Original Studies

Contraceptive Attitudes among Inner-City African American Female Adolescents: Barriers to Effective Hormonal Contraceptive Use

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Abstract. Study Objective: To better understand the contraceptive attitudes of low-income, inner-city African American female adolescents.

Design: We conducted four focus group sessions with African American female adolescents.

Setting: An urban, community health clinic serving low-income patients on Chicago’s south side.

Participants: African American female adolescents (n = 15) between 14 and 19 years of age.

Interventions: Focus group sessions lasting approximately 90 minutes in length were conducted using a predetermined script with set probes and open-ended questions.

Main Outcome Measures: Qualitative analysis was conducted to identify major themes related to adolescents’ contraceptive attitudes.

Results: Six themes related to the contraceptive attitudes of these adolescents emerged: Concerns About Hormones, Concerns About Privacy, Concerns About Compliance, Limited Awareness of New Methods of Hormonal Contraception (HC), Preference for Condoms, and Acceptability of Emergency Contraception (EC). Overall, adolescents in these sessions expressed skepticism and unwillingness to use continuous methods of HC. For some adolescents, concerns about hormones, privacy, and compliance outweighed their concerns about pregnancy.

Conclusion: Concerns about perceived side effects and long-term health risks associated HC and privacy in obtaining contraception and reproductive health care, as well as concerns about ability to comply with daily and weekly HC regimens are common among African American female adolescents and may deter consistent HC use. Although condoms and EC appear to be highly acceptable among this group, adolescents also report a number of barriers to their consistent use. Efforts to reduce early, unintended pregnancy among African American youth should focus on addressing adolescents’ HC-related concerns, improving access to EC, and helping female adolescents effectively negotiate condom use.


Introduction

Despite an overall increase in the use of hormonal contraception (HC) among adolescents in the United States in recent years, compared to Caucasian adolescents, HC use among African American female adolescents remains low, with low-income, inner-city adolescents having some of the lowest rates of HC compliance. Although pregnancy and birth rates among adolescents have declined in recent years, 82% of pregnancies among all adolescents are unintended. The current pregnancy rate among African American females between 15 and 19 years of age is 2.5 times that of non-Hispanic Whites. Non-use or inconsistent use of HC and a tendency to rely on less effective barrier methods of contraception among African American adolescents may contribute to racial disparities in pregnancy and birth rates among adolescents.

Concerns about unwanted side effects may deter African American adolescents from initiating and using HC consistently. In fact, concern about
HC-related side effects may be one of the best predictors of ineffective HC use among low-income, urban adolescents. In addition, several studies have found that African American youth often possess a great deal of misinformation about potential side effects of HC, including misconceptions about its long-term effects on reproductive health, fertility, and physiology. Nonuse and inconsistent use of HC and concerns about potential HC side effects among this group of adolescents may be uniquely exacerbated by a lack of sources for obtaining accurate information about HC and what other researchers have referred to as “urban legends” about negative “side effects” and the ineffectiveness of certain HC methods that get passed on to African American adolescents by family members and friends.

Ambivalence toward pregnancy has also been associated with nonuse of contraception and low motivation to use contraception consistently among African American female adolescents. Studies have shown adolescent pregnancy to be acceptable among some African American youth, who may view early pregnancy as a normal phenomenon that would not significantly affect their life or interfere with their long-term goals. Yet, compared to those who delay pregnancy, adolescents who experience early childbearing are more likely to face numerous negative psychosocial outcomes, including low levels of educational attainment and employment, an increased likelihood of obtaining low-skilled and low-paying jobs, high rates of poverty, and dependence on public assistance.

Given the potential adverse consequence of early childbearing on long-term outcomes for adolescents’ lives, understanding how African American female adolescents make contraceptive choices is essential. Yet, little is known about factors influencing the contraceptive attitudes and choices of young inner-city African American youth. Moreover, despite an array of available methods of HC, there is a dearth of research on the knowledge and attitudes of African American girls’ towards these various methods, as well as the acceptability of newer hormonal methods, such as the vaginal ring and intrauterine device (IUD).

The purpose of this study is to better understand the contraceptive attitudes of low-income, inner-city African American female adolescents. Using a qualitative approach in a community setting, we identify barriers to effective HC use from the perspective of adolescents. As the percentage of sexually active teenagers is increasing, understanding attitudes toward and barriers to effective HC use among African American female adolescents is crucial for designing effective interventions aimed at reducing unintended pregnancy among this high-risk population of youth.

Methods

As part of a larger focus group study of sexuality, pregnancy risk, and contraceptive attitudes and practices among African American and Latino teens, we conducted four focus groups with African American female adolescents in July and August of 2004. We recruited participants on site and through flyers posted at an urban community health clinic serving a predominantly low-income patient population on Chicago’s south side. Eligibility criteria included being between 14 and 19 years of age, self-identifying as African American, and residing in the selected African American community. Adolescents did not have to be sexually active to participate. Participants received $20 to compensate for time and transportation costs. Informed consent was obtained from each participant at the beginning of each focus group session. Parental informed consent and adolescent informed assent was obtained for all participants under 18 years of age. This study and its methods were approved by the Institutional Review Board of the University of Illinois at Chicago.

All focus groups were conducted by an African American female moderator with the aid of a female research assistant trained in qualitative research. At the start of each session, the purpose of the focus group and confidentiality ground rules were explained and participants were encouraged to speak freely. Sessions were conducted using a predetermined transcript of open-ended questions with set probes to help stimulate conversation. Focus group questions were derived from the empirical literature on adolescent sexuality and reproductive health attitudes and behaviors. A panel of experts in the field of contraceptive compliance, adolescent pregnancy, behavioral theory, and ethnographic research was consulted to lend face validity to the focus group guide. As key informants, we asked participants to describe normative sexual and contraceptive behaviors and attitudes among teens in their communities and to reflect on the different influences on such norms. During each session, probes were broadened as needed to clarify participants’ responses. Focus groups lasted approximately 90 minutes. Each session was audio-taped, supplemented by written notes to capture important nonverbal responses and/or strong reactions among participants. Following each focus group, information gleaned from each session was reviewed to identify emerging themes for further exploration in subsequent sessions.

All focus group sessions were then transcribed verbatim from audio tape and all transcripts were reviewed for accuracy. We conducted thematic analysis of transcripts using a qualitative data analysis program. An initial list of codes with operational
and how continuous use of HC might precipitate and/or apprehension regarding long-term health risks, weight gain, irregular bleeding, hair loss, and nausea, as well as fear of unwanted immediate side effects, such as increased risk of chronic disease and thought HC might hasten the development of such conditions. For example, one participant stated, “I don’t really want the hormones cause they act all funky. Every time I take a hormone they got different side effects.” Consistent with this statement, several adolescents described their search for an acceptable method of HC and how unwanted side effects frequently lead to method switching and ultimately to discontinuation. As one adolescent explained, “The pill, if I miss a day my period came out. The three month shot that kept me sick, I had morning sickness every morning… and umm that patch made her gain a lot of weight… so I didn’t use it. No thank you. No, no, don’t use the patch or the injection.” As this statement suggests, our analysis revealed that in addition to personal experiences, adolescents’ concerns about HC use were highly influenced by the experience and advice of female peers and relatives. They explained how “side effects and what they get from the other people” or “rumors” left them leery of HC and unwilling to try certain methods.

In analyzing the qualitative data, we identified six overarching themes related to the contraceptive attitudes of these adolescents: Concerns About Hormones, Concerns About Privacy, Concerns About Compliance, Limited Awareness of New Methods of HC, Preference for Condoms, and Acceptability of the Emergency Contraception (EC). Overall, adolescents in these sessions expressed skepticism and unwillingness to use continuous methods of HC and for some adolescents concerns about hormones, privacy, and compliance outweighed their concerns about pregnancy. Each of the six themes and how it relates to the contraceptive attitudes and choices of these adolescents is discussed below.

Theme 1: Concerns about Hormones
Adolescents in all groups described considerable concerns about continuous use of HC, expressed primarily as fear of unwanted immediate side effects, such as weight gain, irregular bleeding, hair loss, and nausea, and/or apprehension regarding long-term health risks and how continuous use of HC might precipitate chronic illness. Discussions clearly revealed how each of these concerns negatively influenced their willingness to use HC. Concerns about immediate side effects often resulted from personal experience with continuous and long-acting methods of HC. For example, one participant stated, “I don’t really want the hormones cause they act all funky. Every time I take a hormone they got different side effects.” Consistent with this statement, several adolescents described their search for an acceptable method of HC and how unwanted side effects frequently lead to method switching and ultimately to discontinuation. As one adolescent explained, “The pill, if I miss a day my period came out. The three month shot that kept me sick, I had morning sickness every morning… and umm that patch made her gain a lot of weight… so I didn’t use it. No thank you. No, no, don’t use the patch or the injection.” As this statement suggests, our analysis revealed that in addition to personal experiences, adolescents’ concerns about HC use were highly influenced by the experience and advice of female peers and relatives. They explained how “side effects and what they get from the other people” or “rumors” left them leery of HC and unwilling to try certain methods.

In addition to concerns about immediate side effects, many girls lived in families with chronic illness and medical disease and subsequently felt continuous use of HC was unsafe for them. They expressed concerns about potential long-term health risks associated with HC use and how a family history of chronic medical conditions, such as heart disease, may contraindicate the use of hormones. For example, one participant alluded to health warnings on contraceptive advertisements, relating them to numerous health concerns among African Americans, “You can’t have a history of cancer in your family, blood clots, stroke, high blood pressure. I’m say’in that’s everybody black.” Another considered the inevitability of chronic disease and thought HC might hasten these illnesses: “My mother side got cancer and diabetes and my daddy side got cancer and diabetes and high blood pressure. I don’t want to take those chances, it’s already. . . in me. It might come out. I don’t want to make it come early.”

Theme 2: Concerns about Privacy
Adolescents cited a number of concerns about their ability to maintain personal privacy and confidentiality in obtaining and using HC. Participants in our sessions were drawn from a community-based health center. Despite awareness among participants of where to go and whom to speak with, discussions revealed that an unexpected consequence of a convenient neighborhood facility was that many teens felt going to a clinician for a prescription for HC would
compromise their privacy. For example, when asked why sexually active teens might not use birth control, one participant felt most teens in her community were “ashamed” to go to clinic and explained how fear of being seen in clinic by neighbors or friends of parents prevented them from seeking HC. “I might see my mamma’s friend in the clinic with her four kids or somethin’” and “She gonna tell my mamma.” Some were uncomfortable having their name called out in clinic. Others worried doctors would inform their parents of their sexual activity. One adolescent explained how, although she apparently had a regular health care provider, she never discussed contraception with her provider, “I don’t really talk to my doctor… My doctors tell me, if you need to come talk to me, I can…Right, and they gonna tell your mamma.”

Indeed, adolescents indicated a need to conceal their sexual activity from parents and felt daily and weekly contraceptive methods, such as oral contraceptives (OC) and the contraceptive patch, compromised their ability to do so. For some, possessing OC blister packs or contraceptive patches was perceived as too risky, as they suspected their mother of prying through their personal belongings and feared they would discover their contraception and become aware of their sexual activity. For example, one participant stated, “Cause if your parents don’t know…cause I think my mamma be goin’ through my drawer.” Another confessed, “Yeah. I know my mamma’s goin’ through my stuff.” According to participants, this apparent lack of privacy at home, together with a perceived lack of privacy in obtaining reproductive health care, deterred young women in their community from using HC.

**Theme 3: Concerns about Compliance**

Another recurring theme among adolescent girls was a perceived inability or disinterest in adhering to continuous HC regimens. While concerns about their ability to adhere to HC appeared to decrease in conjunction with the complexity of the necessary user behaviors associated with a given method, adolescents explained that girls often had a hard time remembering to take daily medication, change weekly contraceptive patches, or return to clinic every three months for depomedoxyprogesterone acetate (DMPA) injections. One participant explained, “A pill you got to take everyday. Oh that’s what you really forget you know what I’m saying just to keep taking pills everyday. You ain’t.” However, adolescents also emphasized how girls in their community often perceive themselves to be unsusceptible to pregnancy or appear ambivalent about pregnancy and how they subsequently do not take HC “seriously.” As one participant explained, most girls are “thinkin’ they ain’t gonna get pregnant, so they be like, it ain’t gonna happen to me.” Another adolescent characterized girls in her community as unmotivated to prevent pregnancy and described how “even though they know about the patches, they know about the condoms, they know about the shot …they just don’t want to follow the steps that they suppose to take to prevent from getting pregnant.”

**Theme 4: Limited Awareness of New Methods of HC**

Most participants were familiar with OCs, DMPA, and the contraceptive patch. Although some had first-hand experience with these methods, most indicated they received information about these methods from friends and relatives, many of whom had conveyed unfavorable experiences. Yet, adolescents were unfamiliar with newer methods of HC, such as the vaginal ring and IUD. After learning about the vaginal ring and the IUD during the sessions, some were uncomfortable with the idea of having a device, especially one containing metal, placed inside the uterus or with having to self-insert an object into their vagina, but expressed great interest in “birth control that you ain’t got to change everyday.” One adolescent who had tried and discontinued several HC methods due to unwanted side effects and had already experienced three pregnancies was considering sterilization. After being given an explanation of the IUD, she thought the IUD “sounded good,” as she wanted a birth control method that would “last a few years” and was nervous about the permanency of sterilization.

**Theme 5: Preference for Condoms**

Adolescents in all groups described an overwhelming preference for condoms over HC, characterizing condoms as convenient and the “first thing you grab.” They expressed considerable appreciation for the fact that condoms lacked the adverse side effects they commonly associated with HC and explained that unlike HC condoms could be obtained easily, anonymously, and often at no cost.

When asked who was responsible for ensuring consistent condom use, one participant explained, “I mean it’s the female’s cause they got to be the one who are struggling to support a baby and the men don’t have to do nothing.” Another adolescent confessed, “I feel like this…the female wears the pants because when you think about it…I mean, It’s her decision open her legs alright come on…she control what he want too. Even if he did want to do it so bad, you doin’ it cause he want to, you can still [make] him to wear a condom or not. And if he can’t get one, he just won’t get none.” They characterized girls who carried condoms with them as “being safe,” “becoming smart” or “protecting themselves.” Regarding her
own decision to carry condoms, one participant stated, “I mean if they got a problem with it oh well. He can find another female cause this one is going to carry a condom.” Several participants even expressed concern over using a condom provided by a male partner as he might be the type to “poke a hole in a condom” in order to “get her pregnant.” Although discussions about boys tampering with condoms in an effort to “trap” certain girls were clearly based on rumors and second hand accounts, one adolescent explained this phenomenon in the following way, “Well some people that I know they think that the condom is not safe because they believe that they boyfriends be putting holes in them and try to use them and then they be wondering why they come up become pregnant.”

However, further discussion revealed that adolescents’ preference for condoms and willingness to carry condoms did not necessarily translate into consistent condom use. As one participant explained, “It’s not a problem getting them. It’s a problem using them.” When asked why girls in their community were not using condoms consistently, participants described a tendency among girls to forgo condom use in the “heat of the moment,” as they may find it difficult to stop physical intimacy in order to initiate condom use. As one participant explained, “They don’t think about it. It don’t come to mind they just be ready to do it.”

Yet, in their discussions about inconsistent condom use, adolescents in all groups primarily emphasized the difficulty they experienced in negotiating condom use with a male partner. All groups described an aversion to condom use among male adolescents, characterizing male partners as reluctant or unwilling to use condoms due to their perception that condoms would decrease physical sensation and/or pleasure, “Some of them say it don’t feel good.” Imitating a typical response from a male partner to condom use, one participant mimicked “Man, you can’t feel nothin’ with this on.” She went on to state “It’s like they take’em off and throw em out.” They indicated that, in order to avoid condom use, male partners often tried to convince them they would use withdrawal. As one participant explained, “Yeah, they don’t (want to use condoms), ‘I’ll pull it out whenever that’s come… Yeah right!’” They described how difficulty negotiating condom use was often exacerbated by intoxication among males or, as they jokingly referred to it, “alcohol hormones” and by a lacking sense of responsibility among males toward pregnancy prevention, “they just don’t care they just ready (to have sex).”

Finally, as evidenced by their conversations about males tampering with condoms, participants endorsed the idea that some male adolescents actually desire pregnancy and may, subsequently, refuse to wear a condom, or, in extreme instances try to trick girls into thinking they are wearing a condom during intercourse when in fact they are not. As one participant explained, “Some boys do it cause they think they’re slick, so they act like they got on a condom and frickin’ without the condom and um release them self in there and did it on purpose, ‘cause they tell you later ‘I want a baby.’ What’s that got to do with me?”

Theme 6: Acceptability of the Emergency Contraception
A majority (n = 9) of adolescents were familiar with emergency contraception, most of whom reported learning about EC at a “women’s rights march” they attended with a school group. Several had received an advanced provision or prescription for EC in the past. The remaining six adolescents (40%) had never heard of EC.

Adolescents who were knowledgeable of EC and/or had used the medication in the past viewed this short-acting method of HC favorably. Unlike long-acting, continuous methods of HC, these adolescents viewed EC as safe and acceptable and associated few adverse side effects or long-term health risks with this method. When asked whether they had the same concerns about taking EC as they did in using continuous methods of HC, one adolescent responded, “No, cause it’s like a one time hormone, it’s not constantly in your system.” They characterized EC as a viable safety net, empowering them to regain reproductive control following an incident of unprotected sex, contraceptive failure, or failed condom negotiation with a male partner. As one adolescent explained, “I mean you got emergency contraception. If this boy… release sperm inside you… you can go to the clinic that very next day and be on it. You got within, what, 72 hours…some-thin’ like that. You can work hard within them 72 hours.”

Yet many found the process of obtaining EC from a physician difficult and inconvenient. For example, one participant stated, “I don’t like it cause you got to get, you have to have unprotected sex first before the doctor gives it to you… Give it to me just in case, you should have it in your nightstand.” Indeed several adolescents advocated making EC as widely available to teens as condoms and providing advanced provisions of EC to teens, which they believed would “cut down a whole lot of pregnancies.” As one adolescent suggested, “Yeah they should pass it out. Like you know how you got condoms sitting out, they should have that sitting out too.” Another participant agreed, “They should have those out on the streets, in a truck that go to school and give everybody some.”
Discussion

This study assessed contraceptive attitudes among a population of African American girls living in a low-income, inner-city community with high rates of adolescent pregnancy. Overall, we found that concerns about hormones, privacy, and compliance prevented these adolescents from initiating and/or adhering to continuous methods of HC. These HC-related concerns often surpassed adolescents’ concerns about early pregnancy. Participants exhibited limited awareness and knowledge of newer, less user-dependent methods of HC, such as the vaginal ring and IUD. They expressed a strong preference for condom use over HC, yet indicated a myriad of challenges to consistent condom use, including difficulty negotiating condom use with a reluctant and/or intoxicated partner. However, in contrast to their negative perceptions of continuous methods of HC, adolescents in our study who were familiar with and knowledgeable about the emergency contraceptive pills viewed this short-acting hormonal contraceptive as safe and acceptable, advocating widespread distribution of EC to teens. They felt making EC readily available to teens could significantly reduce unintended pregnancy among adolescents.

African American female adolescents in this study were most concerned about potential side effects of continuous use of HC and its perceived ability to hasten impending chronic illness. This finding is significant as it demonstrates that high rates of chronic disease in their community affects their perception of their own health and the safety of contraceptive methods. Although some teens described personal experience with unwanted HC-related side effects, they also discussed how the negative information they received about specific methods of HC left them leery of certain methods and of HC in general. This finding supports those of several previous investigations, which suggests disconcerting stories about HC may be prevalent among African American women. Yet, further research is needed to better understand how information passed on to adolescents about HC from trusted others may shape their overall attitudes towards HC and how unfavorable anecdotes about HC may deter African American adolescents from initiating and adhering to specific HC methods.

While other investigators have found that discomfort and embarrassment in talking about sex-related topics with health care providers can prevent adolescents from seeking contraception, our findings suggest African American urban adolescents may also have unique concerns about going to local health clinics for contraception. Many adolescents in our study were uncomfortable obtaining HC and reproductive care from neighborhood clinics and were particularly worried about being seen at clinic by other members of their community, which might compromise their ability to conceal their sexual activity from their parents. Previous studies of parent-adolescent communication about sex have found that parental discomfort in talking about sex-related topics, perceived lack of knowledge regarding sexual and reproductive health, moral objections to premartial sex, and fear that positive messages about birth control might encourage adolescent sexual behavior prevent African American parents from effectively communicating with their children about sex. Subsequently, conversations about sex may be more likely to center on abstinence and forgo accurate information about contraception, which may leave adolescents fearful of parental disapproval and/or moral judgment of their sexual behavior and prevent them from initiating HC use.

Although teens in this study expressed strong preference for condoms over HC and were comfortable carrying condoms of their own, our findings confirm the work of other investigators who conclude male partner resistance to condom use due to concerns about reduced physical pleasure and/or desire for pregnancy are associated with inconsistent condom use among female adolescents. Perhaps not unrelated is our additional finding that certain high risk situations, such as unplanned sexual activity (e.g., having sex in the “heat of the moment”) and having sex with an intoxicated partner also interfere with consistent condom use. What might be unique is our finding that the adolescents in our study sometimes mistrusted male partners, fearing they would trick and impregnate them intentionally by poking holes in condoms or by not using withdrawal as agreed. Taken in aggregate, these findings suggest that, despite a recent increase in condom use among African American adolescents, African American female youth may not have the skills they need to successfully negotiate consistent condom use. The fact that one of the aspects these adolescents appreciated most about EC was that it allowed them to regain reproductive control after an incidence of unprotected sex further supports this conclusion.

Our findings have a number of implications for reducing rates of unintended pregnancy among this population of adolescents. Educating and counseling adolescents on newer methods of HC, such as the vaginal ring and contraceptive implant, with a particular focus on addressing potential concerns about self-insertion, could increase HC use among African American female adolescents, as these highly effective, non-daily, long-acting methods require fewer user behaviors and may address adolescents’ concerns about long-term compliance and contraceptive privacy. Clinicians and health educators should also
work to increase adolescents’ knowledge of basic reproductive health and be prepared to address potential concern about long-term health risks and unwanted HC-related side effects and to dispel common myths about HC and reproductive health. Talking about the potential health benefits of HC, such as reduction of acne and heavy, painful, and/or irregular menstruation, might also increase the acceptability of HC among teens. However, further studies are needed to determine the acceptability of newer methods of HC among specific populations of youth.

In addition, given their potential concerns over long-term ingestion of hormones and the apparent acceptability of short-acting EC, increasing African American girls’ awareness and knowledge EC appears warranted. Yet, findings from previous studies indicate that simply educating teens about how EC works and when it should be used may not be enough to ensure accurate knowledge and utilization of EC among adolescents. Further research is needed to better understand how adolescents might incorporate EC use as an additional strategy for preventing pregnancy and to identity effective ways of promoting accurate and effective use. Efforts to improve access to EC should address common barriers to obtaining EC specific to this population of youth, including cost of the medication, lack of a regular health care provider, and concerns about confidentiality. Increased access to EC through student health clinics, advanced provisions of EC at routine clinic visits, and/or provision of educational brochures with toll-free hotline numbers for obtaining EC and promoting EC as a backup plan following instances of contraceptive failure, unsuccessful condom negotiation, and unprotected sex could help African American female adolescents prevent unwanted pregnancy.

Finally, given the extent to which African American girls appear to rely on trusting others in their social group for information about contraception, utilizing peer educators or advisors could be an effective way of disseminating accurate and culturally relevant information about HC, including newer methods such as the vaginal ring, IUD, and EC and dispelling common myths. Peer education programs might focus on empowering African American female adolescents to better negotiate condom use, to actively communicate with partners about condoms and contraception prior to initiating a sexual relationship, and to refuse sex with a partner who is unwilling to use a condom. In addition to peer education, efforts to reduce unintended pregnancy among African American female adolescents should also focus on encouraging and teaching parents to effectively communicate with their children about sex, abstinence, and contraception in a non-judgmental way, as adolescents whose parents communicate openly with them about these topics are more likely to delay sexual debut, to use contraception at first intercourse, and to effectively negotiate condom use with a partner. Parents should be made aware that discussing contraception with adolescents can actually increase responsible sexual behavior and has not been shown to hasten the onset or frequency of adolescent sexual activity. Increasing parent-adolescent communication about sex and contraception could also help reduce adolescents’ perceived need for secrecy from parents in obtaining HC and reproductive health care.

This study had a number of limitations. The goal of the study was to explore general contraceptive attitudes among a group of inner-city youth at high risk for pregnancy. Accordingly, we choose a qualitative focus group approach. While this methodology provided rich data on the contraceptive attitudes and opinions of a group of African American female adolescents, it did not allow us to determine the relationship between adolescents’ expressed attitudes and their actual contraceptive behavior. An additional limitation to this study includes its generalizability. Because this study explored the attitudes of youth living in a specific environment that may be subject to distinct social and economic forces, our findings cannot be generalized to the larger population of African American youth. For example, participants in two of the four focus groups had the distinct experience of attending a women’s rights march in Washington, DC, which clearly influenced their knowledge and attitudes toward emergency contraception. These adolescents may also have been more motivated to participate and share their newly acquired knowledge, resulting in some self-selection bias. Yet, the enthusiasm these young women exhibited regarding the benefits of EC and its potential for reducing unintended pregnancy among adolescents points to the potential impact of placing contraceptive education and counseling for African American girls within the broader context of sexual and reproductive empowerment.

References

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