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Misalignment of sexual and reproductive health priorities among older Latino adolescents and their mothers☆,☆☆,★

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ABSTRACT

Objective: The study describes maternal and adolescent perspectives on sexual decision making and the role of mothers in shaping use of contraception for the prevention of unplanned pregnancies and sexually transmitted infections (STIs) among older Latino adolescents.
Study design: Researchers used a semistructured interview guide to conduct focus group discussions with 21 mother–adolescent Latino dyads (n=42). Latino adolescents ages 17–19 were eligible for the study. We recruited families from the South Bronx, New York City, using area sampling methodology. For analysis of qualitative data, we used the framework method involving open coding, identification of dominant themes, refining of codebooks and indexing.
Results: Overwhelmingly, results suggest asymmetric priorities and preferences regarding maternal involvement in older adolescent sexual and contraceptive decision making. Mothers primarily employed practices designed to prevent adolescent sexual activity. Most teens reported already having experienced sexual debut and were currently sexually active. Adolescents expressed a strong interest in practical support for sexual decision making, including maternal guidance regarding effective access to and use of contraception. Mothers offered limited guidance or support with such matters. Maternal views focused entirely on the health and social consequences of sex in lieu of specific guidance on contraception for older sexually active adolescents. The findings highlight a missed opportunity for Latino mothers to support their older adolescent children to prevent unplanned pregnancies, STIs and HIV.
Conclusion: Mothers have the potential to positively shape adolescent contraceptive decision making and behavior. Misalignment of priorities between mothers and adolescents diminishes the potential of reducing adolescent sexual and reproductive health (SRH) disparities.
Implications: Mothers are influential in reducing adolescent SRH risk. However, asymmetric priorities among Latino adolescents and their mothers regarding support for SRH reduce likelihood of reducing adolescent negative SRH outcomes and supporting adolescent health. Programs supporting better alignment of maternal guidance and adolescent SRH needs are warranted.

1. Introduction

Adolescence is a period when youth adopt behaviors impacting long-term health trajectories, including decisions regarding romantic relationships and sex [1]. Sexual debut commonly occurs during late adolescence, with approximately 60% of US adolescents reporting sexual debut by age 18 [2,3]. Unfortunately, adolescents are disproportionately burdened with negative sexual and reproductive health (SRH) outcomes, with ethnic and racial minority youth experiencing the greatest SRH disparities [4–6]. Latinos constitute the most populous minority group, representing approximately 25% of individuals under 18 in the

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United States [7]. Latino adolescents, relative to other adolescent groups, have the highest birth rate and greatest burden of rapid repeat births, defined as subsequent births within 18–24 months [6,8]. Unplanned teen pregnancy and rapid repeat births are associated with health and socioeconomic disparities, including school dropout, poverty and poor SRH outcomes [9,10].

Extant research suggests that parents are influential in preventing adolescent sexual risk taking [11–13]. Latino adolescents report greater interest in parental SRH guidance relative to their non-Latino peers [14–16]. Often, parents express difficulty discussing sex and contraception with their adolescents, citing lack of knowledge, discomfort and uncertainty of timing [17,18]. Parent–adolescent conversations often emphasize the negative consequences of sexual activity and abstinence. Seldom do parent–adolescent conversations focus on effective use of contraceptive and sexually transmitted infection (STI)/HIV prevention methods [19,20].

The current study seeks to explore maternal and adolescent perspectives on the involvement and role of Latino mothers in providing guidance regarding contraception use. The study addresses the less researched topic of potential opportunities to enhance maternal involvement in contraceptive use among older, predominately sexually active, Latino adolescents.

2. Methods

We gathered data from focus groups comprised of Latino adolescents aged 17–19 and their mothers. The research team chose focus groups as the method of data collection to elicit shared group perspectives, while highlighting within-group differences [21,22]. In total, we conducted eight focus groups, divided equally between mothers and adolescents. Each focus group included four to six participants. Males and females participated in adolescent focus groups. Researchers recruited participants using area sampling methods [23] in public housing projects within the Bronx. Research staff screened and recruited eligible families using door-to-door outreach after we identified apartment units based on a random sampling algorithm. We selected Mott Haven given elevated rates of pregnancy, HIV and STIs [24,25]. This research was the first phase of a 5-year NICHD-funded study.

Inclusion criteria for adolescents were (1) 17–19 years of age, (2) self-identification as Latino, (3) residence within Mott Haven and (4) having a mother or primary adult female caregiver. We chose mothers as they are oftentimes responsible for SRH information for their adolescents and our previous work in Mott Haven suggested a high concentration of female-headed households [26–28]. Staff knocked on households and spoke with an adult who was home at the time of initial contact, leaving flyers with contact information underneath unanswered doors. We explained the purpose of the study and assessed for eligibility. Eligible mothers and adolescents provided written informed consent/assent in order to participate. Staff invited consented families to attend focus groups at a local community site and offered flexible scheduling to increase family participation. We collected demographic information through a self-administered demographic questionnaire prior to initiation of focus groups.

Facilitators led separate focus group discussions (FGDs), based on language preference, using semistructured guides. FGD guides included topical areas related to maternal influence, mother–adolescent communication, and adolescent sexual and contraceptive decision making. FGDs lasted 1.5–2 h. After each FGD, facilitators created detailed memos of group dynamics and observations for use during analysis and interpretation of data. Mothers received $15 and adolescents $10 as incentive for participation. Researchers digitally recorded and transcribed FGDs. We obtained institutional review board approval from New York University.

We analyzed qualitative data using the framework method [29,30]. Analysis began with open coding of the transcripts and review of FGD guides to identify dominant recurring themes. Researchers refined codebooks to clarify code definitions induced from transcripts and areas of interest defined a priori. Two researchers, with an intercoder reliability coefficient of 84%, independently indexed the transcripts. A third reviewer independently coded a subset of interviews to resolve coding discrepancies. This resulted in greater than 90% consensus. Coders developed an a priori subjectivity memo to document coder positionalities prior to coding. The research team triangulated data with existing literature on parental influence and adolescent SRH.

3. Results

A total of 21 mothers and 21 adolescents participated in separate FGDs. Thirty-six mother–adolescent dyads were screened for eligibility. Research staff identified 25 mother–adolescent dyads for participation. Three families refused to participate. In addition, one family agreed to participate at recruitment but never attended an FGD after numerous scheduling attempts. We did not identify any refusal or selection bias among refusers. Researchers completed sampling when theoretical saturation was achieved and addition of new dyads did not result in variation of findings or novel perspectives [31].

Table 1 provides demographic information for the mothers and adolescents. The median age of mothers was 46 years old and 18 for adolescents. All dyads were Latino and identified as Puerto Rican (n=10) or Dominican (n=11). Forty-three percent of mothers and 5% of adolescents identified Spanish as their primary language spoken within the home. We assessed sexual behavior with multiple indicators. Ever intercourse refers to whether the adolescent has ever engaged in vaginal intercourse over his/her lifetime. Current intercourse assessed vaginal intercourse within the past 90 days. Sixty-seven percent of adolescents ever engaged in

Table 1
Demographic information of Latino mothers and adolescents who participated in focus group interviews

Sample size N=21	Summary statistic
Adolescents	
Age, mean (range)	18 (17–19)
Ethnicity	
Dominican (%)	52
Puerto Rican (%)	48
Male gender (%)	48
Spanish speaker at Home (%)	5
Born outside the United States (%)	19
Ever vaginal intercourse (%)	67
Current vaginal intercourse (%)	48
Ever oral sex (%)	43
Current oral sex (%)	38
Ever anal intercourse (%)	14
Current anal intercourse (%)	10
Ever use of dual-method contraception (%)	14
Current use of dual-method contraception (%)	5
Reported parent–adolescent communication about delay of sex (%)[b]	81
Reported parent–adolescent communication about contraception (%)[b]	24
Mother[a]	
Age, mean (range)	46 (38–57)
Ethnicity	
Dominican (%)	52
Puerto Rican (%)	48
Spanish speaker at home (%)	43
Born outside the United States (%)	48
Single head of household (%)	33
Reported parent–adolescent communication about delay of intercourse (%)	86
Reported parent–adolescent communication about contraception (%)[b]	33

[a] Mother refers to both biologial and nonbiolgical primary adult female caregivers. Nonbiological caregivers include aunts, grandmothers, foster parents, etc. In all instances, mothers were defined as the adult female primarily responsible for the adolescent.

[b] Contraception refers to any mention of male condoms or hormonal and nonhormonal female contraceptive methods including oral contraceptives, intrauterine devices, injections, emergency contraception, dual methods, etc.

vaginal intercourse, while 48% indicated vaginal intercourse within the past 90 days. We ascertained lifetime and current oral sex and anal intercourse using a similar format. Adolescents reported if they had given or received oral or anal sex. Forty-three percent of adolescents ever engaged in oral sex, while 38% indicated oral sex within the past 90 days. Fourteen percent of adolescents ever engaged in anal intercourse, while 10% indicated anal intercourse within the past 90 days.

Table 2 includes quotes which exemplify the asymmetric/symmetric priorities of Latino adolescents and mothers regarding maternal influence on adolescent sexual decision making. The subsequent section highlights the major emergent themes.

3.1. Mothers have the potential to and do play an important role in adolescent sexual activity and contraceptive decision making

Mothers and adolescents agree on the importance of maternal involvement in adolescent sexual decision making. Adolescents described their preference for practical and direct maternal involvement in their contraceptive decision making. Specifically, teens perceived the maternal role as central to their decision making and that maternal involvement improves adolescent SRH outcomes. Mothers oftentimes expressed concern for their older adolescent's sexual behaviors. Most mothers reported that it was their responsibility to discuss sexual

Table 2
Summary of major themes and codes with asymmetric and symmetric quotes from latino mothers and adolescents

Code	Explanation	Quotes exemplifying symmetry/asymmetry	
		Mother	Adolescent
Maternal potential to shape adolescent SRH			
Importance of maternal role in adolescent SRH	Factors which relate to what the maternal role is and its importance in adolescent sexual decision making.	"My teen should hear about sex from me. I think as his mother, I can have an important impact on whether or not he has sex."	"Just be open with them. I think we need to know everything about sex from our parents, like we need to learn what it really is, how to be safe and when you're ready to do it."
Acceptability of maternal SRH role	Perspectives on the acceptability of maternal influence on adolescent SRH.	"As a mother, I believe it's OK for me to be involved in my daughter's decisions about sex. If not me, who?"	I like talking to my mother. She understands how I am feeling. As a young woman, I need my mom to help guide me with tough decisions like sex."
Maternal influence of adolescent SRH	Maternal influences on adolescent's sexual decision making.	"Even though at times, I wonder if my son is listening to me, he will from time to time surprise me and say 'Ma, I gotta ask you something important about a girl — let's talk.'"	"I know my mother has my back. She wants what is best for me. So, I usually ask her what she think — especially, when it's something big."
Misalignment of maternal influence: maternal and adolescent SRH priorities			
Maternal–adolescent SRH role expectancies	Beliefs mothers and adolescents have regarding appropriate SRH role of mothers.	"I want to protect my daughter from getting pregnant, this means she should have sex and I need to be sure she doesn't."	"My boyfriend and I are close. We have a special relationship. My mother doesn't really understand how much I love him. Sex is a way for us to show we care. If only my mom could get it and understand I could use her support."
		"My son has plenty of time to have sex. Now, he shouldn't start. I try to tell him to wait and that even though he's getting older, he should wait."	"Sex is normal for guys my age. If I like a girl, I think it's OK to do it [sex]. I wish I could trust my mom to get her advice on this stuff but she freaks out too much when she thinks I might be having sex."
Mother–adolescent SRH communication			
Mother–adolescent SRH communication content	Perspectives on topics parents and adolescents SRH communication content.	"I think my job is to tell my son that now is not a good time to be having sex. There is too much bad stuff happening. He needs to get it. Girls get pregnant and there are tons of diseases."	"I need help on the details about how I can best protect myself. Sometimes, my mother says very weird vague things. She never explains. She just says not to do it, or don't bring no babies, or diseases home. But, she never tells me how I can protect myself."
		"Just say no. That's what I say to my daughter. She's got a long life and plenty of time for sex. I don't think now is the time to get wrapped up with a boy and babies."	"If I have a question about birth control, I sometimes want to ask my mom. But she never goes there. She pretends like I am not having sex and says stuff like wait until your married. I don't find this too helpful."
Parent–adolescent communication specificity	Perspectives on the specificity in which mothers should talk or provide guidance to their adolescents about sex and contraception.	"I am afraid if I discuss condoms or birth control, it will tell my teen that it is OK to have sex," "I am really scared that this will send a mixed message."	"I wish my mother would discuss condoms with me, she tells me to use them, but I am not sure how. I am confused about the right way that they work and not sure which ones to use."
Maternal recognition of and involvement in adolescent SRH			
Parent–adolescent SRH comfort	Perspectives on the level of comfort mothers have with recognition of or involvement in their adolescent's SRH.	"I am unsure what to say about birth control to my teen."	"There should already be a point where mom should really expect it to happen and not be upset."
		"Should I mention it? It's really confusing and scary because there is so much I do not know. Nobody ever told me. I got pregnant early on."	"I worry that my mother will get really upset with me if she knew I was having sex. So, I pretend I have never done it. This way, I can avoid a fight."
		"I think I can share some things with my daughter. But if she asks me too many questions, I may not have the right answer. I worry about feeling embarrassed."	"I feel nervous thinking about my mom getting mad or disappointed with me. I think she would be upset if she knew I am having sex."
Specific parental SRH actions	Perspectives on the specific actions mothers should take to improve their adolescent's SRH.	"I just do everything I can to check up on him. I remind him of the bad things going on in our neighborhood. I also have this book that I use to show him pictures of sex diseases. You know STDs. He usually looks scared after we talk and I worry less that he will do something he shouldn't."	"I wish my mom would spend less time trying to scare me to not have sex and focus more on helping me to get birth control."
			"She should take me to the doctor for pills or show me how I can get checked out if I am worried I got something."

activity. Despite mothers endorsing their important role in discussing adolescent sexual behavior, striking was the tendency for mothers to offer little specific guidance regarding protection from unplanned pregnancy, STIs and HIV.

3.2. Perceptions among mothers and adolescents are misaligned about the appropriate maternal role in supporting healthy adolescent sexual behavior and contraceptive use

Mothers and adolescents expressed differing viewpoints on the purpose of maternal involvement in adolescent SRH. Most adolescents stated interest in maternal assistance through providing information about contraception, making SRH visits and facilitating access to contraception. Few mothers provided this level of support due to discomfort, with several mothers noting that provision of contraception access is synonymous with promotion of adolescent sexual activity. Furthermore, mothers expressed gaps in their own SRH knowledge and skills preventing them from providing specific SRH guidance to their adolescent.

Adolescent preference for maternal support of contraception stemmed from their belief that sexual activity is normal given their age and that contraceptive use is a sign of maturity and necessary to protect oneself from unplanned pregnancy and STIs. Adolescents who expressed interest in maternal support of access to contraception deemed maternal involvement as a sign of trust in adolescents' ability to act responsibly in a sexual relationship. Maternal involvement reinforced adolescents' views on the importance of contraception use. Adolescents felt that maternal guidance had been too limited to assist with making informed decisions about preventing unplanned pregnancies and STIs. Adolescents expressed that mothers did not discuss hormonal contraception and dual methods. In the limited instances adolescents mentioned condoms, mothers did not provide specific guidance regarding how to consistently and correctly use condoms to prevent unplanned pregnancies and STIs. Youth acknowledged misinformation or lack of certainty in regards to how to select contraceptive methods and options available to them.

3.3. Mother–adolescent communication prioritizes abstinence as opposed to supporting the uptake of contraceptive methods

Adolescents and mothers viewed parental communication as the most salient mechanism to influence adolescent SRH decision making. Mothers generally perceived their communication efforts to be effective and emphasized the importance of delaying sexual debut and promoting abstinence. Striking was the almost exclusive focus of mothers on delaying their teens' sexual behavior. There was little recognition that their adolescents might currently be sexually active or contemplating sex. In contrast, adolescents described maternal communication efforts regarding sex as having limited usefulness given asymmetric priorities. Adolescents expressed interest in learning how to obtain adolescent-focused SRH services and discussing how the negative outcomes associated with risky sex can be prevented. Adolescents reported that mothers tended to overemphasize negative health consequences and did not provide concrete information about how to protect themselves if currently sexually active. As a result, many adolescents reported difficulty in disclosing sexual activity to their mothers due to fear of punishment or maternal disappointment.

Adolescents acknowledged the misalignment in priorities as weakening their mothers' influence on their sexual and contraceptive decision making. Adolescents indicated a preference for practical maternal guidance on how to protect themselves from negative health and social consequences associated with risky sex. Adolescents were less focused on the unplanned consequences of sexual behavior. Rather, adolescents wanted their mothers to understand that sexual behavior is desirable and as potentially resulting in positive outcomes, such as feeling closer to a partner, serving as an expression of love and being enjoyable. Absent from maternal FGDs was content acknowledging youth perceptions of the potential benefits of sexual behavior.

3.4. Maternal monitoring strategies focus on abstinence versus maternal involvement in the prevention of pregnancy and STIs

Mothers largely resorted to monitoring strategies focused on delaying sex over facilitating contraceptive use for their older adolescents. While most mothers considered parental monitoring an important tool to support adolescent SRH, their efforts were related to parenting practices designed to prevent their teen from engaging in sex. Mothers reported trying to limit the opportunities for adolescent sexual activity. Mothers believed that close monitoring of adolescent activities by calling or texting adolescents, their friends or their friend's parents prevented adolescents from engaging in sex. In contrast, adolescents did not perceive maternal monitoring as effective. Rather, adolescents expressed frustration over fear of punishment if their mothers became aware of their sexual activity. Youth disclosed numerous strategies to prevent their mother from learning of their sexual activity. Adolescents noted that most mothers were unaware of how to competently use technology to monitor adolescents and their social media use. Adolescents stated that they could evade parents by having friends cover for them, blocking parental calls, or not disclosing their activities or whereabouts. Adolescents expressed preferences that mothers foster adolescent self-disclosure through conveying trust and a genuine commitment to providing concrete assistance with adolescent SRH needs.

4. Discussion

While Latino mothers and adolescents agree that parents have an important role in adolescent sexual and contraceptive decision making, their views on the appropriate maternal role differ greatly. While Latino mothers generally voiced a desire to delay sexual debut, older adolescents believed sexual behavior is normal for their age and that sex could result in positive outcomes. Adolescents wanted their mothers to provide specific SRH guidance, including information about contraceptive options, access, correct use and prevention of STIs. Latino mothers and adolescents perceived risks associated with sexual behavior. However, the perception of risk did not equate to mothers and adolescents aligning their respective SRH goals and priorities.

Striking in our data was the need to expand maternal conversations regarding condoms to include greater attention to dual methods. Condoms are an important and effective multipurpose technology for prevention of pregnancy, STIs and HIV. In the United States, condoms are the most frequently used contraceptive method among 15–19-year-olds [32]. Despite being the most frequently used contraceptive method among youth, national data suggest that roughly half of sexually active high school students did not use a condom at last sex [3]. Furthermore, among condom users, extant literature documents common errors and problems that diminish the efficacy of perfect condom use [33–35]. The sole maternal focus on condoms is too narrow and provides sexually active youth with inadequate protection. Recently, national public health efforts have prioritized the uptake of long-acting reversible contraception (LARC), which includes intrauterine devices and implants. LARC is infrequently used during adolescence, with Latino adolescents having the lowest LARC usage [36–38]. Latino adolescents require increased teen pregnancy and STI prevention efforts with emphasis on informing adolescents about dual use methods. Dual-method contraception is reported by 20.7% of females aged 15–24 at last sex, with rates particularly low among those with the greatest SRH disparities, including Latinas [37,39]. Important to note was the omission of any discussion of pre-exposure prophylaxis (PrEP) for HIV prevention. Neither Latino mothers nor adolescents raised PrEP access as a concern despite the rate of new HIV diagnoses being three times higher in Mott Haven compared to the United States [40,41]. Lack of communication about these

topics may be due to lack of knowledge regarding the existence and benefits of PrEP.

A few limitations should be considered when applying these results to mothers and older adolescents. First, notions of transferability may be limited due to recruitment occurring in one setting, Mott Haven, and our study population, Puerto Rican and Dominican mothers and older adolescents [42]. However, we provide detailed descriptions of the methods and results as a means of increasing confidence in the credibility of the findings. Furthermore, positionalities of facilitators may have affected participant responses. We created memos after each FGD in order to consider the facilitator positionality within the analysis and allow for greater reflexivity in the interpretation of data. The research team noted limited evidence of gender differences. However, we did not explore the role of fathers. Paternal effects on adolescent contraceptive decision making may be distinct relative to maternal effects characterized in our findings. Lastly, youth in this study identified as heterosexual and did not report same-sex behavior. Despite these limitations, we believe that the study provides compelling results broadly applicable to improvements in maternal engagement in reducing Latino adolescent SRH disparities.

In sum, our findings suggest that older Latino adolescents view their mothers as a valuable resource with potential for influencing their contraceptive decision making. Previous research related to Latino family–adolescent communication about sex is consistent with our observations [28,43,44]. However, our data advance the current research in that we highlight the missed opportunity for Latino adolescents to receive specific guidance about contraception from an influential source, their mothers. Supporting Latino mothers to move beyond a sole focus on abstinence to include concrete guidance and specific strategies for the prevention of unplanned pregnancies and STIs warrants further research and programmatic development.

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