay virgins until marriage, have children, and be devoted to their husbands, is reinforced to “encourage young women to consider condom use and refusal of sex as ways of protecting themselves” (p. 7). Put another way, the curriculum tells women to comply with compulsory heterosexuality and deny their own desires as a way of protection. The designers acknowledge the heterogeneity of “Latino” culture and Latinos themselves, but nonetheless offer a curriculum based on presumed shared cultural values that does not challenge, but rather reframes, sexism and heterosexism through a focus on

individual behavior in the form of condom use and refusal of sex. In addition to flattening “culture” and disregarding the impact of social and political inequalities, the curriculum focuses on the most conventional or stereotypical Latinx cultural values (i.e., family, masculinity, respect) and fails to incorporate other values also prominent in Latinx cultures (i.e., anti-colonialism, economic justice) that would have considerable impacts on sexual health.

Stockton youth who, in Hannah McNeils’ words, “underwent” these scientifically based curricula most likely learned some important knowledge and skills. But as Jessica Fields reminds us, we ought to not only consider what sex education might *prevent*, but also what it *promotes*. In “asking more” of sex education, Fields redirects our attention to the generative capacity it has to shape the social, collective, and individual experiences of sexuality. What would it look like if sex education in Stockton were reframed with Michelle Fine’s notion of “thick desire” that understands sexuality for all people, across age, gender, or sexual orientation, “within a larger context of social and interpersonal structures that enable a person to engage in the political act of wanting?” What would it mean to theorize policymaking and programming “not merely from a perspective of minimal loss, but from a perspective that sees [young people] as entitled to desire in all of its forms; entitled to publicly funded enabling conditions across racial, ethnic, class, sexual, geographic, and disability lines” (Fine & McClelland, 2006, p. 325)? In other words, rather than cloaking sex in science as to make it appear apolitical, what would happen if sexuality in Stockton was understood as constituted by and mediated by social, economic, and political factors?

## The Progress of Sex and Science

At one Collective Impact meeting, the external facilitator called us back to our seats following a small group activity by exclaiming, “Why are we here? Because we’re making tremendous progress!!” He also told us that the “shared indicators” of success found in our “common agenda” were the “holy grail” of progress. These shared indicators included metrics like “number of youth reached by evidence-based curricula” and “number of condoms” distributed. As I endured these meetings, I often found myself wondering how many of those students saw their lives, bodies, and desires reflected in the lessons they sat through. I wondered how many of those condoms were actually used, how many were used correctly, and how many young people gained the skills to effectively negotiate condom use in consensual, pleasurable sexual activity.

The marriage of sex and science in Stockton does similar work as the Latino culture narrative and the ideology of colorblindness described in Chapter 5: it both produces and constrains what is and can be known about youth sexuality. The deployment of sexual and scientific discourses in Stockton is ultimately about notions of progress, and this discourse mutually constitutes itself. Progress links sexuality to science by positioning a reduction of the teen birth rate as integral to the social and economic progress of the city, as illustrated by Mayor Brown’s 2013 National Day comments: the youth in the city will progress by having “hope,” not getting pregnant, and going on to have a normative, heterosexual, middle-class life course while the professional stakeholders progress in their work as sexual health superheroes by making this happen. In this way, wrapping sex in science not only makes it appear asocial and apolitical, it also reproduces the teen pregnancy prevention industrial complex itself. It enables

stakeholders to extol the importance of structural factors impacting the health of people in Stockton while continuing to focus their efforts on individual behavior change strategies and self-congratulation.

I follow McClelland and Fine (2008) in arguing for a “critical sexuality science” that “suspends the ‘givens’ of adolescent sexualities.” This science would not hide inequality in the language of “giving” hope and opportunity, but instead acknowledge the embodiment of “sexual subjectivities situated in larger yearnings for a life of economic, intellectual, and civic possibilities” (p. 67). In “asking more,” a critical sexuality science dares to interrogate that which is always already assumed. It does not merely aim to prevent certain outcomes but instead promotes agentic sexuality for all people. The productive power of a critical sexuality science lies in its potential to fully respond to the complexities of sex in a world marked by power imbalances.

## CHAPTER 7

### TOWARD A VISION OF SEXUAL AND REPRODUCTIVE JUSTICE IN STOCKTON

Although I reject the notion of “the field” as something “out there” that you “return” from when fieldwork ends, in the fall of 2014 I concluded active data collection in Stockton in order to focus on the analytic and writing aspects of this project. While I continued to follow the teen pregnancy prevention industrial complex through the news media and various professional listserves, this departure represented the first time in seven years that I was not working in Stockton in some capacity. With this distance, I found myself thinking of the work in Stockton as the sort of montage that ended each season of HBO’s acclaimed series *The Wire*. Set in Baltimore, the series is notable for its trenchant examination of how social, political, and economic institutions including law enforcement, the criminal justice system, the school system, public health, and the media fail both the urban poor and the professionals charged with serving them. According to Anmol Chaddha and William Julius Wilson (2011), *The Wire* illustrates how:

Individuals’ decisions and behavior are often shaped by — and indeed limited by — social, political, and economic forces beyond their control...*The Wire* develops complex characters on each side of the law who cannot be placed in unambiguous moral categories — neither castigated for criminal pathologies and the absence of mainstream values toward work nor valorized as one-dimensional hapless victims of society’s cruelty who should command endless liberal sympathy (p. 165).

The montages that end each of the show’s five seasons depict “business as usual” continuing within the city, despite whatever major cases and minor side plots have been resolved: cops continue to bust drug dealers, some drug dealers go to prison while new ones take over their corners, some addicts get clean while others pick up a habit, public servants continue to struggle to do right by the people they serve, youth continue to



struggle with interpersonal and structural violence.

Of course, Stockton is not Baltimore, but the dynamics of the TPPIC bare some similarities to the idiosyncrasies of the law enforcement, drug trade, and politics depicted in the show: there are not distinct good guys and bad guys (everyone is both), people are muddling through doing the best they can given the constraints under which they must work, and the more things change, the more they stay the same. In a similar way, shortly after I ceased active fieldwork in Stockton, some of the characters and circumstances shifted, but the work of the teen pregnancy prevention industrial complex carried on as usual. The culmination of my data collection coincided with several major changes in the city. Malta Brigado left her position as Executive Director of the PASH Network and moved out of state; Hannah McNeil retired from the Stockton Board of Health and moved to a whiter, more affluent neighboring town; the Stockton public school district was placed under state receivership for being “chronically underperforming,” meaning Genario Santos Cruz was ousted as superintendent<sup>1</sup>; Kristina Myers left her position as a high school health clinician and returned to midwifery practice, and so on. Most notably, the 5-year \$1.1 million *Teens Count* initiative ended, and the collection of initiatives carried on loosely and without funding.

With this montage in mind, I want to step back from the details of next season’s “plot” and theorize some implications of the teen pregnancy prevention industrial complex in Stockton. In this chapter I synthesize key findings from my project through the lenses of neoliberalism, whiteness, and middle-class professionalism. Examining the

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<sup>1</sup> He was later appointed superintendent in a major US school district and immediately removed when allegations surfaced of abuse against disabled students in one of Stockton’s elementary schools.

TPPIC through these lenses allows us to understand how the imbricated forms of power operating in Stockton might be opened up to make more space for a critical public health practice. Next, I provide brief case studies of two youth-led organizations working on issues of sexual and reproductive justice: *Forward Together* (national) and *FIERCE* (New York City). I use these case studies to consider how moving toward a sexual and reproductive justice framework can shift the discursive context of youth sexual health promotion in Stockton. Finally, I describe how reframing community health work in Stockton with a vision of reproductive justice enables new ways of knowing and doing that account for multiple and intersecting systems of oppression and envision new forms of agency for marginalized sexual subjects.

### **The Twilight of Health Disparities?**

Neoliberal logics organize and sustain the teen pregnancy prevention industrial complex in many ways. The economic logics of neoliberalism that promote free trade policies and privatization helped to decimate the manufacturing industry and contribute to an upward redistribution of wealth and resources. These changes are felt throughout the world, and acutely in Stockton, as the manufacturing economy has disappeared without a replacement and public assistance benefits are continually reduced or restricted. Meanwhile, the cultural logics of neoliberalism promote personal responsibility and “choice” to privatize the effects of systemic inequalities on to individuals (Duggan, 2003). As countless scholars have shown, neoliberal logics now structure much of social and political life, ranging from the experiences of gender (Gill & Scharf, 2011) and sexuality (Conrad, 2014; Duggan, 2002; Edelman & Zimman, 2014) to health promotion (Ayo, 2012) and schooling (Davies & Bansel, 2007).

The rhetoric of “choice” utilized by the TPPIC in Stockton, most notably in the ubiquitous *You Have Choices/Tienes Opciones!* slogan, and the promotion of individual behavior change (e.g., using LARC) for remedying systemic inequality (e.g., racial health disparities) are hallmarks of neoliberalism. The ineffectiveness and ethical implications of promoting individual behaviors to address structural problems is a widely acknowledged, yet seemingly intractable, problem in health promotion (Buchanan, 2008), one that is enabled, bolstered, and sustained by neoliberal logic. This logic allows the TPPIC to emphasize high teen birth rates, low high school graduation rates, and large numbers of families living in poverty—all consequences of inequality—but privatize responsibility for these inequalities by distributing condoms and hope. Further, it allows the TPPIC to portray young people in Stockton as freely choosing, autonomous actors who are unconstrained by power relationships and material realities: they “choose” to (not) use contraception, (not) become teen parents, (not) go to college, (not) be single parents, (not) be poor, and so on. As a result, stakeholders are able to consolidate the need for their professional roles in health promotion and obscure their social, racial, and economic privilege, thus maintaining the structural violence that created a need for their intervention in the first place.

### **The Invisible Work of Public Health Whiteness**

Whiteness generally went unremarked in Stockton, and yet interrogating it is key to a critical public health practice, particularly in a place where a good deal of the health promotion targeted at people of color is developed and implemented by white people. The invisibility of whiteness in Stockton takes many forms: the unacknowledged white privilege held by most of the professionals in the TPPIC, the disproportionately high

white teen birth rates in comparison to other cities and the state overall, and the colorblind approach to sexual health in the form of collapsing racial inequalities into economic inequalities and promoting long-acting, provider controlled contraception. This invisibility works in tandem with neoliberal logic and the function of the TPPIC as a sort of “jobs program for the white middle-class” described in the next section. Moreover, the invisibility of whiteness supports and maintains a system of stratified reproduction by continuing a historical legacy of “good” and “bad” reproducers (Solinger, 2005). As Omi and Winant (2014) explain, in the neoliberal project of “reinforced social inequality in a US rid of its welfare state, with all the redistributive dimensions of social rights finally repudiated, it would be necessary not to only to oppose demands for racial justice and racial democracy; it would be necessary to take race off the table” (p. 256). By taking race “off the table” in Stockton through the invisibility of whiteness, the TPPIC obscures the racial politics of majority white people regulating the sexuality and reproduction of youth of color, thereby maintaining the complex overall. In other words, the invisibility of whiteness in Stockton sustains the neoliberal logics of health promotion.

A few professional stakeholders I interviewed did acknowledge their whiteness, and some did recognize the power differential. For example, Kristina Myers—who stood out among my respondents as employing a racial justice framework—stated, “I feel funny saying this because, um, you know, I’m a privileged white person so who am I to sort of think that I understand a culture?” Emily Lambert mentioned, “I’ll always be a white lady, and I think I need to be aware of that when I’m talking to a lower class Latino woman.” Similarly, Beth Emmerson told me, “We don’t need us white people coming in there and saying, ‘This is what we think you need,’” an ironic statement considering that

she lobbied heavily for more parent education sessions in Stockton. Although Kristina names white privilege, the quotes from Emily and Beth merely illustrate an acknowledgment of fact of respondents' whiteness itself, rather than the associated unearned, invisible social benefits that it conveys. None of these respondents include actionable steps in their statements or analysis. Racial justice activists and educators argue that this trend toward "acknowledging" white privilege is usually to the benefit of the white person attempting to assuage their guilt, as Mia McKenzie explains:

What I find is that most of the time when people acknowledge their privilege, they feel really special about it, really glad that something so significant just happened, and then they just go ahead and do whatever they wanted to do anyway, privilege firmly in place. The truth is that acknowledging your privilege means a whole lot of nothing much if you don't do anything to actively push back against it (2014, p. 112).

McKenzie is writing with a particular audience in mind, one that already sees themselves as "allies" to people of color. For some white professionals in the TPPIC, acknowledging white privilege would be an important first step to making whiteness visible in Stockton and transforming the youth sexual health promotion industry. This acknowledgment, however, must be followed by specific, material changes in the framing, development, and implementation of youth sexual health promotion, as described later in this chapter. Moreover, making visible the whiteness in the TPPIC must occur in tandem with an interrogation of how professionals benefit from the complex itself.

### **A Jobs Program for the Middle-Class**

Like many reproductive justice scholars, when presenting my work at professional meetings or submitting manuscripts for publication, I am often asked if I'm arguing "in favor" of teen pregnancy, or at the very least I am admonished to include

references to the potential negative outcomes of adolescent childbearing. This question speaks to the need, as I discussed in Chapter 4, for a nonbinary way of thinking about teen pregnancy that refocuses attention to teens' complex, embodied experiences of pregnancy and parenting. The question also helps to elide the ways in which public health professionals and researchers benefit from the pathologization of teen sexuality and reproduction. There's a saying in health promotion that we are "trying to work ourselves out of a job"—ostensibly, once we fix the public health problem at hand, there will no longer be a need for our work and we will move onto something else. While stakeholders differed in their opinions of whether "teen pregnancy" was here to stay, was a problem or not, and so on, the fact that the rates can never get "low enough" to liberate teen pregnancy from being a public health problem speaks to the ways in which the TPPIC is something else altogether, that is, a sort of jobs program for the middle-class. Put another way, there will always be work for (mainly white) middle-class women in preventing pregnancies among low-income youth of color. I say this not to make a rational actor argument that professionals in the TPPIC disingenuously engage in this work to fulfill their own self-interests, but rather that sustaining middle-class jobs (in the form of mid-level human service, clinical, and educational providers) is one noteworthy effect of the youth sexual health promotion industry.

In addition to the question above, a common response to this project has been to critique my taking to task of stakeholders for their failure to attend to structural level problems while promoting individual behavior change. Here I want to consider what this agency/structure tension reveals about public health work and the potential of a critical public health practice. A common, and I believe oversimplified, response to my analysis

of the TPPIC is to emphasize the very real constraints that policymakers and service providers face in their work. This response points to the fact that professionals might very well understand and prefer to work on structural level issues, such as eliminating racism and poverty, but are constrained by the set up of the non-profit industrial complex (INCITE!, 2007). In other words, there is little professional work to be had in “dismantling racism,” and there is a surplus of “teen pregnancy prevention” jobs targeting communities of color. And of course, tackling systemic social problems like racism and economic inequality is much more difficult than distributing condoms and talking about hope.

Here I propose a series of questions: Are professional stakeholders merely giving lip service to the notion of structural inequality because “social determinants of health” is a buzzword concept currently prioritized in research and policy? Possibly. Are they working under very real constraints, most notably the structures of funding and organizations? Certainly. Is it, as a co-panelist once asked me at a sociology conference, “progress” that stakeholders can even have the cognitive dissonance of acknowledging structural level factors while continuing their individual level work? Perhaps. As more than one stakeholder in this project recognized, professionals *do* face considerable constraints in how they frame and fund their work and might very well prefer to be dismantling racism.

While these are important questions, they are also distractions that mask harmful neoliberal logics of much health promotion work. Stakeholders are constrained by funding priorities, but nonetheless make decisions about language, framing, programs, participants, communication and so on that help reproduce teen pregnancy as a pathology

plaguing low-income women of color. That they face constraints on their work does not exempt them from reproducing racist ideologies, even unintentionally. Moreover, it does not obviate their collusion in reproducing the very structures that construct the TPPIC in the first place, including the industry of middle-class health promotion jobs. Although this dissertation did not include a needs assessment component, the digital stories and small-scale needs assessments conducted by *Teens Count* illustrate that young people in Stockton do not see teen pregnancy as a problem in the way that professional stakeholders do, nor do they identify access to contraception and comprehensive sex education as the most pressing issues. A truly liberatory, critical public health practice would start with the health issues that communities identify for themselves, a sentiment that many people working in health promotion express but do not follow. If they did, there would not be a teen pregnancy prevention industrial complex in Stockton, along with many middle-class health and human service jobs.

### **From Preventing Pregnancy to Promoting Liberation:**

#### **A Sexual and Reproductive Justice Framework**

Questions like, “What do you want them to do—devise a program to overthrow racism and patriarchy?” point to limitations on how we “know” teen pregnancy and other issues of social inequality. In what follows, I make the case for an approach to youth sexual health promotion that incorporates a sexual and reproductive justice vision, framework, and social movement. I want us to envision a youth sexual health promotion that centers promoting social, economic, and racial justice, rather than simply preventing teen pregnancy and STIs (which arguably would also be accomplished by moving to a



more just world). This sort of work is already happening at both local and national levels, including the recently announced partnership between reproductive justice organizations and the Black Lives Matter movement (Rankin, 2016). In the next section, I provide two mini-case studies of organizations working with youth of color in a sexual and reproductive justice framework on many of the same issues facing Stockton. Then, I use these organizational profiles as a starting place to envision youth sexual health promotion in the city within a movement for sexual and reproductive justice.

### **Forward Together**

*Forward Together* is a multi-racial organization based in Oakland, CA that works with communities and organizations to “ensure that women, youth and families have the power and resources they need to reach their full potential” by developing community leadership, building networks across communities, and developing campaigns related to sexual and reproductive justice. Founded in 1989 as “Asian Communities for Reproductive Justice,” this organization was renamed “*Forward Together: So all families can thrive*” in 2012 to better reflect the scope of their work and the diversity of their constituents. *Forward Together’s* Executive Director, Eveline Shen, explained the name change:

While our local youth organizing work continues to focus on Asian youth, our national work engages organizations and communities serving Latino, African American, Native and white women, children and families. While we continue to understand the world through the lens of reproductive justice, we also are working increasingly across sectors— with our partners in labor, immigrant rights, criminal justice, and queer and trans people of color (Shen, 2012).

Two of *Forward Together’s* projects are particularly relevant for in work Stockton: the multi-year, national initiative Strong Families, and the youth-led Sex Ed The City project

in Oakland. Each project provides a model for transforming youth sexual health promotion in Stockton both in theory and in practice.

The objective of the Strong Families initiative is to “change the way people think, feel, and act in support of families.” Strong Families works to accomplish these goals through a variety of local and national campaigns in collaboration partner organizations (SOAP is a partner of Strong Families). These campaigns include the “Mamas Day” activist art project, which produces Mother’s Day Cards depicting a wide range of families with the tagline: “Mamahood is not one size fits all. All mamas deserve to be seen and honored in cards that reflect all the ways our families look.” These images are produced by artists who are women, queer, trans, and/or of color and are exchanged as web-based greeting cards and also featured in other online and print reproductive justice settings (see [MamasDay.org](http://MamasDay.org)). A related campaign, #NoTeenShame, works with partner organizations in the “Young Parents Cohort” to use these images in pushing back against the stigmatizing and shameful language and visuals used in teen pregnancy prevention campaigns (SOAP was involved in this campaign, as were some members of The Towne House MAMA group). The cohort also engages in state- and national-level legislative advocacy to support “comprehensive policy change that ensures equitable outcomes for young parents and young families through access to education, childcare, living-wage jobs, housing, transportation, health care and direct access to the social safety net.” The group utilizes a sexual health promotion strategy that includes greater access to “holistic sex education and services and shifting culture to remove stigma and shame around young people’s sexuality and young parenting” (Strong Families, 2016).

The “Sex Ed The City” project also integrates anti-stigma work into its campaign to “make sure that when young people get it on” they have “the power and resources needed to make healthy decisions about their gender, body, and sexuality” (Forward Together Youth, 2012). The project’s 2012 report, titled “Lets Get It On: Oakland Youth’s Vision for Sex Ed,” describes the youth-led participatory action research project that called on the community and school district to implement “sex education justice.” In collaboration with adult allies, the group conducted a needs assessment of high and middle schools students’ perspectives of the state of sex education in the district and what students want their sex education to look like. Throughout the process, youth were the primary writers, thinkers, and facilitators who devised the research methods, conducted surveys and focus groups, analyzed data, wrote up the results, and created a workshop to explain sex education justice to other students. Their vision of sex education justice includes: forms of contraception relevant to all genders and sexualities; inclusion of all pregnancy options (including parenting, abortion, and adoption); education about healthy/unhealthy relationships; inclusion of all gender identities and sexual orientations, relevant information for youth of color, low-income youth, LGBTQ youth, and youth with disabilities; emphasis on positive body image and self-esteem; and workshops on consent and healthy communication. Their needs assessment revealed that students in the district wanted more time spent on sex education in school and for the content to be inclusive of LGBTQ students, non-English speaking students, and students with disabilities. The report’s recommendations highlighted the importance of youth input into the sex education curriculum planning process, prioritizing sex education teachers who

were people of color, and making content and materials inclusive to a range of identities, bodies, and sexualities.

## **FIERCE**

*FIERCE*, which stands for “Fabulous Independent Educated Radicals for Community Empowerment,” is a membership-based youth development organization formed in New York City in 2000. The group was formed by primarily LGBTQ youth of color with an acknowledgement that although there are many organizations where youth receive services, there are few opportunities for youth to direct their own social change agenda. *FIERCE* was founded on the principle that “LGBTQ youth must realize and manifest our own social and political power to change our conditions, to shape our futures, and to become effective agents of change in our communities” (FIERCE, 2016). At the core of *FIERCE*’s work is youth leadership development through community organizing, political education, and anti-oppression trainings. For example, their Education for Liberation Project is a paid leadership development program that enables LGBTQ youth “to gather the self-esteem, skills, and knowledge required to effectively advocate to transform institutions that impact their lives.” By developing leaders and building its membership base, *FIERCE* works to build and exercise the power of marginalized youth across a range of issues including police harassment, displacement from public spaces, and health and wellness.

Similar to Forward Together, *FIERCE* recognizes the critical importance of youth leadership and envisions adults as allies who help build the voices and visibility of those most affected by the issues at hand, that is, marginalized young people. *FIERCE*’s campaigns center the issues and needs that youth identify for themselves, rather than the

issues that service providers or funding agencies identify for them. In addition to prioritizing youth leadership and vision, *FIERCE* understands that the problems marginalized youth face, such as criminalization, homelessness, and concerns of school- and intimate partner-based violence, are the manifestations of larger systems of oppression, including racism, sexism, classism, homophobia, transphobia, and so on. Most youth-serving organizations and projects focus on providing services such as housing, education, and healthcare to meet their immediate needs, but *FIERCE* operates from a position that we must simultaneously work to address the root causes of these issues as part of an overall strategy for social justice (FIERCE, 2013).

*FIERCE* was initially organized in response to the criminalization and displacement of LGBTQ youth of color and other homeless youth from the Christopher Street Pier and Manhattan's West Village. Both locations are sites where LGBTQ youth of color and homeless youth and adults have historically gathered to find safe spaces, build community, and access medical and social services through mobile outreach programs. As part of citywide redevelopment efforts, these areas became the target of "quality of life" policing and youth became the targets of police harassment, false arrest, and racial and gender profiling. In response, *FIERCE*'s "Safe Spaces Save Lives Campaign" fought for an acknowledgment that LGBTQ youth of color are an important part of the community and demanded that their voices be heard in the pier development process. Through strategies including building relationships with community members, merchants, organizations, and elected officials in the neighborhood and providing free summer youth programs on the piers, *FIERCE* youth were able to realize successes

including a rollback of curfews and other efforts to curb access to the piers and the removal of a new \$25,000 fee for mobile health projects to operate on the pier.

### **Moving Toward Sexual and Reproductive Justice in Stockton**

Reproductive justice is at once a framework, a vision, and a social movement that refocuses notions of “rights” and “choice” to a broad analysis of racial, economic, and structural constraints on power. Moving toward sexual and reproductive justice in Stockton must likewise be a framework, vision, and movement that shifts the way we frame youth sexuality and reproduction in the city, engages with transformative social movements, and imagines what youth sexuality and reproduction might look like in a more just world. *Forward Together* and *FIERCE* offer both practical and conceptual tools for imagining and enacting this shift.

First, projects such as “Sex Ed The City” and “Save Spaces Save Lives” offer a framework that prioritizes youth engagement at all steps of the process and provides meaningful opportunities for youth leadership on issues they identify for themselves. For example, teen pregnancy rates in Oakland are higher than both the rate in California and the US rate (Tsoi-A-Fatt, 2009), but youth in the participatory action research project that informed the Sex Ed The City campaign decided to focus on sex education justice, rather than on preventing teen pregnancies. The research findings and campaign focus on many of the same issues that concern professional stakeholders in Stockton—quality sexual health education, access to services, reducing inequalities—but are framed in terms of promoting “the power and resources needed to make healthy decisions about gender, body, and sexuality” and not simply preventing pregnancies and STIs through “access” to hope and opportunity. Likewise, although queer and trans youth of color in NYC face

numerous health, educational, and economic inequalities, including high rates of HIV infection, homelessness, and poverty (FIERCE, 2013), *FIERCE* youth identified access to public space and criminalization as the highest priority issues they faced. Both groups provide opportunities for youth to be direct—rather than token—leaders and agents of social change, not just the recipients of services and programs. In addition to empowering youth, sex education justice, access to community space, and freedom from criminalization would have considerable impacts in improving the lives of marginalized young people of color.

*Forward Together* and *FIERCE* operate from the belief that struggles against injustice are inextricably linked and that working simultaneously across multiple issues is necessary to building a movement for sexual and reproductive justice. For instance, Strong Families works to build the political power of young mothers and other marginalized families at the same that it works for better sexual health education, racial justice, ending mass incarceration, and liberation for trans and gender-nonconforming folks. Similarly, *FIERCE* understands the problems youth face as the manifestations of larger systems of power such as racism, homophobia, and transphobia. The work of both organizations illustrates Audre Lorde’s (1984) maxim that “there is no such thing as a single-issue struggle, because we do not live single-issue lives.” We cannot separate sexual and reproductive inequality from racial inequality, economic inequality, gender inequality, and so on, as they are deeply intertwined and mutually reinforcing.

In envisioning sexual and reproductive justice for Stockton, I am reminded of José Esteban Muñoz’s notion of “educated hope” as a practice not of announcing the way things *ought* to be, but instead imagining how they *could* be (Duggan & Muñoz, 2009).

What could youth sexual health promotion in Stockton look like if it started with the issues and needs that youth identified for themselves, even if those did not include teen pregnancy prevention? What could youth sexual health promotion in Stockton look like if it took into account the legacy of coerced sterilization among Puerto Rican women and the regulation of poor women's fertility cloaked in fears of the welfare queen? What could it look like if it acknowledged the existence of queer and transgender youth, all young people's desire and pleasure, and the persistence of rape culture? What could it look like if health and human service providers centered the embodied experiences and knowledge of pregnant and parenting young women? What could it look like if youth sexual health promotion efforts in Stockton and elsewhere moved toward this vision by prioritizing youth leadership and engaged in training, collaboration, and coalition work with sex positive health educators, critical social scientists, and racial justice activists?

In sum, I want to envision a sexual health promotion that dares to interrogate that which is always already assumed, that does not merely aim to prevent certain outcomes but instead promotes agentic sexuality for all people while centering the voices and experiences of those most marginalized by interlocking systems of racism, classism, ableism, heterosexism, and transphobia. This is the kind of educated hope I want to distribute.



## APPENDIX A

### PEOPLE AND PLACES

#### Places and Projects

Stockton	The Northeastern US city in which the research takes place. A city of less than 50,000 residents, half of whom are Puerto Rican. Stockton is widely known as the city with the state’s highest teen birth rate. There is significant socioeconomic stratification both within Stockton and between the city and others in the region.
Carlsborough	A larger (approximately 100,000 residents) and more racially mixed city adjacent to Stockton. Similar youth sexual health promotion work takes place in both cities. Carlsborough is also a highly racialized city, but is not primarily thought of as a “Latino” city in the way that Stockton is.
PASH Network (Promoting Adolescent Sexual Health)	An umbrella organization formed by Malta Brigado in 2006 that consists of community partnership organizations in the greater Stockton/Carlsborough area. PASH serves as visible organizing presence in the region with the goal of using “research, advocacy, and community education and collaboration to influence policy and practice in adolescent sexual health.” The network administers grants, organizes trainings, structures coalition work, and holds an annual sexual health conference.
<i>Teens Count</i>	A Centers for Disease Control and Prevention funded project in Stockton and Carlsborough from 2010-2015. Teens Count is a project of PASH and SOAP whose goal was to reduce teen birth rates in these cities by 10% in 5 years through community mobilization, clinical coordination, evidence-based programming, and stakeholder education.
Stockton Adolescent Sexual Health Promotion Committee (SASHPC)	A group composed of representatives from city government, health clinics, and social service organizations whose mission is to “develop community-based, multi-faceted approaches to decrease teen pregnancy and sexually transmitted infections (STIs) in Stockton.” SASHPC originated

	from a city committee on economic development.
Statewide Organization on Adolescent Pregnancy (SOAP)	A policy advocacy and provider training organization working in communities across the state. SOAP mobilizes communities around both teen pregnancy prevention and support for young parents.
Stockton Community Health Center (SCHC)	Stockton's federally qualified community health center. SCHC provides primary care, dental care, health education, and case management services and is the major medical provider in the city.
Continuum Health Services (CHS)	CHS is the major provider of sexual and reproductive health services in the region. CHS provides family planning and HIV/AIDS services throughout its many locations. In addition to providing clinical services, CHS engages in policy and advocacy work surrounding sexual and reproductive health.
The Towne House	Stockton's community-based, alternative education high school equivalency program for pregnant and parenting young women. The Towne House provides extensive wrap around services to students including childcare, transportation, healthcare, counseling, and college preparation. The program is nationally recognized for its excellence in the humanities and arts as well as its high graduation and college placement rates.
Moms Are Majorly Awesome (MAMA)	A youth engagement group at The Towne House that focused on strategizing how to use digital stories for strategic communication about teen pregnancy and parenting.

## People

<b>Stakeholders engaged in professional work in Stockton (in alphabetical order)</b>	
<i>Pseudonym</i>	
Malta Brigado	Founder of the PASH network, an OBGYN and Afro-Latina who is a leader in youth sexual health promotion in Stockton and Carlsborough.
Ryan Brown	The mayor of Stockton, a young, white man who grew up in the city and was elected mayor shortly after graduating from college.
Melissa Campbell	A white woman and director of Youth and Young Parent Services at the YWCA.
Amanda Church	A white woman and policy director at SOAP, Amanda was the only lobbyist in the state that advocated on behalf of pregnant and parenting youth.
Beth Emerson	A white nurse in her 60s who conducted research on young people’s perceptions of teen pregnancy in Stockton. Beth was a regular participant in SASHPC activities although she was not affiliated with an organization.
Ana Gutierrez	A 20-something Latina who grew up and Stockton and was working on a master’s of public health degree at the time of our interview. Ana worked for a community-based organization conducting sexual health education for youth in state-funded residential homes.
Emily Lambert	A white program manager at a large regional behavioral health organization that administers a number of programs for pregnant and parenting teens focusing on parenting skills and secondary pregnancy prevention.

Amy Lexington	A white woman and director of grants management at SOAP, Amy was responsible for managing the grant that funded the <i>Teens Count</i> initiative.
Greta McNally	The coordinator of the Stockton public schools' science and health curricula, a white woman who was forced out of her position during my fieldwork and refused to be interviewed for my research.
Hannah McNeil	A white woman and retired nurse who has lived in Stockton all her life. Hannah served as a commissioner for the city board of health and chaired the SASHPC committee.
Kristina Myers	A white nurse-midwife who worked as a nurse practitioner in the Stockton High School teen clinic.
Lourdes Navarro	The education director at The Towne House, Lourdes grew up in Puerto Rico and has worked in Stockton for several decades.
Clarisa Ortiz	A 20-something Latina who grew up in Stockton and now manages the teen health program at the Stockton Community Health Center.
Patina Peron	A 20-something Latina who grew up in both Puerto Rico and Stockton and managed Stockton's teen parent shelter program.
Elizabeth Randolph	A white woman from Carlsborough who manages the clinical services at CHS. Elizabeth had worked in sexual and reproductive health for all of her career.
Mark Rowan	A white man, assistant superintendent of Stockton public schools.

Genario Santos Cruz	The Superintendent of schools in Stockton, Dr. Cruz grew up in South America and had served as superintendent for one school year at the time of our interview.
Farrah Silecio	A white woman who works as a nurse practitioner at the Stockton High teen clinic and regularly participated in SASHPC.
<b>Young parents discussed in the text (not all participants in the digital storytelling workshops)</b>	
Amal	A 20-year-old Middle Eastern woman pregnant with her first baby <sup>1</sup> , Amal lived in Stockton with her boyfriend and his family.
Amanda	A 21-year-old Latina mother of a baby who also had custody of her 15-year-old sister.
Amethyst	A 20-year-old Latina mother of a toddler, Amethyst lived in Stockton with a friend but was not originally from the area.
Angela	A 17-year-old Latina mother of a toddler, Angela grew up migrating back and forth between Puerto Rico and the greater Stockton area.
Catherine	A 20-year-old Latina mother of a toddler who was married and pregnant with her second at the time of the workshop.
Flor	An 18-year-old Latina mother of a toddler who grew up in Stockton.
Inez	A 20-year-old married Latina mother of two who grew up in Puerto Rico.
Kati	A young Latina mother of a baby who appeared in the Stockton High School teen pregnancy prevention video with her boyfriend, Miguel, and their baby.
Magda	An 18-year-old Latina mother of a toddler

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<sup>1</sup> As part of helping to maintain confidentiality for youth participants, the specific ages and genders of their children are withheld.

	who lived in Stockton.
Marianne	A 21-year-old Latina mother of a toddler who grew up in Carlsborough and currently lived in a family shelter.
Mary	A young white mother of a baby who lived with her grandmother in Stockton and was interviewed for the Stockton High School teen pregnancy prevention video.
Miguel	A young Latino father who appeared in the Stockton High School teen pregnancy prevention video with his girlfriend, Kati, and their baby.
Tamara	19-year-old Latina mother of two toddlers who lives in Stockton with a grandparent.
Vienna	A 19-year-old Haitian mother of a mother of a toddler, Vienna was from the capital city but landed in Stockton while being moved around the state's teen parent shelter system.
Yara	A 22-year-old Latina mother of a toddler who grew up in Stockton.
Zemora	A 21-year-old Latina mother of two who grew up in Stockton and split her time between her mother's home in the city and her sister's house in adjacent town.

**APPENDIX B**  
**INTERVIEW GUIDE**

Tell me a little bit about yourself.

Tell me about the work that you do. How did you come to work at \_\_\_\_\_? How long have you been doing this work? What do you like about this work? What do you find difficult or challenging? What kind of training or education did you complete before doing this work?

What are some of the most important issues facing Stockton today?

When you think of teen pregnancy in Stockton, what is the first thing that comes to mind?

Why do you think Stockton continues to have the highest teen birth rate in the state? Why do you think we see such different rates of teen birth across the state? What groups of young women do you see as more likely than others to become pregnant when they are still young?

Do you think that teen pregnancy in Stockton is a problem? Why or why not? If so, what kind of problem is it (i.e., educational, economic, clinical)? Who is it a problem for and why?

Do you think that race and social class are in any way related to teen pregnancy and parenting? How so?

What do you think are the sexuality/sexual health needs of young people in Stockton? What about pregnant and parenting young women?

How do you think we can best go about meeting these needs?

What are your thoughts on the use of stigma in preventing teen pregnancy?

Tell me a story about a memorable interaction you have had doing this work (with a young person, colleague, etc.).

Is there anything else you'd like to share about youth sexuality and/or teen pregnancy in Stockton?

## APPENDIX C

### CODEBOOK

- I. Race and Racism**
  - a. Seeing and knowing race and racism
  - b. Race talk/“I hate having to use vaguely racist language.”
  - c. Seeds of racial justice
- II. Conceptualizing Stockton**
  - a. The “Two Stocktons”
  - b. Teen pregnancy’s effect on Stockton
  - c. Making sense of city politics
- III. Telling social and political narratives**
  - a. Progress narrative
  - b. Making sense of the “problem”
  - c. Social power and teen parent stories
  - d. “making up” youth sexuality and teen parents
  - e. Latino culture/family narrative
- IV. Public health discourses and epistemologies**
  - a. Causal fantasies
  - b. Making sense of data
  - c. Producing knowledge in particular, authoritative ways
- V. Sex and sexuality**
  - a. Responsibility and sexual values
  - b. Sex talk and silences
  - c. Pleasure and desire
  - d. Reductive ways of understanding sexuality
  - e. Contraception and the tension between freedom and control
- VI. Doing the work**
  - a. “the struggle”
  - b. funding the work
  - c. benevolent emancipators
  - d. youth sexual health work as raced/classed/gendered
  - e. participation and presence



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