National Latina Institute for Reproductive Health

REMOVING STIGMA: TOWARDS A COMPLETE UNDERSTANDING OF YOUNG LATINAS' SEXUAL HEALTH

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INTRODUCTION

The past decade has seen increased advocacy and media attention paid to Latina teen pregnancy. This attention was heightened after the National Vital Statistics Report revealed that U.S. teen births, along with birth rates among adult women, rose 3% in 2006, ending a 14 year decline in birth rates among U.S. teens.[1] In 2007, although teen births overall increased again by about 1%, births among Latina teens decreased by 2%.[2] Most recently, data from 2008 show that births to Latina teens decreased again, by 5% from 2007, to the lowest rate since the U.S. started collecting this information for Latinas.[3] In all of these years, Latina adolescents gave birth at a rate more than twice that of white teens.

While the topic has been treated as sensational and urgent by journalists, advocates, and policymakers, births among Latina girls is not the only, and perhaps not even the most pressing health issue facing young Latinas. For example, young Latinas are significantly more likely to be diagnosed with a sexually transmitted infection (STI),[4] have higher rates of depression,[5] and lower rates of prenatal care[1] than their white counterparts. Therefore, focusing narrowly on teen pregnancy prevention leaves out issues critical to ensuring that Latina youth, and all girls, can integrate positive and empowered senses of their sexuality and reproductive health into their lives, both now and as they enter adulthood. In order to achieve this vision, it is imperative to pay attention to issues like health care access, sexual pleasure, STIs, healthy relationships, and the experiences and needs of lesbian, gay, bisexual, transgender and queer youth. Ensuring that teens have the information and resources to make healthy choices in these areas, and ensuring that they have a healthy environment in which to do so is also paramount to address when supporting teen health.

Reproductive justice and youth advocates have noted that despite the tremendous gains in reducing teen births by more than 30% in the past 15 years, there is still a great need to implement policies and programs to promote and improve the sexual and reproductive health of adolescents. The National Latina Institute for Reproductive Health agrees; a narrow focus on teen pregnancy prevention categorically excludes the particular contexts and concerns of Latina teens' sexual and reproductive lives that are just as important to them as pregnancy prevention and planning. Policies that give young women the skills and resources to delay pregnancy until they decide to become parents must also speak to their right to a healthy pregnancy, to have an abortion, to parent with dignity, to an education and well-paid career, and their human desires, dreams, and experiences of forming relationships and families.

This white paper reviews recent research on adolescent sexuality and reproductive health, sets forth a reproductive justice framework for advancing the sexual health of Latina adolescents, and lays out policy approaches to ensure that communities in which healthy decisions about sexuality and reproduction are supported and available to adolescents. We suggest paying attention to these policies in particular for several reasons. First, many of them have been put in motion by the recent health insurance reform law, and it is imperative that in their implementation they achieve their purposes of providing higher quality reproductive health services to more people. Second, many of these policies have the potential to reduce or eliminate barriers that prevent young Latinas from making informed decisions about how and when to parent, and to create a society in which young Latinas can achieve their full potential. This white paper also holds closely the larger mandate that we have to eliminate health inequities, and therefore proposes policies that directly address the causes of health disparities in addition to the causes of poor outcomes in and of themselves.

ADOLESCENT SEXUAL & REPRODUCTIVE HEALTH: DATA & RESEARCH

A large and sometimes unwieldy body of social science literature has addressed the causes and consequences of early births since the 1960's. A newer, additional question also being addressed in research is why there are such stark disparities between the birth rates of white and Latina girls. This section does not provide an exhaustive review of this research, but instead aims to highlight the information that is most up-to-date and can therefore inform policy approaches to Latina adolescent sexual and reproductive health.

Latina Adolescent Births: Looking at Access and Opportunity

In 2007 Latina adolescents gave birth at more than twice the rate of white girls.[2] While we know the direct cause of any birth, including those among teens, is having sex and choosing to keep the resulting pregnancy, white and Latinas girls do not have significantly different rates of reported sexual activity. Latina adolescents, however, are at much higher risk for pregnancy because they have significantly lower rates of contraceptive use.[6] Specifically, Latinas girls' use of birth control pills declined dramatically between 1991 and 2007, and they are more likely than white girls and black girls to use "no method" of pregnancy prevention when having sex.[6] The causes of these disparities are not as simple as Latinas' versus white girls' preferences for using contraception, but instead are closely connected to social and economic inequity. For example, one study, using a nationally representative longitudinal survey, found no racial or ethnic differences in teen birth rates among adolescents in the same socioeconomic quartile.[7]

One reason why Latina adolescents are less likely to use contraception is because they are less likely to have the money to afford it and less likely to have health insurance. Latinas are also more likely to live in areas with poor access to family planning services. Research shows that neighborhood-level variables, like higher median household income, and better access to family planning services, are predictors of higher contraceptive use among adolescent women.[8] Per capita income and income inequality (the proportion of cumulative income earned by the wealthiest 10%) are also significantly associated with teen births, including among Latinas specifically.[9,10] Latina girls are more likely to be without health insurance than white girls: of Latinos age 17 and under, 20% have no health insurance, a figure nearly three times higher than that of white youth.[11] As of this writing, sweeping health care reform legislation has just recently been signed into law; though it is difficult to know exactly how this will impact them, we do know that there will be more opportunities for at least some young Latinas to gain access to health insurance.

Some adolescent Latinas and Latinos may also be more likely to start their families early because they don't have the resources and support to enter and finish college. Many women and men delay childbirth to finish their education, but a disproportionate number of Latino youth leave high school, and many others simply cannot afford the cost of university tuition. For low-income adolescents with fewer opportunities, early childbirth is "less costly in terms of opportunities lost."[7] Indeed, research indicates that being in school, doing well in school while one is there, and believing that one will be able to continue on to college are all protective against early childbearing.[7] This is likely because those students perceive a greater likelihood of entering higher education, which, under currents systems, would be complicated or made impossible by having a child. Latinas who drop out of school at young ages are more likely to have a pregnancy in their teens than their peers who drop out at an older age.[12]

Although teen pregnancy is often cited by advocates and media as a cause of poverty and tremendous public expenditure, the evidence for such claims is equivocal at best.[13] The most recent research suggests that while teen mothers are less likely to graduate from college compared to women who wait until after 30 to have children, if those same mothers had delayed childbearing until they were no longer teens, they likely would not have had starkly different socioeconomic circumstances overall. Specifically, they are not likely to earn significantly less money and are not more likely to use public benefits, compared to if they had waited until their 20's or later to start their families.[14] Public health research has suggested that for low-income youth of color who experience structural exclusion and disadvantage, the potential benefits of delaying parenthood are much lower than for affluent and white youth because goals like university are very much out of reach.[15]

Maternal and Child Health Inequities Affect Latinas of All Ages

It is often mentioned that teen birth is a problem because adolescent parents and their children have worse health outcomes than older mothers. And while Latina teen pregnancy in particular is a popular issue for discussion and advocacy, the fact is that Latinas of all ages have poorer sexual and reproductive health, and par-

ticularly, maternal health than white women on a range of critical outcomes. Research indicates that socioeconomic disadvantage and differential access to health care are the major determinants of these disparities, not mothers' age.

Latinas have the lowest rate of health insurance coverage of women of any other racial or ethnic group.[11] This directly contributes to the fact that Latinas remain at higher risk for unplanned pregnancy compared to white women; they also have been documented as using contraception less and less consistently and are significantly more likely to have an abortion.[16] Additionally, significantly fewer Latinas receive prenatal care in the first trimester of pregnancy or at all compared to white women.[17]

Research has shown that some Latinas have key birth outcomes, like infant mortality and rates of breastfeeding, that are actually equal to that of white women despite factors like lower incomes.[18,19] However, perinatal outcomes that are equal to white women are primarily among Mexican-origin immigrant women, and this "health advantage" attenuates the longer they are in the U.S. It essentially disappears in the second and certainly in subsequent generations.

National-level data also masks poor health outcomes among different Latina groups and communities. For instance, Puerto Rican women are significantly more likely to experience preterm birth, low birth weight, and infant mortality, and less likely to gain adequate weight during pregnancy, compared to white women.[17] Similarly, Latinas of nearly all country-of-origin groups, except Cubans, are more likely to have gestational diabetes, a condition that can cause severe pregnancy complications and poor outcomes, and can lead to Type II diabetes after pregnancy.

While teen birth is often pointed to as a cause of many of these and other disparities, in fact age is not shown to be the primary cause of these inequitable outcomes. Though poor infant outcomes *are* more likely among teen mothers aged 14 years and younger, there were fewer than 6,000 births to all girls 14 and under in 2008, compared with nearly half a million teen births overall.[3] The vast majority of teen births are to women ages 18 and 19, who have infant health outcomes equal to women in their 20s.[20] Another study found that the odds of having learning disabilities was the same for children of teen mothers and older mothers after controlling for other variables, like educational attainment and income.[21] Therefore, an effective approach to eliminating maternal and child health disparities impacting Latinas is not public policy targeting teen births, but the causes of health inequity for all Latinas of reproductive age, like low income, and lack of health information and insurance.

Latina Adolescents and the Immigrant Context

Much of the research on adolescent sexual and reproductive health does not address the particular context and experience of Latina immigrant youth, and perhaps even more importantly, the context of being from an immigrant family. The proportion of Latino youth who are immigrants has actually decreased in recent years; only 11% of Latinos under age 18 are immigrants themselves.[22] However, more than half of all Latino youth are the children of immigrants and nearly 9 million Latinos live in mixed immigration status households.[23]

The immigrant experience shapes adolescent sexual and reproductive health in several critical ways. Latino immigrant youth have lower rates of sexual activity and later sexual debut than non-immigrant children,[24] but they also find themselves with fewer resources for obtaining quality health care and education. First, immigrant families, particularly those with undocumented workers, are more likely to be low-income and be working in jobs that do not provide health insurance compared to non-immigrant Latinos and non-immigrants in general. [23] The 5- year bar on public health insurance and other public benefits for documented immigrant children was lifted at the federal level only in 2009, and it is not yet clear if individual states are taking up this new opportunity to offer them coverage.[25] The recently-signed health care reform legislation leaves the 5-year bar intact, and excludes undocumented persons not only from receiving subsidies that other Americans will receive, but also bars them from purchasing policies from the exchange with their own money.

Immigrant parents are also less familiar with the U.S. health care system. They are less likely than non-immigrants to have access to reliable, accurate and linguistically appropriate information about what resources and options they have to obtain health care and other benefits for their children. The same is true for their children: although they may be U.S. citizens, Latino children of immigrants may not know the U.S. health care system as well as their non-immigrant counterparts, especially safety net and youth-oriented services, like Title X clinics and Planned Parenthood. NLIRH conducted a series of in-depth interviews with Latina community grasstops leaders in three states and many reported that young immigrant Latinas and children of immigrants

have little information about their health and rights. Particularly, the interviews revealed that Latino immigrant youth often do not know how to access affordable, confidential contraceptive counseling and methods, abortion information and services, and other critical resources and support that many affluent and non-immigrant youth know about.

The same is true for Latino youth and access to education: as immigrants or children of immigrants, they are less familiar with the U.S. education system and have little information about their rights and opportunities for finishing high school and college. In many cases, even high school counselors may not know what type of financial aid immigrant youth can and cannot obtain, or worse, assume that college is not in their plans. Resources, not just information, matter as well: there may be a popular perception that there is a significant amount of scholarship money dedicated to minorities, but studies show that isn't the case. A 1994 report by the General Accounting Office found that less than 5% of college scholarship dollars were designated for people of color, not nearly enough to ensure that all Latino youth who want to study can do so.[26] While college financial aid has grown tremendously in the 16 years since that report, most of that growth has been in merit-based scholarships, which are meant to recruit top students, not increase access to education overall.[27] Merit-based scholarships disproportionately benefit high-income and white students, often exacerbating education disparities. Finally, documented immigrants who are not legal permanent residents, and undocumented immigrants, are not eligible for federal financial aid, and rarely, if ever, state aid for college. In all, tremendous barriers to education and training make delaying parenthood for school a moot point for those immigrant and non-immigrant Latino youth who do not have such an option.

Research Underscores the Need for a Social and Economic Justice Commitment to Adolescent Health

It is not uncommon to hear arguments for addressing teen pregnancy that appeal to concerns about cyclical poverty, welfare expenditures, and tax burdens. These supposed impacts of teen birth are not only inaccurate, but they also preclude policy advocacy strategies that target fundamental inequities facing Latina adolescents, like poverty and health care access. Despite the equivocal evidence and the stigmatizing nature of "social cost" arguments, this is unfortunately still a common approach to getting policymakers' attention about the importance of addressing teen pregnancy. Such arguments make it difficult, if not impossible, to advance adolescent health through contraceptive equity and other reproductive justice approaches.

What diverse research has shown is that an approach that is broader than just "teen pregnancy prevention" is needed to advance adolescent sexual and reproductive health because

- Latina adolescents have a range of needs in this area that are critical to address in the teen years,
- severe health disparities in sexual and reproductive health, including maternal and child health, negatively impact Latinas of all ages, and
- relying on a pregnancy prevention approach doesn't point to how to support young Latinas who are pregnant and parenting.

Research has also shown that

- Being low-income, lacking health insurance and access to health care, and immigration status are fundamental causes of these sexual and reproductive health inequities, including higher teen births, and
- policies and programs that make substantial social and economic commitments to the reproductive health of adolescents have been shown to help adolescents delay childbearing.[28,29]

Calling for a Shift in Discourse on Young Motherhood

As a part of the reproductive justice community, we share a set of values that we believe will allow all persons to live their lives freely and in good health; we value sexual freedom, integrity of the body and personal autonomy, and we reject any system of reproductive coercion. In fact, a key aspect of reproductive justice is advocating for all persons to be able to make the reproductive decisions that they feel are best for them, and to eliminate all the systems that create barriers to these decisions being made freely. Because we share these justice values, we believe it is important to change the discourse surrounding young motherhood and the policies meant to address the issues young mothers face.

More specifically, the current discourse surrounding young motherhood is both stigmatizing and insensitive, and presents young motherhood as a problem in itself as opposed to the real problems that often surround it, such as poverty and lack of access to timely and high quality health care services and

educational opportunities. Some advocates feel that the social stigma of teen pregnancy and parenthood should be reinforced in order to dissuade teens from becoming pregnant or giving birth.[30,31] However, pursuing an adolescent sexual and reproductive health strategy that centers on stigmatizing "teen pregnancy" does little to advance teen health and in fact may have deeply harmful consequences, as many researchers and advocates have shown.[32,33]

The successful stigmatization of "teen pregnancy" is dependent upon racialized imagery, and ascribing perverse motivations and devastating consequences to the actions of, specifically, adolescents of color. For example, despite the fact that the majority of youth who give birth are white and the majority of women on welfare are adults, "Latina teen pregnancy" is consistently discussed in conjunction with public welfare expenditures, "overpopulation", and "illegal" immigration. This stigmatizing and inaccurate narrative about "teen pregnancy" serves to reinforce unequal social relations; that young women of color have historically been institutionally excluded from education and economic opportunities is at once masked and undergirded.[34] This rhetoric makes it difficult or impossible to achieve policies and programs that improve adolescent sexual and reproductive health and eliminate health disparities because it "encourages an individualistic explanation of young women and girls' pregnancies and poor adolescent health."[32]

Secondly, these stigmatizing strategies construct the identities of young women of color as irresponsible, out of control, and in need of constraint instead of support, a characterization that gets translated into the policy arena. Stigmatizing "teen pregnancy" does not create a negative view of teen pregnancy as a singular abstract condition, but instead identifies young women of color as threats to social order and to the sexual innocence of other youth.[32] How do young women of color internalize the stigmatization of their bodies, sexuality, and reproductive choices? What about the stigmatization of sexuality education? The stigmatization of young women making choices that acknowledge, respect and nurture the health of their sexuality and bodies? Far from actually preventing teens from becoming parents, the stigmatization of "teen pregnancy" disempowers young women, and creates sexist and racist barriers to healthy sexuality and reproductive health.

Though most adolescents who become young mothers do not plan their pregnancies, many other young mothers do plan their pregnancies, and these decisions must be both respected and supported. This is not to say, however, that young women's decisions about their pregnancies and bodies are or should be completely individualized; while some young women may come to a conclusion regarding their capability to parent on their own, for others consulting family and community members is an important part of their decision-making.

As a reproductive health organization, we support many of the policies that are put in place to "address teen pregnancy": comprehensive sexuality education, increased affordability and access to contraception, and the expansion of public programs that address reproductive health, such as Title X and Medicaid. However, we support these policies as part of a platform to increase women's ability to make informed choices that are relevant to their lives, and not to make choices for them. Additionally, we support initiatives that expand young women's options – particularly low-income young women and young women of color – for higher education and job access such as tuition reimbursement, loan forgiveness, affirmative action, fair wages, and organized labor. It is important to remember that these policy initiatives are valid in and of themselves, and attempting to use them to steer women's reproductive health choices to what those in power find to be socially acceptable devalues them and can create skepticism towards what would otherwise be valuable initiatives.

Lastly, as a part of supporting all women's reproductive decisions, it is imperative to create a system of support for young mothers. Though policymakers often cite statistics regarding young mothers' likeliness to drop out of school or live in poverty, much less often do we see policies presented to meaningfully address these issues for young mothers, such as initiatives to create subsidized child-care centers at colleges and universities. Young women do not lose their rights or personhood when they decide to become mothers, and should be afforded the same opportunities to lead fulfilling lives as young women who parent later in their lives or do not parent at all.

The National Latina Institute for Reproductive Health (NLIRH) supports the development and implementation of policies that make young Latinas empowered and equipped to make their own best decisions about their reproductive health. This means supporting policies that make healthy decisions possible and rewarding so Latinas and all women can have healthy teen years, avoid pregnancy and birth when they want to, and have healthy pregnancies and children when and if they choose to become mothers.

POLICY APPROACHES

Focusing narrowly on teen pregnancy in advocacy and research does not allow for policy approaches that broadly support the needs of adolescents because so many of those needs fall outside of preventing pregnancy. Recently, many reproductive rights and justice advocates, including NLIRH, have voiced their concern that the planned shift of federal funding for abstinence-only education to the narrow category of "teen pregnancy prevention" may exclude the development and support of programs that use different, but just as important outcomes measures.[3] Public policy should be committed to improving the full range of sexual and reproductive health outcomes for teens, and to doing so in ways that address the fundamental inequities between Latinas and white girls, thereby achieving the Healthy People 2010 goal of eliminating health disparities.

For example, a House of Representatives bill introduced in the 110th Congress to specifically address teen pregnancy manages to offer incentive opportunities to already college-educated mentors to spend quality time with under-resourced adolescent girls in order to mentor them into college and delaying pregnancy. The proposed program offers student loan forgiveness to the mentors, but no real material pathway to college for the program participants. While many advocates have noted the importance of giving girls real opportunities, program responses like mentorship and peer-education programs are unable to close the gap between the reality of teens' lives and their desire to finish high school and go to college. If anything, a growing body of research has documented that youth need to see real material and financial opportunities in order to see the cost benefit of delaying parenting.[7,35] Interestingly, the findings of this particular bill acknowledge the role of poverty in increasing the risk for teen birth, but lacks a mechanism for addressing this cause directly. NLIRH praises polices like this one that support Latina adolescents' health and education, and looks to advance policy that complements this work. For example, many Latino youth sorely need material improvements in the quality of public high school education and standard tuition remission for low-income students to attend college or trade school. Behavioral interventions must be accompanied by policy commitments to attend to the social and material realities of Latina adolescents' lives. These commitments should aim to address Latinas' lack of full and confidential access to reproductive health services, comprehensive sexuality education, and real access to quality high school and college education.

Policies to Watch:

✓ Teen Pregnancy Prevention Initiatives

The Obama Administration has prioritized teen pregnancy prevention – the 2010 budget included $114.2 million for teen pregnancy prevention, and the proposed budget for fiscal year 2011 includes $133.7 million. While many have been pleased with the increases in funding, leading voices in the sexuality education movement have expressed some disappointment about the narrow nature of the funding stream. The funding will be distributed as grants through the Department of Health and Human Services and the Centers for Disease Control, and it will be important to monitor the goals and effects of the programs that receive them.

✓ Medicaid Expansion

Medicaid is an essential program to young Latinas and young women of color, because they are disproportionately poor and uninsured. A recent study showed that in the U.S., young women (18-24) who were without health insurance were significantly less likely to use prescription contraception methods.[36] This indicates that education is not sufficient – adolescents and young adults, like all people, need adequate information *and* health care resources to achieve sexual health and plan their families. Health care reform has expanded Medicaid eligibility to 133% of the Federal Poverty Level, and will remove some restrictions that have made it difficult for some low-income people to qualify. This expansion begins to address disparities in access to health care services and in health outcomes. However, because the five-year bar remains in place, otherwise-eligible legal permanent residents will not qualify unless they have had that status for five years or more.

✓ Family Eligibility and Definition

Individuals' health is inextricably linked to the health of their families. A model that covers individuals without regards to family is incomplete and insensitive to the ways in which people access health care. As health care reform begins its implementation phase, it is important to keep track of the ways families will become eligible, including whether these definitions will be broad enough to include LGBT families, immigrant families, and families in all their forms. Immigrants tend to live in mixed-legal status households and because of rules regarding coverage for immigrants, only certain family members may then be able to access health insurance. Complicated rules about CHIP and Medicaid eligibility for younger and older children also leave many families who have "mixed eligibility" without health insurance. In these families, some members are eligible for CHIP, some for Medicaid, and some have no options

for health insurance. Families with mixed-eligibility children have lower levels of insurance overall, leaving adolescents uninsured at a critical time in their sexual and reproductive lives.[37] NLIRH supports the ability of youth to access confidential reproductive and sexual health care when they believe this is necessary, and family health care eligibility models that include mechanisms to allow youth to access confidential care can ensure that Latina adolescents have access to services and support that they may not have now.

✓ Sexuality Education

As part of a platform that supports young women in having healthy, fulfilling relationships and in making the choices that work best for them, NLIRH supports comprehensive, developmentally-appropriate, evidence-based sexuality education for all people. To be able to make informed, healthy choices about their bodies and relationships, young women must fully understand the range of their options and their relative risk. NLIRH supports the Responsible Education About Life (REAL) Act, which would create a stream of federal funding for these programs. Though health care reform includes $75 million for evidence-based sex education, it also includes $250 million over five years to re-authorize Title V, the failed abstinence-only until marriage initiative.

✓ Development and maintenance of community health worker models.

Community health worker models, such as the *promotoras de salud* model, promote positive health behaviors and connect underserved communities to services in a culturally and linguistically competent manner. Studies have shown community health workers to be effective in increasing vaccinations, breastfeeding, breast cancer screening and other chronic disease screening among Latinas and in other communities.[38-40]Public health professionals and researchers have called for the community health worker model to be incorporated into the U.S. health system.[41]

Young people will not always get the information they need at school or from their parents; therefore a *promotora de salud* can provide young people with accurate comprehensive information on their health. Health care reform has funded community health worker models for medically underserved communities, and it will be important to monitor how these programs are implemented and executed.

✓ Expansion of Community Health Centers (CHCs) and Title X clinics.

Over 20% of Latinas receive reproductive health care services from Title X clinics and family planning programs and 28% of Title X clinic clients are Latino.[42]

CHCs and Title X clinics are an essential source of reproductive health and preventive services, especially for low-income Latinas and immigrant women. Increasing the number and capacity of these clinics would promote health and wellness for the underserved Latina and immigrant communities. Community Health Centers received $11 billion in new funding through health care reform.

✓ Innovative programs to support parenting college and high school students

College and high school students who are parents must have the same opportunity to study and attend classes as non-parenting students. Community colleges and technical and four-year institutions have a critical role in reducing health disparities: education level is a primary predictor of health outcomes. Providing affordable child care, that can be included in financial aid packages, is a key service to ensure young parents' access to education. Other campus-based or accessible family support should include:

- Family housing as part of affordable campus housing and
- The provision of the Nurse-Family Partnership for low-income first-time moms. The Nurse-family Partnership, where first-time low-income moms get home visits from nurses for the first 2 years of their babies' life, is one of the only programs to demonstrate high effectiveness in improving health outcomes, like lower infant mortality and increased breastfeeding for mothers and their babies. This program will often meet mothers where they are at, especially teen mothers, who may be in school or have little private home space if they live with family or friends. This program could be expanded to partner with schools to ensure that young moms in school have access to the program.

Latinos have become a political force in recent years. The number of Latino children has nearly tripled since 1980. Projections by the U.S. Census Bureau indicate that by 2025, nearly three in ten children in this country will be of Latino ancestry. Young Latinos today are tomorrow's political leaders, voters, and professionals, and there must be a vision for their reproductive and sexual health that responds to much more than changes in teen birth rates from year to year. The sexual and reproductive health of young Latinos is non-negotiable. It is in our best interest to address the health care needs of our future leaders.

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Advocates for Youth, Washington, DC

Catholics for Choice, Washington, DC

Choice USA, Washington, DC

The Guttmacher Institute, Washington, DC

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(1) Martin JA, Brady HE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Mathews, TJ. Births: Final data for 2006. National Vital Statistics Report 2009;57(7).

(2) Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary Data for 2007. National Vital Statistics Report, 2009;57(12):1-23.

(3) Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary Data for 2008. National Vital Statistics Report, 2010 April 16;58(16):1-17.

(4) Gavin L, MacKay AP, Brown K, Harrier S, Ventura SJ, Kann L, et al. Sexual and Reproductive Health of Persons Aged 10--24 Years ---United States, 2002--2007. *Morbidity and Mortality Weekly Report* 2009 July 17;58(SS06):1-58.

(5) Twenge JM, Nolen-Hoeksema S. Age, gender, race, socioeconomic status, and birth cohort differences on children's depression inventory: a meta-analysis. *Journal of Abnormal Pyschology* 2002;111(4):578-488.

(6) Santelli JS, Orr M, Lindberg LD, Diaz DC. Changing Behavioral Risk for Pregnancy Among High School Students in the United States, 1991–2007. *Journal of Adolescent Health* 2009;45(1):25-32.

(7) Driscoll AK, Sugland BW, Manlove J, Papillo AR. Community Opportunity, Perceptions of Opportunity, and the Odds of an Adolescent Birth. *Youth & Society* 2005;37:33-61.

(8) Averett SL, Rees DI, Argys LM. The impact of government policies and neighborhood characteristics on teenage sexual activity and contraceptive use. *American Journal of Public Health* 2002;92(11):1773-1778.

(9) Leigh WA. Does place matter? Birth to African American and Latina adolescents. *The Review of Black Political Economy* 2004:47-64.

(10) Gold R, Kawachi I, Kennedy BP, Lynch JW, Connell FA. Ecological analysis of teen birth rates: Association with community income and income inequality. *Maternal and Child Health Journal* 2001;5(3):161-167.

(11) U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2008. 2008; Available at: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html. Accessed July 27, 2009.

(12) Manlove J. The influence of high school dropout and school disengagement on the risk of school-age pregnancy. *Journal of Research on Adolescence* 1998;8:187-220.

(13) Furstenberg FF. Teenage Childbearing as a Public Issue and Private Concern. *Annual Review of Sociology* 2003.;29:23-29.

(14) Hotz JV, McElroy SW, Sanders SG. Teenage childbearing and its life cycle consequences: Exploiting a natural experiment. *The Journal of Human Resources* 2005;40:683–715.

(15) Stevens-Simon C, Lowy R. An Adaptive Strategy for the Socioeconomically Disadvantaged or a Strategy for Adapting to Socioeconomic Disadvantage? *Arch Pediatr Adolesc Med* 1995;149(8):912-915.

(16) Henshaw SK, Kost K. Trends in the characteristics of women obtaining abortions, 1974 to 2004, New York: Guttmacher Institute, 2008.

(17) Health, United States, 2008 With Chartbook. 2009;Library of Congress Catalog Number 76–641496.

(18) Hummer RA, Powers DA, Pullum SG, Gossman GL, Frisbie WP. Paradox found (again): Infant mortality among the Mexican-origin population in the United States. *Demography* 2007;44(3):441-457.

(19) Kimbro RT, Lynch SM, McLanahan S. The Hispanic Paradox and Breastfeeding: Does Acculturation Matter? Evidence from the Fragile Families Study, Princeton, NJ: Center for Research on Child Wellbeing: Princeton Department of Sociology and Office of Population Research, 2004.

(20) Phipps MG, Sowers M. Defining early adolescent childbearing. *American Journal of Public Health* 2002;92:125-128.

(21) Gueroguieva RV. Effect of teenage pregnancy on educational disabilities in kindergarten. *American Journal of Epidemiology* 2001;154(3):212-220.

(22) Fry R, Passel JS. Latino Children: A Majority are U.S. Born Offspring of Immigrants, Washington, DC: Pew Hispanic Center, 2009.

(23) Passel JS, Cohn D. A Portrait of Unauthorized Immigrants in the United States, Washington, DC: Pew Hispanic Center, 2009.

(24) McDonald JA, Manlove J, Ikramullah EN. Immigration measures and reproductive health among Hispanic youth: Findings from the National Longitudinal Survey of Youth, 1997–2003. *Journal of Adolescent Health* 2009 1;44(1):14-24.

(25) Horner D, Guyer J, Mann C, Alker J. The Children's Health Insurance Program Reauthorization Act of 2009. 2009 February 13; Georgetown University Health Policy Institute Center for Children and Families.

(26) Higher Education: Information on Minority-Targeted Scholarships. 1994 January; GAO-HEHS-94-77.

(27) Trends in Student Aid 2004, Washington, DC: The College Board, 2004; Available at: http://www.collegeboard.com/prod_downloads/press/cost04/TrendsinStudentAid2004.pdf. Accessed July 26, 2009.

(28) Tiezzi L, Lipshutz J, Wrobleski N, Vaughan RD, McCarthy JF. Pregnancy prevention among urban adolescents younger than 15: Results of the 'In Your Face' program. *Family Planning Perspectives* 1997;29(4):173-197.

(29) Philliber S, Kaye JW, Herrling S, West E. Preventing pregnancy and improving health care access among teenagers: An evaluation of the Children's Aid Society-Carrera Program. 2002;34(5):244-251.

(30) Whitley R, Kirmayer LJ. Perceived stigmatisation of young mothers: An exploratory study of psychological and social experience. *Social Science & Medicine* 2008;66:339-348.

(31) Reject. The National Campaign to Prevent Teen and Unplanned Pregnancy. Available at: http://www.thenationalcampaign.org/images/store/rejectLg.jpg. Accessed April 28, 2010.

(32) Fields J. "Children having children": Race, innocence, and sexuality education. *Social Problems* 2005;52(4):549-571.

(33) Geronimus AT. Teenage childbearing as cultural prism. *Britsh Medical Bulletin* 2004;69:155-166.

(34) Kelly DM. Stigma stories: Four discourses about teen mothers, welfare, and poverty. *Youth & Society* 1996;27(4):421-449.

(35) Jumping-Eagle S, Sheeder J, Kelly LS, Stevens-Simon C. Association of conventional goals and perceptions of pregnancy with female teenagers' pregnancy avoidance behavior and attitudes. *Perspectives of Sexual and Reproductive Health* 2008;40(2):74-80.

(36) Nearns J. Health insurance coverage and prescription contraceptive use among young women at risk for unintended pregnancy. *Contraception* 2009 February;79(2):105-110.

(37) Hudson JL. Families with mixed eligibility for public coverage: Navigating Medicaid, CHIP and uninsurance. *Health Affairs* 2009 June;28(4):w697-w709.

(38) Lewin SA, Dick J, Pond P, Zwarenstein M, Aja GN, van Wyk BE, et al. Lay health workers in primary and community health care. *Cochrane Database of Systematic review* 2005(1):CD004015.

(39) Reinschmidt KM, Hunter JB, Fernández ML, Lacy-Martínez CR, Guernsey de Zapien J, Meister J. Understanding the success of Promotoras in increasing chronic disease screening. *Journal of Health Care for the Poor and Underserved* 2006;17:256-264.

(40) Viswanathan M, Kraschnewski J, Nishikawa B, Morgan LC, Thieda P, Honeycutt A, et al. Outcomes of Community Health Worker Interventions. 2009 June;Evidence Report/Technology Assessment No. 181.

(41) Freudenberg N, Eng E, Flay B, Parcel G, Rogers T, Wallerstein N. Strengthening individual and community capacity to prevent disease and promote health: In search of relevant theories and principles. *Health Education Quarterly* 1995;2(3):290-306.

(42) Fowler CI, Gable J, Wang J, and Lyda–McDonald B. Family Planning Annual Report: 2008 National Summary. 2009 November.

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