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What Influences Adolescents' Contraceptive Decision-Making? A Meta-Ethnography

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Increased access to and use of contraception has contributed significantly to the decline in teen birth rates since 1991, yet many teens use contraception inconsistently or not at all. This meta-ethnography was conducted to identify the factors that influence adolescents' contraceptive decision-making. Fourteen qualitative studies were examined using G. W. Noblit and R. D. Hare's (1988) meta-ethnographic approach. Three themes of self, partner and family were found to influence contraceptive decision-making in both positive and negative ways. Assisting adolescents to maximize positive and reduce negative influences regarding contraceptive decision-making has the potential to assist teens to more effectively avoid unintended pregnancy and sexually transmitted infections.

DESPITE A SIGNIFICANT decline in teen birth rates in the United States since 1991, the rate (29.4/1000 15–19 year olds) remains higher than many other countries worldwide (Hamilton, Martin, & Ventura, 2013; United Nations Statistics Division, 2011). The majority of teen pregnancies are reported by teens to be unintended (Jaccard, Dodge, & Dittus, 2003; Rosengard, Phipps, Adler, & Ellen, 2004) and represent a continued public health challenge for the nation (Hamilton, Martin, & Ventura, 2009; Martin et al., 2009; Moore, 2008; Santelli, Orr, Lindberg, & Diaz, 2009). Increased access to contraceptive services, use of contraception, and comprehensive sex education programs have been identified as contributing most to teen pregnancy prevention efforts (Santelli, Lindberg, Finer, & Singh, 2007). However, many adolescents encounter significant barriers to comprehensive reproductive care including access to contraception and condoms.

Delays in obtaining reproductive health services can result in unintended pregnancies and sexually transmitted infections (STIs) (Lara-Torre, 2009). Early motherhood can have significant consequences on educational, developmental, social, mental health, and financial outcomes of the teen mother, child, partner, the families of the teen mother and father, as well as, the community (Terry-Humen, Manlove, & Moore, 2005). Unprotected sex can also result in STIs. Infection rates with chlamydia (3329.3/100,000 females; 735.5/100,000 males) and gonorrhea (568.8/100,000 females; 250/100,000 males) are high among 15 to 19 year-old adolescents and estimates suggest that young people, 15-24, acquire half of new STIs (Centers for Disease Control & Prevention [CDC], 2010a; Martinez, Copen, & Abma, 2011; Weinstock, Berman, & Cates, 2004). Annually, 26% of all new HIV diagnoses are among adolescents and young adults (CDC, 2010b; 2012). Adolescents are less likely to seek care for reproductive issues than other health care services, making it all the more important not to miss any available opportunities for education and prevention (Ford, Bearman, & Moody, 1999).

The reasons teens decide to not use contraception or use it intermittently while sexually active are numerous. A recent study by Harrison, Gavin, and Hastings (2012) examined the reasons given by 15 to 19 year old adolescent females (n = 2321) who had a live birth and reported that their pregnancy was unintended. Half (50.1%) reported that they were not using contraception at the time of conception; the rates were similar across all racial/ethnic groups. The reasons for not using contraception included misconceptions regarding their ability to get pregnant (31.4%) or the belief that they or their

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partner was sterile (8%) (Harrison et al., 2012). Many reported that their male partner did not want to use contraception (23.6%) and 22.2% reported that they "would not mind if they got pregnant" (Harrison et al., 2012, p. 27). Lack of access to birth control (13.1%) and side effects of contraception (9.4%) were also identified as reasons for not using contraception (Harrison et al., 2012).

The literature contains many qualitative research studies that provide greater insight into the influences on adolescents' contraceptive decision-making. Presently, these studies exist as "respected little islands of knowledge" (Glaser, 1978, p. 148). An increased understanding can be gained if these studies are translated into each other to produce a more complete view of the phenomenon. The aim of this study was to synthesize the existing qualitative research literature specific to contraceptive decision-making among adolescents in the United States using Noblit and Hare's (1988) meta-ethnographic approach.

Method

Meta-ethnography was chosen for this study to gain an in-depth understanding of adolescent contraceptive decision-making by synthesizing relevant qualitative research. This method

> …go[es] beyond single accounts to reveal the analogies between accounts. It reduces accounts while preserving the sense of the account through the selection of key metaphors and organizers. The "senses" of different accounts are then translated into one another. The analogies revealed in these translations are the form of the meta-ethnographic synthesis. (Noblit & Hare, 1988, p. 13)

The factors that play a role in decisions about contraceptive use are complex and this method of analysis provides the researcher with the opportunity to "see phenomena in terms of others' interpretations and perspectives" (Noblit & Hare, 1988, p. 29) and then to gain a more holistic interpretation of the phenomenon.

Procedure

The inclusion criteria for this study were research papers that focused on contraceptive decision-making in adolescents (11 through 21 years-old), used a qualitative research design, and a United States sample. Adolescence is defined as ages 11 to 21 years by the American Academy of Pediatrics (2008). A comprehensive literature search, of published and unpublished qualitative studies, was conducted through the use of Cumulative Index to Nursing and Allied Health Literature, PsycINFO, PubMed, Ovid, Google Scholar, ProQuest and Dissertation Abstracts online databases specific to publication dates of 2000–2012. The key words adolescent, teen, attitudes, birth control, decision-making, contraception, pregnancy prevention, qualitative research, grounded theory, phenomenology, and focus group were used in various combinations to identify relevant literature. Each of the identified article's reference lists was examined to identify any other relevant articles for inclusion in the meta-ethnography (Sandelowski & Barroso, 2007).

Demographic information included in each study was closely examined to determine the number of adolescents included and mean age of participants. Studies with a greater range of ages than those of the inclusion criteria were included only if the majority of participants were under the age of 22 years or the mean age of the sample was less than or equal to 22; none of the studies had participants who were less than 11 years old. In the few studies that included participants who were older than 22, only quotes from the reference range, if identified by age, were included in the analysis. The sample size was calculated using only those adolescents 21 years and younger.

Sample

The sample consisted of 13 published studies and 1 unpublished dissertation completed between January 2000 and April 2012. Articles were obtained from a variety of disciplines including nursing (5), medicine (3), public policy (1) and public health (4); the dissertation was from public health. Four of the studies consisted of interdisciplinary research teams. With the exception of two studies (Martyn & Hutchinson, 2001; Martyn, Hutchinson, & Martin, 2002) each study had an independent sample of adolescents. Martyn and colleagues (2002) used a purposive subsample ($n = 5$) of their original study ($n = 17$) (Martyn & Hutchinson, 2001). The final sample consisted of 461 adolescents between the ages of 12 and 21 years (355 female, 106 male), and was an ethnically, racially and geographically diverse sample from the United States. These studies included adolescents who were pregnant or parenting. Two studies (Gilliam, Warden, & Tapia, 2004; Raine et al., 2010) reported the mean age of participants, not ages. The demographic characteristics of the participants included in studies are described in Table 1 and the methodological characteristics of each study are included in Table 2.

Data Analysis

Noblit and Hare's method of analysis is accomplished through a seven-phase process. Each of these steps is revisited as many times as necessary throughout the analysis. This approach is "driven by the desire to construct adequate interpretive explanations" in the "form of reciprocal translations" (Noblit & Hare, 1988, p. 11). The researcher first identifies an area of interest through the use of "how" or "why" questions and then searches for qualitative studies relevant and specific to the research question. Next the researcher reads the identified studies and identifies the key