



A Community Conversation on Adolescent Pregnancy and Parenting Services: Networks of Support, Gatekeepers to Care, and Non-Compulsory Fathering in a Black Urban Community

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## **Keywords**

Community Based Participatory Research; Urban Community; Teen Pregnancy; Access to Services; Support Networks

## **Cover Page Footnote**

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### **ABSTRACT**

This study employed Community-Based Participatory Research (CBPR) methods to document needs and capacity around adolescent pregnancy and parenting in one predominately Black, low-income urban community. Using an iterative focus group method, we engaged 60 participants in a two-day community conversation. Quantitative data from an enrollment questionnaire and qualitative transcripts of the discussions are analyzed. Our results indicate that the community's greatest capacity lies in a network of women. Men tend to participate in parenting more holistically once formal paternity is established. Neighborhood women typically introduce adolescents to prenatal care, so delays in revealing the pregnancy to them serves as a barrier to accessing prenatal care. Overall, participants want health agencies to uphold their formal social contracts with the community, but to entrust informal services to community members who have the necessary insight and expertise to deliver support and information that is usable in their social context.

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## INTRODUCTION

Similar to other health issues, adolescent pregnancy and parenting is geographically concentrated. High poverty communities often face higher rates of teen pregnancy than other communities (Hogan & Kitagawa, 1985; Kirby, Coyle, & Gould, 2001; South & Baumer, 2000; South & Crowder, 2010). Bearing the burden of high rates of adolescent pregnancy places strain on communities, as it is associated with elevated levels of high school drop-out, community violence, and a host of other socioeconomic limitations (Driscoll, Sugland, Manlove, & Papillo, 2005; Harding, 2009; Hoffman, 2008; Hogan & Kitagawa, 1985). Neighborhoods with excessive rates of teen pregnancy are also faced with the challenge of providing emotional support, life skills and parenting education, leading to potential strain on a community's informal resources.

High rates of teen pregnancy and parenting are experienced at the intersection of four contexts: individual, relationship, community and societal (Bronfenbrenner, 1979). There is a plethora of empirical evidence that, although adolescents' personal characteristics are important (Brodsky, 1999; Kennedy, 2005; Masten, 2001), community conditions—especially poverty—are a robust predictor of teen pregnancy rates (Harding, 2003). Supportive community-level relationships (Beers & Hollo, 2009; Klaw, Rhodes, & Fitzgerald, 2003; Unger & Cooley, 1992) and community-based comprehensive, socio-culturally relevant programs (Nation et al., 2003) can positively shape adolescent pregnancy and parenting behaviors. Furthermore, neighborhood and community characteristics can moderate the effect of parental caregiver parenting style on adolescent sexual behavior (Gardner, Martin, & Brooks, Gunn, 2011).

In turn, high rates of teen pregnancy influence socioeconomic dynamics at the community level. The high rates can affect the quality of public schooling (Pillow, 2004) and can perpetuate stigma that limits all of the neighborhood residents' access to resources (Geronimus, 2003). In sum, there is a reciprocal relationship between neighborhood conditions and teen pregnancy rates. Having a large concentration of teen parents in their community affects the lives of grandparents, siblings, cousins, neighbors, and friends. It also affects the functioning of youth serving organizations such as local schools, neighborhoods, and churches. Yet, existing qualitative information on the experience of teen pregnancy in these areas continues to focus on the teens' experience, not the community one (Gallup-Black & Weitzman, 2004; Henderson, Champlin, & Evashwick, 1998; Klaw, 2008). There is limited information about the experience of teen pregnancy from the viewpoint of the community as a whole. The focus of the present study is not on the individual experience of teen parents, but instead on the collective experience of the community, as it is impacted by teen pregnancy. Our goal is to contribute new, meaningful information to the limited existing research on the community-level experience of teen pregnancy.

In this study, we investigate the community-level experience and meaning of high rates of teen pregnancy in one high-poverty, predominately Black urban neighborhood. We specifically attempt to answer the question: are there unanticipated or under-recognized community resources and/or community needs, especially from health agencies' perspectives? Our intention is to produce results that can guide future efforts in both the academic and applied realms. The study is designed to capture the lived experience of high rates of teen pregnancy so that efforts to provide pregnancy and parenting services *to the community, not necessarily just teen parents* can be more contextually relevant. Our community-level, largely inductive design seems to have led to more comprehensive, holistic, and culturally informed information from participants than is often seen in existing focus group studies. It also provides information about the experience,

assets, and needs in a community that experiences teen pregnancy, not just individuals who are teen parents.

## **METHODS**

### The Setting

The research took place in a historic Black urban community located in Indianapolis, IN that is home to approximately 5,500 residents. The main portion of the research was hosted at a Methodist Church in the community of interest. In 2008, the church turned its very traditional summer camp style program for youth into a completely different model and began training teenagers to become “roving listeners” in their neighborhood. Teenagers would rove from block-to-block gathering information on the gifts and talents of neighbors, and attempted to connect them together to build community and economy. The programming change came about due to continued high rates of negative social outcomes (homicide, single parent households, drugs, etc.) in the neighborhood. The clergy and church board of directors felt that a complete change in practices was necessary. As they became more familiar with Asset-Based Community Development (ABCD) and its practices, they made a concerted effort to ensure their actions aligned with this framework (McKnight & Block, 2011). Implementation of the roving listener practice was central to this shift.

The present project tapped into this existing program to recruit participants for the study since the roving listeners were already well connected and trusted in the community (roving listeners were only involved in recruitment, not in data collection). It also offered the opportunity to recruit community residents without introducing a common bias in this type of study: recruiting through agencies or organizations and therefore only obtaining the select group of individuals affiliated with public or parochial institutions. During the summer of 2011, the youth roving listeners compiled a list of potential participants who fell into the researchers’ four categories of interest: pregnant or parenting teens; former pregnant or parenting teens; caregivers, families and friends of parenting teens; and other, only indirectly affected community members. These four categories were identified to ensure that we could respond to the research question, which focuses on the *community* experience rather than the experience of teen parents.

### The Participants

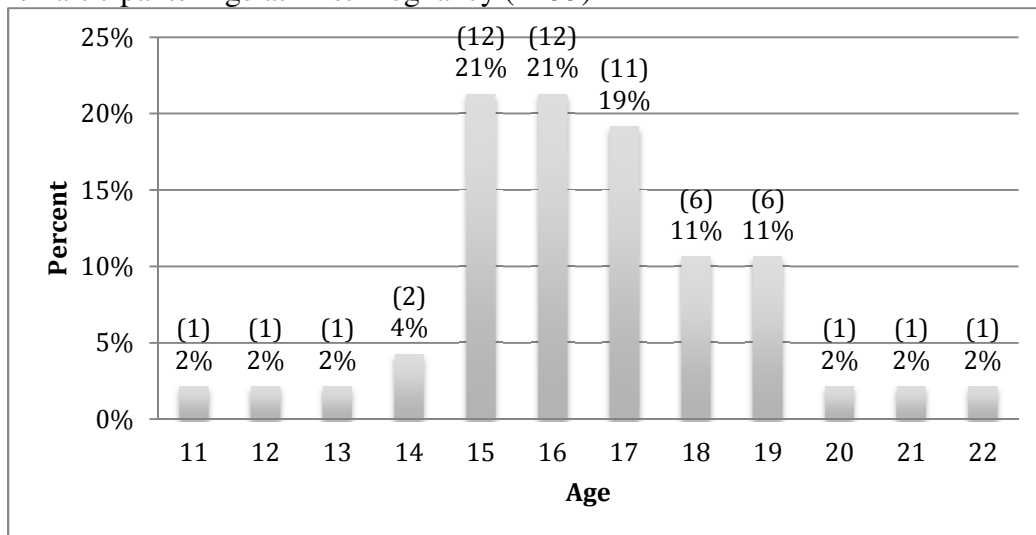
In the two weeks preceding the community conversation event, the research team contacted the potential participants and invited them to participate. At that time, 60 participants enrolled in the study: nine teen parents; 21 former teen parents (five between the ages of 20 and 22); 12 family, friends and caregivers; and 18 community members (though during the conversation, we learned that 10 of these individuals fell into the categories of former teen parents or family, friend or caregivers to teen parents). These participants represent a diverse group of neighbors (with the exception of race). As is seen in Table 1, the group is diverse in age, marital status, and educational level. The participant pool captured heterogeneity within a neighborhood widely known as a low-income (18% of households live off of less than \$10,000 per year), under-educated (19% of adults lack a high school diploma), Black (64%) community (Davern, Quinn, Kenney, & Blewett, 2009).

**Table 1:** Demographic Background of Participants (n=60)

	Mean	Min. – Max.	
Age (yrs.)	35	17	61
Age at First Pregnancy (yrs.)	16	11	23
Neighborhood Residence (yrs.)	15	0.3	48
<b>% of Participants</b>			
<b>Gender</b>			
Women	79%	_____	_____
Men	21%	_____	_____
<b>Education</b>			
Less than High School	16%	_____	_____
High School	59%	_____	_____
Some College	23%	_____	_____
Master’s Degree	1%	_____	_____
<b>Marital Status</b>			
Single	63%	_____	_____
Married	10%	_____	_____
Cohabiting	06%	_____	_____
Divorced	10%	_____	_____
Other	11%	_____	_____

Despite this heterogeneity, teen pregnancy represents a shared experience in the neighborhood (health department statistics indicate that there were 11 births to teen mothers in the neighborhood in 2010 alone). Our stratified recruitment strategy only mandated that 50% of the participants experienced a pregnancy during their teen years, but the data in Figure 1 reveals that almost every participant that had experienced a pregnancy (96%) experienced his or her first pregnancy prior to the age of 20.

**Figure 1:** Participants' Age at First Pregnancy (n=55)\*



\*Note: Five participants had never been pregnant. Also, raw numbers are given in parentheses.

### The Process

The research process was guided by the National Institutes of Health's best practices for mixed methods research as it applies to the social sciences (Creswell, Klassen, & Plano Clark, 2011). This included focus group methods, which were ideally suited to the task at hand (Krueger & Casey, 2009; Stewart, Shamdasani, & Rook, 2007). As a method of qualitative scientific inquiry, focus groups (guided conversations) identify participant perceptions, attitudes, beliefs, and opinions as they emerge in the context of and interaction with other research participants. We integrated these methods into the Community Based Participatory Research orientation.

The planning phase of the project was initiated by soliciting advice, ideas and feedback from a group of five adult and youth community members—three teen parents, the director of youth services at the church, and one parent of a non-pregnant teen—who constituted the advisory board. These members were recommended by the youth roving listeners and were then ineligible to be community conversation participants. In five meetings, the board helped to frame the context of the discussion and to decide on conversation topics. This board acted as a steering committee, exerting significant influence over the nuances of the project to complement the rigorous study design (Israel, 2005; Viswanathan et al., 2004).

Potential participants were contacted by the research team and were invited to participate in the conversations (using methods approved by the IRB). Interested individuals were provided with the details of the project and were then asked to give their signed consent. Once consented, participants were asked to complete a six-page paper and pencil enrollment questionnaire that covered various topics. This questionnaire was designed to provide quantitative data on participants' background information and demographic data, and all questions were close-ended. More importantly, it was used to create a quantitative database of participants' reported use of services, service eligibility, sources of support, pregnancy and birth history, parenting responsibilities, etc. Several of the modules in the enrollment questionnaire were pulled from the Fragile Families (McLanahan et al., 2003) project to serve as previously validated measures. Once collected, the data from the enrollment questionnaire were entered into a secure quantitative database and analyzed using Stata 11.

The core aspects of the study proceeded according to industry standards as presented in *The Focus Group Kit* (Morgan & Krueger, 1997). The moderators/facilitators were local community members who underwent 24 hours of training (three, eight hour days) and conducted two mock focus groups prior to the study. The research team employed a facilitator/co-facilitator design with participant numbers ranging from 8 to 12 community members per group to ensure proper balance between collecting rich data at individual levels and maintaining vibrant discussion at group levels. Participants were fully oriented to the focus group processes prior to participation and were fully debriefed at conclusion. Question routes were prepared in advance, moving from general to specific, employing probes to maximize the detail and validity of participant data. Facilitators conducted each group to achieve saturation of items in the facilitators' guidebooks. When possible, parallel groups were established to provide for between-group comparisons.

On the first day of the study, participants were separated into small roundtable discussions in groups of ten. Each group (a) contained at least one person from each of the four participant categories and (b) did not contain multiple participants from the same family. Each set of roundtable discussions (i.e. the sets of focus groups) were followed by a large community conversation involving all of the participants. The trained focus group facilitators utilized a printed study guide that covered three common topics. Students from Indiana University -

Purdue University, Indianapolis who underwent eight hours of training served as recorders/note-takers in each room to gather the notes that served as our qualitative data.

At the end of the first day, the entire research team gathered to discuss emerging themes. The principle investigators took this feedback and existing notes to identify four themes that were most prevalent in the first day's focus groups: abortion, childcare, economic opportunity, and family communication. On the second day, participants self-selected into one of these groups and focused on one of the four topics for the entire day. Again, the trained facilitators led the discussions using a printed facilitator guide.

### Data Analysis

The quantitative data analysis was purely descriptive. It consisted of producing basic univariate statistics and bivariate comparisons. The qualitative data provides the majority of our information. Two days following the community conversation, all of the researchers, hosts, facilitators, and recorders met to debrief and to ensure quality of the qualitative data (Stiles, 1993). In the following weeks, the recorders transcribed all of their notes. Notes from the facilitator post-group debriefings and transcripts of focus group sessions were analyzed according to established grounded theory processes (Emerson, Fretz, & Shaw, 1995; Emerson, Fretz, & Shaw, 2011).

The research team performed two rounds of open coding and four rounds of focused coding to analyze the qualitative data (Emerson et al., 1995). Analysis continued until at least two investigators agreed on convergence and saturation in each of the identified coding themes. Through these analyses, we identified three sets of results that comment on both community capacity and previously underemphasized needs.

## **RESULTS**

### Networks of Women as a Source of Community Capacity

Individual participants commented positively about several of the programs and institutions serving the community (specifically, a local health center, Planned Parenthood, "security dads," and WIC). However, the most pervasive and consistent evidence of the community's capacity to support teen parents is rooted in familial relationships, including both biological and voluntary/chosen kinship relationships (i.e. "people perceived to be family but not related by blood or by law" (Braithwaite et al., 2010, p. 390)). The data reveal that networks of women permeate the pregnant and parenting teens'—both the men's and women's—system of support and services. Mothers play a salient role in these networks, but grandmothers also have a dominant presence. Aunts, aunties, godmothers, and family friends are also involved in these networks. Together, these women fulfill essential needs related to the health and well-being of the teen parents and their children.

These findings echo Carol Stack's (Stack, 1974) classic research on Black women raising children, and extend the line of research she spurred to include young black fathers. From the onset of their pregnancies, teenage mothers and fathers seemed unclear about their new roles as parents and reported that they needed valuable information. Mothers and other extended kinship members—i.e. local women who are not connected biologically, but who are thought of as family and given corresponding names such as "Auntie"—help to fill that need. As the following sample statements indicate, these women simultaneously serve as sources of information, emotional support, and tangible support to both young men and young women.

### **Emotional Support**



Leech et al.

- *“Being a teen Mom is very hard. I was fortunate to have support but some aren’t that lucky. I kept my teenage years but I had my family. My Godmama helped a lot she gave a lot of support” (former teen mother)*
- *“My Aunt is there to support me, talks to me and give me advice” (teen father)*

#### Stability

- *“That’s where the stability comes from: the grandparents. It’s where the children go and they don’t have to be hungry and thirsty. . . Kids want to go to their grandma. They know grandma gone take them shopping or whatever.” (community member)*
- *“My grandmother is really close to us, because she didn’t let us get in the system, she really cares about us like [his daughter] was her own. My Mom got shot—if my Mom passes on, she would take care of us [and take us in]. . .” (teen father)*

#### Childcare

- *“I stopped going [to school]. It was hard, and I got kicked out actually because I had childcare problems. I didn’t have a strong support system at first. My Mom and Aunt watch her if I need help.” (teen parent)*
- *“If it wasn’t for my Auntie with my first two kids, I wouldn’t have been able to go to work or school. I had her right when I became a freshman. My mom worked. . . . if it wasn’t for my family, I wouldn’t be able to have daycare. I got CCDF [Childcare and Development Fund], but I started making too much, and they cut me off.” (former teen mother)*

#### Informal and Formal Custody

- *“I had the baby but I still didn’t know what I was doing. My mother took over . . .” (former teen parent)*
- *“I started having suicidal thoughts. . . Talked to my Auntie to get temporary custody. She said yes. One week before she signed the papers, I got locked up. If she didn’t sign the papers, my son wouldn’t have childcare.” (former teen parent)*

There was some evidence of support emerging from extended networks of men. Comments about these networks were neither as common nor as persuasive as those alluding to networks of women. Comments about support from men were largely confined to people serving as surrogate fathers, and grandfathers did not seem to play a role parallel to that played by grandmothers.

In general, networks of women represent the most clearly articulated, consistent form of community support given to parenting teen mothers and fathers. Women in the networks offer advice, assist with child rearing and in some cases take full responsibility—whether through informal or formal custody—for the teens’ offspring. This level of support is offered even in the midst of limited resources and other responsibilities.

Networks of Women as Gatekeepers to Information and Health Care

Although the previous results are already prevalent in the literature, focusing on the *community* experience of high pregnancy rates reveals evidence of a potentially interesting interplay between the informal networks of women and the formal sources of care. First, the enrollment data indicate that participants prefer these informal sources of support and advice over guidance from formal sources, even for information or knowledge typically thought of as part of the realm of formal health services. Using the Fragile Families project as a model, the enrollment survey asked people “During the next year, if you needed help who could you count on” to provide an array of support specified in Table 2.

**Table 2:** Support

Who Could you Count on to:	
<ul style="list-style-type: none"> <li>• Loan you \$20</li> <li>• Loan you \$200</li> <li>• Provide a place to live</li> <li>• Give you good advice</li> </ul>	<ul style="list-style-type: none"> <li>• Help with babysitting or childcare</li> <li>• Help you make a decision about your child’s health</li> <li>• Provide you with comfort when facing a problem</li> </ul>
Respondents could choose any of the following:	
<ul style="list-style-type: none"> <li>• Child’s father/mother</li> <li>• Your spouse/partner</li> <li>• Your friends</li> <li>• School/school official</li> <li>• Government Agency</li> </ul>	<ul style="list-style-type: none"> <li>• Your neighbors</li> <li>• Your family</li> <li>• Church/church official</li> <li>• Community organization</li> </ul>

As shown in the table, there are four institutions participants could report turning to for help—churches, schools, government, and community organizations. Over two-thirds of the community participants (69%) reported that they would *not* turn to *any* of the institutions for advice, and an even larger portion—9 out of 10—indicated that they would not turn to any of these institutions for help making a decision about their child’s health. Conversely, the vast majority of participants (89% and 78%, respectively) indicated that they turn to at least one informal tie—family, friends, spouse, and/or neighbors—for this guidance. This decision making process does not reflect dual parents/couples consulting each other in the decision making process; instead, family and friends were both more common responses than spouse/partner. It is important to remember that the participants providing this information are not limited to current teen parents. This data indicates that the very large majority of people parenting in this community—teen parents, adult parents, grandparents, other family-member caregivers, guardians—are all turning to friends and family (not parenting partners or health professionals) for advice and guidance related to children’s health. This advice is not in addition to formal health care advice but in lieu of it.

During the conversations, community members expressed general mistrust of institutions based on previous experiences, and they transferred that general mistrust to specific institutional efforts. Additionally, specific knowledge about services (not name recognition of services) also represented a usability issue to community members. Although most participants are aware of existing services, many reported that usable information about the program—location, eligibility requirements, restrictions, etc.—is difficult to obtain. Indeed, when asked to propose solutions for the negative experiences the community has had with teen parenting and pregnancy, two

groups proposed a one-stop-shop devoted entirely to dispersal of information (they titled them “Program or agency for strategic distribution of information” and “Multi-service center”). The problem did not seem to be recognition of services that are available, instead it is knowledge about how to access and navigate the agencies’ systems. As one participant puts it,

*“We need an advisor to give you all the information; it would be better. Some type of administrator that says this is how this goes. These are the stipulations. If you don’t get all that information, then you making 17 trips on the bus so they can turn you back around.”*

Perhaps to fill this need, the community members relied upon the wisdom and experience within their community’s informal network of women. The data indicate that the interplay between these informal conduits of information and formal support systems serves as an unanticipated barrier to accessing care, one which is not—to our knowledge—discussed elsewhere in the literature. The informal networks of women typically introduce pregnant teens to formal medical care during the pregnancy, so delays in disclosing the pregnancy to the informal network results in delays accessing formal medical care. The network of women explicitly serves as a gatekeeper to prenatal care. In turn, when worries about disappointing female caregivers leads young people to delay disclosing their pregnancy to these gatekeepers, the worries themselves serve as a barrier to accessing care.

Many (over two-thirds) of the participants—men and women—reported that the first person they informed about a pregnancy was a woman in their kinship network. These were usually aunts, sisters, and mothers.

- *“I told my Auntie first because I could trust her. I knew my Mama would look down on me. I trust my Auntie.” (former teen parent)*
- *“I don’t like hiding stuff so I told. Got pregnant at 16 and couldn’t tell grandmother. Had my aunt tell her.” (parenting teen)*
- *“I didn’t talk to my boys. I went home and told my Mama.” (former teen father)*

However, a large number of participants reported hiding the pregnancy; indicating that their mothers (or other female primary caregiver) first learned of the pregnancy when the teen “started to show.” Although these women eventually became the new parents’ primary source of support, adolescents initially feared revealing the pregnancy because of strong anti-teen pregnancy cultural values (Gallup-Black & Weitzman, 2004). As the data below indicates, these fears were not unfounded, as even adults in this community report strong negative sanctions against teen pregnancy.

- *“[I] never told my Mama. I don’t know if the fear was there. . . I just didn’t tell her. . .” [added fieldnote from researcher: She said she showed and her mother pretty much knew]”(former teen mother and current care giver)*
- *“Said she didn’t want an abortion and so didn’t tell her parents until she was showing” (recorder’s notes referring to a statement by a former teen parent)*
- *“I didn’t tell my Mama. They found out on their own and took me to the doctor. I thought my mom would put me out.” (former teen mother)*
- *“The pastor made me stand up during the service and say I was sorry for getting pregnant.” (parenting teen)*

- *“I was embarrassed. I was 15 and I knew my baby daddy for 6 months, so I waited to tell people until I was 3 or 4 months along. My gramama jus’ say I need to get them pills [prenatal vitamins] and take them every day ‘til the baby is born.” (teen mother)*

These delays in revealing the pregnancy serve as a potential barrier to care—specifically prenatal care. Parents and other concerned individuals cannot reasonably assist with prenatal health if they are unaware of the pregnancy. Nonetheless, once the pregnancy was revealed, many of the participants reported that their female family members were the first people to introduce them to prenatal care (see above examples). Furthermore, the community as a whole believed these individuals (not the fathers) *should* be the ones to help them access prenatal care.

- *“I would say parents should go to the doctor. If not, a close friend to be support.” (community member).*
- *“I mean, I can drive her there. But she need a lady to understand those things.” (male caregiver)*
- *“I don’t want no-one but my Auntie takin me to those examinations. [My partner] don’t need to see all that. (teen mother)*

In sum, fear of stigma or losing instrumental support were the main reasons for any delay in revealing the pregnancy, even if in the end most women in the network “took care” of them. But at the same time, the shared community belief is that the women in the network *should* bear the responsibility for supporting teen mothers’ prenatal health. The provided examples illustrate a unique balance of networks of women as sources of support, sources of stigma, and gatekeepers to care. If the community stigma is too great, there is not only a delay of informal support, prenatal care is also delayed.

### Paternity Testing as a Potential Conduit to Fathering

Once the pregnancy was revealed, the community was concerned about needed structures and services that are unavailable or under-available. Community members had found innovative ways to access or create many of the services that fell into this category. Nevertheless, they reported that there were limited, formal services fulfilling needs that are related to men’s roles in the teen parenting and pregnancy experience.

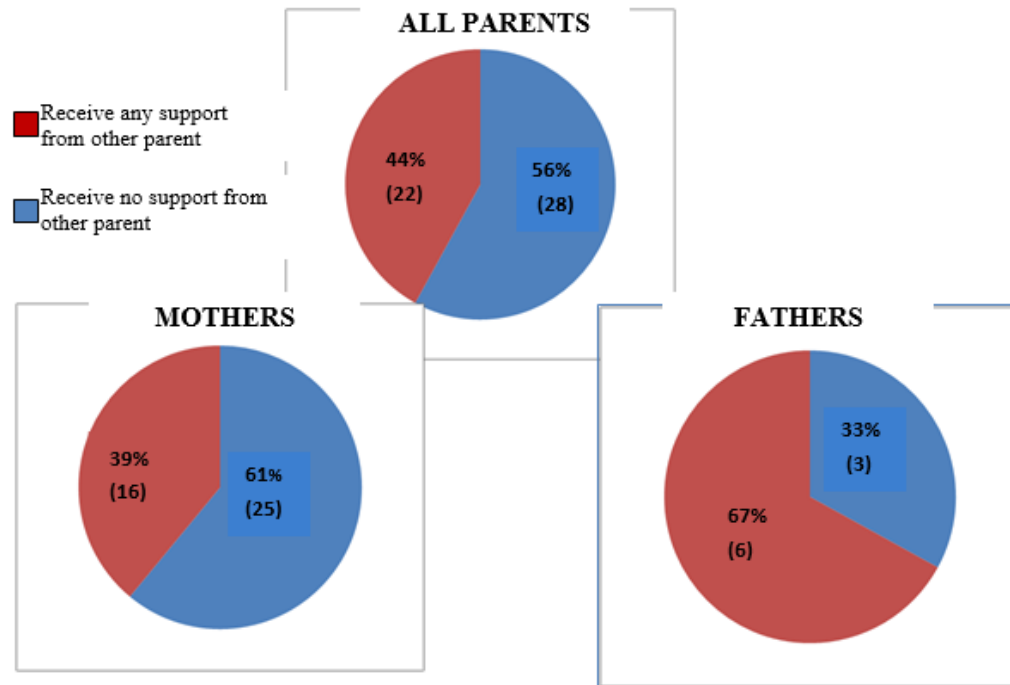
During the conversations, participants indicated that there was a paucity of—but not complete absence of—fathering in the community. There was large agreement that fathers should play two roles. According to the participants, “real” fathers are physically and emotionally available to children and also provide financial support for their children.

- *“A father is somebody that’s there. I don’t have a baby daddy, I have a baby father. There is a difference. That counts.” (teen parent)*
- *“I was scared to death, just holding my baby. Then I thought, ‘I can mold it to be better than me.’ It’s power. It is hard to understand, real parents understand. I don’t do baby mama drama, I’m the yes man. [chuckles from the other men] I take care of mine.” (former teen father)*

The quantitative data indicates that fathers are largely failing to fulfill these expected roles, and the qualitative data indicates that paternity testing services could help to alleviate this problem. Figure 2 again uses information from the questions regarding sources of support. Several of the questions captured financial support while others captured emotional support. Unfortunately, the figure indicates that 56% of participants with children receive no form of

support—neither financial nor emotional/social—from the other biological parent of their children. It also shows that this is largely driven by women lacking support from men: a majority of women (61%) receive absolutely *no* support from men while, in direct contrast, a similar proportion of men (67%) report receiving substantial support from women.

**Figure 2:** Parents Receiving Financial or Social Support from Other Biological Parent, by Gender



\*Note: Raw numbers are given in parentheses.

During the conversation, it became evident that much of the needed support from fathers was not related to finances. Perhaps contrary to popular depictions, many of the participants did not use child support as a means of financial gain. Participants shared many stories about being reluctant to file for child support or enforce child support for various reasons, including the fact that it represents a large hassle for little return.

- *“They get a break now-a-days because women don’t enforce child support. So long as they [men] come over and give whatever money they need they don’t go to the court to get child support.” (community member)*
- *“I told her ‘don’t go to court.’ It won’t make him be a Daddy. And you have to hear all that mess from his Mama.” (family member)*
- *“It just takes too much [effort]. You have to go to these offices and fill out all this paper work and nobody wants to go through all of that.” (former teen parent)*
- *“And you want to put all your business out there for \$15 a month? [chuckles from the other participants]” (teen parent)*

One of the most common specific reasons for their reluctance was the negative effect filing for child support had on the relationship the teen mother and child have with the paternal family.

- *“I said ‘I’m gonna have to file for support.’ That was it. We couldn’t go to dinner no more. [This was part of a story about the mother taking her child to dinner on Sundays at the paternal aunt’s house.]” (former teen parent)*
- *“I can see why [the paternal grandmother] was so angry. She do everything for that child. And then the mama said she was going to file for child support. He don’t have nothin to give!” (community member)*
- *[In response to a question about whether a mother considered filing for child support.] “And then what? Who’s gonna watch the baby when I go to school? Not his mama.” (teen mother)*

However, a large portion (42%) of women did file for child support; primarily because it garnered them access to father attachment through paternity testing. Establishing paternity was reported as a pre-requisite to close relationships between teen fathers and their children. This formal paternity seemed to have effects similar to those seen in voluntary paternity acknowledgement programs—support from the father and cooperative behavior between parents (Brown, Cook, Wimer, & Poverty, 2005).

- *“Like my baby’s father, he wasn’t around at first. [I] got a test and proved it was his, and now he is around.” (former teen parent)*
- *“His Auntie say [the baby] ain’t his. I think that make him think. But now he see her after the papers.” (teen parent)*
- *“My son’s father went into the service [the military], and I hadn’t heard from him in four years. So in order for my son to see his father, I went and filed for child support.” (former teen parent)*

Overall, the evidence indicates that the child support process is cumbersome and causes a lot of conflict within the community and within extended family relationships. However, many mothers in this community are forced to access the child support system to gain access to free paternity testing. Thus, the lack of available paternity testing—outside of the child support system—represents a needed service in the community. Some participants advocated offering paternity testing as an accompaniment to pregnancy testing. Access to these services outside of the child support system could simultaneously support paternal involvement in the lives of children, and decrease conflict within parenting relationships.

## **DISCUSSION**

Although this study provided an opportunity to enhance the understanding of needs and capacities of a community through better understanding of the impact and implications of teen pregnancy and parenting, there are important limitations. Our study suffers from the limitations of any focus group analysis, as well as those attributable to small sample sizes. All facilitators went through extensive training, but any research of this kind is subject to facilitator bias as well as discussions being dominated by only a few voices. The results should also not be generalized to all communities with high rates of adolescent pregnancy and parenting. Instead, they should be interpreted as informative ideas and concepts for future consideration by researchers and practitioners – especially those working in ethnic enclaves. We recognize that for the information to be most effective and meaningful, a cross cultural comparison is necessary in future research.

Our study attempted to document some of the under-recognized community resources and community needs in this one neighborhood, and the associated findings should be evaluated in a larger study.

Nonetheless, the data from the community conversations illuminate important social processes and cultural dimensions of this community's experience with teen pregnancy and parenting that warrant further investigation. Despite limited economic resources in this community, informal networks of women serve as the main source of wisdom, information, and guidance among teen parents in the community. This phenomenon has been well established in existing literature (Haxton & Harknett, 2009; Sarkisian & Gerstel, 2004; Stack, 1974). More importantly, the participants in our study were emphatic that this is how they want to continue to receive their information and advice—not from formal agencies. Researchers and health practitioners have long acknowledged the Black community's caution when interacting with the medical system and government agencies (Brandon, Isaac, & LaVeist, 2005; Freimuth et al., 2001). Less emphasis has been placed on the groups Black young adults *do* trust to provide health education and advice: older women, especially grandmothers and Aunties (Heinig et al., 2009). For example, there is evidence that grandmothers can positively influence healthy dietary behaviors during a pregnancy (Kannan et al., 2008) and breastfeeding after the pregnancy (Bentley, Gavin, Black, & Teti, 1999). Thus, pregnancy and parenting agencies' may want to explore ways to integrate local, elder women into their health education efforts geared toward low income, Black teens.

They may also want to explore grandmothers and aunties as gatekeepers to formal health care. In the community under study, these extended kinship members seem to be the primary people referring and/or introducing pregnant teens to prenatal health care services (Pescosolido, 1996). However, this gatekeeper role means that when the women are not aware of teen pregnancies, teens will not have access to care. Many of the participants in our study delayed revelations of pregnancies *even within families and communities with a large prevalence of and long history of teenage childbearing*. In practice, failing to reveal the pregnancy to a mature woman meant failing to access prenatal care.

Older women in the neighborhood we studied played a role in prenatal care and parenting services that mirrors much of the research on the Black clergy's role in mental health services (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). There is longstanding evidence that leaders in the Black church are the first people to whom Black young adults divulge mental health issues (Ayalon & Young, 2005; Kane & Green, 2009). There is also evidence of Black clergy being useful allies in referring young people to mental health care, if the stigma of accessing mental health care can be overcome (Adksion-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005; Molock, Matlin, Barksdale, Puri, & Lyles, 2008). Both of these issues—being natural confidants for youth around a highly stigmatized health issue—run parallel to the role of elder community women. Intervention and education efforts concerned with early access to prenatal care should (a) further investigate the phenomenon of elder women being gatekeepers to prenatal care and (b) refer to/model efforts to overcome stigma and mobilize Black clergy as gatekeepers to health care.

Finally, academic and applied efforts concerned with paternal support should investigate the effectiveness of increasing access to non-punitive paternity testing as an intervention strategy. In this community, paternity tests play a key role in securing support from fathers. Many mothers did not access the child support system to garner financial support; instead they accessed services as a medium to encourage fathers to play an active, emotional role in their

children's lives. At the same time, they bemoaned the negative effects of the child support process on the maternal-paternal (including paternal family) relationship. There is strong evidence of a relationship between legislated child-support and child-father contact and emotional involvement (Argys & Peters, 2001; Peters, Argys, Howard, & Butler, 2004). However, we are unaware of any studies investigating the relationship in the opposite direction. In other words, does non-legislated monetary/tangible support increase as a result of emotional non-residential paternal involvement? The participants in this study seem to believe that when fathers interact more with their children, monetary support may be a natural result of a process that they view as voluntary instead of compulsory. They also believe that non-compulsory paternity testing can be an impetus for this natural progression.

## CONCLUSION

In sum, the data and associated findings from this study should be of interest to both scholars and practitioners interested in pregnancy and parenting services within low-income areas. The study of this neighborhood has generated hypotheses that warrant further academic investigation: e.g. is the relationship between monetary child support and non-residential paternal involvement unidirectional? It also provides guidance for public health practitioners: e.g. look toward other examples of asset-based community interventions that simultaneously address stigma and mobilize community-identified power brokers. Overall, our study reveals several sociocultural adaptations to limited resources that shape the context within which formal pregnancy and parenting services are offered. The results expand upon themes in the current social science literature and provide examples of the ways that one low-income, Black community experiences high rates of teen pregnancy: at the center of a nexus of networks of support, limited resources, and innovative adaptations.

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