Factors that influence contraceptive decision-making in African American women, an intergenerational perspective

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FACTORS THAT INFLUENCE CONTRACEPTIVE DECISION-MAKING IN AFRICAN AMERICAN WOMEN, AN INTERGENERATIONAL PERSPECTIVE

a dissertation

by

ALLYSSA L. HARRIS

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For Daddy: I hear your father’s & your words echoing in my ear. “Son, each generation should strive to better than the one before. If not, then I would have failed you.” Guess what? We made it —All 5 of us!!!!!!!!!!
Abstract

FACTORS THAT INFLUENCE CONTRACEPTIVE DECISION-MAKING IN AFRICAN AMERICAN WOMEN:
AN INTERGENERATIONAL PERSPECTIVE

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African American women represent a unique group of women in the United States and have a long history of lack of reproductive freedom. Slavery and forced procreation, sterilization abuses, the Eugenics movement, and federally mandated contraception have all impacted on African American women’s independence in contraceptive decision-making. Given this population’s history, it is important for healthcare providers to understand African American women’s contraceptive decision-making, as women often seek their guidance.

The purpose of this dissertation research was to discover the intergenerational influences on African American women’s contraceptive decision-making. The specific aims of this study were to: 1) develop an understanding of African American women’s contraceptive decision-making process; 2) identify the factors that influence their decision-making; and 3)
develop knowledge that can be used to influence nursing practice. Included in this exploration were questions on the role of mothers and grandmothers in adolescents’ decision-making, familial beliefs about contraceptive choices and whether societal and social factors continue to influence contraceptive decision-making in the 21st Century.

For this work, I used a qualitative descriptive approach to develop an understanding of the phenomenon from the participants’ worldview. I recruited a purposive sample of 7 triads from a metropolitan community in the northeast United States. I conducted an individual interview, using a semi-structured guide, with each participant. Six themes emerged from the data: 1) southern influences; 2) a worldview of relationships; 3) communication: key to preparedness; 4) seeking information from Mom; 5) "I got caught up in the game"; and 6) contraceptive use and beliefs.

African American women's contraceptive decision making is influenced by a variety of factors including familial beliefs, attitudes, culture, and ethnicity. These patterns are transferred to each succeeding generation. Nurses have a significant role to play in providing appropriate contraceptive information and education in a culturally competent context that will meet the needs of these women and their families.
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CHAPTER 1

A Different Outlook

Introduction

Reaching puberty and menarche are pivotal points in women’s lives. Both herald the passage of girls into womanhood and mark the development of physical and emotional changes that constitute this transition, but these changes also represent another event in women’s lives, the ability to procreate. Although welcomed by most women, this transition also leads to another milestone, deciding whether or not to become sexually active. When the young woman decides to do so, she then faces a decision about pregnancy prevention and/ or delay. Understanding how women make this decision is important to health care providers. There are multiple pregnancy prevention options available to women for fertility control including hormonal and non-hormonal methods. During a brief medical visit, a woman must decide which method is best for her, weighing the risk and benefits of each method within the context of her life. But how does a woman reach this decision and what factors influence her decision- making? Is a woman’s contraceptive choice influenced by her ethnicity and culture? What factors influence contraceptive decision-making in a particular ethnic group? Is the decision making process African American women use unique?

According to the Alan Guttmacher Institute (2008), there are sixty-two million women of childbearing age, 15 to 44, in the United States. Of these, 43 million are sexually active and do not want to become pregnant (Guttmacher Institute, 2008). Among women who are sexually active, 7.4 % are not using a contraceptive method, according to
2002 statistics from the National Survey of Family Growth, (Mosher, et al., 2004).

Women are at risk for pregnancy from menarche through menopause, which constitutes approximately one-third of women’s lives, making reproduction and contraception major factors in the lives of women.

Choosing a contraceptive method can be a complex and daunting task. It is a decision most women must make at some time during their life. The complexity of this task is even more frightening when one considers that method failure, whether through inappropriate use or hormonal failure, can have negative consequences for women and/or their partners. This decision is often confusing to women and can be influenced by many factors including provider knowledge, cultural and personal beliefs, and familial, historical and societal influences. The decision-making process is important to health care providers as we are often asked for guidance during this process. The process of choosing a family planning method is important to both patient and health care providers as our knowledge, beliefs, culture and communication skills are called into play. Understanding the factors that influence the contraceptive decision-making process will enable us to guide the patient in choosing a method that is best for her.

African American women represent 8.8% of the female population and are a special population (U.S. Census Bureau, 2005). African American women have had a long history of enforced family planning through United States public policies. Since slavery, African American women have had little control over their fertility; often they were forced to procreate with multiple African American males slaves as well as their masters. There were multiple reasons for this including increasing the slave population,
improving the owner’s economic conditions, and for their master’s pleasure. Later, during the Eugenics movement, women were forcibly sterilized and castrated in the name of improving society by eliminating procreation among the socially inadequate (Roberts, 1997). Margaret Sanger’s birth control movement also had a negative influence on African American reproduction. Although Margaret Sanger advocated for a woman’s right to control her fertility, her later alignment with the Eugenics movement had negative consequences for African Americans. She believed that the Black population’s continued uncontrolled breeding led to further deterioration of the population by increasing rates of poverty, overcrowding, and disease (Schoen, 2005). Many believed that her motives were racist.

The introduction of the contraceptive Norplant® was met with great enthusiasm at first. It was a simple method that promised fertility control for up to five years. Many women chose this method for its convenience and ease of use. Experiencing side effects, many women requested its removal and were met with resistance by physicians. Women’s reported feelings of being pressured to keep this method, despite the side effects, were related to their low socioeconomic status and participation in government welfare programs. Many felt that they were the victims of government sponsored reproductive engineering.

*Purpose of the Study*

Given this population’s long history of lack of reproductive freedoms, it is important to understand African American women’s contraceptive decision-making. The purpose of this qualitative study is to discover the intergenerational influences on African
American women’s contraceptive decision-making. Included in this exploration are questions on the roles of the mother and grandmother in adolescent decision-making, familial beliefs about contraceptive choices, and whether societal and social factors continue to influence contraceptive decision-making today. The specific aims of this study were to: 1) develop an understanding of African American women’s contraceptive decision-making process; 2) understand the factors that influence their decision-making; and 3) develop knowledge that could influence nursing practice.

*Impetus for the Study*

The women’s health department was particularly busy that day. I had 12 patients scheduled for my morning session, but could never count on my schedule to plan my day. The health center’s population is such that patients often show up for appointments or walk in when they feel that their health problem is important on a particular day. These factors lead to patients with emergent problems being interspersed with routine appointments throughout the day. These circumstances make for a challenging day for me, but I thrive on it. The urban community health center in which I practice serves both privately and publicly insured patients, as well as uninsured and under-insured patients for whom healthcare is often number four or five on a list of challenges that they face daily in their lives.

Fifteen year-old Shaunda presented for a gynecological exam. She reported being sexually active for one year. Her partner is a fifteen year-old boy from her neighborhood and she has known him since kindergarten. She lives at home with her mother, grandmother and two brothers. She is in the tenth grade at a local high school and reports
her grades are “okay, but not great.” Both her mom and grandmother are aware of her sexual activity and encourage her to use condoms. She admits to using them occasionally but often forgoes them stating “He don’t like them anyway.” When I asked her about contraception, she stated that she didn’t want any: “They cause problems with your body.” I engaged her in conversation to gather a better understanding about this statement’s meanings. She began to tell me that none of her friends use birth control methods for a variety of reasons including not liking them, not believing in them and the belief that they make women sterile. I queried her about her mother and grandmother’s beliefs about contraception. She stated that both have told her that contraception causes problems with the body. Her gynecological exam was normal. I provided education on sexually transmitted infections and HIV, as well as information on the importance of annual pap smears. At the end of the visit, I again queried her about considering a contraceptive method. She said that she’ll consider using condoms but remained resistant to a hormonal method.

Later that afternoon I met with Garnet. Garnet, a 40 year-old women, presented with complaints of vaginal discharge; reporting that the discharge began approximately 3 days ago. She reported that she is sexually active with a 43 year-old male and that “she is monogamous” and does not need to use condoms. Her sexual history is benign but she reported that she’s never used a hormonal contraceptive method and had used condoms occasionally in the past. Upon questioning, she reported that she didn’t need contraception, “I’ve always believed that they weren’t good for you”. She reported that she learned this from her mother and believed this despite knowing that “times have
changed”. I completed the exam, wrote her prescription and provided her with education on the importance of condom use as well as the risks of sexually transmitted infections.

Providing contraceptive education to the health center’s population can be a challenging task. I am often faced with patients whose beliefs are cultural and ingrained in their health practices, as well as influenced by spiritual, ethnic and community values. Careful thought must be given to life factors including educational goals and career development, which may afford women the opportunity for greater life satisfaction, goal attainment and economic independence. Even with careful consideration and thoughtfulness, many women have reported that they have shown a lack of commitment to their contraception. Among African Americans, approximately 57.4% were using contraception, while 42.6% reported not using a contraceptive method (Mosher, et al., 2004). As advanced practice nurses, we are cognizant of the statistics regarding lack of contraceptive use.

Sex and sexuality are highly personal topics and many individuals including health care providers find the topic discomforting. The patient must be able to impart the information contained in a sexual history without feeling discomfort and the nurse practitioner must be able to convey that the information will be received in a non-judgmental way. The nurse-patient relationship is envisioned as one that is trusting, empathic, respectful and nurturing in which the patient is able to express him/herself without fear. Inherent in this relationship is that the exchange of confidential information will result in diagnosis, treatment and education. Also inherent is that the nurse has an understanding of the context in which she practices, including its culture, beliefs and
environment. Knowing the environment provides a context within which to provide healthcare.

The goal of this research was to develop knowledge that may eventually lead to practice changes in how health care providers address contraceptive issues. Why is this important? One cannot attempt to make changes without understanding the issues. Of particular importance is understanding the phenomena from the lived experiences of the participants. These lived experiences constitute their reality and, as such, impact their worldview. As a nurse, seeking to develop knowledge leading to theory development and practice changes, my contribution through this research, was to develop nursing science about African American women’s contraceptive decision-making. In Chapter 2, I will set the background for the study in the extant literature.
CHAPTER 2

Background for the Study

Review of the Literature

In order to gain knowledge about a particular subject, it is important to examine and analyze the literature pertaining to that subject. In this chapter, I will explore the literature related to women’s contraceptive decision-making, in particular African American women. Some of the literature cited may seem dated, but the subject matter is important to develop the context within which African American women experience the world in which they live. This review of the literature is inclusive of published studies through early 2007.

Decision-Making

The Oxford American Dictionary defined the term decision as the action or process of deciding something or resolving a question (Oxford American Dictionary, 2002), while in Webster’s Dictionary decision is defined as a determination arrived at after consideration (Merriam-Webster, 2003).

Theories of decision-making, found in many disciplines, are grounded in utility theory and were developed in the fields of mathematics and economics and later adopted by behavioral scientists and psychologists. These theories were developed as an approach to understand how rational individuals make decisions.
Women's Family Planning Decisions

Understanding the concept of decision-making within the discipline of nursing is important. Nurses' interactions with patients provide an opportunity for education and guidance as patients make important health care decisions. It is important to understand the decision maker’s goals or values, knowledge of the subject, and predilections or prejudices. This process is approached from a social, cultural, interpersonal and historical context (Matteson & Hawkins, 1990). Decision-making is a complex and multidimensional process that is influenced by personal and environmental components.

Family planning plays an integral part in a woman’s life. Delaying childbirth allows women the opportunity for a better life. Completing educational goals and developing their professional careers allow women the opportunity for greater life satisfaction, goal attainment and economic independence. Choosing a contraceptive method can be a complex and daunting task for a woman. Consideration must be given to contraceptive beliefs, knowledge, effectiveness, side effects, and social and cultural beliefs as well as the individual’s values. Understanding the factors that influence the decision-making process will allow health care providers to offer guidance and support to women as they make their choices.

Seeking greater understanding of women’s contraceptive decision-making, Cheung and Free (2005) conducted a qualitative study of the factors that influence the process. Women from London, England, were recruited from family planning clinics, general medical practices and hostels for homeless youth. Three major themes emerged: the desire to avoid pregnancy concerns about medicines and hormones, and menstruation.
Menstruation was further divided into two subcategories—natural menses and menstrual control. Women who reported a greater desire to avoid pregnancy were more likely to continue with contraceptives despite side effects and concerns about hormonal influences than were women who reported pregnancy ambivalence. Women expressed concern about the effects of hormonal contraceptives on their bodies with many believing that they were unsafe or dangerous. Many took breaks from their contraceptives to allow their bodies to return to “natural balance”.

Menstrual regularity was a common theme, which represented naturalness and validated that pregnancy did not occur. Noone (2004) used a grounded theory approach to answer the question of how contraceptive decision-making occurs. “Finding the best fit” was the core category that emerged with three additional subcategories. The subcategories were: becoming aware, weighing what’s best for me, and navigating a course. Within the category finding the best fit, women chose the method based on their knowledge, experience and evaluation of what would be the best fit within the context of their current life situations. The choice might not be the best available, but the best within the context of a woman’s current situation.

This concept was also supported in Swanson’s study (1988). The major concept privatized discovery emerged, which described a process of finding out something unknown by identifying options, tailoring these options to self, adjusting to situations and coordinating/ cooperating with partners to bring options into alignment. Lethbridge (1991) conceptualized this process with her theory of “Women’s Contraceptive Self-Care”, wherein the theme of choosing and using contraception emerged. However,
Wyatt, et al. (2000) found two broad categories in their study entitled “Factors Affecting HIV Contraceptive Decision-Making”: those who make decisions alone and those who make decisions within the context of their relationships with partners. Decisions were affected by attitudes and beliefs about the context of sex, the importance of relationships, who should decide about contraception and past sexual experiences of the women, as well as demographic characteristics.

Matteson (1995) developed a grounded theory called “Advocating for Self” (p.9), in her groundbreaking work on women’s contraceptive decision-making. This researcher found that the process of choosing a contraceptive method is a complex process based on life’s needs. Women’s decisions are influenced by factors including partner perceptions, interactions with health care providers, self-empowerment and care. The process is dynamic with changes based on the context of women’s lives.

Although all of these researchers included African Americans in their samples, none focused exclusively on the factors that affect African American women’s contraceptive decision-making. It is important to situate this decision-making contextually within the culture of African American women, particularly the meanings of Black motherhood.

**Black Motherhood**

Many people consider Black women to be the backbone of African American families. They are the glue that holds families together with strength, wisdom and pride. The context and institutions of society in which African American women find themselves shape Black Motherhood and Black Motherhood shapes society. It has been
characterized as dysfunctional, pathological, incapable, and yet glorified by African American society as a strong woman able to withstand objectification, oppression and discrimination with grace and dignity.

The institution of motherhood is one of the many contexts in which Black women define themselves. Washington (1988) stated, “being a mother is an important source of identity and meaning and experience that . . . provides immediate and frequent rewards” (p. 189). This role serves as a context within which Black women learn self-definition, self-reliance, independence, empowerment and the importance of valuing and respecting themselves (Hill Collins, 2000).

To understand Black Motherhood, one must have an understanding of how Black families are structured. Organization of the Black family has been shaped by the society in which its members find themselves. Black families are as diverse as the rest of the population of the United States. They represent individuals who are tied together by biological, marital, familial, adoptive, formal or informal, and kinship bonds. Single mothers and fathers, grandparents, cohabitating couples and two-parent households are all representative of Black families.

The Black family is unique in that its development grew out of forced migration of a group of individuals, the institution of slavery, to the Americas. The impact of slavery continues to be felt today. No other ethnic group in the United States has had to contend with overt and covert discrimination in daily life. Few groups have had to live with the knowledge that they might be seen as less than or invisible to other members of society.
For a people enslaved, family was a source of kinship, support, knowledge development and strength in a society in which they were deemed “other”. The structure of the family unit was so influential that slave owners, to insure dominance and moral authority, often used separation of the family unit as a tactic. In *Killing the Black Body, Race, Reproduction and the Meaning of Liberty*, the author noted that denial of slaves’ right to family was critical aspect in denial of political and moral autonomy (Roberts, 1997). Denial of family was and is an act of denial of humanity.

Black Motherhood is also rooted in the history of slavery. Female African slaves were often seen as breeders as well as workers for slave owners. Women and girls were often instructed to mate with other male slaves at their owner’s discretion. Some other methods used to increase the fertility rate of plantations included incentives such as decreasing the amount of work, increasing the food and clothing rations, as well as moving the slave from field work to the “big” house. Slave owners and their sons often routinely raped slave girls for both sexual gratification and procreation. The forthcoming offspring were considered property of the owner, thereby increasing his worth.

One would expect that slave mothers might reject children born under harsh circumstances, but they did not. Washington (1988) reported that slave mothers were fiercely maternal, loyal and resisted efforts to separate families. In fact, slave owners respected the maternal bonds of many slave women taking great pains to keep mothers and children together. This practice set up the dynamic of the maternal family group in which the Black mother’s role of family responsibility flourished (White, 2006).
After slavery, Black women continued to support and protect their families. Because Black men often faced racial discrimination at home and work, Black women played a pivotal role in contributing to the economic support and development of the Black family. Despite their employment, motherhood and childrearing played an important role in women’s lives. Many authors reported that motherhood was and continues to be highly valued in African American communities (Alexander, 2004; Carothers, 1998; Hale, 2007; Polatnick, 1996; Washington, 1988; White, 2006). The value placed on motherhood is extrinsically linked to importance of children in African American communities. Children represent the hope for a better future and providing a nurturing environment along with educational attainment can be seen as the catalyst for societal change (Polatnick, 1996).

_African American Mother-Daughter Communication_

Communication between parent and child is crucial in child development and is a tool by which parents provide the knowledge and skills needed for children to learn to navigate the world. Communication is especially important as adolescents grow, mature and seek to develop and navigate their sexual identity. The teenage years can be fraught with tension and strife, as mother and daughter attempt the communication dance that is the developmental period of adolescence. As the daughter attempts to develop self-identification as a developing woman, following in her mother’s footsteps, her mother strives to provide protection within a nurturing relationship while fostering her daughter’s growth and independence (Holland-Hall & Hewitt 2006). Carothers (1998) reported that the “interactions between mothers and daughters are a critical source of information on
how women perceive what it means to be female” (p.315). This is especially important, as African American mothers must raise their children to live and understand two cultures, both African American and the wider American culture.

Inherent in the education of a child is the development of sexual identity and need for education. But what makes African American mother-daughter communication different? Several researchers have reported that African American and Hispanic adolescents initiate sexual activity at an early age, have higher rates of sexual activity, multiple partners, pregnancy and sexually transmitted infections (Eisenberg, Bearinger, Sieving, Swain & Resnick, 2004; Hutchinson, Jemmott, Sweet Jemmott, Braverman, & Fong, 2003; Jaccard, Dittus & Gordon, 1996; Meneses, Orrell-Valente, Guendelman, Oman & Irwin, 2006; Miller, Kotchick, Dorsey, Forehand & Ham, 1998) The risky behaviors that adolescents engage in highlight the need for effective communication about sex, sexual activity and the consequences of these activities. Miller et al. (1998) reported that children and adolescents cited parents as their preferred sources of information about sex.

African American mothers use different strategies to provide information about sexuality, sex education, pregnancy, contraception and relationships with their daughters. Some common methods are audiovisuals, books, spiritual advisors, sharing experiences and kinfolk relationships. Using narrative analysis, Nwoga (2000) explored story telling among African American mothers. The mothers used storytelling to provide sexuality education for their children. These stories were provided from their own experiences to accomplish socialization and enculturation and to discourage repeating past mistakes.
DiLorio, Pluhar and Belcher (2003) conducted a literature review of parent child communication about sexuality between the years of 1980-2002. Ninety-five articles from a variety of journals representing multiple disciplines were reviewed. The authors found mixed results. All parents had some level of communication about sex, sexuality and contraception with their children. The depth and breadth of the conversations depended on the age, gender, ethnicity/race and the parent’s level of comfort or discomfort with the topic.

A descriptive exploratory comparative study was conducted by Mims and Biordi (2001) to ascertain whether there was a difference between African American adolescents’ perceptions of their communication patterns with their parents about pregnancy. These authors reported that adolescents’ perceptions of their mothers, and mother-daughter reasoning, were positively correlated with mother-daughter quality of communication and problem solving. Mothers’ communication with their daughters was significantly related to higher problem solving on the mothers’ part. This research is supported by the work of Hutchinson, Jemmott, Jemmott, Braverman and Fong (2003). In a study entitled “The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study”, these researchers found higher levels of mother-daughter sexual risk communication to be associated with a significant reduction in the number of episodes of intercourse and unprotected intercourse.
Historical Perspectives

The Tuskegee Syphilis Experiment is one historical event that continues to affect health care and indeed contraceptive decisions by African Americans today. This experiment, which began in 1932, was initiated by the U.S. Public Health Service as a project to understand the natural progression of syphilis in Negro males in the southeastern United States. The study was discontinued in 1972 when a physician exposed the experiment to a reporter. Despite the development for clinical use of penicillin in the 1940s, which became the gold standard of treatment for syphilis, the study’s participants were never informed about their diagnosis nor received treatment for their disease. In fact, a concerted effort was undertaken to ensure that participants and their families did not seek treatment.

For many, the study defines the dynamics of African American and European American relationships. Thomas and Quinn (1991) reported that the study helped to lay the foundation for African Americans’ distrust of public health. Others believed that it symbolizes Nazi science in America (Kirp, 1995) and it is evidence of a conspiracy to eliminate African Americans and justification for continued mistrust (Thomas & Curran, 1999). Participants in Friemuth et al.’s (2001) work believed that their study confirmed distrust of the U.S. government. Northington Gamble (1997) described the study as the singular reason behind African American distrust of medicine and public health today. In a study by Brandon, Issac, and Thomas (2005), these researchers found that although the Tuskegee experiment was not a central event in African American culture, knowledge of the study was cited as an example of why the medical establishment could not be trusted.
Even though the Tuskegee Syphilis Experiment continues to cast a shadow, African Americans were suspicious of the medical community long before this experiment was conducted. During slavery, physicians often conducted experiments on their slaves. Medical dissection, operations, and medical experiments on slaves were common during the antebellum period (Savitt, 1982). Although poor whites were also subjects, slaves were used to a greater extent. Gamble (1997) wrote that slaves were often subjects because they were considered property, without legal rights or the ability to refuse to participate. This was illustrated in an article by Boney (1967) who described medical experimentation on a slave. The slave, named Fry, was ordered to spend time in a heated pit until he lost consciousness; he was then revived and returned to the pit. This was repeated for 5 or 6 times. The purpose of the experiment was to ascertain which medicine could be used to treat heatstroke.

Long after the conclusion of the Civil War, it is believed that Blacks continued to be exploited and manipulated when seeking care from medical providers. This is evidenced by the references of nightriders or student doctors stealing cadavers in folk tales and historical stories (Fry, 1984). African Americans still harbor beliefs that physicians continue to use and/ or view them as experiments. This was evident in a number of studies where participants expressed the view that they were human “guinea pigs” and distrustful of the discipline of medicine (Friemuth et al., 2001; Gamble, 1997; Savitt, 1982; Shavers et al., 2002; Thomas & Quinn, 1991).

Forced sterilization and the Eugenics movement represent another historical event that gave African Americans reason to mistrust the medical community. The Eugenics
movement, started in the late 1800s, was an attempt by its members to improve society. In America, the movement embraced the theory that intelligence and other traits were genetically determined and therefore inherited. The idea of rational control of reproduction by individuals considered inferior led to the implementation of policies that sought to control the population of inferior races, including African Americans. Members of society, believing that African Americans were incapable of controlling their sexual urges, began to castrate men as punishment for a crime, including rape, attempted rape or kidnapping of white women (Roberts, 1997). This later progressed to individuals who were considered to be feeble-minded, the poor and ethnic minorities.

Advocating for sterilization, the Indiana State Legislature became the first state body to pass a law to sterilize “unwilling and unwitting” people in 1907 (Rodrigues-Triaz, 1982, p.147). Thirty states later passed laws known as the Eugenics laws. Many African American women were sterilized as a result of these laws. Rodrigues-Triaz (1982) reported that more than 63,000 people were sterilized between 1907 and 1964 in the United States and its colonies as a result of the Eugenics laws. Roberts (1997) reported in her book Killing the Black Body, “It was a common belief among Blacks in the South that Black women were routinely sterilized without their informed consent and for no valid reason” (p. 90). Despite the repeal of many of these laws, there continues to be advocates of sterilization and forced family planning for individuals requiring public assistance.

Another method of sterilization is a procedure called a hysterectomy, which is the surgical removal of the uterus. Hysterectomies were performed on many African
American women for non-medically indicated reasons including ending a woman’s childbearing potential. Two authors reported that this procedure was so commonly practiced in the South that the operations came to be known as Mississippi appendectomies (Roberts, 2000; Rodrigues-Triaz, 1982).

In the 1990s, the contraceptive product Norplant® was licensed for use in the United States. Because of the device’s duration of long-term use, 5 years, convenience and effectiveness, many individuals chose this contraceptive option. However, in December 1990, the Philadelphia Inquirer published an editorial suggesting that Norplant® was a method that could be used to break the cycle of poverty, under which many African American women and children lived. The editorial suggested that women on public assistance should be offered financial incentives to use Norplant®. Despite the loud outcry from African Americans about the editorial’s racial overtones, a number of legislatures considered measures that would provide incentives for women choosing this option. Although none of the legislatures passed these incentive proposals, advocates and consumers remained skeptical of the product. Boonstra et al. (2000) noted that all 50 states covered Norplant® under Medicaid insurance plans, making it accessible to low-income ethnic and minority women, who were disproportionately represented. Some advocates, about the perception of coercion, raised concerns.

**Contraceptives Beliefs**

According to statistics, there are 62 million women of childbearing age, 15-44 years old in the United States and 62% are currently using a contraceptive method (Alan Guttmacher Institute, 2005). African American women represent 8.8% of the female
population (U.S. Census Bureau, 2005). For these reasons, it was important to understand the beliefs and attitudes about contraception held by African American women. Historically, African American women have participated in the contraceptive movement. Since slavery, women have used common folk methods such as vaginal poultices of Vaseline® and quinine, alum water douches and plant compounds (Harrison, 1997; Roberts, 1999). African American women and community leaders were aware of the importance of family planning for spacing children and economic and educational improvement. Despite the undertones of Eugenics in Margaret Sanger’s birth control movement, African American women found value in supporting her efforts to bring birth control to them. In 1939, the Division of Negro Service, under the Birth Control Federation of America, opened two pilot birth control clinics in Tennessee and South Carolina (Roberts, 1999). Although many women used these services, they were not without criticism. Many community leaders of that period felt that Blacks needed to increase their numbers in an effort to prevent extinction (Weisbord, 1973) and others voiced fears of racial genocide.

*Social and Cultural Beliefs*

Understanding the social and cultural beliefs of African Americans about contraception is important for developing knowledge, guiding care and eliminating health disparities. Researchers have shown that discrimination has been present during family planning visits. Given the risks of pregnancy, sexually transmitted infections, HIV/AIDS, and poor social and economic outcomes, it behooves providers to gain a better understanding of the factors that influence contraceptive decision-making.
So, what factors influence decision-making? Grady, Klepinger and Billy (1993) proposed that decisions are influenced by the “perceived educational, labor-force and other opportunities costs of an unintended pregnancy, where those opportunities are defined at the community or national level” (p. 4), meaning that community factors and social norms can dictate what is acceptable or a social norm.

Sexuality and sexual activity are considered normal expressions of self within the African American community. Therefore, there is little stigmatism for out of wedlock births and African Americans are more accepting of non-marital childbearing (Harrison, 1997). Although many African Americans use contraception, a number report feeling that they are un-natural or dangerous and refuse to use them (Noone, 2004).

Religiosity has been found to influence contraceptive decision making among African Americans. African Americans have relied on religion and spiritual beliefs to cope and manage their daily lives including their health care needs (Freedman, 1998). In an attempt to understand the influence of religiosity on contraceptive use among African American women, Woodsong and colleagues (2004) conducted a qualitative study. Nineteen focus groups and 69 individual interviews were conducted in two southeastern cities. These researchers showed that participants referenced God when discussing beliefs about childbearing, sexuality and contraceptive use and that one’s body has a natural order related to these. Participants also believed that anything that disrupts the natural flow (contraceptives) might be viewed as dangerous because it interferes with God’s plan on two levels: God’s plan on how the body works and God’s plan for childbearing as a natural role for women (p. 68). Recognizing that individuals’ cultural beliefs, knowledge
of health and disease and socioeconomic status as well as spiritual and religious beliefs influence contraceptive behavior and choices, the authors noted that these factors might counteract formal medical knowledge and practice.

Grady and colleagues (1993) found that community characteristics affect contraceptive choices. Indicators of socioeconomic status, number of family planning clinics per capita, and concentration of religious adherents were positively associated with the level of contraception chosen by women. However, these authors found that indicators of labor force opportunities and participation had no effect on the use of effective contraceptives. The authors surmised that economic forces, such as employment or unemployment, influence women’s decisions about the effectiveness of their contraception.

Conspiracy Theories

Conspiracy theories are often not viewed through the lens of health care. However, this concept can greatly influence a patient’s decision making in seeking health care, trusting her provider and making choices about risky behaviors. In the African American culture, belief in conspiracy theories may play a significant role in health care. In daily practice, individuals who are skeptical of health care providers and the health care system confront me with their beliefs. Patients often express concern about discrimination, fear of victimization, distrust and exploitation. Indeed, Lillie-Blanton, Brodie, Rowland, Altman and McIntosh (2000) reported that physician attitudes and interactions with patients are often colored by the race of the patient.
A conspiracy is defined as the act of conspiring together; a secret plan by a group to do something unlawful or harmful; an agreement among conspirators (Oxford American College Dictionary, 2002). In the online dictionary, The Oxford Dictionary of English (2005) conspiracy is defined as an act of working in secret to obtain some goal, usually understood with negative connotations. A theory is defined as a supposition or system of ideas intended to explain something, especially one based on the general principles independent of the thing to be explained (Merriam-Webster 11th Collegiate Dictionary, 2003).

The concept, conspiracy theory, is defined in the Oxford American College Dictionary (2002), as “a belief that some covert but influential organization is responsible for an unexplained event” (p. 296). The Merriam-Webster 11th Collegiate Dictionary (2003) defined it similarly as a theory that explains an event or set of circumstances as the result of a secret plot by usually powerful conspirators. Keely (1999) defined conspiracy theory as a proposed explanation of some historical event (or events) in terms of the significant causal agency of a relatively small group of persons, the conspirators, and acting in secret.

In relationship to a particular group, Bird and Bogart (2005) defined conspiracy beliefs as beliefs about large-scale discrimination, by the government and health care system, against a group. Conspiracy theories are understood as a class of Ethnosociologies that refers to the theories ordinary people use to explain social phenomena and use to explain social misfortunes by attributing them to the deliberate actions of a particular group of people, often secretly planned (Waters, 1997).
Conspiracy theories are common in African American cultural beliefs. Scholars from a variety of disciplines including history, sociology, political science and public health have studied conspiracy theories widely. Although some of these rumors may defy logic, they often color the way in which African Americans interact with the larger white society. In *The Tuskegee Experiment’s Long Shadow* (Ruffin, 1998), the author reported that academic scholars believe conspiracy beliefs develop as a reaction to racism as individuals relate their uneasiness to a concrete idea. Some scholars believe that these ideas are useful for political or social change, while others believe that they can be detrimental to the well being of African American culture. The medical community believes that they threaten the public health of African Americans.

To understand the pervasiveness of conspiracy beliefs one need only examine the literature. Crocker et al. (1999) looked at a sample of relatively advantaged black and white college students. Ninety-one Black and 96 white college students were randomly selected from a predominantly white, northeastern university. In the analysis, race predicted belief in conspiracy theories even when controlling for socioeconomic status and this belief was partially mediated by system blame, but not powerlessness or greater externality of attributional system. In another study, *Beliefs in Conspiracy Theories Among African Americans: A Comparison of Elites and Masses*, the researchers, Crocker et al. (1999), surveyed African American locally elected leaders and churchgoers from Louisiana for their beliefs about conspiracy theories. The authors found that churchgoers believed in two categories of conspiracy theories, malicious intent and benign neglect, with benign neglect theories being more likely to be believed. Elected leaders responded
positively to believing in conspiracy theories. The conclusion reached by the authors was that African American elected officials believed in conspiracy theories to the same extent, as does the general African American public. Parsons et al.’s (1999) survey of 1,104 African Americans in Louisiana showed that there is a significant belief in many different conspiracy theories and that a large percent suspect some type of conspiratorial plot aimed at their race by the government.

In relation to health care, conspiracy beliefs are also prevalent. Bird and Bogart (2003) conducted a cross-sectional telephone survey to explore the relationship of birth control conspiracy beliefs and perceived discrimination to contraceptive attitudes and behavior among an African American sample. Between 5 and 49% of their respondents endorsed conspiracy beliefs about birth control. Bogart and Bird (2003) also looked at the relationship of conspiracy beliefs and HIV/AIDS among African American adults. These authors found that many respondents endorsed conspiracy beliefs about HIV/AIDS with 70% believing somewhat or strongly that “A lot of information about AIDS is being held back from the public” and 52.9% somewhat or strongly endorsing the statement that “There is a cure for AIDS, but it is being withheld from the poor” (p. 1061).

Fears of racial genocide, in relationship to family planning, have also been noted in the literature. In the popular magazine Essence, Grisby Bates (1990) noted “Since slavery, there have always been those who thought that white America has targeted us for extinction, just as soon as we have outlived our collective usefulness” (p. 79). There is a long history of individuals who believe that family planning programs were targeted to reduce the number of Black Americans. Roberts (2000) quoted the Black nationalist
leader Marcus Garvey as being opposed to birth control as a form of “race suicide”, while civil rights leader W.E.B. DuBois favored family planning programs as a means of improving Black health and “denouncing the argument that blacks should rely on a high birthrate to fight discrimination” (p. 93). In their landmark study, “Family planning, race consciousness and the fear of race genocide” (1972), Darity and Turner sought to determine to what extent are fears of race genocide held and whether the use or nonuse of family planning methods are attributed to these fears. Thirty-seven percent of their subjects rejected the use of all contraceptive methods and all the correlation coefficients related to family planning methods and a belief in racial genocide were statistically significant except for one indicating that Black Americans are wary of family planning programs.

Using a different sample, Turner and Darity (1973) again explored the concept of racial genocidal fears in relationship to age, sex and region. Their findings indicated that younger African Americans generally expressed more fears than older adults. Northerners expressed more fears than southerners and males indicated a greater belief than females in genocidal plots. Individuals of lower socioeconomic and educational status were more likely to express genocidal fears than those of higher status. Individuals who had been victimized in the past reported an increased sensitivity to continued crimes. Among the subjects, 62.6% agreed with the statement “As blacks become more militant there will be an effort to decrease the black population”. Only 39.1% agreed with the statement “Birth control programs are a plot to eliminate blacks” suggesting that,
although African Americans have some genocidal fears, they don’t necessarily believe that family planning programs are designed specifically to reduce the population.

Later researchers also supported these findings (Bird & Bogart, 2003; Farrell et al., 1983; Farrell & Dawkins, 1979; Weisbord, 1973). Although one might be tempted to dismiss these genocidal beliefs as hysteria or irrational by uneducated individuals, Waters (1997) found that African Americans who believe in conspiracy theories are better educated, politically active and community oriented with closer ties to interethnic conflicts.

**Health Care Disparities**

So why are African Americans so distrustful of the medical community and individuals of European dissent? Given African Americans’ long history of persecution, racism and discrimination it is understandable that this group is distrustful. A number of researchers have noted that discrimination by health care providers negatively impacts African American health outcomes (Bird & Bogart, 2005; Boonstra et al., 2000; Carlson & Chamberlain, 2004; Lillie-Blanton et al., 2000). In a study by Lillie-Blanton et al. (2000), these authors reported that 80% of African Americans and 75% of Latinos compared to 68% of Caucasians stated that racism is a major or minor problem in health care. Van Ryn and Burke (2000) reported that physicians are somewhat less likely to have positive perceptions of Blacks than whites even when controlling for socioeconomic status. Given the number of researchers documenting health disparities (Carlson & Chamberlain, 2004; Freedman, 1998; Randall, 1996; Thomas, 2001), it is not surprising
that African Americans believe that they will receive substandard and/or unequal treatment when seeking care.

**Stereotypes of African American women.** When seeking family planning services, African American women often have to contend with preconceived notions by family planning counselors and/or providers. Stereotypes about African American sexuality are pervasive in the literature and society. Two images that depict racial sexual stereotypes are the images of the “Welfare Queen and the Jezebel”. Roberts (1997) described the welfare queen as “the lazy mother on public assistance who deliberately breeds children at the expense of taxpayers to fatten her monthly check” (p. 17), while the jezebel or “hoochie-mama” was described as a Black woman with an insatiable sexual appetite, which threatens society’s stability (Shambley-Ebron & Boyle, 1994). Both stereotypes project such negative images of Black women that women are frequently hesitant about seeking care and such images allow objectification of Black women by health care providers (Taylor, 1999), leading to discrimination. In fact, according to a study by Thorburn Bird and Bogart (2005), 67% of respondents who had seen a health care provider for family planning services in the past reported experiencing discrimination and 51.8% reported experiencing African American stereotype-related discrimination. Thorburn Bird and Bogart (2005), in another study, found that African Americans may be more suspicious of certain contraceptive methods and may be more likely to choose a non-hormonal method or one that doesn’t require a medical visit.
Areas for Future Study

With the increasing array of method both hormonal and non-hormonal, women must consider a variety of factors when making a decision. Consideration must be given to medical and social cultural concerns. However, it is important to have a clear understanding of the context in which the decision is made. Historical factors and health disparities often make patients wary of health care providers. Social and cultural norms, economic realities and perceptions of African Americans are often intertwined with decisions around fertility and contraception. Patients often look to health care providers for guidance as they make their decisions.

Nurses are presented with a unique opportunity to provide education and guidance to women. However, in providing education it is important that we understand all the complexities of our patients’ lives. African Americans have a unique history in terms of contraception and fertility. Slavery, the Eugenics movement, the Tuskegee Syphilis experiment and continued racial discrimination have been etched in the minds of many African Americans and as such, they are passed to each succeeding generation. With the passage of time, many believe that those historical factors have little influence on decisions today. Although there have been a number of researchers who examined factors that influence decision-making, few have looked exclusively at the African American experience. This study was designed to provide a voice to African American women and the factors that influence their contraceptive decision-making within the context of their lives. Giving voice to these unique stories will enable nurses to develop a thorough
understanding of the decision-making process, and develop theories that can guide practice.

In the next chapter, I will describe the method appropriate to answering my research questions and explicate my plan for the dissertation research.
CHAPTER 3

Methodology

Research Design

In research, the method is directed by the question asked and as such, I chose a qualitative perspective of investigation. This method was chosen because the question lends itself to knowledge discovery from the participants’ worldview. There are many definitions of qualitative research, which encompasses a wide body of literature and research traditions. Qualitative research methods are designed to allow the researcher to develop an understanding of the phenomena. Milne and Oberle (2005) stated, “qualitative research seeks not to reveal “truth” but insights” (p. 413). It is through these insights that the researcher finds answers to questions from the perspective of the participants who are living the experience. Denzin and Lincoln (2005) stated that qualitative researcher seeks to locate the observer in the world within a situated activity and Hadjistavropoulos and Smythe (2001) defined qualitative research as seeking to understand and articulate the meanings of people’s experiences rather than to formulate general laws of behavior. Using language, observation, interviews, field notes and memos to self, the researcher attempts to describe routine and problematic instances within the participants’ lives.

Qualitative research is not only a research method, but also a philosophical approach that underpins the view of the world and research data collection. This genre of research reflects the beliefs, values, and assumptions about the nature of humans, the environment and the interactions between the two (Dombro, 2007). According to
Munhall (1989), the researcher would perceive reality and assign meanings to research interpretations based on the following philosophical assumptions:

- Individuals are viewed as active participants, capable of understanding, interpreting and making meaning of their own lives.
- Groups and individuals have varying perceptions of their histories, futures and present, which create a changing and evolving world, which assume a dynamic reality.
- “Truth” is an interpretation of some phenomenon, which when shared lends credibility to its factualness but it remains temporal and cultural.
- Objectivity must not be suspended when interacting with participants, but a realization of the importance of maintaining reliability and validity.
- Meanings arise from the source and are without presumptions, assumptions and assignment while the subjective experience of the individual is to be valued and described.
- Individuals’ experiences are infused with cultural, linguistic and social patterns. (Munhall, 1989, p.162)

Selection of Method

This was a qualitative descriptive study. I chose this method as it allowed the researcher to describe and gain an understanding of the phenomena. The phenomena are understood within the context of the participants’ lives without interpretation from the researcher. Although no research is completely free from interpretation, this method entails data collection that allows for a lesser degree of interference than do other qualitative methods (Sandelowski, 2000).

The qualitative descriptive method has its underpinnings in naturalistic inquiry. The researcher studies the phenomena in their “natural state” without pre-selected or manipulated variables as well as no *a priori* commitment to any one theoretical view of
the phenomena. The goal of qualitative descriptive research is to provide a rich description of the experience or phenomena in everyday language (Sandelowski, 2000). Sullivan-Bolyai, Bova and Harper (2005) stated that the description allows for researcher agreement of the information about the experience that might lead to an explanation of the phenomena with the potential to be generalizable. Qualitative description lends itself to healthcare research. Understanding phenomena in healthcare was important before seeking to develop interventions for specific problems for health improvement.

*Framework*

The world of health care has become increasingly diverse both ethnically and culturally. It is of paramount importance that nurses understand the environments from which their patients come. Using culturally appropriate frameworks will enable the discipline to capture the patients’ authentic voices and help nurses respond accordingly. Although feminist theory has been used within the nursing discipline to enable improvement in understanding of patient problems, the Black feminist paradigm has not been routinely used to increase knowledge of African American women’s lives. Gaining knowledge of African American women’s culture, environment, and philosophic life will improve the way in which we assess, respond and educate this ethnic group.

Feminism is a member of the postmodern tradition, which rejects single descriptions of science and reality. Postmodern philosophy recognizes that there are multiple realities, truths and power relationships that exist and all are important to knowledge (Rodgers, 2005). Social, cultural and economic realities affect knowledge also, and must be considered in scientific equations. Discourse and deconstruction are
important in this philosophy. Deconstruction is the breaking down of reality through analysis of language, knowledge and power, which leads to understanding that there are multiple ways of knowing, being and experiencing reality. Deconstruction of knowledge encourages us to ask questions and consider multiple points of reference. Discourse has been defined as a conversation, dialogue or discussion (Oxford English Dictionary, 2002). In the postmodern tradition, discourse has been defined as the use of language, which plays a role in human existence. Language carries multiple meanings, including social, cultural and political, which reflect a group’s status and values providing for group cohesiveness. Included in verbal communication are a participant’s non-verbal cues. All are subject to interpretation in postmodern philosophy.

Feminist philosophy, which developed out of critical social theory, has been defined as a world view that values women and seeks to confront systematic injustices that are based on gender. Feminist philosophy has spawned a number of movements within feminism denoted as radical, cultural, and liberal feminism. All are based on the principle of justice, and the belief that knowledge is developed by social, political, and cultural structures of the world in which we exist. Feminists also believe that knowledge from a woman-centered view is an appropriate alternative to traditional (read white male centric) approaches to knowledge development (Rodgers, 2005). Women experience the world differently than men. Values, morality and ethics are central to the development of knowledge for women. This view is contrary to empiricism, which posits that knowledge is gained from experience or sense data (Weiss, 1995).
Black feminist theory, sometimes called Womanism, is a framework developed to articulate the African American women’s experiences of racism, classism and sexism that are part of their everyday lives, which blend to shape their reality. As in classic feminist thought, the African American woman is central to knowledge development and only she can define and interpret her reality. Key components of Black feminist theory, as defined by Shambley-Ebron and Boyle (2004), are: 1) resistance of oppression and the ideas that justify it; 2) common challenges and experiences of Black women that result in core themes, including a legacy of struggle; 3) group knowledge and experience that is connected through social activism; 4) the importance of the role of Black feminist scholars and intellectuals in creating Black feminist thought; 5) the significance of change in articulating Black women’s knowledge; and 6) its relationship with other projects in the broader struggle for human justice. Understanding the definition of Black feminist theory can help with understanding of Black women’s thoughts.

How do Black women develop knowledge? First, one must consider the context within which this group’s knowledge was developed. All Black societies share a common link of core African values that have stood the test of racism and oppression. These core values, which are family, religion and community, foster the development of Afrocentric consciousness that resonates through Afrocentric epistemology (Collins, 1989).

An Afrocentric worldview, articulated by Taylor’s in her 1988 article entitled “Womanism: A methodologic framework for African American women”, includes human-nature oneness, harmony with nature, survival of the group, inclusiveness/synthesis, cooperation and collective responsibility, corporateness and
independence, spiritualism and circularity, complementarity/understanding, groupness/commonality and humanism/religion. Womanism is different from the European American worldview. All of this context must be taken into account when understanding African American knowledge. Four dimensions of knowledge are understood by black feminist epistemology. They are 1) concrete as a criterion of meaning; 2) use of dialogue in assessing knowledge claims; 3) an ethic of caring; and 4) an ethic of personal responsibility (Collins, 1989).

**Experience as a criterion for meaning.** For African American women knowledge is seen as different than wisdom, which comes with experience. Knowledge is having an understanding about a particular thing or experience, whereas wisdom is seen as knowing how to apply this information in a particular experience. Having wisdom is a tool that Black women use for survival as a group of oppressed individuals. This wisdom with experience is seen as credible and validated by the group.

**Use of dialogue in assessing knowledge claims.** Communication with the community is very important. Communication is used to express opinions, try out ideas and share experiential knowledge, as well as build or nurture connections between people. Promoting connections is very important within the community through dialogue, which is rooted in African oral tradition and African American culture (Banks-Wallace, 2005). The use of language in words or phrases provides insight into culture and conveys both the reality of the ongoing struggle and the importance of nurturing a unique African American experience. Dialogue provides an opportunity for women to share their knowledge, experience, and wisdom.
*Ethic of caring.* The three components that comprise the ethic of care, personal expressiveness, emotions, and empathy, are evaluated when assessing this ethic. Highly valued in the culture, personal expressiveness is emphasized by the uniqueness of each individual expressed by a common spirit, power, or energy. Knowledge claims are evaluated in terms of both content and depth of feeling associated with them. Emotions are considered indicative of a speaker’s belief in the validity of her argument. A sense of concern or connection between the speaker’s claim and the individual evaluating the claim is an essential part of assessing the claim’s validity. Empathy implies a level of concern grounded in the realization that everyone’s well being is connected.

*An ethic of personal responsibility.* Individuals are expected to develop their knowledge claim through dialogue, represent themselves in a way that establishes caring, and be accountable for their knowledge claims. Collins (1989) stated that assessment of knowledge claims simultaneously evaluates an individual’s character, values and ethics.

Black feminist theory values and centers African American women’s experience as central and empowers them to interpret their realities and define their objectives. It also enhances the interpretation of the sociocultural reality of Black women. Using a paradigm developed for women of color eliminates the distortions and bias that are generated when researchers operate from a Eurocentric view. It is through this lens, that I sought to develop an understanding of the factors that influence the contraceptive decision-making process of African American women.
Setting

The proposed research setting was the neighborhoods of Boston, Massachusetts. Boston and its surrounding neighborhoods have a diverse population including a large community of color. Historically, African Americans migrated to Boston from the southern region of the United States. The neighborhoods in which they settled were Roxbury, Dorchester, and Mattapan. Although these areas are comprised of many different ethnic groups, Roxbury is considered the center of African American culture and the community (Roxbury Crossing Historical Trust, 2003).

Residents of the Roxbury, Dorchester, and Mattapan communities often use local neighborhood community health centers to seek healthcare services. In the state of Massachusetts, over 3 million visits were generated at 52 community health centers and one out every nine patients receives care at community-based organizations (Massachusetts League of Community Health Centers, 2007). The community health centers’ populations include both ethnic and economically diverse patients, which will allow for maximum variability of the sample. Community health centers are often affiliated with partner hospitals and federal agencies and, as partners of these organizations, research proposals are submitted to the larger organizational institutional review board (IRB). This research proposal was presented and approved by the IRB of Boston College.

Sample

Qualitative research requires that the researcher choose a sample size that will adequately reflect the phenomena studied, support the methodology used, and ensure
rigor (Sandelowski, 1995). Qualitative researchers also sample for “meaning” as our interest is in the “what” of the phenomena or experience (Morse, 2007). This entails recruiting participants who are the experts as well as have the qualities of being good informants about the phenomena under exploration. These qualities will ensure that the researcher will be able to describe the full experience in question. Power analysis or computer programs, used in quantitative methods, are not used to determine *a priori* the number or minimum sample size required to ensure sample adequacy; therefore sampling continues until data saturation occurs. Saturation is defined as the point when the data offer no new information. A sample size of 10-15 female triads was suggested as a minimum to obtain saturation. Although the sample is not statistically significant, it is considered to be informational representative of the characteristics of the population and phenomena in question (Sandelowski, 1995).

As I sought information and a description of contraceptive decision-making by African American women, I recruited a purposeful sample. The type of purposeful sampling used was homogenous and maximum variation sampling. This spoke to the single ethnic group design while seeking participants from diverse socioeconomic backgrounds from which I drew my sample. American born African American women will be the population. The sample was African American intergenerational families consisting of adolescents, their mothers, and their maternal grandmothers. The two younger women were of childbearing age, while the grandmother was postmenopausal.

The term African American is generally used in the United States to represent all Black ethnic groups. However, African Americans may represent many different
countries including the Caribbean Islands, South America, and Africa. Each group has a unique history, including slavery, emancipation and their interaction with the dominant group as well as distinct cultural beliefs. United States-born African Americans have a unique culture, belief system, and historical perspective that are distinct from those of other ethnic populations by virtue of the group’s continued economic deprivation and racial prejudice from the majority group. This study focused on African American women born in the United States. Black women from other ethnic groups were excluded from the study.

Intergenerational research has been conducted in many disciplines including anthropology, sociology and social work, but there have been no studies using an intergenerational approach in nursing. This approach has been found to be useful in research and a number of studies have been conducted (Brannen, 2006; Goodman, 2003; Kahn & Anderson, 1992; Platt, 2005; Reitzes & Mutran, 2004; Thornberry, Freeman-Gallant, Lizotte, Krohn, & Smith, 2003). Veeder (1992) used an intergenerational approach in her study about Irish women’s decision-making. The researcher noted that “women’s development across the life span is characterized by flexibility, affective interaction and progressive growth in capacities and competencies” (p. 29) and research methodologies must not be confined to methods that are deterministic causal and predictive but instead flexible and scientifically sound (Veeder, 1992). Intergenerational research can also serve as a proxy for longitudinal studies (Kahn & Anderson, 1992; Veeder, 1992). The question of contraceptive decision-making was studied using an intergenerational approach. This design allowed me to use an historical perspective to
explore the familial influence on the decision-making process. It also allowed for the exploration of changes in the decision-making process over time.

Families were chosen that included a female adolescent age 13-17 years old, her adult mother, and her maternal grandmother. All three participants had contact with each other and operated within the family triad. All family members did not reside at the same location, but they all resided within the greater Boston area. In this study, I explored the decision-making process used by African American women, all of whom were born in the United States. Inclusion criteria were 1) families of three-generation African American women all of whom were born in the United States; 2) families with an adolescent female, her mother and her maternal grandmother; 3) English speaking; and 4) members of the Boston community.

Recruitment of participants. Participants were recruited through advertisements community centers and local community health centers. Purposive sampling and the snowball technique were used to recruit participants. Purposive sampling ensured that those who have experienced the phenomena of interest were indeed the participants. A snowball technique allowed participants already in the study to recommend other persons who might have been interested and eligible, to make referrals to the researcher.

Participants received a gift card at the conclusion of their participation in the study as a token of appreciation for participating. Gift cards, in the amount of $25.00, were purchased from a variety of local stores including Stop & Shop, a grocery chain, Target, and Marshall’s. Each participant was allowed to select the gift card of her choice.
Data Collection

Written consent for participation in the research project was obtained from all parties. Adolescents gave their assent separately after each adolescent’s parent had given written consent. The mothers and grandmothers were aware of the daughters/granddaughters are sexually activity before enrolling the triad in the study. After completion of the consent process, interviews were conducted at a time and place convenient for the participants. I conducted all of the interviews and interviewed each family member separately. Conducting the interviews separately allows for protection of the participant’s confidentiality. Content of the interviews were shared among the family triad. I conducted one-time interviews with each participant; no additional interviews were needed for clarification. A copy of the interview was mailed to each participant with a letter explaining how to contact the researcher if the participant believed that the transcript did not represent their meaning accurately.

Data was gathered through semi-structured interviews using an interview guide for adolescents and another for their mothers and grandmothers (see Appendix). Semi-structured interviews are organized around particular phenomena and allow for flexibility in scope and depth (May, 1991). I chose the semi-structured interview technique because it supposes that the researcher has some knowledge of the phenomena (Morse & Richards, 2002). It also allowed the researcher to guide the interview, ensuring that all topics of interest are addressed.

Following introductory comments and recording of demographic data, I will asked a series of open-ended questions to learn about the participants’ perceptions and
experiences. Interviews were conducted until the participants provide no new information. All interviews were audiotaped to ensure accuracy and validity of the data. Participants were encouraged to respond to each question in detail, taking as much time as necessary. Each participant received a copy of her transcript to review for ensure accuracy of participant’s meaning. Audiotapes will be stored in a locked file cabinet accessible only to me. Audiotapes and demographic information will be stored separately and securely. Field notes about the environment, context and tone of the interview were recorded as soon as possible after the interview. At the end of the study, once data analysis is complete and the results from the study have been presented and published, the audiotapes and transcripts were shredded.

Data Analysis

Content analysis is a method used by qualitative researchers to provide a systematic and objective means to make inferences from verbal, written and visual data in order to describe and quantify specific phenomena (Downe-Walbodt, 1992). All interviews were transcribed verbatim by a trained transcriptionist who was HIPPA certified. During the initial review, I read the transcriptions while listening to the tapes and reviewing the field notes. This was important as it allows the researcher time to absorb the interview text and look for any gross errors. It also served as the sorting out process (Creswell, 1998).

After receiving confirmation from the participants that the transcripts accurately reflect their thoughts, the coding process began. In the coding process, the researcher uses the data to generate codes to designate similar content (Morgan, 1993). The coding
method used was topic coding. This method facilitated identifying material for
description, categorization and conceptualization. Its purpose was to provide a way for
the researcher to analyze “up from the data” (Morse & Richards, 2002, p. 117), allowing
reanalysis of the data from one level to another. I reviewed the transcripts numerous
times, becoming immersed in the data. During the first level of coding, reviewing the
data line-by-line will helped me identify key phrases. Key phases are those that represent
ideas, thoughts or concepts identified by the participants and were captured and coded
using the participants’ own words. The second level of coding developed clusters or
subcategories that depicted related phrases. The final level of coding was formulating
categories that reflected more than those axial codes and key thoughts that were the result
of combining broad categories which represented ideas and concepts that contributed to
the conceptual understanding of African American women’s contraceptive decision-
making and could be used to guide nursing practice.

Rigor

In research, rigor refers to the reliability and validity of the research. In
quantitative research this means that the research must be replicable and accurately
reflect, the phenomena studied. However replicating a qualitative study would be difficult
if not impossible as the data collected reflect the context in which they were set and
judging the phenomena reflects the social reality as a social construction. Instead, the
researcher must work to ensure that the data are trustworthy (Anastas, 2004). This is done
by demonstrating that the research is free of bias, the data collection process remains true
to the philosophic underpinnings of the method used, the member checks are conducted,
and the coding emerges from the data. An independent researcher, my dissertation chair, also reviewed all transcripts, the coding process and findings to ensure credibility. The data was also reviewed for transferability, dependability and confirmability. Each of these represents rigor in qualitative research (Sandelowski, 1993). At the conclusion of the study, participants were given a copy of the results to ensure that the findings accurately reflect the participants’ experiences.

An audit trail was instituted and maintained, which involved record keeping of the decisions made during the research process, and was designed to ensure that the research process was documented for auditing purposes (Morse & Richard, 2002).

**Ethical Issues.** According to Munhall (2007), the ethical aim in qualitative research, is understanding what our means and aims are. It is important to remember that healthcare research often involves changing health behaviors but from a qualitative perspective, it entails understanding the different behaviors and offering acceptance and support. Ethics is defined as moral principles that govern a person or group’s behavior (*Oxford American College Dictionary*, 2002, p. 463). In conducting research, the researcher must take care to ensure that ethical principles guide the research process. Conveying trustworthiness, openness, honesty, and respectfulness are qualities of ethical principles that are entwined with rigor (Davies & Dodd, 2002). Research participants are considered collaborators entailing mutuality, with assurances that the researcher will protect them and do them no harm. I worked to ensure that the ethical standards for research were met.
Summary.

I designed this study with the hope that it would shed light on the decision-making process, as well as the generational influences used by African American women seeking contraception.
CHAPTER 4
Analysis of Data and Findings From the Study

Description of the Sample

For this study, I interviewed a total of 19 individuals. One grandmother declined to be interviewed after I had conducted the initial interviews with her daughter and granddaughter. There were two family triads that included the same grandmother. All the women are African American and lived in the neighborhoods of Roxbury and Dorchester, Massachusetts, at the time of the interviews. I recruited the women who are all members of a local community health center, the study site. I interviewed the women separately in their homes for the participants’ convenience and kept all interviews confidential from the other women in the sample.

The study participants ranged in age from 13 to 67 years old with a mean age of 34.1 years. The group’s educational level varied with most of the adolescents attending middle school and high school. All of the mothers and grandmothers had completed high school, 1 mother was attending college, 1 had completed college and another had completed graduate education. All of the women sought health care on a yearly basis with an average of 4.3 visits per year; 11 participants reported yearly Papanicolaou smears, 2 reported seeking screening every 2 to 3 years and 5 of the adolescents were not sexually active and did not require screening. Participants reported menarche between 10 and 16 years old with an average age of 13 years. All but 2 of the women reported being in a relationship within the past year with the number of partners ranging from 0 to 5. Of
the mothers and grandmothers, I reported being currently married; another was divorced, while the rest reported never having been married.

*Analysis of Data*

All interviews were analyzed through the lens of Womanism. This lens allowed me to gain insight into the experience of being an African American woman within the context of her sexuality.

Themes. Six themes emerged from the data and are as follow. Theme one I entitled southern influences, which embraces the roots and culture of this cohort of women. A worldview of relationships the label I chose for the second theme to describe the mothers’ and grandmothers’ attempts to provide their daughters the knowledge within which to situate their future and current relationships. Communication: key to preparedness, the third theme, expresses the importance of communication within the family unit. The fourth theme I entitled seeking information from mom. All 19 women identified their moms as the primary source of sexual knowledge. This theme is characterized by three sub-themes: 1) fathers, just being dads; 2) media limited influences; and 3) spirituality and religion. The fourth theme, “I got caught up in the game” describes how the women felt about their first sexual encounter and the final theme, contraceptive use and beliefs, describes the methods the women used, the problems they encountered or didn’t encounter with particular methods and their beliefs about the methods. In the next section, I will discuss each of these themes in detail, using quotes from the participants to illustrate.
Southern influences.

Southern culture and values permeate how these mothers and grandmothers raise their children. All the participant grandmothers were raised in the southeastern United States and moved to the New England area when they were young adults. They all have ties to the southern region, including North Carolina, Georgia, and Alabama. Grandmothers reported a variety of reasons for moving north including extended family, educational needs and employment opportunities. Information about marriage, work ethic and social mores they felt responsible for imparting to their children. When these children were “grown”, they were old enough to make their own decisions. This respect for individuality and personhood is important in southern culture.

My mother did all the work and my grandmother raised us and we went to school, we got up, my sister and I, we’d get up. I hate to say it, the earliest my grandmother would wake up sometimes 3:30 in the morning to get up, cook breakfast, kept getting my brothers and sisters dressed, get ourselves dressed, help make clean the beds up and do my sister’s hair. By 7:30, the bus was there because we was in the rural area, we had a school bus pick us up. We was raised up on it. So I didn’t know nothing else but get on the floors, scrub the floors, wax the floors with rags. She also reported that she “courted in the living room . . . because you know down there, you know how they guard you. (Skeet, age 66)

And from Baylee, age 67: “My mamma was very strict. From Alabama. We don’t mess around. You had to get your own house.” Talking about an earlier boyfriend making his own decisions, she said “He do what he wants to him because they be old enough to do it. They’d be old to get a license, drive a car, do anything he wanted to do”. Another example of southern culture is the idea of properness. Properness represents the idea of acceptable customs and etiquette about the information that should be shared with visitors, neighbors and friends versus the intimate family. For example,
conversations about sex and sexuality are not considered proper for open discussion; therefore, these are often not discussed. “Sex was hush, hush. We don’t talk about that. And Mama never talked about it. No that was something that only married people talked about. Only adults talked about it and you never heard them.” (Nae Nae, age 54)

Education is another important value stressed in southern culture and by these mothers and grandmothers. Grandmothers and daughters seek to impress upon their daughters the importance of completing their education. Although all mothers had completed high school and a number had some college education, they report that they wanted their children to have additional opportunities in life that only education can provide. One mother, Nisha age 31, reports that it was understood by her children that their job was to attend school and obtain passing grades and she would be there to support them in all ways. “. . . All you all have to do is go to school, get good grades and I got you . . .”.

A worldview of relationships. Throughout the generations, each mother tried to impart knowledge about relationships as well as information about sexual activity and contraception. Adolescent girls are particularly influenced by the relationships of their mothers and grandmothers. Young girls are taught to protect themselves and their emotions from boys. A comment by Nookie, age 16, is illustrative of this: “Boys just want to take your virginity or whatever.” But the young girls also have ideas about what they should look for in a boyfriend. The adolescents describe characteristics including a clean appearance, well dressed, socially active, employed, outgoing and have a good
personality and transportation. Interestingly Lexie age 16 mentions that he has to have “respect for himself and his mother.”

Mothers in particular had been in relationships with men who were problematic. At 15 years old, Toni, age 44, became involved in a long-term relationship with her first boyfriend, a 17-year-old “street wise” male. The relationship was stable for the first two years, but then he became abusive. She reports that it took her many years before she was able to end the relationship. This experience colored her next relationship and she reports that she was “like really scared to really commit myself to anyone. . . I don’t know how he’s going to react or come out. . .”.

The mothers seek to protect their daughters from making some of their mistakes. Nisha states that she received very little information about relationships her mother and as a consequence, she says, “I’m like preaching constantly” to her children. Tookie, age 32, reports telling her daughter, “Don’t be swindled by peer pressure, virginity is precious and can’t bring it back.” Also talking about a past relationship and the father of her daughter, she says “he’s a typical man.” Granddaughters seem to understand that all men are not trustworthy. They are able to sift through the information, gather knowledge, and apply it to their life circumstances. When I ask ‘Lique, age 16, if this information made her cynical about boys and relationship, she states that she “gives everyone the benefit of the doubt”. She also reports that her grandmother imparted these words of wisdom “not every boy just wants one thing. . . it’s going to take awhile for you find that one person and when you do you’ll be happy.”
Communication: Key to preparedness. Communication is very important to these women. Mothers seek to have open communication with their daughters because they feel that they themselves were unprepared for sexual activity and had little knowledge of contraception. Four mothers report not receiving sex or abstinence education in school, while 2 mothers report receiving sex education but did not connect the education to the actual act of intercourse. Nina, age 24, reports that it “went in one ear and out the other.” Mothers use a variety of methods to ensure open communication. These methods include weaving questions into normal conversations, pointing out behaviors that aren’t appropriate and using “scare” tactics. This is illustrated by Chocolate, age 37, who talks about using scare tactics to persuade her daughter from having sex:

I try to scare her and tell her that’s all they want. Once they get it, they’re going to talk about you around school, right your name on the bathroom walls. I always tell her stuff like that. I do. I will be trying anything I can to scare her because I want her to do that.

She also comments that she is: “On my daughter’s side regardless.”

When discussing the knowledge that she passes to her daughter, Angie, 33 says that she “tells her the truth, for everything there’s a consequence. For good things, you get benefits. For bad things, you know you’ll reap things that are not good for you.” Michelle tells her daughter: “I want you to be prepared, don’t be like me.” The mothers also seek information and assistance from health care providers including pediatricians and social workers.

Toni received literature to read with her daughter but she is clear with her stating:
I don’t tell them when you’re ready to have sex come and ask me for a condom, I don’t do that. I tell them that you are a better person than that. I always tell them that I’m open for them, anything you want to talk about, whether its good or bad, we can work it out together. . . . You’re a beautiful person and I would like it if you would wait. I tell them that.

Clearly, these mothers want their daughters to be open, trust them with any questions, learn from their mistakes but abstain from sex for as long as possible. The clear message that they want their daughters to receive is that they are supportive of them, no matter what.

*Seeking information from mom.* Adolescents report that their mothers are their most important sources for information. They are guided by their mothers’ wisdom and knowledge about contraception and sexual activities.

Lexie, age 16, reports her information comes from “My mother and my grandmother and my aunt” and that she learns from the information given to her. In response to a question about her mother’s age of sexual debut and whether it was worth it or not she states:

* I don’t think I would follow because she had me at sixteen and I’m sixteen and uh uh. I wouldn’t follow what she did, but I just take the stuff that she said. I don’t take for granted that I’m going there, but I just take it easy.

Additional sources of information are grandmothers, aunts and cousins. Nookie reports feeling uncomfortable talking to her mother about sex but she seeks her advice about relationships. For intimate sexual knowledge, she seeks information from an aunt. Lique’s mother provides her with sex education but she reports that her mother is uncomfortable with the discussion. However, her grandmother “broke it down” for her. When I ask her about that discussion she says,
I never heard the birds and bees thing. I never heard about that. She explained female organs and male organs and what happens and I was just like kind of in shock because I wasn’t expecting my grandmother to say that to me that way but I was like okay. I got you. Yes.

She says that the information was helpful.

All the adolescents have received some sexual education from their school curriculums, but have found it lacking. Education on sex and contraceptive methods was provided but not where to obtain birth control and they received limited information of side effects. However, they have received the message about condom use and sexually transmitted infections. Although peers who are sexually active surround these adolescents, they don’t seek their advice, instead they listen, absorb and discard. Lexie, 16 years old, states that she doesn’t participate in the conversation but listens, stating at one point “that girls can be stupid” in response to a question about sexually transmitted diseases. Some adolescents do seek advice from their peers. Nookie reports seeking contraceptive advice and Shea also seeks information on menstruation and its associated problems.

Grandmothers report receiving limited information about sex, their sexuality, and no information about birth control. Skeet, talks about her grandmother who told her “Leave these boys alone . . . if you want to have sex you should be married.” Nae Nae reports that her mother didn’t believe in birth control and that she didn’t learn about contraceptive options until she went for her 6-week postpartum check up after the birth of her first child. “They said what kind of birth control would you like to use? I said wow. A day short, a dime short . . .” Leeann states that she didn’t use birth control during her first sexual relationship at 14 years old; indeed she reports no knowledge of contraception.
at all. This seems to be related to the period of time in which the women were raised. Contraception as we know it today was not available during these grandmothers’ mothers’ time and they report no conversations about this with their mothers. Instead, they sought information from their peers, and family members, which included condoms, foam and information about sexually transmitted infections. However, they were provided some health information about their bodies and puberty in school.

Subcategory: Fathers, just being dads. Fathers are in the lives of two of the adolescents, but are not considered a viable source of information. Fathers are considered to be “just d”, protecting their daughters. When asked whether her father provides any education about sex, Jay, age 16 states, “He doesn’t want me to. He said that guys are just . . . they only want one thing and that’s it and he tells me . . . he just don’t like me having boyfriends. He don’t like none of that.”  ‘Lique reported that her father attempted to discuss sex, sexuality and relationships with her but began to tremor and perspire during the conversation so she ended it: “He looked relieved but I appreciated that he tried”’. The information provided to their daughters seems to be in the form of protection, but not information in the context of learning about sex and contraception.

Subcategory: Media, limited influences. These participants report limited influence on their contraception decision making from media sources. Although there are advertisements in magazines and commercials on television, adolescents seem to be unaware of them. Jay, 16 years old says, “I don’t even watch TV . . . I play videogames, I’m outside.”  Shea stated that she sees that commercials on TV but only “somewhat” pays attention to them. Mothers seem to be more aware of the media sources of
information, but their use of these sources is to seek additional information from healthcare providers. Interestingly, one mother reports using the Internet as a source for health information, but not as a source of contraceptive information. She does not seek out women’s health sites in particular.

Two of the adolescents report reading urban literature but feel that this type of fiction doesn’t influence their view sex and relationships unduly despite the descriptions of explicit sexual acts weaved in the plots. Another adolescent, Nookie, feels “the information in that book is just telling us what not to do in situations” and “like a learning process . . . you read it in a book and you’re like see what happens to them so you think its going to happen to you so you won’t do it at all. Not even mess with it”. She feels that adolescents are learning life lessons. Angie, a mother of an adolescent, reports that she finds many of the adolescents are reading these novels, sharing them with their peers, both older and younger, and discussing their sexual plots. Her concern is that adolescents imitate the characters and equate sexual acts with gift giving; in effect prostitution on a smaller scale but don’t realize what they are engaged in.

Subcategory: Spirituality and religion. Adolescents and their mothers report having some knowledge of religious views of sex and contraception but do not report these as being significant. Religion and spirituality appear to have had a greater effect on the grandmothers. Two report being Christian and one is actively involved in the church, seeking additional training as a deacon. Baylee states: “I’m a Baptist and I’ll be a Baptist until I die. You know in the Baptist church they say you shouldn’t get pregnant and all that kind of stuff but once you have them, you have them.” For Skeet, her religious
beliefs led her to celibacy. She currently is involved with a “friend” who is also a deacon in the church and has found relief from the pressures of a sexual relationship. She says that she can be “a good friend to a man and he don’t expect nothing out of me. He teaches me especially like church stuff but I really appreciate that.” She also says “When God sends me my husband, I want to be like a new bride, like a virgin. That’s my goal.”

“I got caught up in the game.” Sexual activity began at an early age for some of these participants. The event was unplanned and all of their partners seemed to be older, in one instance approximately 8-10 years older. Shea says that she was “probably like 12 . . he was probably like a year older. We were bad. It just happened.” Tookie reports that she was just 15 years old when she first had intercourse and that she had “No experience, nothing. I got caught up in the game. And like I say he was already experienced, so he already knew what he was doing. I didn’t know . . I didn’t know nothing.” These older partners set the stage in which the act occurred, made decisions about condom use or non-use, and were more experienced. All the women were involved in relationships and felt peer pressure to engage in sexual activity.

Tookie relates:

_They were saying act like a old woman because I all I do is hang out with my mother and go home after school and stuff like that. I need to get out and hang out with them, with the boys and fresh I guess like them. Then, yes, I also felt pressured because their father at the time, like I knew him forever because we all grew up in the same area, but he was never my type. I never liked him. But it was another girl that she was liking him and then all of a sudden now I like him because she likes him. I don’t know, teenage stuff. Yes and I’m going okay, I don’t even like this guy. Yes, it was competition._

Nisha’s first sexual encounter was at 15 years old and was an attempt to “grow up”. She became pregnant immediately and had her daughter just prior to her 16th
birthday. Chocolate describes her first sexual encounter at 16 years old with an 18-year-old male as “just messing around being curious”, while Nae Nae states that her first act was not planned instead it “just happens . . . the place is always right because even if they’re not right, the situation makes it right. Her partner was an experienced 17 year-old and she was just 16 years old. She became pregnant within two years and says that they had knowledge of condoms but “it wasn’t a pressing issue for him, for us both really”. For many of the participants, pregnancy and contraception were not concerns, believing that they would not become pregnant. This magical thinking is part of normal adolescent development. Due to their early sexual debuts, mothers seek to postpone sexual activity in daughters. They know that sexual activity is inevitable, but would like their daughters more prepared so that their first encounter is meaningful. Nisha age 31 states:

I’m not in denial that you are going to be sexually active, but I would hope and pray that you would respect yourself enough to know better that this person wants you for you and he wants to be with you and make a life with you, not just to experiment with you.

Contraceptive use and beliefs. Contraception is being used among these triads of participants. Past and current contraceptive methods include IUDs, Norplant®, oral contraceptive pills, condoms and the injectible contraceptive, Depo Provera®. Participants primarily rely on medical providers for information about contraception, but the decisions about their choices are their own. Family members’ opinions about contraception seem to be more influential than peers’ opinions. One participant reports her primary source of contraceptive information is her physician and friends. She was constantly seeking information about contraception “the doctors gave me a lot of
information because I was always calling. I need another appointment. I got to talk to them.”

Surprisingly these women did not consult their partners when choosing a method, believing that it was their decision alone. Baylee says that her decision was her own but her partner knew about birth control. “I tell him about birth control. He didn’t believe in birth control. I chose the foam at first. I went to the store and bought that myself.”

Three participants did not use contraception for long periods of time because they believed it was unnecessary. They report having unprotected intercourse for a number of years that did not result in pregnancy. Sister, age 67, reported that she didn’t use birth control because “I didn’t think I needed it. Because I wasn’t the type of person to get pregnant like most women did.” For one adolescent, contraceptive use is linked to her belief about her fertility. Her belief stems from her current sexual practices of unprotected intercourse for the past 3 years without a pregnancy. Because of this history, she believes that a contraceptive method is not necessary. Her cycles are irregular and her flow is light. Shea states “I like started late and it will come on probably be like three months later. . .”. Of her contraceptive use, she says “ I use condoms sometimes but . . . I’ve been messing for almost three years so it didn’t happen yet.” But if her menstrual cycle was regular then “ I would, yes.”

Reports of side effects are common, but participants report symptoms that they believe are related to their contraceptive method. Beliefs include a feeling of weakness, blues, and that contraception is linked to sterility despite a return to fertility once the method is discontinued. Michelle says
You know, I did before. Not now. Actually, I’m not going to say . . . I think I do have side effects. Sometimes I can’t tell, but I feel like I need vitamins. I feel like I feel blue. Weaker than before; like I’m a walker and stuff. I’m always keeping busy. I don’t sit still too long, but yes sometimes I feel lazy and that’s not like me. Like walking up and down these stairs, yes. Walking up and down Grove Hall. So, it’s like everywhere I go I walk or take the bus and some days I just be like, I’ll do it later or tomorrow or something. I think it’s the Depo. I do. Yes, I think it’s the Depo.

When I ask about their beliefs about contraception, some participants share their belief that long-term use is detrimental to their health and that medical providers are not forthcoming with this information. One grandmother believes that medical providers and pharmaceutical companies collaborate to keep negative information about contraception from consumers, leaving it to the media to uncover harmful effects. Nae Nae reports that her mother does not believe in birth control pills, “She didn’t believe that they worked. No you got one baby, you better not be taking nothing that you messed up and got another baby.” Nae Nae believes that her mother’s beliefs stem from the era in which she was born and her lack of trust of physicians, her skepticism of medicine in general as well as her southern roots.

At different points of their lives, my participants chose different contraceptive methods. One woman reports that she chose to use condoms during the time that she was actively using illicit substances and returned to oral contraceptive use once she was sober.

Chocolate:

When I was using drugs, I didn’t take them. So, I didn’t take them for like ten years (birth control pills). But I wasn’t really. . . if I was sexually active when I was using drugs, I always used a condom. If I was any kind of sexually active, you know because I knew that with me using that I wasn’t in love with this person. I knew that. This was either get some honey out of him or this was either because I
wanted to get high. So, I knew that. I wasn’t about to not use nothing with this person, but after I got clean I chose birth controls because to me, I felt that they was the best thing for me.

When discussing condom use, LeAnn reports using them in the past for protection, but her beliefs stem from “when you don’t know if your man’s been out there messing around or not. I think that’s the best protection there is and when I felt he was cheating or messing around out then, condoms.” Shea also reported using condoms in the past when you had intercourse with a different partner. These women reported that their partners accepted the need for condoms.

One interesting point noted during the participant interviews with mothers and grandmothers was a reference to being put on a contraceptive method by physicians. As noted earlier these participants were often unaware of birth control and its available options until they became pregnant. Some sought a birth control method but others seemed have had a method chosen for them. Sister reports that after her pregnancy her IUD use was due to “the doctor’s choice” but “if they had left it to me, I wouldn’t have used anything”. Upon further questioning, she denied by coerced. Skeet and Baylee also had little contraceptive knowledge and were also given a method of birth control by the physician. Though all three of these participants denied being coerced, given the time in history it seems as though their contraceptive “choice” was based on the paternalistic actions of physicians.

Summary

The emerging themes of this study reflect the words of the participants. It is clear that the influences upon their contraceptive decision-making choices are reflective of the
world in which they live. Words of wisdom, knowledge and cultural values are passed through each generation. Not only does each generation seek to impart knowledge about sexuality but also to give them the foundation by which to navigate relationships.

Interestingly spirituality and religion, the backbone of African American culture seems not to have played a role in the decisions and choices made by these women. In this digital information and media era, participants seem to be unaware of or place little value on the contraceptive information delivered by these sources. Fathers play a limited role in the lives of the granddaughters in this study. Only 2 granddaughters report having fathers in their lives, making their impact restricted.

In the last chapter, I will discuss the findings of this research, and implications of this research in relation to the existing literature as well as the next steps.
CHAPTER 5

Significance of the Findings and Implications for Nursing Knowledge

The purpose of this study was to describe the factors that influence African American women’s contraceptive decision-making from a generational perspective. I chose a qualitative method as it allows the development of knowledge from the participants’ worldviews, without interpretation from the researcher. I used a qualitative descriptive method to answer the research question as it allowed me as the researcher to develop an understanding, knowledge, and insights about the phenomenon of interest. I analyzed the data from a Womanist perspective, which allowed these African American women’s realities and experiences to be central in their worldview. In this paradigm, African American women’s knowledge is free of biases and distortions that are common in a Eurocentric paradigm. In this chapter, I will shed light on the themes that emerged, examine the relationships between the generations, across families, and discuss how these relationships influence the women’s contraceptive decision-making and choices. I will then discuss the implications for nursing knowledge, practice, education, healthcare and reproductive health policy, as well as the implications for addressing health disparities. Finally, I will discuss the limitations of this research and suggest future research initiatives.

A Worldview of Relationships.

Interpersonal intimate relationships played a role in this study. Mothers sought not only to provide education about contraceptives, but also about sexuality and the development of intimate relationships. In my sample, one mother was currently
married while two mothers were involved in an intimate relationship and the others were not currently involved. The sample of grandmothers included one divorcee, one in a current relationship, and the rest were neither married nor involved in a relationship. While this sample is relatively small, it is significant as it mirrors current African American women’s relationships. According to 2002 US Census data, 43% of African American women had never been married and were less likely to marry. In 2002, women maintained 43% of African American household families with no spouse present (McKinnon, 2003). Although these statistics may seem dismal, it is important to understand that many African American women expect to be alone. This is not to say that they don’t want loving relationships but as Patricia Hill Collins stated “. . . most African American women know that Black men are hard to find” (2000, p. 161).

There are many factors that support this statement. Continued high rates of unemployment and poverty, Black male incarceration, HIV/AIDS infection and US social policies, as well as the fact that there are approximately 1 million more African American women than men (Tolnay, 2003) have all affected the number of African American males available to partner African American women (Dyer, 2007; Jordan-Zachary, 2007; Livingston & McAdoo, 2007; National Urban League, 2007). Also noteworthy is the state of African American intimate relationships. Historically, African American intimate relationships have been challenged by slavery, racial and economic discrimination, as well as psychosocial factors. Today, the relationship between the sexes is complex.

African American women’s prosperity continues to outpace that of men in employment, education, income and life expectancy (McKinnon, 2003). Another reason
for the fragility of African American relationships is the stereotype of the angry Black woman. In this stereotype African American women are portrayed as aggressive, independent, self-reliant, strong, and hostile to Black men (Chapman, 2007). This stereotype is pervasive in American society today and plays a significant role in relationships. As African American women seek partners, they must combat this stereotype and the myth that African American males are worthless, unemployable, and absent fathers. Why is this important? The positive or negative intimate relationships in which African American women participate can impact on their children’s perceptions of relationships.

The participants in my study are conscious of these influences and have included them as part of their daughters’ education. When Tookie, Nisha and Toni discuss their past relationships with their daughters, they are imparting the knowledge and skills necessary to navigate successful relationships. Daughters are very aware of the problems that their mothers have encountered. Their disclosure that the ideal man must be respectful, appropriately dressed, clean, and economically secure reflects the past encounters that their mothers and grandmothers have shared. Although one would think that these adolescents would have a grim view of men and relationships, they are able to be hopeful about the future of their relationships. This hopefulness seems to reflect the general resiliency of male-female relationships and the future of uniqueness in African American intimate relationships in particular.
Southern Influences.

Since the beginning of civilization, individuals have gathered in groups, villages, towns and societies. As humans evolved, the importance of family groups emerged. The family unit allows individuals a place of nourishment, nurturing, education, support and a sense of history. The family unit became the backbone of society. Nowhere is this more evident than in the African American family. It is one of the strongest and most important traditions within African American culture (Franklin, 2007). This tradition has survived the institution of slavery, reconstruction, discrimination, poverty, urbanization, and adverse governmental policies. The African American family is unique from the perspective that it often comprises extended family members, provides individuals with connectedness, legitimacy, and personal well-being, educates and provides knowledge on cultural traditions and norms, and lastly prepares children for existence within a racially hostile environment, as well as provides a refuge from this environment (Nobles, 2007).

All but one of the family triads in my sample had roots in the southeastern United States. Grandmothers and mothers report that extended family networks and opportunities, education, employment opportunities and improved living conditions influenced their migration from the South. These individuals are representative of the “Great Migration”. The migration of African Americans to the northern and western United States has been well documented (Appiah, 2006; Franklin, 2007; Roberts, 2006; Tolnay, 2003). The “Great Migration” of African Americans within the United States occurred in two waves, early 1900s and post World War II, resulting in the greatest population redistribution within the 20th century. At the end of the Civil War, nearly 91%
of the African American population lived in the southeastern United States (Appiah, 2006); nearly 100 years later, over 4 million Southern born African Americans lived outside the southeastern region (Tolnay, 2003). Their migration was largely due to economic deprivation, resulting from segregation and discrimination, and an increasingly hostile environment, which included the enactment of Jim Crow laws. The resulting migration led to extension of families across the United States.

Southern traditional values are prevalent today. These values include respectability, conservative Protestant religious beliefs, and strict regulation of sexuality (Beck, Frandsen, and Randall, 2007). As a result of their historical ancestry, Southern African American values had some influence on their interpersonal relationships and contraceptive beliefs and use as reflected in the experiences my participants shared about communicating with their daughters.

*Communication: Key to Preparedness.*

“The family is the primary context within which socialization of children occurs” (Dilorio, Hockenberry-Eaten, Maibach, Rivero & Miller, 1996, p. 366). It is because of this socialization that communication is important between mothers and daughters. Through communication parents provide knowledge, expectations, impart values, customs and social norms. This is significant, for without their guidance and support, daughters would not have the skills to interact in society. Carothers (1998) also stated that mother daughter interactions are essential as these provide the basis by which daughters learn the meaning of being female.
Researchers have shown that African American adolescents are more likely to initiate intercourse at younger ages, have older partners, use condoms inconsistently and have higher rates of sexually transmitted infections (DiIorio, 1996; Holcombe, Ryan & Manlove, 2008; Hutchinson et al., 2003; Hutchinson & Montgomery, 2007). For these reasons communication about sexuality and contraception is particularly important between African American mothers and daughters.

It is evident, from my research that mothers and daughters do communicate. Daughters are able to express their thoughts, ideas and feelings about sexual activity and contraception. Younger adolescents are able to articulate their reasons and feelings about delaying sexual activity. They are also able to rationalize the decisions they have made. Older adolescents who had initiated intercourse are also able to recall the conversations with their mothers about becoming sexual active. Although some of the mothers in my study did not recall detailed conversations with their mothers, it is clear that they received the message of postponing sexual activity. The message that children listen to their mothers and the information imparted is clear. The importance of mother daughter communication is supported by the literature. Hutchinson and Montgomery (2007) reported that parent child communication about sex is one of the most important parenting processes that can influence sexual risk behaviors in adolescents. These authors stated “mothers who communicate with their daughters about sex can affect their daughters’ sexual behaviors in positive ways” (Hutchinson & Montgomery, 2003, p.105).

So how do mothers and daughters communicate? The mothers in my research demonstrated varied communication styles. Chocolate mentions that she uses scare
tactics; other mothers weave questions into normal conversations and storytelling to illustrate points. African Americans have a rich tradition of oral history and storytelling (Banks-Wallace & Parks, 2001). Banks-Wallace (1999) defined stories as “the depiction of an event or series of events encompassed by temporal or spatial boundaries” (p.20). Storytelling is used as a way to pass historical facts, cultural values, and convey the universal yearnings or struggles of humans to each generation. It has been said that storytelling is a technique by which to ask and answer epistemological and ontological questions and storytelling has played a significant role in the survival of African Americans (Banks-Wallace, 2002; Gates, 1989). Because of this tradition, it would be natural for African American mothers to use storytelling to provide sexual education to their daughters. Nwoga (2000) conducted research entitled *African American Mothers Use Stories for Family Sexuality Education*. This researcher used narrative analysis to examine stories shared by 11 mothers. Nwoga found that storytelling was a strategy used by mothers for socialization and enculturation about sexuality. As with my study, mothers used stories to provide knowledge or illustrate a point on a sexual topic. Participants in my study also used scare tactics and intimidation as a way to discourage their daughters from becoming sexually active or pregnant (Nwoga, 2000).

*Seeking Information From Mom*

Another factor of critical importance is the quality of this communication. Adolescents report that they take the information they receive from their mothers, sift through it and learn from it. Their comments about knowing that their mothers have their best interest at heart also reflect of their trust. Stiffler, Sims and Noerager Stern (2007) in
their research entitled *Changing Women: Mothers and Their Adolescent Daughters*, found that conversations about sexuality can often lead to conflict between mothers and daughters, but without ample communication between them, daughters may be left to develop their own values from their own environments. Jaccard, Dittus and Gordon (1996) conducted a study with 751 African American adolescents and their mothers or caretakers living in Philadelphia. The purpose of this study was to examine the nature of parent-child communication about sexual activity and contraception, as well as parental influence on adolescent sexual behavior. These researchers found that the adolescents’ perceptions of the quality of their relationships with their mothers were related to initiating sexual activity, frequency of coitus, and contraceptive use consistency (Jaccard, Dittus & Gordon, 1996). The authors also reported that when adolescents acknowledged mother-daughter relationship satisfaction, they were more likely to listen, process and accept information about sex from their mothers.

Using the Parent-Teen Sexual Risk Communication Scale (PTSRC-III), Hutchinson and Montgomery (2007) also examined the parent communication and risk behaviors among African America adolescents. These researchers found that PTSRC was associated with decreased sexual risk behaviors and greater communication between parents and adolescents. In their study, Mims and Biordi (2001) found that adolescents’ perceptions of their mothers’ mother-daughter reasoning were positively correlated with the quality of their communication and improved problem solving. In addition, they reported that daughters perceived that mothers’ openness and free exchange of ideas were important to these adolescents when seeking to discuss concerns with their mothers.
study by Hutchinson et al., (2003), these researchers reported that sexual risk communication between mothers and daughters was positively associated with a decrease in the number of episodes of sexual activity and the number of days of unprotected intercourse.

Two subcategories emerged from my data. They are Fathers, just being Dads, and spirituality and religion, and media as limited influences. Participants reported limited or no influence on their contraceptive decision making on each of these.

Fathers are increasingly absent in the lives of African American women and children. Although women continue to be single parents, they feel the absence of their children’s fathers. Not only do fathers offer a different perspective on sex and sexuality, they also bring their own attitudes, values and cultural perspectives to these discussions. Peterson (2006) conducted a study titled, *The importance of fathers: Contextualizing sexual risk taking in “low-risk” African American adolescent girls*, in which 100 African American adolescent girls from the southeast United States completed multiple questionnaires to explore the relationship between self-esteem, sociodemographic factors, father-daughter relationships and sexual risk taking. Results showed that father’s education was the most significant predictor of sexual risk, with self-esteem as a lesser, but significant predictor of sexual risk. A secondary qualitative analysis was also conducted on a subset of the initial sample to examine father-daughter sexual communication. Three distinct categories emerged from the analysis and were directive, insightful and absent/avoidant. Fathers that were described as directive communicated clear messages about using protection during sexual activity and perceived social norms.
and expectations but also communicated there beliefs about abstinence while insightful fathers engaged in conversations that addressed the emotional factors involved in male-female sexual relationships. However, absent/avoidant fathers engaged in few or delayed or no conversations about sex. It is clear from this study that fathers must be encouraged to have meaningful and constructive dialogues with their daughters.

A majority of the participants reported that spirituality and religion where not influential in their contraceptive decision-making. Of the participants sampled, only one grandmother and one family triad reported that religious principles governed their sexuality as well as guided the adolescents’ beliefs about engaging in premarital sexual activities. These religious beliefs and principles are guiding the lives of three generations of women. For the single grandmother, religion and religious beliefs are guiding her sexual practices presently. Multiple authors reported that African American culture is steeped in religious beliefs and plays a significant role in African American society (Beck, Frandsen & Randall, 2007; Green, 2003; Parks, 1998). It is striking that few of my participants report that religious or spiritual beliefs were influential.

In this age of technology and on-demand information from media sources, one would expect that the media saturation of sexual images, themes, overtones and health resources would have an impact on my participants’ decisions on contraception. The adolescents reported that they had limited access to media influences including Internet sources, advertisement of products on television and magazine advertisements. The adult participants reported that they did not remember advertisements for contraceptives. Only
one mother reported using the Internet for healthcare information, but did not use sites designed specifically for women nor did she seek information on contraception.

I asked all participants if they read books, specifically a genre of fiction labeled Urban lit. Urban literature or Hip-Hop fiction is a genre of African American literature that exploded onto the literature scene in the late 1980s and early 1990s. This literature is set in urban American world of street hustlers, thugs, pimps, prostitutes, and young adults within the context of their every day lives. Initially self published, this class of fiction has moved into the mainstream and many authors have been acquired by major publishing companies. What is significant about this genre of fiction to African American women and their reproductive health is that the female characters in these novels often engage in sexual activities without regard to the consequences. Women have been depicted in violent scenes being raped, traded for drugs, bartering their bodies for clothes, food and for a chance to move up the social latter as the girlfriend of a major drug dealer or gangster. The female characters are more then willing to participate in these activities often justifying their actions as a way to become rich or improve their socioeconomic status. Rarely is the use of contraceptives described nor do the characters seem to be motivated to practice safe sex.

The significance of this phenomenon is that women are the leading purchasers of these books (Venable, McQuillan, & Mingo, 2004). Not only are women purchasing these books but many African American girls report reading this literature, exchanging novels with their friends as well as discussing the actions of the characters, somewhat related to an informal book club. In my sample, most of the mothers and daughters were
aware of and had read this type of novel. Two of the grandmothers were unaware of this
genre; the rest were aware but did not read this type of literature, finding it unacceptable.
Adolescents reported that they enjoyed reading the books but did not agree with the
behavior of the women. When questioned whether they thought that adolescents were
influenced by the behavior of these women, they reported that they were not influenced
but that some of their friends might be influenced and it had a negative impact on their
views of sex and sexuality. Due to the negative portrayal of African American women in
these novels, it is important for mothers to have thoughtful discussions with their
daughters.

“I Got Caught Up in the Game”

Many of the participants in my sample reported initiating sexual intercourse at an
early age. According to 2002 teen sexual health statistics, the median age for sexual
intercourse was 16.9% and 17.4% for boys and girls respectively (Kaiser Family
Foundation, 2006). However, African American adolescents were 16.5% more likely to
have initiated sexual activity before the age of 13 than were their Hispanic and Caucasian
counterparts (Hutchinson et al., 2003; Morbidity & Mortality Weekly Report, 2006). The
literature also supports the thesis that participants’ partners are more likely to be older;
that partners do not use a contraceptive method at their first act, and that the sexual acts
are unplanned (Eisenberg, Bearinger, Sieving, Swain & Resnick, 2004; Guttmacher,
2006; Jaccard, Dittus, & Gordon, 1996; Lemay, Cashman, Elfenbein, & Felice, 2007).

My participants reported that their first sexual encounter was unplanned and was
influenced by peer pressure or that they just “. . . got caught up in the game.” There is
ample evidence in the literature to demonstrate that peers who are sexually active
influence adolescents’ sexual behavior and they often succumb to pressure beginning
sexual activity (Haglund, 2006). Fasula and Miller (2006) found that adolescents having
peers who were sexually active had a significant negative effect on delaying initiation of
sexual activity. Ryan, Franzetta, Manlove, and Schelar (2008) in their study also provided
negative evidence of the role that older partners have in young adolescents’ reproductive
health outcomes. Using logistic regression and contrast analysis of three waves of data,
1995-1996 and 2002, from the National Longitudinal Study of Adolescent Health, these
researchers found that adolescents less than 16 years old whose partners were older, had
greater odds of having a teenage birth, a non-marital birth and acquiring an STD. They
were also more likely to have an increased number of sexual partners and decisions
related to condom use were likely made by the person in the relationship who had the
greatest perceived power (Ryan, Franzetta, Manlove & Schelar, 2008).

Contraceptive Use and Beliefs

The use of contraception by my participants and their beliefs about the methods
were evident in my findings. Grandmothers in the sample believe in and use
contraception; however, they report no knowledge of contraceptive use by their mothers.
The great grandmothers of these participants were likely born at a time when
contraception, as we know it today, was not available nor was it discussed. Although
there is evidence that African Americans practiced folk methods of contraception and
abortion in the antebellum south and later after emancipation and early 1900s (McFalls &
Masnick, 1981), women had to rely on their mothers and grandmothers to share this information.

However, grandmothers in my sample went out of their way to ensure that their daughters were educated about methods. Grandmothers and their daughters report using many different methods. Although many of these women were introduced to contraceptive methods after they had become pregnant, my participants report being introduced to the methods by a physician. It was unclear whether some of the women chose a method or a method was chosen for them. One grandmother insisted that she chose oral contraceptive pills as her method and was not coerced. It was not uncommon during earlier eras for physicians to present women with a method that they believed were best for them (Benkert & Peters, 2005).

Methods used by participants include oral contraceptive pills, intrauterine devices (IUDs), Depo Provera®, and condoms. The methods chosen by the participants are consistent with the literature. According to the Guttmacher Institute’s Facts on contraceptive use (2008), oral contraception is one of two leading contraceptive methods used by U.S. women overall, although sterilization is the leading method among African American women. However only one participant mentioned a desire for sterilization. Women of lower socioeconomic status are twice as likely to chose Depo Provera® than women with higher incomes and condom use is reported as common among adolescents, young adults, childless and never married women (Guttmacher Institute, 2008). Reasons for method discontinuation include break through bleeding, method dissatisfaction, and concern about side effects. These reasons for discontinuation are consistent with evidence
Beliefs that women have about contraception are important. The women in my study had a variety of beliefs about contraception including lack of effectiveness, detriments to health, sterility, and a withholding of side effect information by medical providers and pharmaceutical companies. The beliefs held by these women are documented in the literature. Einsenberg, Bearinger, Sieving, Swain, and Resnick (2004) reported that minority parents are more likely to given inaccurate information about condoms and oral contraception use, efficacy, STD prevention and safety. According to study results of these researchers, a smaller proportion of participant minority parents than Caucasian parents “believe that the pill prevents pregnancy almost all of the time (33% vs. 54%), that the pill is very safe (30% vs. 40%), and that most teenagers are capable of using the pill correctly (29% vs. 40%)” (Einsenberg et al., 2004, p. 54.). Additionally, results of qualitative descriptive study of adolescent mothers’ views of contraceptive use before and after pregnancy revealed that adolescents’ beliefs about different contraceptive methods play an important role in their decision-making when choosing a particular method (Lemay et al., 2007).
Nursing Implications and Future Research Endeavors

Limitations of the Study

In this study, my aim was to describe the factors that influence African American women’s contraceptive decision-making. I examined the factors that affected their contraceptive decision-making from a generational perspective by interviewing family triads that included an adolescent, her mother and grandmother. Not all of the adolescents I interviewed were sexually active. However, all have had discussions with their mothers and grandmothers about sexual decision-making and contraceptive methods. Nineteen women participated in this qualitative study; therefore, it is limited in scope and generalizability. The participants were all of African American descent. My sample does not include other ethnic groups of African decent that are generally included in the umbrella term of African American; consequently, the themes that emerged from the data may not fit other groups. All of the women I interviewed lived in urban neighborhoods of metropolitan Boston and some of the women were insured for health care with public funds. As a result, my work does not address the experiences and influences of women who live in suburban neighborhoods and have private insurance. Also, all of the families I interviewed have roots in the southern region of the U.S.; women with roots in the northeast or west may have different beliefs or experiences with contraception. Although there are a few limitations of this study, the factors that influence the contraceptive choices of my participants are worth exploring with other African American women.
Implications for Nursing Knowledge

This study has significant implications for nursing practice, education, research and women’s health care and public health policy. Procreation and reproductive health as well as the decisions made related to these have implications for women’s lives. African American women have had a history of lack of reproductive freedom, often do not trust healthcare providers, and have faced numerous challenges because of discrimination. Because of these reasons, it is important to develop an understanding of how African American women make decisions that affect their contraception and how these familial beliefs are passed along to future generations.

Nursing Practice

This research provides additional evidence that contraceptive decision-making is influenced by the beliefs, knowledge and practices of prior generations. Mothers’ attitudes, knowledge, beliefs and values greatly impact their children’s beliefs, values, attitudes, and knowledge about sex, sexuality, reproduction, and contraception. As nurses are often the first healthcare provider patients encounter, they can play a significant role in guiding African American women as they make healthcare decisions. However, it is important that nurses understand the complex history of contraceptive practices of African American women as well as their beliefs and values. This understanding must include knowledge of cultural and ethnic ideas so that guidance may be offered in the context of these women’s lives. Querying women about their beliefs, attitudes and values demonstrates respect and understanding as well as building trust between the patient and healthcare provider.
Education and Women’s Health

Participants in this study remarked that they received sex education in school. Depending on their age, the content of sex education programs varied, ranging from health education about their bodies to education of sexually transmitted infections, contraceptive methods and their uses. What is striking is that my participants did not connect sex education with the sexual act. The quality of sex education varies by school, school district, community and state. Individuals often develop sex education curriculums that provide students with limited information about sex and sexuality. It is vital to provide education on where and how to obtain contraception as well. The information received by adolescents must be accurate and complete. More importantly, sex education providers must connect the information about sex with the actual coital act for adolescents. Without making this connection, the education is of little value and places adolescents at risk for pregnancy and sexually transmitted infections, as evidenced by the stories of these participants. As mothers are influential in knowledge development of their children, nurses must ensure that mothers have the correct contraceptive information.

Women’s Healthcare Policies

There are several implications for African American women’s healthcare and public healthcare policies that emerged from these data. African American women continue to face overwhelming challenges to their health including reproduction. African American women are more likely to be impoverished, be unmarried, be uninsured and/or underinsured and lack access to reproductive healthcare. These factors, coupled with
inadequate contraceptive knowledge, leave them vulnerable and at risk for unintended pregnancies. In addition, U.S. healthcare policies have limited access to affordable contraceptives, while increasing funding for abstinence-only sex education to adolescents despite evidence of its failure. There are several steps that can be taken to improve African American women’s reproductive and contraceptive healthcare.

First, it is imperative that African American women be provided with better sex education and access to healthcare. National programs on reproductive health including contraceptive education must be instituted and be evidence-based. The curriculums must be culturally sensitive, include historical implications and reflect community values. Key stakeholders including state, county and local departments of public health, local community health centers, parents, educational and religious institutions, and community leaders must work together to foster the development of these programs.

Second, public funding for sex education must be allocated for programs that have well documented effectiveness. These programs should include all aspects of sexuality and sex education including abstinence. Funding for reproductive programs must be comprehensive and not be guided by the philosophical values and morals of any particular group.

Third, all women requiring or requesting reproductive healthcare services should be afforded access, as the lack of these services has long term social and economic implications for African American women and the society at large. As a significant number of insurance programs do not cover contraceptive services including counseling and some methods, many women often must chose methods based on insurance coverage
and co-payments instead of based on the best fit for their lifestyles. Public health care dollars must be allocated to ensure equal coverage and access for all women.

Fourth, healthcare providers must be able to communicate effectively with patients. Education on communication and counseling skills, techniques and strategies for communicating with adolescents and parents is essential. Healthcare providers must be up to date on the latest contraceptive advances, have access and offer new FDA approved products, and have educational materials available. Contraceptive and reproductive health educational programs should be offered annually to healthcare providers, including primary care providers and nursing professionals. If possible, healthcare providers must include parents in the discussions of adolescent sexuality and contraceptive needs. Without parental support, oftentimes it is difficult to change the contraceptive beliefs and attitudes of adolescents.

Fifth, educational programs on addressing adolescent sexuality must be developed for parents to help them effectively counsel their children. Researchers have found that parents with limited knowledge of contraceptives do not communicate effectively nor do they pass on correct information (Swain, Ackerman, & Ackerman, 2006). Parents will benefit from such programs that provide them with the information and skills necessary to educate their children.

Finally, despite wide recognition and public health outcry, healthcare disparities continue to exist for all minority groups but especially for African Americans. The status of women’s health differs across racial and ethnic lines with multiple factors affecting health disparities (Browne, 2008). According to an Institute of Medicine report, Unequal
Treatment: Confronting Racial and Ethnic Disparities in Healthcare (2002), contributing factors include provider biases, prejudice and stereotyping of patients. African American women’s reproductive healthcare has suffered as a result of these disparities (Brindis, 2002; Hogue, 2002; Noone, 2000; Stewart & Hwang, 2006). Continued research on reproductive healthcare disparities is needed. Provider biases and sexual stereotyping continue to have an impact on African American women’s reproductive rights as well as access to care. Intervention studies should be initiated that address provider bias.

Future Nursing Research

African American’s women’s health has long been at the margins of women’s health care policies and research. Researchers studying the health problems and solutions for African American women often do not speak to their needs. Furthermore, the majority of women’s health research has been conducted on women of European descent whose culture and principles do not mirror African American culture, but nonetheless the findings are considered generalizable. Any research design must speak to the inherent racial and social inequalities as well as advance the knowledge and culture of African American women. Areas for future research echo my recommendations for women’s healthcare policies. For my study, I had a limited number of participants and therefore the findings are not generalizable. Additional research using survey and quasi-experimental approaches is recommended to capture a larger sample including women representing various socioeconomic groups. Using a wider sample will enable investigators to capture information about various population demographics, values, attitudes and beliefs, thereby making the findings more generalizable to the African American population at large.
Another research endeavor would be to replicate this study with different ethnic groups. Discovering similarities and differences characterizing contraceptive decision-making between populations are important so educational programs may be tailored to meet an individual group’s needs.

Conducting interdisciplinary participatory action research may be beneficial for assessing and implementing community educational programs. This research method is designed to generate knowledge and address community social concerns. Thus, it could be used to address women’s reproductive health needs while speaking to community culture and values. An example would be engaging African American parents in designing and implementing their own programs to provide sex education to their children.

My research focused on African American women only. While recruiting for this study, many women expressed interest in an opportunity to discuss the knowledge they provided to their sons. Although researchers have shown that fathers are often the providers of sex education to their sons (Hutchinson & Montgomery, 2007), many boys do not have fathers in their lives and/or limited male role models, making their mothers the primary sources for this information. In addition, a couple of mothers believed that information provided to boys was not guided toward pregnancy prevention or toward preventing sexually transmitted infections. I suggest that additional research be undertaken to describe the knowledge that African American boys receive from their mothers and fathers. It would also be interesting to assess their level of knowledge of contraceptive methods.
The influence of urban literature on African American culture including adolescents and women’s sexual beliefs and behaviors as well as reproductive health is not well understood. Research into this genre’s influence and impact must be conducted. Nurses can play a key role in assessing the scope of this phenomenon. Many patients often bring books to read while waiting for their healthcare visit. They may encounter this literature in schools, libraries, and after school programs. These settings may be ideal for engaging society members in conversations about the content of these novels, as well as assessing their influence on behaviors.

Lastly, healthcare disparities exist. In a 2005 study, Thorburn and Bogart found that African American women are often the victims of racial discrimination when seeking family planning services. Their study was limited to African American women’s reports of discrimination based on race only. Other factors that may cause discrimination were not considered; therefore, additional research should be conducted to examine other causes as well as how these experiences have affected women’s choices.

Summary

Qualitative studies are conducted to gather knowledge about particular phenomena. Qualitative methods allow investigators to gain insights that may lead to future studies. The purpose of this qualitative descriptive study was to develop an understanding of African American women’s contraceptive decision-making process; to describe the generational influences on contraceptive decision-making and to develop knowledge that can influence nursing practice. The philosophical framework that guided this study was Womanism. The sample included 19 African American women
participants who lived in the surrounding neighborhoods of Roxbury, Dorchester and Mattapan Massachusetts.

I conducted confidential interviews using a semi-structured interview guide that I developed.

The following themes emerged from the data and are representative of the factors that influence contraceptive decision-making in African American women. These themes are: 1) Southern influences; 2) A worldview of relationships; 3) Communication; Key to preparedness; 4) Seeking information from Mom; 5) “I got caught up in the game”; and 6) Contraceptive use and beliefs. The theme Seeking information from Mom had three additional subcategories I titled Fathers just being Dads, Spirituality and religion, and Media-- limited influences.

African American women have a culture rich in history and traditions. As an ethnic group, African American women have been the victims of sexism, racism, classism, as well as negative socioeconomic and political policies that have impacted their health, healthcare leaving them with disparate care. Despite the challenges faced, African American women continue to thrive, providing love, support, education and a cultural and racial identity to their daughters.

This research provides an understanding of the generational factors that influence of contraceptive decision-making within the context of African American women’s identifies and culture. The result is a deeper understanding of African American women and the role that contraception in plays in their lives, which can guide the development of improved of healthcare interventions for this population. The specific contributions to
nursing knowledge, implications for nursing practice, healthcare policy and suggestions for future research stand as challenges to clinicians, researchers, educators and policy makers.
References


Davies, D. & Dodd, J. (2002). Qualitative research and the question of rigor. Qualitative Health Research, 12, 279-289.


Appendix A
Participant Demographics

1. Name: _____________________________________________________

2. Participant alias: ___________________________________________

3. Age: _________

4. Mother’s name: ______________________________________________

5. Grandmother’s name: __________________________________________

6. Please circle your highest educational level completed.
   a) Grade school
   b) High school
   c) College
   d) Graduate degree

7. At what age did you begin to have your period? __________

8. Do you have your pap smear yearly? Yes No
   a) If no, how often do you have it done? __________

9. How often do you visit your health care provider
   a) Less than yearly
   b) 1-2 visits/ year
   c) 3-5 visits/ year
   d) 5-10 visits/ year

10. Have you ever been pregnant? Yes No
    a) If so, how many times? ______
    b) How many children do you have now? ______

11. How many partners have you had in:
    a) The last 3 months? ______
    b) The last year? _________
Appendix B

Boston College
Adult Consent Form
Boston College, William F. Connell School of Nursing

Informed Consent for Participation as a Subject in Factors That Influence Contraceptive Decision-Making in African American Women, An Intergenerational Perspective
Investigator: Allyssa L. Harris PhD(c), MS, RNC, NP
Date Created: June 27, 2007

Introduction
• You are being asked to be in a research study about how contraceptive decisions are made by African American women.
• You were selected as a possible participant because you have expressed an interest in participating in the study and have met all of the following criteria 1) you are a US born African American woman; 2) you reside in city of Boston; 3) you are a member of an African American family that includes an adolescent daughter, her mother and grandmother.
• I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study:
• The purpose of this study is to develop an understanding on what factors influence your decision to use or not to use a contraceptive method.
• Participants in this study are from the city of Boston, MA. The total number of participants is expected to be 35-40.
*Please note that neither I nor any members of my dissertation committee have a significant financial interest in any medical products or services.

Description of the Study Procedures:
• If you agree to be in this study, I would ask you to do the following things: to participate in a confidential interview in which I will ask you questions about how you arrived at a decision to use or not to use a contraceptive method. The interview will last approximately 1-2 hours and will be audiotaped.
• You will be contacted after the interview to read the transcript of the interview to ensure that it is accurate and reflects your opinion.
• I may also contact you after the interview to explain or clarify something you shared during the interview.
Risks/Discomforts of Being in the Study:
• This study is designed for the researcher to learn more about African American women’s contraceptive decision making and is not designed to treat any illness or to improve your health.
• There are no reasonable foreseeable (or expected) risks to you for participating. It is possible that you could become upset talking about your history of sexual activity or choices of contraceptive methods. There may be unknown risks.

Benefits of Being in the Study:
• The purpose of the study is to 1) explore and describe the factors that influence how African American women choose to use or not to use contraception; 2) to explore and describe how the influence of the family on contraceptive decisions; 3) develop knowledge and understanding, for advanced practice nurses and other health care providers, about African American women’s decision to use or not to use contraception.
• Although you as a participant may not directly benefit from participating in this study, you may indirectly benefit by being able to tell your story.

Payments:
• You will receive a $25.00 gift card of your choice for participating in this research study. This will be given to you at the end of the interview. If you complete only part of the interview and then ask to stop, you will receive a $10 gift card of your choice.

Costs:
• There is no cost to you to participate in this research study.

Confidentiality:
• The records of this study will be kept confidential. In any sort of report I may publish, I will not include any information that will make it possible to identify you as a participant. Research records will be kept in a locked file.
• All electronic information will be coded and secured using a password-protected file. All audiotapes will be stored in a locked cabinet, accessible only to me the researcher. Audiotapes will be erased/destroyed at the end of the research study by removing the audiotapes from their cassettes.
• Access to the records will be limited to me and the chairperson of my dissertation committee; however, please note that regulatory agencies, and the Boston College Institutional Review Board and internal Boston College auditors may review the research records.

Voluntary Participation/Withdrawal:
• Your participation is voluntary. If you choose not to participate, it will not
affect your current or future relations with the health center for Boston
College.
• You are free to withdraw at any time, for whatever reason.
• There is no penalty or loss of benefits for not taking part or for stopping your
participation.
  *You will be provided with any significant new findings that develop during the
course of the research that may make you decide that you want to stop
participating.

*Dismissal From the Study:
• If you do not follow the instructions you are given, you will be dismissed from
the study.

*Compensation for Injury:
• If you experience emotional stress as a direct result of your participation in
this research, you will receive a referral to a Behavioral Health Clinic located
at Roxbury Comprehensive Community Health Center. Medical and/or mental
health services will be billed to your health insurance. Decisions regarding
care and compensation for any other research related injury will be made on
a case-by-case basis.

Contacts and Questions:
• The researcher conducting this study is Allyssa L. Harris (PI). For questions
or more information concerning this research, you may contact her at 617-
913-8025.
• If you believe you may have suffered a research related injury, contact
Allyssa L. Harris at 617-913-8025 who will give you further instructions.
• If you have any questions about your rights as a research subject, you may
contact: Director, Office for Human Research Participant Protection, Boston
College at (617) 552-4778, or irb@bc.edu

Copy of Consent Form:
• You will be given a copy of this form to keep for your records and future
reference.

Statement of Consent:
• I have read (or have had read to me) the contents of this consent form and
have been encouraged to ask questions. I have received answers to my
questions. I give my consent to participate in this study. I have received (or
will receive) a copy of this form.

Signatures/Dates
Your Name: ____________________________________________________________

Today’s Date: __________________________________________________________

Home phone (in case of emergency): ______________________________________

Person providing information and witness to consent: ________________________
Appendix C

Boston College Adolescent Assent/Consent Form
Boston College, William F. Connell School of Nursing

Informed Consent for Participation as a Subject in Factors that Influence Contraceptive Decision-Making in African American Women, An Intergenerational Perspective.

Investigator: Allyssa L. Harris PhD(c), MS, RNC, NP
Type of consent form: Child Assent, ages 12-17
Date Created: June 27, 2007

Introduction
• You are being asked to be in a research study about how contraceptive decisions are made by African American women.
• You were selected as a possible participant because you have expressed an interest in participating in the study and have met all of the following criteria 1) you are a US born African American adolescent female; 2) you reside in city of Boston; 3) you are a member of an African American family includes an adolescent daughter, her mother and grandmother.
• We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study:
• The purpose of this study is to develop an understanding on what factors influence your decision to use or not to use a contraceptive method.
• Participants in this study are from the city of Boston, MA. The total number of subjects is expected to be 35-40.
*Please note that the responsible investigator and/or other members of the research team have a significant financial interest in any medical products or services.

Description of Study Procedures:
If you agree to be in this study, we would ask you to do the following things: to participate in a confidential interview in which the researcher will ask you questions about the sexuality and how you arrived at a decision to use or not to use a contraceptive method. The interview will last approximately 1-2 hours and will be audiotaped. You will be contacted after the interview to read the transcript of to ensure that it is accurate and reflects your opinion. The researcher may also contact you after the interview to explain or clarify a statement made during the interview.
Risks to Being in Study:
• There are no reasonable foreseeable (or expected) risks. There may be unknown risks.

Benefits of Being in Study:
• The purpose of the study is to 1) explore and describe the factors that influence how African American women choose to use or not to use contraception; 2) to explore and describe how the influence of the family on contraceptive decisions; 3) develop knowledge and understanding, for advanced practice nurses and other health care providers, about African American women’s decision to use or not to use contraception.
• Although the participant may not directly benefit from participating in this study, they will indirectly benefit by being able to tell their story.

Payments:
• You will receive a $25.00 gift care of your choice for participating in this research study. This will be given to you at the end of the interview.

Costs:
• There is no cost to you to participate in this research study.

Confidentiality:
• The records of this study will be kept private. In any sort of report we may publish, we will not include any information that will make it possible to identify a participant. Research records will be kept in a locked file.
• Access to the records will be limited to the researchers; however, please note that sponsors, funding agencies, regulatory agencies, and the Institutional Review Board may review the research records.
• All electronic information will be coded and secured using a password-protected file. All audiotapes will be stored in a locked cabinet, accessible only to the researcher. Audiotapes will be erased/destroyed at the end of the research study by removing the audiotapes from their cassettes.

Voluntary Participation/Withdrawal:
• Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University.
• You are free to withdraw at any time, for whatever reason.
• There is no penalty or loss of benefits for not taking part or for stopping your participation.
*You will be provided with any significant new findings that develop during the course of the research that may make you decide that you want to stop participating.
**Dismissal From Study:**
- If you do not follow the instructions you are given, you will be dismissed from the study.

**Compensation for Injury:**
- If you experience an emergency medical problem or injury as a direct result of your participation in this research, you will receive a referral to a Behavioral Health Clinic located at Roxbury Comprehensive Community Health Center. Medical and/or mental health services will be billed to the participant’s health insurance. Decisions regarding care and compensation for any other research related injury will be made on a case-by-case basis.

**Contacts and Questions:**
- The researcher conducting this study is Allyssa L. Harris (PI). For questions or more information concerning this research, you may contact her at 617-913-8025.
- If you believe you may have suffered a research related injury, contact Allyssa L. Harris at 617-913-8025 who will give you further instructions.
- If you have any questions about your rights as a research subject, you may contact: Director, Office for Human Research Participant Protection, Boston College at (617) 552-4778, or irb@bc.edu

**Copy of Consent Form:**
- You will be given a copy of this form to keep for your records and future reference.

**Statement of Consent:**
- **For Adult Consent Form or older child (12-17 years) combined Consent/Assent (Full form):**  
  I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study. I have received (or will receive) a copy of this form.

- The researcher will be taking photographs of the participants with their consent. Participants may decline to have the photo taken and still participate in the study. Do you want to have your picture taken? Yes ____ No ____

**Signatures/Dates**
- **For Adult or Subject's Legal Representative or older child consent (Full Form):**
- Study Participant (Print Name): ________________________________
- Participant or Legal Representative Signature: __________________Date _____
• For Parental Permission/Consent:
  Study Participant (Print Name): ____________________________________
  Parent/Guardian (Print Name): _____________________________________
  Parent/Guardian (Signature): __________________________ Date _______
Appendix D

Boston College
Adolescent/Parent Consent Form
Boston College, William F. Connell School of Nursing

Informed Consent for Participation as a Subject in Factors that Influence Contraceptive Decision-Making in African American Women, A Intergenerational Perspective
Investigator: Allyssa L. Harris PhD(c), MS, RNC, NP
Type of consent form: Parent/Child Consent Form, ages 12-17
Date Created: June 30, 2007

Introduction
• You are being asked to be in a research study about how contraceptive decisions are made by African American women.
• You were selected as a possible participant because you have expressed an interest in participating in the study and have met all of the following criteria 1) you are a US born African American woman; 2) you reside in city of Boston; 3) you are a member of an African American family includes an adolescent daughter, her mother and grandmother.
• We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study:
• The purpose of this study is to develop an understanding on what factors influence your decision to use or not to use a contraceptive method.
• Participants in this study are from the city of Boston, MA. The total number of subjects is expected to be 35-40.
*Please note that the responsible investigator and/or other members of the research team do not have a significant financial interest in any medical products or services.

Description of the Study Procedures:
• If you agree to be in this study, we would ask you to do the following things: to participate in a confidential interview in which the researcher will ask you questions about the sexuality and how you arrived at a decision to use or not to use a contraceptive method. The interview will last approximately 1-2 hours and will be audiotaped. You will be contacted after the interview to read the transcript of to ensure that it is accurate and reflects your opinion. The
researcher may also contact you after the interview to explain or clarify a statement made during the interview.

**Risks/Discomforts of Being in the Study:**
• There are no reasonable foreseeable (or expected) risks. There may be unknown risks.

**Benefits of Being in the Study:**
• The purpose of the study is to 1) explore and describe the factors that influence how African American women choose to use or not to use contraception; 2) to explore and describe how the influence of the family on contraceptive decisions; 3) develop knowledge and understanding, for advanced practice nurses and other health care providers, about African American women’s decision to use or not to use contraception.
• Although the participant may not directly benefit from participating in this study, they will indirectly benefit by being able to tell their story.

**Payments:**
• You will receive a $25.00 gift card of your choice for participating in this research study. This will be given to you at the end of the interview.

**Costs:**
• There is no cost to you to participate in this research study.

**Confidentiality:**
• The records of this study will be kept private. In any sort of report we may publish, we will not include any information that will make it possible to identify a participant. Research records will be kept in a locked file.
• All electronic information will be coded and secured using a password-protected file. All audiotapes will be stored in a locked cabinet, accessible only to the researcher. Audiotapes will be erased/destroyed at the end of the research study by removing the audiotapes from their cassettes.
• Access to the records will be limited to the researchers; however, please note that regulatory agencies, and the Institutional Review Board and internal Boston College auditors may review the research records.

**Voluntary Participation/Withdrawal:**
• Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University.
• You are free to withdraw at any time, for whatever reason.
• There is no penalty or loss of benefits for not taking part or for stopping your participation.
*You will be provided with any significant new findings that develop during the course of the research that may make you decide that you want to stop participating.

**Dismissal From the Study:**
- If you do not follow the instructions you are given, you will be dismissed from the study.

**Compensation for Injury:**
- If you experience an emergency medical problem or injury as a direct result of your participation in this research, you will receive a referral to a Behavioral Health Clinic located at Roxbury Comprehensive Community Health Center. Medical and/or mental health services will be billed to the participant’s health insurance. Decisions regarding care and compensation for any other research related injury will be made on a case-by-case basis.

**Contacts and Questions:**
- The researcher conducting this study is Allyssa L. Harris (PI). For questions or more information concerning this research, you may contact her at 617-913-8025.
- If you believe you may have suffered a research related injury, contact Allyssa L. Harris at 617-913-8025 who will give you further instructions.
- If you have any questions about your rights as a research subject, you may contact: Director, Office for Human Research Participant Protection, Boston College at (617) 552-4778, or irb@bc.edu

**Copy of Consent Form:**
- You will be given a copy of this form to keep for your records and future reference.

**Statement of Consent:**
- I have read (or have had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study. I have received (or will receive) a copy of this form.
- The researcher will be taking photographs of the participants with their consent. Participants may decline to have the photo taken and still participate in the study. Do you want to have your picture taken? Yes _____ No _____

**Signatures/Dates**
*For Adult or Subject's Legal Representative or older child consent (Full Form):*
- Study Participant (Print Name): ______________________________________
- Participant or Legal Representative Signature: _________________________ Date _____
Appendix E
Interview Guide: Adolescent

1. Please tell me a little about yourself? For instance, if you had to write a quote about yourself for your yearbook today, what would it say? Tell me more about that.

2. At what age did you start to have a sexual intercourse? Can you tell me about how you arrived at that decision?

3. Are you currently in a dating relationship? If so, how long?

4. Please tell me what contraceptive method or method of protection, if any, you are currently using?

5. What other methods have you tried and how did they work for you?

6. Why did you choose __________?

7. With whom did you talk about contraception with?
   a. mother
   b. grandmother
   c. friends/peers
   d. siblings
   e. extended family members such as aunts, cousins
   f. partner
   g. others

8. Please tell me about the information they gave you?

9. What other persons or sources of information (magazines, etc.) besides family and friends played a role in your choice and how do they influence you?

10. What beliefs, values, religious/spiritual consideration enter into your decision? Tell me about them?

11. Did you receive any information from your father? If so, what things did he tell you?
Appendix F
Interview Guide: Mother/Grandmother

1. Please tell me a little about yourself?

2. At what age did you become sexually active? Can you tell me about how you arrived at that decision?

3. Are you currently in a relationship? If so, how long?

4. Please tell me what contraceptive method or method of protection, if any, you are currently using?

5. What other methods have you tried and how did they work for you?

6. Why did you choose __________?

7. With whom did you talk about contraception with?
   a. mother
   b. grandmother
   c. friends/peers
   d. siblings
   e. extended family members such as aunts, cousins
   f. partner
   g. others

8. Please tell me about the information they gave you?

9. What other sources of information besides family and friends (such as magazines, other media) played a role in your choice and how do they influence you?

10. What beliefs, values, religious/spiritual considerations enter into your decision? Tell me about them?

11. What did you tell your daughter about becoming sexually active and contraception?

12. What do you believe is important, now to tell your daughter about contraception?
13. What do you think is important for her to hear from you rather than someone else?

14. What things did your mother tell you about contraception? Was this information helpful to you? Did the advice/information influence your decision?

15. Did you receive any information from your father? If so, what things did he tell you?
Do you ever wonder how women choose a contraceptive method?

SEEKING AFRICAN AMERICAN WOMEN TO PARTICIPATE IN AN INTERVIEW ABOUT HOW WOMEN MAKE CHOICES.

Participate in a research study.

To be included in the study you must be:
♥ U.S. born African American female
♥ Family group of an adolescent, mother & your maternal grandmother
♥ Adolescent must be at least 13yo.
♥ Reside in the neighborhoods of Roxbury, Dorchester & Mattapan
♥ English Speaking

A small gift will be provided to participants for taking part in the study.

Appendix G
Appendix H

BOSTON COLLEGE
Institutional Review Board
Office for Human Research Participant Protection
Waul House, 2nd Floor
Phone: (617) 552-4778, fax: (617) 552-0948

IRB Protocol Number: 07.105.01
DATE: September 25, 2007
TO: Allysa Harris
FROM: Institutional Review Board – Office for Human Research Participant Protection
RE: Factors Influencing Contraceptive Decision-Making In African American Women, An Intergenerational Perspective

Notice of IRB Review and Approval
Expedited Review as per Title 45 CFR Part 46.110, FR 60366, FR, # 6 & 7

The project identified above has been reviewed by the Boston College Institutional Review Board (IRB) for the Protection of Human Subjects in Research using an expedited review procedure. This is a minimal risk study. This approval is based on the assumption that the materials, including changes/clarifications that you submitted to the IRB contain a complete and accurate description of all the ways in which human subjects are involved in your research.

This approval is given with the following standard conditions:

1. You are approved to conduct this research only during the period of approval cited below;
2. You will conduct the research according to the plans and protocol submitted (approved copy enclosed);
3. You will immediately inform the Office for Human Research Participant Protection (OHRPP) of any injuries or adverse research events involving subjects;
4. You will immediately request approval from the IRB of any proposed changes in your research, and you will not initiate any changes until they have been reviewed and approved by the IRB;
5. You will only use the informed consent documents that have the IRB approval dates stamped on them (approved copies enclosed);
6. You will give each research subject a copy of the informed consent document;
7. If your research is anticipated to continue beyond the IRB approval dates, you must submit a Continuing Review Request to the IRB approximately 60 days prior to the...
IRB approval expiration date. Without continuing approval the Protocol will automatically expire on September 25, 2008.

Additional Conditions: Any research personnel that have not completed NIH certificates should be removed from the project until they have completed the training. When they have completed the training, you must submit a Protocol Revision and Amendment Form to add their names to the protocol, along with a copy of their NIH certificates.

Approval Period: September 25, 2007- September 24, 2008

Boston College and the Office for Human Research Participant Protection appreciate your efforts to conduct research in compliance with Boston College Policy and the federal regulations that have been established to ensure the protection of human subjects in research. Thank you for your cooperation and patience with the IRB process.

Sincerely,

[Signature]

Christina Booth Steele, MS, CIPP
IRB Designee
Administrative Director