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Sex, Pregnancy, and Contraception-related Motivators and Barriers among Latino and African-American Youth in Washington, DC

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ABSTRACT *Twelve focus groups were conducted with African-American and Latino youth (age 14–19) in Washington, DC to inform the development of a program to postpone sexual involvement among younger teens (age 12–14). The study's objectives were to uncover the prime motivators for early sexual involvement, examine attitudes towards pregnancy and contraception, explore peer and family influences on sexual decision-making, and identify the youth's preferred sources of information and advice on sexual matters. The data suggest that sex is a peer norm for these youth and generally begins by age 15 or before. The prime motivator for early sex among the young women appears to be social pressures from boyfriends, peers and even older siblings. In contrast, young men seem to be more motivated by physical desire, and draw a clear distinction between relationships that are exclusively sexual and those that are more serious and romantic. Early pregnancy was universally viewed as undesirable, but not always as a hindrance to one's future. While motivation to avoid pregnancy appears to be less pronounced among the African-American youth, potential barriers to contraceptive use seem prominent in both groups due to strong negative opinions about the safety and efficacy of various methods. Condoms are viewed as being appropriate for casual sexual encounters, but not for longer, more established relationships. Parents received mixed reviews as sources of information and guidance on sexual matters. Latino youth were more likely than African-Americans to view parents as being influential in their sexual decision-making, but appear less likely to rely on them for information and advice. All youth preferred clinics to schools for sex education and related services. Overall, these data signal the need for interventions that generate peer support for delaying sex and pregnancy, correct misinformation about contraceptives, and encourage frank, open discussions between youth and their parents or other caring adults.*

Introduction

Although the teen pregnancy rate in the USA declined during the 1990s, four in 10 girls still become pregnant at least once before they reach age 20 (National Campaign to

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Prevent Teen Pregnancy, 2001a). This is a sobering fact when one considers that the US teen pregnancy and birth rates are about twice as high as those found in England, Wales, and Canada, which have the next highest rates in the industrialized world (National Campaign to Prevent Teen Pregnancy, 2001a). It is even more sobering to acknowledge that some of the highest teen pregnancy and birth rates in the USA occur in its capital, the District of Columbia. In 1996, the District of Columbia ranked fortieth among the 50 largest US cities, with a teen birth rate of 103 per 1000 females age 15–19, compared to the national average of 54 per 1000, and an average of 78 per 1000 for all 50 cities collectively (Annie E. Casey Foundation, 2000). According to the most recent (1997) figures from the Centers for Disease Control and Prevention (CDC), the teen pregnancy rate in the District of Columbia was 250 pregnancies per 1000 females aged 15–19, and 27 per 1000 females under age 15, about three times the national averages of 91 per 1000 and 6 per 1000 respectively for that year (CDC, 2000a). In 1998, the childbearing rate for District teenagers was 87 live births per 1000 female adolescents age 15–19, compared to the national average of 51 per 1000 (Ventura *et al.*, 2000). A significantly higher percentage of District births to women under age 20 in 1998 were among African-American (19%) and Latina (13%) teens than among white teens (6%) (Curtin & Martin, 2000).

The risk of teen pregnancy increases with early sexual debut. This is because younger adolescents are more vulnerable to coercion, less likely to use contraception, and more likely to combine sexual activity with other risk behaviors such as alcohol or drug use (Moore *et al.*, 1995; Kirby, 2001). African-American and Latino teenagers report having more sexual partners than their white counterparts at any given age, partially because they report initiating sex at an earlier age (Kirby, 2001). In a recent study of African-American and Latino students (ages 11–14) in the District, 56% of males and 19% of females reported experiencing sexual intercourse (Raine *et al.*, 1999). According to the most recent (1999) District of Columbia Youth Risk Behavior Survey (YRBS), which compiled responses from 1762 high school students (roughly ages 14–18), almost half had initiated sex (47% of females and 49% of males), and of these, 32% of males and 9% of females reported initiating sex by age 13, and 40% of males and 20% of females indicated having four or more sexual partners in their lifetime so far (CDC, 2000b).

Numerous biological and psychosocial factors influence the initiation of sexual intercourse among teens, including, among others, the physical and hormonal changes of puberty, peer pressure, parental supervision, school performance, and alcohol and tobacco use (Moore *et al.*, 1995; Raine *et al.*, 1999; Kirby, 2001). As the antecedents of teen sexual involvement are so varied and numerous, it is virtually impossible to assign a relative 'weight' to each one, although a teen's own sexual beliefs and attitudes are generally the most potent predictors of his or her behavior (Kirby, 2001). In addition, the myriad risk factors for early sexual involvement make it impossible for any single intervention program to address them all. For this reason, as a recent review of teen pregnancy prevention research findings suggests, anyone designing an intervention to address this issue should first research the most important antecedents to sexual risk-taking among the youth being targeted (Kirby, 2001).

The focus group data presented in this report were collected as part of a pilot study designed to generate strategies for the development of a pregnancy prevention program targeting Washington, DC junior high school students (ages 12–14). Survey data on early sexual initiation signaled the need to reach younger adolescents, and the program's goal was to delay the onset of sexual activity, thereby reducing the chances of pregnancy and

other negative outcomes among these youth. In order to develop an intervention to delay sexual activity, focus groups were conducted with slightly older (high school age, ages 14–19) adolescents from the same community to explore the prime motivators for sexual involvement, attitudes towards pregnancy and contraception, peer and family influences on sexual decision-making, and preferred sources of information and advice on sexual matters. The pilot study and resulting intervention program were conducted under the auspices of the National Institutes of Health (NIH) and District of Columbia Initiative to Reduce Infant Mortality in Minority Populations (NIH–DC Initiative). This report summarizes the findings of eight focus groups conducted over a 1-year period with 57 African-American and Latino female adolescents aged 14–18, with points of corroboration from four groups held with 33 African-American and Latino males, aged 15–19.

Focus Groups

Focus groups represent a qualitative data collection technique originally developed by market researchers as a tool to interpret data from large-scale consumer surveys (US Department of Health and Human Services, 1992). Focus group data, although not quantifiable in the same manner as survey data, can reveal valuable information about the beliefs of a target audience, which can be used to generate hypotheses for quantitative studies, develop messages for media and communication programs, or, as in the case of the current study, inform the design of a risk reduction intervention (US Department of Health and Human Services, 1992).

Focus groups are usually conducted with 4–12 participants who represent the age, gender, and ethnic background of an investigator's target audience. Using a discussion outline covering the topics of interest, a moderator initiates and facilitates the discussion, allowing participants to talk freely and probing for further information once concrete themes and opinions emerge. Conducting a series of focus groups with different participants drawn from the same population can help an investigator develop hypotheses about the opinions of that population (Crump *et al.*, 1999).

Focus groups, by their nature, involve group dynamics, and individuals may respond quite differently to questions in a group setting than they would in an individual interview. For example, individuals who are more passive in an individual setting can be more vocal about a controversial topic in a group setting if they perceive a sense of support from others in their group (Kitzinger, 1999). Focus groups can also provide a forum for discussion of topics that are taboo, rarely discussed in naturally occurring group settings, or about which participants have not yet explored their feelings, attitudes, opinions, and motivations (Suter, 2000).

A caveat of this technique, however, is that the group interaction can mask individual opinions and make the group appear more homogeneous in its attitudes and beliefs than it really is (Boeree, 1998). Vocal individuals within the group who have strong opinions about a particular issue or even moderators with a particular ideological bent can end up steering the group process in such a way that the diversity of individual opinions is not reflected in the discussion. Group discussions on controversial topics can also generate more emotion than any particular individual participant may feel on the topic (Boeree, 1998).

Despite these potential problems in analysis and interpretation of discussion group data, focus groups remain extremely useful for studying the way in which knowledge and ideas on a given topic develop, and for exploring levels of understanding and belief that could not be attained by more conventional data collection methods such as surveys

(Kitzinger, 1999). Focus group discussions also allow investigators to observe the shifts and variations in belief that surface as a conversation develops. Beliefs are dynamic and can evolve during the group itself, influenced by the very interaction the discussion produces (Halstead & White, 2001).

Focus groups have been particularly useful in studying sexual attitudes among adolescents (Stanton *et al.*, 1993). The focus group setting gives youth an opportunity to discuss sensitive issues in a 'safe' environment, free from the threat of sanction from teachers or other adults (Halstead & White, 2001). Focus groups are also a culturally sensitive data collection technique useful for exploring the ways in which knowledge and ideas develop within a given cultural context, making them ideal for cross-cultural settings or studies with ethnic minorities (Kitzinger, 1999).

Methods

Ninety young African-American and Latino adolescents were recruited form the areas of Washington, DC with the highest teen pregnancy rates. A total of 57 young women and 33 young men participated in the focus groups. Six of the 12 groups consisted exclusively of African-American female patients recruited from an adolescent health and family planning clinic at a large private hospital. Recruitment took place in the clinic waiting room where the patients were waiting to be seen by their health care provider for both general and sexual health issues. A research staff person gave an informal presentation about the study, its eligibility criteria (female, not pregnant or parenting, age 14–17), the risks and benefits of participation, and answered questions from potential participants. Those who met the eligibility criteria and expressed an interest in participating were given two lengthy consent forms: one for their parent or guardian and one for themselves.

The consent forms, which followed the format and content required by the Institutional Review Board (IRB) overseeing the study, explained the purpose of the research, what was expected of focus group attendees, the risks and benefits of participation, and the right of the attendee to remain silent or leave the group at any time. The researcher explained that the two forms (parental consent and personal assent) would have to be signed and handed in on the day of the discussion and that participants would receive copies of the forms for their own records.

Acceptance rates were mediocre initially, due in part to parental skepticism (if the parent was present in the waiting room), or the candidate herself being 'put off' either by the study topic or the lengthy consent forms. In order to increase the pool of potential participants, the original $10 incentive for participation was raised to $25, with approval from the IRB for protection of human subjects.

Potential participants were asked for a telephone number where they could be reached. Once a date, time, and location for each focus group had been established, these potential participants were contacted to reconfirm their interest in participating and to invite them to the group. For each group, researchers invited twice the desired number of attendees (i.e. for a group of eight, 16 potential participants were called) due to the high no show rate expected among this teenage population. This method only 'backfired' once, when all but two of the young women actually attended the session and the research staff were forced to conduct two separate groups simultaneously. The signed consent and assent forms were collected prior to the beginning of the discussion and those who did not bring them were not permitted to participate.

In order to diversify the pool of focus group participants and to access a larger number of males than was available at the previous clinic, young African-American men were recruited from a health clinic at Job Corps, a teen and young adult vocational training center in a different section of the city. Twenty-one males participated in two groups and were paid $10 each for their participation, following the original protocol. Recruitment was handled by the clinic as per their suggestion. As most of the young men were living away from their parents, the parental consent requirement was waived. The assent form was read aloud by the moderator and then each participant signed his own form prior to the beginning of the discussion. The researchers also waived the 'childless' requirement, as roughly a quarter of the young men were already fathers.

Thirty-two Latinos (20 young women and 12 young men) participated in four groups (two groups each for males and females), and were recruited from a community-based health and family planning clinic in a predominately Latino community in North-west Washington. Based on the advice of the clinic director, recruitment for these groups was conducted by the clinic's own nursing and community outreach staff, who called youth at home to discuss the study and invite their participation. The eligibility criteria were the same as for the African-American women. Consent forms were translated into Spanish and reviewed and signed before the groups began. The clinic suggested that only the assent form be used in order to provide more privacy and anonymity to the youths, whose parents may have refused their participation. Two native Spanish-speaking moderators trained in focus group methodology conducted the groups in Spanish using the same discussion guide developed for the other groups, with a slight variation in phrasing of questions to allow a more gradual transition into the topic of sex. This was deemed necessary, as the original guide was considered too abrupt for the Latino population. Each participant was paid $25 for his or her participation, as per the revised protocol.

Participants attended only one group discussion and each group ranged in size from four to 12 attendees. Every effort was made to convene groups of young people who did not know each other prior to the discussion, although this was not always possible. All groups were held in the conference rooms of the respective clinics.

Each focus group was staffed by a moderator, who posed questions to the group from a previously developed discussion guide, and a note taker, who did not participate in the discussion, but recorded key comments and themes, and observed participants' facial expressions and body language. These were research staff persons not affiliated with any of the clinics. Prior to each discussion, participants were asked to complete a brief anonymous questionnaire. Items on the questionnaire asked for the participant's age, school grade, prior sexual activity (ever had sex, age of sexual initiation, number of partners in the last year), contraceptive method use (use of condoms, birth control pills, other methods), and pregnancy history (ever pregnant or impregnated someone, resolution of pregnancy). After completing the questionnaire, participants were instructed on the rules of the focus group, such as their right to remain silent or to leave the group at any time, and the need to respect others when they speak and to keep all information shared during the group confidential.

All focus group discussions began with an icebreaker activity such as the 'Lifeline Exercise', which was used during the groups with young women. In this exercise, the young women were asked for their opinions on the appropriate age for a particular life event, such as getting a job, finishing school, or going out on a first date. The exercise ended with questions on the best age for one's first sexual experience and pregnancy, which provided a mechanism for leading into the discussion topic. In the young men's

groups, the moderators (who were also male) used word association games or simply asked the young men how they meet and approach girls they like.

Focus group discussion questions were always worded in a manner that asked participants what their friends and associates think and feel about a particular subject. This was done deliberately in order to minimize embarrassment and eliminate the need for a participant to divulge personal information. Despite this cautious approach, participants often 'opened up' and discussed personal anecdotes once the initial period of discomfort had subsided.

The discussion groups lasted about 90 minutes each and were tape-recorded and transcribed. Codes were developed to summarize the major themes of each discussion. For example, SEXATT was the code used to mark the sections of the transcripts that addressed themes related to sexual attitudes, and SEXMOT was the code used to label comments regarding motivations to have sex. Two investigators coded transcripts manually and independently. Coding discrepancies were resolved by discussion and consensus. The same coding scheme was used for all groups, although new codes were developed to address unique themes and opinions expressed during the Latina female groups. Once the coding was completed, the data were entered into the *ETHNOGRAPH* computer software package to analyze code frequencies. Due to time and resource constraints, full coding and analysis were completed only for the eight (six African-American and two Latina) female groups.

This report contains both questionnaire and focus group data from the eight female groups, with qualitative points of corroboration from the four male focus groups.

Results

All participants were present for at least 60 minutes of discussion, with late arrivals and early departures accounting for less than 10% of the total study population. For both the Latino and African-American groups, there were no outright refusals once the groups were convened, although some participants were more talkative and others very reserved. The only refusals were among those who did not complete the questionnaire, which included three of the 37 African-American female participants and three of the 17 Latina participants. Tables I and II show the results of the data collected on the anonymous female questionnaires. The age range of the participants was 14–18, with a relatively even distribution in ages 15, 16, and 17. Ninety-one per cent of the African-Americans and 88% of the Latinas were enrolled in school. The first group of Latinas was very diverse, with one participant from Honduras, two from Nicaragua, four from El Salvador, and four from a mixed heritage, including one whose parents were Columbian and Spanish, another whose parents were from Peru, one who said she was a mixture of Puerto Rican, Dominican, and African-American heritage, and one who said she was from the USA and did not give a Latin American country of origin. The second group was much more homogeneous, with seven participants from El Salvador and two from Guatemala. Length of time in the USA ranged from 1 month to the participant's entire life.

The major areas addressed during each focus group discussion included:

(1) *Sexual activity* (age of initiation, reasons to become sexually involved, peer pressure, sexual relationships);

TABLE I. Characteristics of African-American females

	N	%
All participants*	34	100
Ages		
14	1	3
15	9	26
16	11	32
17	13	38
Enrolled in school	31	91
Sexually active	27	79
Sexually active participants	27	100
Age at first intercourse		
12	4	15
13	8	30
14	5	19
15	6	22
16	2	7
17	2	7
No. of partners in the past year		
1	11	41
2	8	30
3	2	7
4	2	7
5 or more	4	15
Ever used birth control pills	12	44
Ever used a condom	19	70
Ever used other method	5	19
Ever been pregnant	4	15

* Three participants did not complete the questionnaire.
All participants using an 'other' method reported using depot-medroxyprogesteron e acetate injections.

(2) *Pregnancy* (reasons teenage girls become pregnant, personal and social consequences of teen pregnancy);
(3) *Contraception* (methods, efficacy, side effects and hazards, negotiating contraceptive use in relationships);
(4) *Family influences* (on sexual activity and the best sources of information and guidance regarding sexuality and pregnancy prevention).

1. Sexual Activity

Sex happens early. Forty-seven per cent of the Latina and 79% of the African-American participants reported prior sexual activity. Eighty-six per cent of sexually active African-Americans and 75% of sexually active Latinas initiated sex by age 15. Forty-one per cent of African-Americans reported only one partner in the last year as compared to 75% of Latinas. One Latina and four African-American participants reported five partners in the last year.

Information regarding the best age for a girl's first sexual experience was discussed during the Lifeline Exercise. Opinions were mixed, but the majority of participants

TABLE II. Characteristics of Latino females

	N	%
All participants*	17	100
Ages		
14	2	12
15	5	29
16	4	24
17	5	29
18	1	6
Enrolled in school	15	88
Sexually active	8	47
Sexually active participants	8	100
Age at first intercourse		
12	0	0
13	2	25
14	2	25
15	2	25
16	1	13
17	1	13
No. of partners in the past year		
1	6	75
2	1	13
5 or more†	1	13
Left question blank	1	13
Ever used birth control pills	3	38
Ever used a condom	2	25
Ever used other method	4	50
Ever been pregnant	2	25
Left question blank‡	3	38

* Three participants did not complete the questionnaire.
† One participant marked 'no' for the 'ever had sex' question, but reported four or more sexual encounters, five or more partners in the previous year, use of the pill as a family planning method, and a previous miscarriage (although she had also marked 'no' for the 'ever pregnant' question).
‡ Of the three participants who did not list a birth control method, one reported a prior pregnancy.

believed that sexual activity should be postponed until one is 'grown', and 'can take care of themselves'. Those girls who specified an age mentioned the later teenage years (age 17 and above) as the ideal time to initiate sex. Despite these opinions, well over 30% of participants reported sexual initiation by age 15, and 36% of African-Americans reported sexual activity by age 13 on the anonymous questionnaire. According to one Latina participant, 'We start sexual activity around age 14, but American [non-Latina] girls are starting around age 11'. Some girls expressed regret at having begun sexual activity so early. One African-American participant said she wished she had waited until she was 'at least age 16' before becoming sexually involved.

A minority opinion expressed by a few female participants in each group was that sexual activity could begin at any age and that 'You should do it when you want to … [because] no one is going to stop you'. These participants seemed to believe that

initiation of sexual activity should not be determined by a specific age, but by a person's level of maturity and ability to handle the consequences; as one Latina participant put it, 'because there are many 15 year-old girls who are responsible and more mature in their thinking than adults, and they know how to make decisions and take care of themselves. That's why I said [the best time for a girl to initiate sex] is when she feels sure of herself'. Another Latina mentioned love as a prerequisite: 'I'm talking about, I mean, if a woman is going to be with a man, it's because she loves him, and with love, age is not an issue'.

As the Lifeline exercise was not done in the young men's groups, the question of when to initiate sex was not posed in the same way. In one of the Latino male groups, the moderator said he was 'interested in the age at which young men and women should begin having sex'. One participant responded that 18 or 19 would be the ideal age because that is when a woman's 'organism' is well adapted to sex and childbearing. The majority of participants discussed sex as if it were a 'given' and did not specify an appropriate or ideal age of initiation. Indeed, all but one of the African-American male participants and nine of the 12 Latinos reported being sexually experienced on the anonymous questionnaire. The majority had initiated sex by age 15.

Motivators for early sex and sexual relationships. Direct questions regarding outright sexual coercion were not asked, although female participants were queried about sexual pressures from peers and partners. Some participants felt that many girls have sex to 'keep up' with their female peers and older sisters. They mentioned that when girls listen to their female friends talk about sex, it makes some of them want to experience it for themselves. Others described sexual pressure as direct, claiming that those who remain abstinent are subject to teasing and name-calling.

Strong opinions regarding sexual pressure from males were expressed by a majority of participants in all female groups. Males were viewed as having a specific sexual agenda—that is, to sleep with as many girls as possible with no emotional attachment. Participants stated that some girls would succumb to this pressure and have sex in order to keep a boyfriend from straying. One African-American female participant said, 'He [the boy] will say, "If you don't have sex with me, I'm going to leave you and go get somebody else who will."' According to participants, boys will tell girls that sex is a necessary expression of true love and commitment, but this is all really a part of their game:

> [Guys] are smart when it comes, they plan this thing. See girls don't know they plan it. It's a set, they have a plan for it, it's a scheme. (African-American participant)

> Guys are dogs, they just want to have sex, they can go from girl to girl (Latina participant; paraphrased)

Both African-American and Latina participants expressed the opinion that girls can exert some control over this pressure if they choose to; as one African-American participant explained, 'Women control men. We got what they want'. Although this was a minority opinion and consensus was not achieved, those who expressed this view were passionate in their remarks. With equal fervor, they suggested that 'ignorant' or 'trifling' (stupid) girls were those who did not utilize this feminine control and who were promiscuous, thus leaving themselves vulnerable to pregnancy and disease. Teasing a boy (making or accepting sexual overtures and then refusing sex) was viewed with equal disdain. The participants who expressed this disapproval appeared to believe that girls who conduct

themselves in this manner (i.e. through promiscuity or teasing) almost deserve whatever negative consequences befall them.

The male groups corroborated a lot of the information that has been described. As for sexual relationships, African-American males acknowledged that there were two types of women, those you have sex with and those you have a relationship with, suggesting that the latter were the women they respected more. Although they flatly denied pressuring girls to have sex, the conversation revealed that the young men were interpreting 'pressure' as forced sex, not as the more subtle tactics used to convince young women to have sex (i.e. proof of love, etc.). Both African-American and Latino young men seemed to believe that most girls would eventually consent to sex, given the right circumstances, especially if they say 'no' in the right way:

> There are lots of ways that she [the girl] can say no when she really means yes. (African-American male participant)

Although many of the young African-American men stated that they would be willing to wait for a while before having sex, the majority indicated that they would not remain in a relationship indefinitely if the girl continued to refuse sex. Several of these participants mentioned that they were having 'sex on the side' (i.e. having a main girlfriend and at least one other girl on the side, mainly for sex). About half of the Latino males indicated that waiting to have sex is a sign of respect for a girl and that one would not pressure a girl one liked into having sex:

> If you use the 'proof of love' tactic, then it is a proof for you, that you really don't love her. Because with a girl you love and respect, it doesn't even pass through your mind that you want to go to bed with her. (Latino participant)

Many young Latino men stated that in order to get into a sexual relationship with a girl, one has to get to know her and her family. Getting to know a girl's family is considered a sign of a boy's genuine interest in a girl—not just for sex. On the other hand, group participants acknowledged that many boys use the 'prueba de amor' (proof of love) as a tactic to get sex. Latino males spoke of three different types of women: those you marry, those you go out on dates with, and those who you just sleep with.

The young Latino men also spoke about the different mores between their home countries and the USA, the latter being far more liberal and the girls much more 'facil' ('easy' to have sex with) and sexually aggressive. The majority opinion was that in their home countries (El Salvador, Peru, Ecuador, Puerto Rico and the Dominican Republic) young women were much more likely to refuse sex in the beginning of a relationship even if they were sexually attracted to a young man. Approaching a girl with sexually explicit language and suggestions was definitely not tolerated in these countries, and young women at home will often say that they are 'señoritas' (unmarried ladies, implying virginity) when a boy attempts a sexual advance. In the second Latino male group, two young men dismissed this notion, stating that some of the girls at home who claim to be virgins have a 'cave bigger than you', using 'cave' as a crude anatomical metaphor for the vagina of a girl who had lost her virginity. The young Latino men believed almost universally that the Latinas they have met here in the USA are much more sexually forward than the girls back home, and that sometimes they (the girls) make the first sexual move. Another majority opinion was that American (non-Latina) girls are even more forward than the US Latinas. The word 'easy' was universally used to describe girls who are sexually forward and/or willing to have sex without a lot of convincing.

Although not a majority opinion, several participants in both the Latino and African-

American male and female groups mentioned money and gifts as prime motivators for sexual involvement among girls:

> But it is like prostitution [among girls] because it's like after they have sex, 'I need my hair done, I want this', you know. (African-American female participant)

When asked what a girl expects from a sexual relationship, half of the Latino boys in one group said money. One African-American male was particularly blunt in describing his 'dates': 'When I go on a date, here's what I do. We coming to pick you up for my bedroom. That's a date. I might ask you out for something to eat, but you gonna do it'.

In one of the Latina groups, two participants stated that some Latin girls go out with older men because of the money and things they can get out of the relationship: 'Some [girls] are interested, you know. When a man has money, they [girls] want to be with him for the money'.

Other motivators for sexual involvement mentioned by a minority of both male and female participants during the focus group discussions included pleasure and curiosity (as motivators for both males and females). A few of the girls in each group (not a majority) also mentioned the emotional need for love as one reason girls they know become sexually involved. A strong majority of males and females acknowledged that a boy's motivation for sex is primarily physical and not emotional.

2. Pregnancy

Fifteen per cent of the African-Americans and 25% of Latinas reported prior pregnancies. This higher pregnancy rate for Latinas coincides with the national trend, which shows a slower rate of decline in pregnancy among Latinas as compared to African-Americans and whites (National Campaign to Prevent Teen Pregnancy, 2001b). One Latina participant reported a prior delivery, indicating a possible error in recruitment. All other pregnancies had been resolved by spontaneous or induced abortion.

Motivators for pregnancy. The majority of the female participants believed that most girls get pregnant accidentally, although several respondents indicated that pregnancy could be a conscious or unconscious tactic to gain approval or keep a boyfriend:

> Like my sister is pregnant because she thinks she is going to keep this boy. And I keep trying to tell her that a man ain't worth it. (African-American participant)

> Some females have babies, but don't know they have babies for this reason, but they need to feel loved. (African-American participant)

In general, pregnancy was viewed as common, and even natural according to a few of the African-American participants:

> I think it's to a point where as though now, if you don't get pregnant you don't, and if you do, you do.

> One thing that you got to realize—getting pregnant is natural … Parents got to realize it's natural.

For Latinas, pregnancy was associated more with deviant behavior:

> *Moderator*: Why do some girls get pregnant?
> *Participant*: Some do because they left the house. Because a friend of mine ran

> away from home. She spent some time in the streets and then got a boyfriend, and that's how she got pregnant … The boyfriend was using drugs and she was too until she found out she was pregnant. The boyfriend hit her and everything while she was pregnant.

Overwhelmingly, participants mentioned emotional maturity and financial independence as prerequisites to childbearing. Latina participants stated that one should postpone childbearing until one's early to mid-twenties because 'that's when you get married'. The majority of African-Americans said that one should wait until one has a job and one's own apartment before having a baby.

Personal and social consequences of teen pregnancy. The major disadvantage of teenage pregnancy was considered to be the limitations it places on a girl's freedom and social life. Latinas spoke more frequently of the negative consequences from a girl's family if she gets pregnant: 'because my father frequently says to me, "If you get pregnant, you're leaving the house"'.

The majority of African-American girls did not seem to believe that pregnancy necessarily hindered one's studies: 'My school, in the beginning of the school year, looked like a maternity ward. It really did'. Another participant stated: '[girls] may have to get up a little earlier, but they can bring the baby right to school'. In contrast, most Latina participants apparently felt that pregnancy and school definitely do not mix: 'They [teachers, school staff] won't let you go in class. If you go in a class and you're pregnant, you have to make sure they don't see you, OK?'.

Pregnancy was generally viewed as undesirable, but as potentially having both positive and negative consequences. Not all participants believed that becoming pregnant and having a child limit a girl's personal freedom. A small minority of both Latinas and African-Americans believed that a girl's life can go on pretty much as usual because she can have her own mother take care of the child after it is born. When asked if there were any advantages to having a baby as a teen, the majority of participants responded negatively, while a small minority of girls in each of the African-American groups mentioned that pregnancy can be an asset to some girls by giving them 'something to love', a means of 'getting attention from friends', and a reason to 'grow up and get themselves together':

> But I know some females that have had kids and say, 'Oh look, I got to get my life together'. They made their life better so they can provide a better life for their child. So in some instances it's okay. (African-American participant)

Latinas did not share this view of the social advantages of pregnancy. When asked how they would feel if a girl they knew got pregnant, they invariably mentioned that they would feel badly for her because of the negative social consequences, such as parental wrath and punishment, being abandoned by the baby's father, leaving school, or having to leave their own home in order to live with the baby's father's family. The following three quotations, made by different participants in the two groups, are typical of the sentiment:

> I feel really bad when I see that [pregnant] girl.

> … because every day she'll cry because her boyfriend left her. She'll cry every day and later there won't be a way of controlling her nerves. She and the baby will suffer.

> My friend lived with her mother and her mother worked from 6 pm until 2 am. My friend stayed alone all afternoon and evening, so she would invite her

> boyfriend over. When they celebrated her fifteenth birthday, she was already pregnant. When her mother found out she got mad and hit her.

The only advantage to pregnancy, mentioned cautiously by Latinas, was that a girl could usually count on the support of her female friends, although they will talk about her in less than glowing terms 'behind her back'.

In the male groups, the overall opinion was that pregnancy is definitely undesirable and problematic, but not necessarily catastrophic in terms of one's life and future plans. One of the African-American males stated that pregnancy did not have a big effect on his life: 'It don't affect me too much, because I just see the baby for a couple of hours and I'm gone'. Another participant's opinion was different: 'Yeah it affects your life. It takes away your quality time that you used to have'. A third participant talked about the need to be responsible when one fathers a child: 'The only way you can prove yourself as a man would be to take care of it [the baby]'.

The Latinos also had mixed opinions, but generally believed that an unplanned pregnancy could have a big effect on their lives. One participant put it like this: 'It [pregnancy] would affect me a lot. It would scare me a lot. To begin, I'm studying. I'd have to leave my studies to work'. Another participant said he would marry a girl if he impregnated her, even if she were an 'easy' girl with whom he was not having a serious relationship. There was disagreement about this within the group, and one participant stated that marrying a girl due to pregnancy was definitely a bad idea. Of the nine Latinos who reported being sexually active on the anonymous questionnaire, only one marked 'yes' (the marking was very faint as if he were hesitant in responding) to the question of ever impregnating a girl. He did not answer the question on pregnancy resolution.

3. Contraception

On the anonymous questionnaire, 38% of Latinas and 44% of African-Americans who reported being sexually active indicated that they had used birth control pills as a form of contraception. Only 25% of Latinas reported prior condom use as compared to 70% of African-Americans. Nineteen per cent of African-Americans and 50% of Latinas reported use of other methods, including 'depo' (DMPA or 'Depoprovera' injections), 'vaccination' (supposedly also referring to Depoprovera injections), and 'withdrawal'. All of the sexually active African-Americans indicated using some form of contraception, while three of the eight sexually active Latina respondents did not record any method of birth control on the questionnaire.

Barriers to contraceptive use. Perhaps the most striking element emerging from the focus groups was the level of misinformation regarding contraceptive method use, function, and efficacy, especially among the young women. There appears to be an enormous amount of erroneous information circulating among these participants, their peers, and others in their environment. The misinformation is spread primarily through anecdotes about friends, relatives, neighbors, or acquaintances becoming pregnant, seriously ill (i.e. with cancer), or even sterile after using one of the hormonal methods of contraception. Side effects such as irregular bleeding, weight gain, and varicose veins were also mentioned as disadvantages to using these methods.

> *African-American Participant 1*: This girl, she got Norplant in her arm. And some other girls told me it don't work, but she got pregnant when she had hers.
> *Moderator*: Somebody got pregnant with Norplant?

African-American Participant 1: That's what she told me.
African-American Participant 2: They say it's not for everybody to get Norplant.
African-American Participant 1: Well it won't be for me.

Latina Participant: Many women have altered veins because of the pill.
Moderator: What kind of veins?
Latina Participant: Swollen, bulky veins.
Moderator: Oh, varicose veins.

African-American Participant: Our parents don't agree with us using birth control for the simple fact of all the problems you have to go through with it. The news media talking about cancer and all that stuff … We ain't got money for all these medical problems, so you better just use the condom.

Moderator: And what do you think is the best [contraceptive] method?
Latina Participant: None.
Moderator: No method?
Latina Participant: Maybe condoms or injections, and the pill.
Latina Participant 2: But they say that condoms break sometimes.
Latina Participant: Yes, they break.

Some Latina participants spoke favorably about condoms but mentioned the 'machismo' of Latino men, particularly older ones, as the reason why many Latinas avoid this method. However, the majority of Latinas believed that younger Latino men would use condoms mainly for sexually transmitted disease (STD) prevention, and secondarily for pregnancy prevention. In general, condoms were thought to be effective for both pregnancy and STD prevention, but were also seen as unreliable because they can 'bust' (term used by African-American participants). Another problem with condoms, according to the African-Americans and Latinas, is that boys complain of reduced sensation and pleasure, and pressure girls into avoiding condoms as a sign of trust and fidelity in a sexual relationship. One African-American girl put it like this: 'When you always say put on a condom and you been going together for like two years, [boys say], "Put on a condom? What, you don't trust me or something?"'. This was corroborated by several African-American males, who said they would not use a condom with their 'primary' or 'main' girl because she would suspect that he was being unfaithful.

During one of the Latino male groups, one participant mentioned that he no longer carried condoms in his wallet because his friends had told him that the heat generated by carrying a wallet in one's hip pocket renders the condoms ineffective. When the moderator asked if any of the participants were carrying condoms with them at that moment, only one boy raised his hand. Perhaps shyness or embarrassment kept others from raising their hands, but the idea of being prepared, that is, carrying condoms on one's person as a matter of course 'just in case', was not strongly endorsed by girls or boys in the discussions. Girls who carried condoms seemed to be viewed as sexually forward, as evidenced by remarks of a Latino male participant, who spoke about a girl who propositioned him with condom in hand. He admitted to being 'put off' by her advances and promptly declined her offer. This apparent lack of support for carrying condoms is important in light of the fact that teenagers generally describe their sexual experiences as being sporadic, and therefore, they are less likely to be prepared when an opportunity for sex presents itself (Kirby, 2001).

The interesting paradox is that while artificial contraception was almost universally believed to be necessary for avoiding pregnancy (only one Latina participant mentioned a man she knew who was successfully 'protecting' his wife through withdrawal, and another Latina claimed that she had been using aspirin successfully for contraceptive purposes), none of the methods were strongly endorsed. Condoms received moderate but hesitant endorsement and the hormonal methods were viewed as problematic, ineffective, and potentially harmful. It appears that pregnancy is seen as almost inevitable, even if contraceptives are being used. The comment 'nothing is 100%' was made frequently.

When youth were asked who should take responsibility for avoiding an unwanted pregnancy, the strong majority of respondents indicated that the burden rests equally with both sexual partners. However, a few youths suggested that the primary responsibility rests with one or the other—the girl because she is the one who gets pregnant, and the boy because he should protect his own interests in case his partner is untrustworthy, as the following exchange indicates:

> *African-American Male Participant 1*: But what about the broad that lies to you? She say she on birth control, but you find out …
> *African-American Male Participant 2*: It's your fault, you see what I'm saying? If the girl tells you [she's] on birth control, man you can't trust no girls man. I mean, you can trust some of them, but the majority of them, you can't trust man. You can't go by what they say, man.

The majority of male and female opinions seemed to link condoms with STD prevention and the hormonal methods with pregnancy prevention. The other coitus-dependent barrier methods such as diaphragms, spermicides, and cervical caps were not mentioned at all. This is probably because these methods, especially diaphragms and cervical caps, are not commonly promoted for use among teenagers.

4. Family Influences on Sexual Activity and the Best Sources of Information and Guidance on Sexuality and Pregnancy Prevention

When asked whom they would talk to for advice on sex and contraception, African-American female participants were more likely to mention friends or a female relative such as their mother or sister. Latina participants said they would not necessarily go to their friends or peers for advice because they 'may not know any more than I do, or may talk about my business behind my back'. For them, knowledgeable adults (doctors, nurses, counselors) were strongly favored as sources of information and guidance on these personal matters.

Motivators and barriers to discussing sex with parents. Latina participants spoke of strong parental influences on sexual activity and contraception, and of the strict socialization of girls within the household as compared to the permissive socialization of boys. According to these young women, Latino boys are encouraged and expected to date and become sexually involved. 'Some parents practically give their sons condoms', stated one participant. Girls, however, are likely to have their dates scrutinized by parents and are expected to remain virgins and 'behave like little nuns' until they are married. Once married, they are expected to engage in sex only for procreation. As a deterrent to sexual involvement, girls are sometimes threatened with expulsion from the household if they should become pregnant. Latino male and female participants also mentioned that parents are often strict, avoid discussing the topic of sex, and work long hours, thus leaving their teenagers at home unsupervised for substantial periods of time.

Several Latino males spoke of getting information and guidance from older siblings or from friends and peers both 'in the street' and in school. In general, with a few exceptions, the Latin youths viewed parents as being unapproachable, too strict, out of touch with their reality, or more apt to scold rather than counsel and advise. 'Parents will wait until you already know these things and then they'll tell you', quipped one Latino male participant. These youth appear to be 'stuck' between the more permissive values of the US culture and the more conservative mores of their parents and home countries.

Among African-American girls, parents, especially mothers, were viewed as either approachable or unapproachable. Mothers who were approachable were regarded as a source of support and information regarding contraception and pregnancy. Those who had unapproachable parents turned to other adults who were viewed as more receptive or to siblings and peers. Approachable parents were defined as being open, and proactive in terms of discussing sex with the youth (i.e. they were not waiting for their child to bring up the subject), and started the discussions early (i.e. prior to puberty):

> My mother is very open. She's been that way forever [because she herself was a teenage mother]. That's why I didn't rush out to have sex. Some girls really rushed … Where I was, elementary school girls [aged 12 and below] were having sex. (African-American female participant)

On the other hand, as with the Latina participants, several of the participants spoke of strictness, and overprotective behavior on the part of parents as a deterrent to discussing sex with them:

> Some people's mothers aren't there for them. They don't have anyone to talk to. Some people's parents are so strict and so set and [the parents say] 'this is the way it's going to be'. (African-American female participant)

In these situations, African-American participants often turn to siblings, especially older sisters, who can either provide role modeling for initiating sex or for staying away from it. Brothers, on the other hand, tended to provide examples of stereotypical male behavior that the girls could learn from. In most groups, parents and family in general were mentioned as having a strong influence, either positive or negative, on sexual knowledge, attitudes, and behavior among youth. Parents were rarely mentioned in the African-American male groups as most of these participants were already living independently.

Motivators and barriers to sex education in the school setting. The majority of male and female participants reported receiving some form of sex education in school, although the courses were viewed as inadequate because they dealt only with reproductive functioning and not with relationships and feelings. School personnel were almost universally viewed as being out of touch with young people, and therefore not credible or trustworthy. 'I'm not going to talk to those old ladies [in school] about these things', said one Latina participant. Participants, both male and female, were generally disappointed with the way in which sex education is taught in school. The chief complaints were that the programs were not comprehensive, and that the information was too sterile, negative, and didactic, focusing on textbook facts rather than the realities of sex and relationships:

> I bet you can't never open an AIDS class or sex class and see the meaning for sex and the reasons for having sex, and the only thing you see is the bad things you get out of sex and the things you could get from sex. And they don't never

> tell you [about the positive things]. Because sex is not all bad. (African-American female participant)

Those who had positive experiences with sex education classes equated the success of the classes with the directness and openness of the teacher:

> *African-American Female Participant 1*: I think it depends on who the teacher is because some teachers they act like they scared to tell you about it.
>
> *African-American Female Participant 2*: You a health teacher, you get graphic. I want to know details. Get graphic. Teach me. I want to know.

Unfortunately, however, many adults in the school setting were viewed as untrustworthy, and most participants believed that there was no anonymity for students seeking sex and family planning-related information or services in school. For example, some youth mentioned that students in their schools had to give their names in order to get condoms from the school nurse or counselor and that these officials could not be trusted with personal information.

Motivators for attending clinics. Clinics were generally viewed as better sources of information and services with better treatment and confidentiality for the youths:

> And my point of view [is] you can learn more in the clinic or wherever than the school. (African-American participant)
>
> Actually, when you're in the clinic, it's more personal. You're not going to ask what you want to ask in the [school] classroom in front of people. (African-American participant)

Focus group members were generally happy with the services they were receiving at the respective clinics. Among the Latinos, there were roughly even percentages of those who were regular clinic attendees, those who had only recently started using its services, and those who had not yet accessed services. Those who attended the clinic noted its important positive features, namely, the Saturday hours (which enabled youths to attend without missing school), the chance to be seen on a walk-in basis, a pleasant atmosphere, and a kind, knowledgeable staff. For these participants, clinic personnel were strongly favored as sources of information and guidance on sexual matters. One Latina participant spoke of her fear of coming to the clinic after all the bad things she had heard about contraceptives. She stated that she finally overcame her fear, came to the clinic, and was relieved to get sound information from credible health professionals. Another Latina stated that the information she got from the clinic helped her avoid getting pregnant. The African-American and Latino males also confirmed that they preferred getting sexual and reproductive health information and services in the clinic setting.

Discussion

Although not conclusive, quantifiable, or representative of the entire target population, these focus group data corroborate previous quantitative reports of early sexual initiation among youth in this community and help justify the strategy of working with younger teens. A majority of the adolescents interviewed suggested that sexual activity among their peers commences before or during the middle teen years (age 14–16). While many females expressed rather conservative attitudes towards sex, suggesting it be postponed until the later teen years (age 17 and above), there was no consensus on this point and those who mentioned emotional maturity as a prerequisite for sex indicated that this

'maturity' could occur at a any age. A small minority of Latina and African-American females expressed the opinion that girls could control their sexual relationships with boys through their actions and the way they carried themselves. In other words, boys would respect them if they [the girls] acted like they respected themselves.

Among the young men interviewed, sexual activity seems to be natural and expected from an early age. Only one Latino male expressed the opinion that sexual energy should be channeled into other activities such as sports. There were few comments made in support of postponing sex except in the case where one is pursuing a relationship with a girl. Both Latino and African-American males drew a clear distinction between girls they just have sex with and girls they have a relationship with, the latter being girls for whom their interest is more serious and romantic, rather than purely physical.

Overall, the responses suggest that sex is a peer norm, and that the advantages of sexual abstinence, such as avoidance of pregnancy and STDs, may not be proximal enough to override such motivators as that of being a part of the 'in crowd', maintaining a relationship, satisfying one's curiosity or emotional needs, or, in the case of young men, doing what is expected of them (including having multiple partners). Therefore, promoting abstinence as a sole prevention strategy might be difficult unless it is established as a solid peer norm or can be linked with something else that these youth value. Indeed, data currently available on the success of 'abstinence only' programs in the USA are inconclusive at best (Kirby, 2001). Based on these findings, the researchers decided to design a teen pregnancy prevention program that followed an 'abstinence-plus' format—that is, promoting abstinence as the best means of avoiding pregnancy and disease, with an added educational component on contraception (Aarons *et al.*, 2000). Previous research has shown that this dual message is not confusing to young teens and does not make them more prone to sexual experimentation (Howard & McCabe, 1990; Kirby, 1997, 2001; National Campaign to Prevent Teen Pregnancy, 2001c). The program focused on assertiveness skills for avoiding sexual pressure (Howard & Mitchell, 1990), which has been cited as an important component, particularly for girls (Halstead & White, 2001).

All focus group participants viewed pregnancy as undesirable, but not always as a catastrophic event that ruins one's life. Motives for preventing pregnancy were not strong and universal. Indeed, several African-American females mentioned peers who continued their studies despite pregnancy and reaped other benefits such as emotional maturity and increased social support. Among the African-American males, there was roughly an even split between those who believed pregnancy had negative consequences and those who believed it did not. If pregnancy is not seen as a hindrance to future plans, then the motivation to avoid it may be weak unless youth adopt goals that are incompatible with childbearing.

With the rise of STDs and the HIV/AIDS epidemic in minority communities (Kirby, 2001), pregnancy may be taking a 'back seat' to other reproductive health concerns among teens. One African-American female participant illustrated this idea with the following comment: 'Pregnancy is like sort of not as big of a problem [as STDs] because you have a lot of options'. Therefore, using unintended pregnancy as a 'scare tactic' to encourage abstinence or faithful use of contraception may not be effective in communities of adolescents that view pregnancy as a common occurrence, with little social stigma and few serious repercussions.

Latinas reported a higher rate of pregnancy than the African-Americans on the anonymous questionnaire. Although the Latino youth seemed to believe that teen pregnancy was common in their community, there appeared to be much more social

stigma surrounding it and several adverse consequences were mentioned, such as abandonment, quitting school, and possible expulsion from one's home. However, Latinos generally believed, as did the African-Americans, that the positive or negative consequences of teen pregnancy were more a function of the emotional maturity, resources, and family situation of the boy and girl involved, than of their age and educational level.

The level of misinformation and skepticism regarding contraceptive method use and efficacy is particularly noteworthy, and constitutes a probable barrier to their consistent use. It is well accepted that a teen's contraceptive behavior is influenced by the attitudes and behaviors of his/her peers (Kirby, 2001). Contraceptives were never discussed in a completely positive light. As soon as any method was mentioned during a discussion, negative comments regarding their use or side effects ensued almost immediately. Hormonal methods were viewed as causing serious side effects and possible adverse health consequences, in addition to being ineffective at times. Several girls admitted to a fear of using them. There appeared to be a greater fear of contraceptives than of pregnancy and childbirth, which are seen as natural. More must be done to educate adolescents about the relative safety of contraceptives in comparison to the risks associated with pregnancy and childbirth. After each female group, the moderators attempted to clear up the misconceptions and misinformation about contraception that had arisen during the discussion, explaining, for example, that the hormonal methods, if used correctly, are well over 95% effective.

Condoms, although not believed to be as problematic as the hormonal methods, were viewed as having their own negative attributes, including the possibility of breakage, and the difficulties associated with negotiating their use within a relationship. Even though they received high marks for their ability to prevent STDs, condoms were almost universally associated with casual sexual relationships, rather than longer term ones. Although the fear of AIDS may have tapered some negative attitudes towards condoms, it appears that issues of trust, fidelity, and physical pleasure limit their use within the longer, more established relationships these teens have. This is consistent with national data on teen contraception, which show that although condoms are the most commonly used form of birth control at first sex, their use declines significantly as youth get older and have longer sexual relationships (Kirby, 2001). Some Latina girls mentioned 'machismo' as a reason why some Latino males shun condom use. More probing would be needed in future groups on the extent of this machismo, how it is manifested, and which males are most likely to exhibit it. The comments made during the groups suggest that this occurs more frequently with 'older' men. It would be important to learn how much 'older' these men are, and how frequently the young women date older men as opposed to men their own age.

A relative acceptance of teenage pregnancy as an undesirable yet common occurrence may be working synergistically with the negative attitudes towards contraception to constitute the main 'engine' driving the high teen pregnancy rates in this community of teens. Another researcher on this study explores this issue in depth in a separate manuscript, citing a possible ambivalence about pregnancy and its prevention among the African-American female adolescents (Crump *et al*., 1999). The Latina participants expressed far more negative attitudes towards pregnancy than the African-Americans, yet seemed to have even stronger objections to contraceptives and reported lower usage rates, particularly for condoms. This is consistent with national trends, which report contraceptive use among Latino teens aged 15–19 (males and females, all methods) to be well below the national average, both for first sex and most recent sex (within the past

3 months) (National Campaign to Prevent Teen Pregnancy, 2001b). There is a host of possible reasons for this, including language, cultural and religious differences (such as a strong Catholic tradition, which forbids contraception), and familial attitudes towards sex, contraception, and pregnancy. These are issues that should be explored in future groups.

Familial influences on sexual decision-making appear to be strong among these teens and the effect can be either positive or negative, depending on the behavior of siblings and/or parents. Feelings about parental guidance on sexual matters were very mixed, with some participants stating that they could talk openly with their parents and others who felt that their parents were not approachable at all. Positive parental involvement is a known protective factor for adolescent sexual risk-taking (Raine, 1999; Kirby, 2001), and in a recent nationally representative sample of teens aged 12–19, respondents rated parents over friends as having the most influence on their sexual decision-making (National Campaign to Prevent Teen Pregnancy, 2001c). When asked why teens become pregnant or cause a pregnancy, younger respondents (aged 12–14) were more likely to say that their 'parents weren't paying attention' than the 15–19 year-old respondents, who cited 'lack of sufficient motivation to avoid pregnancy' as the primary reason. Forty-one per cent of all teen respondents said they had learned the most about preventing pregnancy from their teachers, as opposed to 34% who said they had learned the most from their parents. Of the adults who were surveyed as part of the same study, over 88% agreed that parents know the importance of talking to their children about sex, but often don't know how to (National Campaign to Prevent Teen Pregnancy, 2001c).

The Latino teens interviewed for the current study suggested that many of their parents were unavailable to discuss sex due to strict rules, cultural taboos, or a heavy work schedule. In a recent focus group study of Latino parents (National Campaign to Prevent Teen Pregnancy, 2001d), several participants commented that they felt uncomfortable and sometimes reluctant to discuss sex with their children because they had not had such discussions with their own parents when they were growing up. Many of these parents seemed to link teen sexuality with disobedience on some level because they commented that they themselves simply obeyed and respected their own parents when they were told to abstain from sex until marriage, thereby making parent–child discussions about sex unnecessary. The parents believed that today's youth lacked the level of respect for adults that they had when they were young, and some stated that any discussion of sex should be reserved for youth who are at least 18 and/or preparing for marriage. They corroborated the comments made by the Latina teens in acknowledging gender-based differences in addressing sexual matters with their children, with a 'wink and a nudge' for boys and direct vocal disapproval for girls.

Many parents also mentioned that the Catholic tradition, which forms the basis of their value system and formally disapproves of premarital sex and contraception, directly influences what they say to their children about these issues. Some also admitted to a fear of discussing sex with their children, suggesting that such discussions could 'put ideas into their heads'. Nevertheless, the majority cited insufficient communication between parents and teens as the chief reason for the high rates of teen pregnancy in the Latino community. Several parents stated that they were interested in learning how to discuss sexual topics with their children.

As for sex education and services, many participants appeared to have a strong preference for the clinic setting because of greater confidentiality, access to knowledgeable adults, convenient hours, and a pleasant atmosphere. However, as the majority of the participants were clinic attendees, this was a biased group. Schools were generally

viewed as inadequate for sex education purposes unless they possessed good teachers or counselors willing to provide information in a candid, forthright manner, and to keep individual student concerns confidential.

Implications for Further Research

This study provided a 'snapshot' of adolescent attitudes on sex, contraception and pregnancy in a community that possesses one of the highest teen pregnancy rates in the USA and, possibly, in the industrialized world. Although not conclusive or fully representative of the diversity of attitudes and opinions in this group of teens, these data provided the researchers with guideposts for the design of both a pregnancy prevention intervention for younger adolescents and an evaluation instrument to measure the intervention's success. In addition to validating the need to target younger adolescents, the issues raised during the focus groups prompted the researchers to add questions on such issues as parental communication, maternal work outside of the home, attitudes towards sex within casual versus longer term relationships, and about carrying condoms 'just in case' to the baseline and follow-up questionnaires. The baseline and follow-up data from the full intervention protocol are reported elsewhere (Raine *et al.*, 1999; Aarons *et al.*, 2000).

Although the data served their purpose of informing an intervention design and evaluation instrument, they left many unanswered questions that are worthy of exploration in future research endeavors. The main area in need of further study is the apparent ambivalence about pregnancy and contraception. While not a new phenomenon (Crump *et al.*, 1999), more qualitative work (focus groups and in-depth interviews) is needed to investigate whether it is truly ambivalence being observed or rather, an acceptance of pregnancy as a preferable outcome to STDs/HIV and/or the harmful health consequences of contraceptives. As both sex and pregnancy appear to be peer norms in this community of adolescents, more research is needed on how to establish peer norms that favor abstinence and delayed childbearing. This might involve an in-depth ethnographic study of abstinent youth from the same environment in order to identify the protective factors that influence their attitudes and behavior and enable them to resist peer and societal pressures to become sexually involved. It would be important to find out about the value system and future orientation of these youth to see if there are themes that could be 'distilled' and packaged for a larger audience of youth. This information could then be used in focus groups to develop specific messages for communications campaigns promoting abstinence in these same communities. In addition, it would be important to interview girls who appear to have a high level of self-efficacy to control their sexual interactions with boys. Lack of control and self-efficacy to refuse sex appears to be an issue for some girls and has been cited by other authors as an area in need of intervention (Halstead & White, 2001). The exchange of sex for gifts and money, which appears to occur with some degree of frequency, is another extremely important issue to address in future work.

As the concern about the safety and efficacy of hormonal contraceptives was strong in groups consisting largely of clinic attendees, it would be imperative to conduct other groups with adolescents who do not access clinic services to see whether these concerns are even more pronounced. It is important to work with health professionals and other influential members of the community and with the popular media to make sure accurate information about contraception is publicized and erroneous information circulated by misguided rumors is corrected. Some of this work is already under way, as two of the clinics that participated in this study were recently cited for excellence in their teen

pregnancy and STD prevention programs (District of Columbia Campaign to Prevent Teen Pregnancy, 2000), and the moderator for the Latino male groups hosts a local television program in Spanish which covers a host of health topics, including adolescent sexuality.

Poor school performance and involvement in other risk behaviors such as smoking and alcohol use are highly correlated with sexual risk-taking (Raine *et al.*, 1999; Kirby, 2001). Focus groups and outreach activities are needed in the school setting to uncover ways in which the schools can work together with parents and students to help youth improve their grades and avoid other risk behaviors, in addition to improving their sex education programs. It was interesting that Latinas were more likely to associate pregnancy with school drop-out than the African-Americans. Is this because they attend schools with tougher sanctions against pregnancy than the African-Americans?

As for the Latino youth, more qualitative research is needed on how country of origin, home environment, and the process of acculturation influence their sexual decision-making. In addition, it is necessary to study the diffusion of information within this community, particularly among the recent immigrants. Apparently, much information is shared among neighbors, as several Latina participants reported getting some of their information on sex and contraception from 'vecinas' (female neighbors). Future research endeavors should attempt to study recent immigrants apart from more acculturated youth in order to get a clearer picture of the attitudes and beliefs of each. This is particularly important in light of the fact that Latinos have among the highest rates of teen pregnancy and birth, and will represent the largest teen ethnic minority in the USA by 2005 (National Campaign to Prevent Teen Pregnancy, 2001b).

Implications for Pregnancy Prevention Programs

In addition to the aforementioned benchmarks for further research, these focus group data corroborated national trends in teen sexual activity and contraceptive use and the current thinking on the best approaches to teen pregnancy prevention programs. In a newly published report of research findings from the most successful teen pregnancy programs in the USA and Canada to date (Kirby 2001), Douglas Kirby outlines the following among the characteristics of effective programs.

Start early and stay late. These focus groups clearly demonstrated that sexual activity begins early for these teens and the necessity of reaching them before or during puberty cannot be overstated. Not only should pregnancy prevention programs begin before youth become sexually involved, they should also be in effect for a sufficient amount of time to have an impact. The intervention program that was designed based on the results of this study began with seventh (12–14 year-olds) graders and continued over two school terms (about 1 year in total). The authors concluded that the program's impact was diminished by its 'late' start, particularly for boys (56% of whom were already sexually active), and insufficient duration (Aarons *et al.*, 2000). The same research group is currently beginning a new intervention study targeting fifth graders (10–11 year-olds) and plans to follow them over a 3-year period with a more intensive educational program.

Include information about abstinence and contraception. The youth interviewed in this study were in dire need of accurate information on contraception. Youth do not view the dual message of abstinence and contraception as confusing or contradictory. Teens who are not yet sexually active need access to sound information on contracep-

tion to help them to make better choices once they do become active. For some of the young women interviewed, getting the information they needed helped them overcome fear, make healthier choices for themselves, and avoid negative outcomes. At the end of one of the Latino male groups, one participant asked about HIV transmission, and the moderator addressed this issue after the formal discussion had ended and talked more about condom use. It was clear that these teens were 'hungry' for sound, reliable information from caring, knowledgeable adults. They had got the 'nothing is 100%' message about contraception, but not the 'something is better than nothing' message. Contraceptive education should include the issue of how to be 'prepared' for unplanned sexual encounters. A recent report on the evolution of sex education practices in US public schools since the late 1980s cites a disturbing trend in the opposite direction; that is, contraceptive education is down and 'abstinence only' education is up, due in part to increased government funding for these types of programs (Darroch *et al.*, 2000). At the time this study was conducted, the District of Columbia Public School System had sex education guidelines for each grade level, but no standard curriculum.

Involve parents. These focus groups demonstrated that parents can have a significant impact on what their teens think, feel, and ultimately do. This is particularly true in the early teen years when parent–child bonds tend to be stronger. As mentioned earlier, younger teens tend to rate parental influence as being the strongest factor in their sexual decision-making. Parents have also expressed interest in learning how to talk to their children effectively about sexual issues. For this reason, the researchers designing the new intervention targeting fifth graders will include a parent outreach component in their program.

Limitations of the Current Study

The data presented are specific to the participants, and not generalizable to youth of a specific age group or ethnic background. As mentioned earlier, focus groups are not without their difficulties and the data they generate must be viewed with caution. To begin, although the moderators did a good job of asking open-ended questions the majority of the time, it was difficult for them not to ask leading questions at times, particularly when they were trying to steer the conversation in a particular direction or to get answers to specific questions. The problem with leading, closed-ended questions (e.g. 'Do you think it would be a good idea to cover these sex education topics on television' or 'Would you like to learn some of this information from peer leaders slightly older than yourself') is that they can influence participants' answers and lead to 'socially acceptable responding', that is, providing an answer that is believed to be desired by the moderator rather than expressing one's own true opinions.

In focus groups, single responses can also be taken out of context and be misinterpreted, once again not reflecting a person's true feelings. In addition, responses can be influenced by the dynamics of the group itself. For example, in most of the groups, the moderators had to strike a delicate balance between using the discussion guide to direct the topics of conversation and allowing a spontaneous flow of ideas and issues brought up by the participants themselves. It was necessary for moderators to limit the contributions of some of the more talkative participants to prevent them from dominating the conversation, while deliberately soliciting the participation of the quieter youths. It is possible that participants with conflicting views kept their opinions to themselves, particularly in those groups that had dominant, strong participant personalities. In most

groups, there were invariably one or two participants who were extremely quiet and visibly uncomfortable, indicating that perhaps the subject matter made them uneasy even though they had agreed to participate in the study and stayed for the duration of the discussions. Therefore, the groups did not benefit from their contributions, and responses were skewed towards the opinions of the more verbal participants.

In addition, the three clinics served different types of teens, with the Job Corps (African-American male) participants being slightly older, out of school, parenting in some cases, and living independently, as opposed to the other youth, who were non-parenting, generally in school, and living at home. These lifestyle variations definitely impacted attitudes and responses to the questions. Differences in recruiting methods across the three clinics also affected which teens attended the groups and possibly influenced their level of participation. The fact that some of the teens knew each other (particularly in the Latino groups, for which recruitment took place within a smaller, more insular community) also clearly impacted their answers. In the Latino groups, the level of participation was also influenced by the teens' country of origin and length of time in the USA, with the more acculturated youths being much more open and verbal than the recent immigrants. Future qualitative studies could try to address this by having separate groups for newly arrived teens and those who have been in the USA for some time. Teens from the Caribbean countries such as Puerto Rico and the Dominican Republic appeared to be more sexually liberal than those from Central and South America, but this may have been due to a greater level of acculturation, as most of them had spent more time in the USA.

Finally, this was not a complete ethnographic study, and did not employ other qualitative research methods such as in-depth interviews, which would have provided a clearer picture of individual teens' true attitudes and beliefs. Although the focus groups and anonymous questionnaires did yield some valuable themes for program planning purposes, the data are insufficient to allow precise conclusions to be drawn about these youth and the communities they represent.

Conclusions

These focus group data assisted researchers in the design of an intervention strategy for delaying sexual intercourse, and provide guideposts for further study of sex, pregnancy, and contraception-related motivators and barriers among a particular group of youth. The data point to a need for programs that provide teens with sound information on sex, pregnancy, and contraception in a developmentally appropriate manner. Parents also need information and guidance about how to talk to their children about sex without embarrassment and in a non-judgmental fashion. Teens need a new peer-related norm in favor of delayed sex and childbearing, and knowing that they have the right and capacity to do what is best for them. In order for youth to be able to do what is best for them, they should have sufficient information and skills for both delaying sex and for using contraceptives effectively when they choose to become sexually involved.

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