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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

Table 1 Demographic characteristics of participants of the individual studies included in the meta-ethnography.

Study	Year	Sample size/gender	Ages (mean)	Age 11–21 years *n*	Race/ethnicity	State/region
Aarons and Jenkins	2002	57 F/33 M	14–18	90	AA/L	DC
Clark et al.	2006	72 F	12–18	72	AA/L/W	PA
Cowley et al.	2002	15 F	≤ 18	15	L/W	CO
Gilliam et al.	2009	15 F	14–19 (16)	15	AA	IL
Gilliam et al.	2004	39 F	18–26 (22.2)	nr	L	IL
Horner et al.	2009	65 F/59 M	14–19 (15.9)	124	AA/BR	Northeast/southeast
Kendall et al.	2005	77 F	14–38 (21)	38	AA/L/W	LA
Martyn and Hutchinson	2001	17 F	19–26	11	AA	GA and midwest
Martyn et al.	2002	5 F*	19–26	nr	AA	GA
Mendez	2011	14 M/14 F	14–17	28	AA/L	TX
Raine et al.	2010	64 M	19–26 (22)	nr	AA/L/AP/MR/W/AI	CA
Roye and Seals	2001	39 F	15–21 (18.7)	39	AA/L/C/W/O	Northeast
Spear	2004	8 F (pregnant)	13–19 (16)	8	AA/W	VA
Wilson et al.	2011	21 F (mothers)	13–17	21	AA/L/W	NC

F-female; M- male; AA-African American; AI-American Indian; AP-Asian/Pacific Islander; BR bi-racial; C-Caribbean; L-Latino/a/Hispanic; MR-mixed race/biracial; W-white/Caucasian; O-other.
*sample included in Martyn and Hutchinson (2001); nr-ages of participants not reported in study.

metaphors, themes, concepts, and ideas of each study. In the fourth phase, the researcher begins to make sense of how each of the studies is related to each other and then translates one study into another. Translations in meta-ethnography are analogies but "protect the particular, respect holism, and enable comparison" (Noblit & Hare, 1988, p. 28) of each account and allows for comparison among the studies. Synthesizing the translations into a complete description of the phenomenon under study is the initial goal and is accomplished by the researcher identifying the individual study metaphors (e.g. themes, concepts, perspectives, or organizers) and making a more complete picture of the phenomenon. The final phase expresses the synthesis typically in written form, but may also be expressed through music, a play or other artistic work.

Results

Three prominent and dichotomous themes were found in the studies included in this meta-ethnography: self, partner and family. Each of the themes influenced adolescents' contraceptive decision-making in both positive and negative ways. Positive influences are those that support an adolescent's use of contraception. Conversely, negative influences are those that prevent or inhibit access to or use of contraception. Each of the themes was examined through reciprocal translations from both the female and male perspective because the beliefs and desires of each partner to prevent or promote pregnancy are influenced by the individual's beliefs and desires as well as the beliefs and desires of their partner and their family. A strong

Table 2 Methodological Characteristics of the Qualitative Studies Included in the Meta-ethnography.

Author	Discipline	Qualitative research design	Data analysis
Aarons and Jenkins	Public health/medicine	Focus groups	Qualitative
Clark et al.	Medicine	Focus groups	Qualitative
Cowley et al.	Nursing/medicine	Semi-structured interviews	Qualitative
Gilliam et al.	Medicine	Focus groups	Themes
Gilliam et al.	Medicine	Focus groups	Themes
Horner et al.	Public policy/health medicine/psychology	Semi-structured interviews	Content analysis
Kendall et al.	Public health	Interviews	Themes
Martyn and Hutchinson	Nursing	Grounded theory	Glaser
Martyn et al.	Nursing	Grounded theory	Glaser
Mendez	Public health	Semi-structured interviews	Strauss and Corbin
Raine et al.	Public health/medicine	Focus groups	Content analysis
Roye and Seals	Nursing	Interviews	Qualitative
Spear	Nursing	Naturalistic qualitative	Sandolowski
Wilson et al.	Public health	Semi-structured interviews	Themes

undercurrent of embarrassment was identified in the quotes throughout the themes, especially for female adolescents. Embarrassment was found to influence adolescents' choices about seeking and using condoms and contraception. The fear or potential for embarrassment also negatively influenced communication between teens and their families, partners and health care providers.

Figure 1 illustrates the complex impact of the multiple influences on adolescents' decisions related to contraception and condom use. The model depicts the positive and negative influences of self, partner and family on contraceptive decision-making and the potential outcomes of contraceptive decisions: consistent use, inconsistent use, and non-use of contraception. The influences of self, partner, and family are each discussed for their positive and negative influences on decision-making with illustrative quotes taken from the studies. Table 3 provides the individual study themes, concepts and metaphors found to influence contraceptive decision-making in this metasynthesis.

Self

Adolescents were influenced by a variety of personal beliefs about contraception and its use. Negative influences were found to be real or perceived barriers to contraception. Positive influences served as motivators to seeking and using contraception. Much disagreement related to whose responsibility it was to decide to use contraception to avoid pregnancy and STIs was found among teens. However, many teens, male and female, expressed that it is ultimately the decision of the female partner to obtain, use contraception, and insist that their partner(s) use condoms.

Negative influences: Barriers

Multiple factors prevent the use of contraception by adolescents. Six subthemes related to self were evident and included lack of knowledge about and access to contraception, a general fear of side effects and health problems, sexual spontaneity, confidentiality concerns, misinformation about unprotected sex, and financial constraints.

Lack of knowledge about and access to contraception. Many teens simply lacked knowledge about available contraceptive options (Gilliam et al., 2004; Gilliam, Davis, Neustadt, & Levey, 2009; Raine et al., 2010; Wilson, Samandari, Koo, & Tucker, 2011) and awareness about contraceptive services in the community. "I didn't know where to get [other contraceptives], and I didn't want to tell my mom" Female, age 16 (Wilson et al., 2011, p. 232). Teens described the need for condoms to be "handy" (Roye & Seals, 2001, p. 82) because otherwise sex was likely to occur without condoms. "Yeah they [health care providers] should just pass it out. Like you know how you got condoms sitting out, they should have that [birth control] sitting out too" (Gilliam et al., 2009, p. 101). Other adolescents explained "you have to have unprotected sex first before the doctor gives it to you…Give it to me just in case, you should have it in your nightstand" (Gilliam et al., 2009, p. 101). A teen suggested contraception should be available "out on the streets, in a truck that go to school and give everyone some" (Gilliam et al., 2009, p. 101). Pregnant and parenting teens reported that the first time a clinician had ever offered or discussed contraception was either during or following a pregnancy—but not before (Wilson et al., 2011).

Fear of side effects and health problems. The fear of side effects or illnesses related to various contraceptive methods, other than condoms, were articulated by teens in several

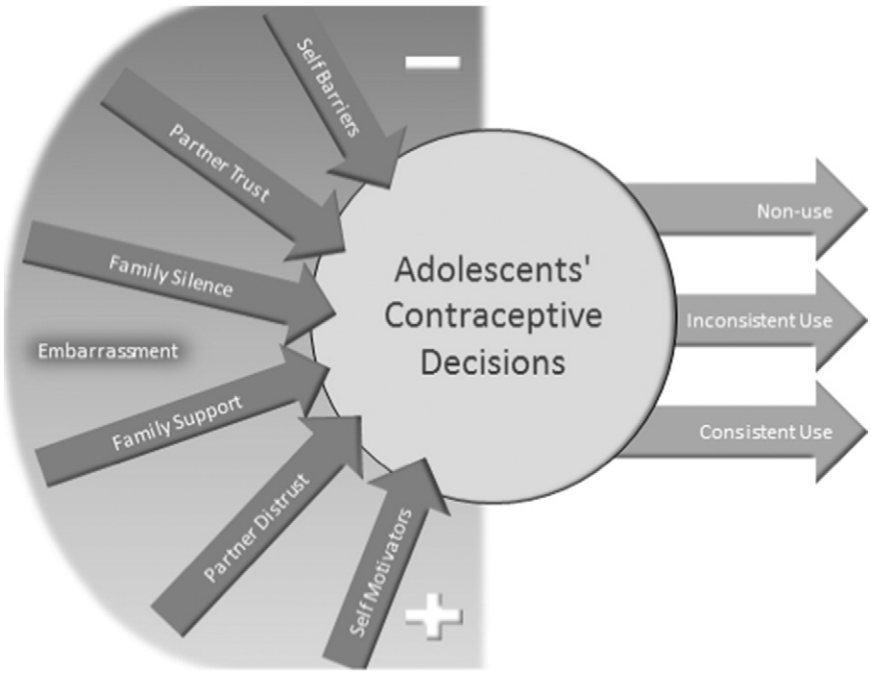

Figure 1 Adolescents' contraceptive decision-making model.

studies (Clark, Barnes-Harper, Ginsburg, Holmes, & Schwarz, 2006; Gilliam et al., 2009; Gilliam et al., 2004; Kendall et al., 2005; Roye & Seals, 2001; Wilson et al., 2011) and either prevented teens from initiating contraceptive use or to stop the use of a contraceptive method. "I don't really want the hormones 'cause they act all funky. Every time I take a hormone they got different side effects" (Gilliam et al., 2009, p. 99). For some, pregnancy was seen as inevitable because "nothing is 100%" (Aarons & Jenkins, 2002, p. 19).

Beliefs about side effects were often the result of personal experiences, information they had received at home or through interactions with peers. For example, an adolescent explained her belief that oral contraceptive pill use resulted in varicose veins; "Many women have altered veins because of the pill…swollen bulky veins" (Aarons & Jenkins, 2002, p. 18). Another explained, "My mother side got cancer and diabetes and my daddy side got cancer and diabetes and high blood pressure. I don't want to take those chances, it's already…in me. It might come out. I don't want to make it come early" (Gilliam et al., 2009, p. 99). Compounding these fears, common side effects, like vaginal bleeding, caused doubt about a method's effectiveness (Clark et al., 2006). "I heard that if your period come on after you get your Depot shot, that mean it didn't work" (Clark et al., 2006, p. 216). Amenorrhea, a common side effect of contraception, caused worry about pregnancy. "You wouldn't know that you was pregnant 'cause your period not supposed to come on [with Depo] and your period not supposed to come on [when you are] pregnant…so you don't know you're pregnant until after the baby" (Clark et al., 2006, p. 216). Many teens explained that having a monthly "normal" menstrual cycle was not only desirable, but also necessary and natural; "We need our periods to clean out our bodies, every month" (Clark et al., 2006, p. 216). Side effects and fears led teens to "rest bodies from contraception" and to switch methods (Kendall et al., 2005, p. 306; Wilson et al., 2011). Male adolescents also expressed unwillingness for a partner to use hormonal contraception because of the perceived risks (Raine et al., 2010).

Condoms were viewed by many adolescents as ineffective because they "bust" (Aarons & Jenkins, 2002, p. 18; Horner et al., 2009; Roye & Seals, 2001). Condoms were not used because of the reported irritation experienced by girls (Roye & Seals, 2001) or complaints about the lack of or decreased sensation by adolescent males (Aarons & Jenkins, 2002; Horner et al., 2009). A male teen explained he stopped carrying condoms because he had heard that the heat associated with carrying a condom in a pocket made them ineffective (Aarons & Jenkins, 2002). Males shared that they were "put off" by girls who carried condoms and viewed them as being forward (Aarons & Jenkins, 2002, p. 18). Adolescents desired access to and education about condoms stating "teach us how to use condoms…encourage the use of condoms" (Mendez, 2011, p. 73).

Sexual spontaneity. It was very clear that many teens do not anticipate or plan for sex or contraceptive use (Martyn et al., 2002; Roye & Seals, 2001). Teens often reported that "I didn't think about, like having sex. It was like something that just happened out of the blue. So I didn't think about it, did I need to be on birth control, anything like that" (Wilson et al., 2011, p. 234). Sex occurred in the heat of the moment without planning for condom use; "They [males] don't think about it…It don't come to mind they just be ready to do it" (Gilliam et al., 2009, p. 101). Others described that it is exciting to have sex without protection. "I think young people like the thrill…I think that they want to go ahead and go through that and see how far they can go" (Gilliam et al., 2004, p. 282).

Confidentiality concerns. There were significant concerns about accessing contraception because they feared family members, neighbors or parent's friends would see them in a health care agency and tell on them. "I might see my mama's friend in the clinic…or something…she gonna tell my mamma" (Gilliam et al., 2009, p. 100). Others distrusted the health care providers and did not believe that they would keep their visits private. "I don't really like to talk to my doctor…my doctors tell me, if you need to come talk to me, I can…Right, and they gonna tell your mamma" (Gilliam et al., 2009, p. 100). In addition, the cost of contraception and the need to use their parent's insurance provided a significant barrier because they "cannot go to the doctor without your parents" (Gilliam et al., 2004, p. 282) and feared their parent's reaction if they were found to be seeking contraception (Gilliam et al., 2004) because of medical bills or explanations of benefits that were sent home.

Misinformation about unprotected sex. Limited and often incorrect knowledge of the risks associated with unprotected sex influenced contraceptive use. Misinformation ranged from not using contraception because "it did not go on for more than a minute [sex], like 30 seconds, it was an in and out thing" (Roye & Seals, 2001, p. 82) to male teens describing withdrawal as a dependable method of STI and pregnancy prevention making condom use unnecessary (Aarons & Jenkins, 2002; Horner et al., 2009). "Because if, like he don't get none of his fluids inside of you then maybe the disease won't get transmitted inside you" Female, age 15 (Horner et al., 2009, p. 785). Unprotected sexual activity that did not result in a pregnancy or STI reinforced beliefs that it was possible to not use contraception and avoid both pregnancy and STIs (Gilliam et al., 2004; Wilson et al., 2011). "Before I got pregnant I really didn't think that it would happen to me" (Wilson et al., 2011, p. 232). Other teens expressed fears about infertility because they had engaged in unprotected sex and not gotten pregnant (Gilliam et al., 2004, 2009; Spear, 2004). "We went a whole year and I never got pregnant. And I was thinking, is there something wrong with me?" (Gilliam et al., 2004, p. 282).

Financial constraints. Some teens reported missing appointments for contraception refills because of financial or insurance reasons (Kendall et al., 2005). Condoms, typically regarded as the easiest method to access because of cost and availability, were viewed as difficult to obtain. A teen explained that she and her partner would be more likely

Table 3 Individual study metaphors related to themes of self, partner and family.

Study	Self - Barriers	Self + Motivators	Partner - Trust	Partner + Distrust	Family - Silence	Family + Support
Aarons and Jenkins (2002)	Erroneous information about contraception use, function, efficacy by teens, peers and community Condoms break sometimes Boys complain of reduced sensation and decreased pleasure Condoms ineffective if in wallet, so did not carry Girls who had condoms sexually forward Endorsed use of withdrawal Pregnancy inevitable "nothing 100%" (p. 18)		Pressure girls to not use condoms as a sign of trust and fidelity "When you always say put on a condom and you been going together for like 2 years [boys say], 'put on a condom? What, you don't trust me or something?'" (p. 18) Machismo	"The boy should protect his own interests in case his partner is untrustworthy" (p. 19) "What about the broad that lies to you: She says she is on birth control, but you find out..." (p. 19) "If the girl tells you [she's] on birth control, man you can can't trust man. You can't go by what they say, man." (p. 19)	Avoid discussing sex, strict but leave teens unsupervised Latino males viewed parents as unapproachable, too strict, 'out of touch with reality,' more apt to scold rather than counsel or advise "Parents will wait until you already know these things and then they'll tell you." Girls' dates scrutinized Expected to remain virgins, sex only for procreation Threaten to be thrown out of the house if pregnant "Some people's mothers aren't there for them. They don't have anyone to talk to. Some people's parents are so strict" (p. 20)	Latino boys are encouraged and expected to be sexually active "Some parents practically give their sons condoms" (p. 19) Approachable mothers seen as a source of support and information about contraception & pregnancy Approachable is being open and proactive about discussing sex, started conversations early "My mother is very open... That's why I didn't rush out to have sex." (p. 20) If parents un-approachable teen turned to other adults, siblings or peers for advice
Clark et al. (2006)	Menstruation is natural and should not be altered Period necessary for cleansing body Spotting, bleeding and amenorrhea caused					

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Table 3 (*continued*)

Study	Self - Barriers	Self + Motivators	Partner - Trust	Partner + Distrust	Family - Silence	Family + Support
	concerns about contraceptive effectiveness, pregnancy, health and fertility Fear of hormonal side effects blood clots, menopause, excess bleeding					
Cowley et al. (2002)		Condoms used to allow for treatment and/or resolution of reproductive problems, post-pone pregnancy, undertake personal changes to prepare for motherhood		"Contraception allowed time to explore concerns about their partner or to test the strength of the relationship before conceiving" (p. 194, 196) Male partner changed mind about pregnancy and encouraged birth control		Contraception obtained as a result of conversations had with an important person in life (mother, aunt or other relative)
Gilliam et al. (2009)	Side effects and fear of chronic illness Confidentiality Hard to remember Limited knowledge "Not a problem getting condoms, it's a problem using them" (p. 101) "Heat of the moment" (p. 101) "Give it to me just in case" (p. 101) Infertility	Aware of contraceptive methods and proper use Make easily available Female is responsible for contraception "being safe, becoming smart" (p. 100) Protecting self Condoms convenient "first thing you grab" (p. 100) Condoms anonymous and often free		Boys tamper with condoms to "trap" "Poke a hole in a condom" to "get her pregnant" (p. 101) Withdrawal alternative to condoms If male wants baby he may pretend to use condom "They just don't care" (p. 101) "Alcohol hormones" (p. 101) made it difficult to	Conceal sexual activity and contraception from parents Daily/weekly methods compromised ability to keep secret Fear of discovery of contraception mother looks through belongings	

				negotiate Partner doesn't like condoms	
Gilliam et al. (2004)	Religious views/cultural values prohibit birth control use "If it is God's will then you're going to get pregnant; don't worry about birth control" (p. 282) Minimal and late information from school Access/knowledge from school but did not get it Providers not a source for contraception Cost and "cannot go to doctor without parent" Encouraged by not getting pregnant Unprotected sex exciting Cost largest obstacle to IUD Worried about side effects Safety fears post-partum No consequences Withdrawal works if do not want pregnancy Infertility concerns	Learned condoms protected against STIs from school Contraception after pregnancy Pregnancy provided entry into medical system and contraceptive counseling Assumed responsibility for contraception following pregnancy Use of more effective methods after birth Greater access and acceptance of contraception favorable views about female sterilization and limiting family size "Take care of myself" (p. 283)	Advocated use of withdrawal "El me cuida" (he takes care of me) (p. 283)	Withdrawal effective if the male wants it to work Could not always talk to partners about condoms Uncertain about consistent use, depends on male partner Males do not feel preventing pregnancy is their responsibility "if you get pregnant, it is your fault because you are stupid, or you don't take care of yourself" (p. 283)	"…Your parents never really talk to you about birth control… if your parents are very traditionally Mexican, birth control is wrong and sex itself is bad when you are young and not married" (p. 282) Mothers did not provide contraceptive teaching Mothers "too embarrassed" to discuss sex (p. 282)
Horner et al. (2009)	Condoms unnecessary can use withdrawal instead Withdrawal viewed as a skill "knows how	Pregnancy scare changed opinion of using withdrawal as a method	Withdrawal selected by couple as a long-term method of contraception "Negotiated safety"	Girls skeptical, did not feel could always trust partner to pull out in time Felt pressured by	

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Table 3 (*continued*)

Study	Self - Barriers	Self + Motivators	Partner - Trust	Partner + Distrust	Family - Silence	Family + Support
	to do" (p. 783) Indication of sexual prowess		(p. 783) and committed relationship, implies closeness, familiarity and trust Earn the right to go in without condoms	male partners		
Kendall et al. (2005)	Contraception misinformation Side effects drove switching or discontinuation Missed pills and appointments Financial inaccessibility Effectiveness suspect due to side effects Questioned duration of effectiveness Risk of infertility and cancer Need to rest bodies Condoms pop, fail, slip off Did not always have condoms	Condoms temporary or default method while changing methods Began contraception because partners were apathetic to condom use	Little discussion about contraception between partners Request for partner use a condom can undermine trust Reluctant to insist or confront a male use condom for fear it would jeopardize relationship More likely to risk a pregnancy than confront partner "He knows I wouldn't sleep around, and I think he doesn't… If he brings back something (STD), I would just die but I just don't do anything about it" (p. 307)	Condoms intentionally perforated by partners so they "can get the woman pregnant" (p. 306–307) Bring their own condoms Would check condom integrity after sex		
Martyn and Hutchinson (2001)		"I don't think [teen pregnancy] is cute." (p. 246) Motherhood is self-defeating "love…is not enough." (p. 246) Fear of financial troubles "Have the grade[s] to do what you want to do in life."	"We'd go get tested and make sure both of us were fine. I knew I was only with him and because we were together so much" (p. 250)	Good male partners with similar life goals Older partners more insistent on contraceptive use "Mutual self-protection" (p. 249) "We decided [to use condoms] it was mutual" (p. 249) "He looked out for my safety, and I looked	"[My father] never talked to me…that was the end of it. Same way with mom." (p. 247) "My mom didn't suggest it (birth control), I did" (p. 249)	Belief in God provided moral compass; value messages from parent or parental figure "know right from wrong" (p. 246) Parental religious faith provided protection from wrong

		(p. 246) "I just knew right from wrong. I had guidance from church." (p. 246) "If you don't want any kids, you shouldn't have sex." (p. 249) Told boyfriend "I am a virgin. I'm having sex." (p. 249) Condoms to prevent STDs Keeping busy with school and work		out for my own." (p. 250) Boyfriend insisted on condom use		Clear expectations of parents to avoid pregnancyv Both parents in the house
Martyn et al. (2002)	"Lived day to day, not thinking about my future" (p. 156) "Babies…and pregnancy didn't cross my mind" (p. 156) "By God's grace" avoided pregnancy (p. 158) Heat of the moment	Protecting future		Boyfriend committed to condom use followed partner's lead	Parent not discussing sex put teen at risk for pregnancy	Grandmother mandated contraceptive use Told to delay sexual activity or use contraception if sexually active Strong parental messages to avoid pregnancy
Mendez (2011)		"That's the responsible thing to do if you're gonna do it, to use a condom" (p. 72) Fear of pregnancy and STI facilitated condom use "…you can keep your life going forward instead of putting it to a pause." "if you're not ready (for a pregnancy) then it's the smart thing to get a condom." (p. 66)	"Some girls don't even like taking them [birth control] and they don't even tell their boyfriend, and when they boyfriend wanna have sex, they get pregnant." (p. 65)	"The girl…she is responsible for it [preventing pregnancy]… I don't know if a guy wants that [to prevent a pregnancy] "they just gets a woman pregnant, they don't really care." (p. 62) Girls should provide and use birth control." Both genders	Lack of communication with the son or daughter, poor parenting, enabling opportunities for teens to engage in sexual activities, and failing to see the signs that teen was sexually active.	

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Table 3 (*continued*)

Study	Self - Barriers	Self + Motivators	Partner - Trust	Partner + Distrust	Family - Silence	Family + Support
		Pregnancy worse than STI Protect yourself "It's my responsibility" (p. 69)		agreed males did not have the self-discipline to control their sexual thoughts/urges Males cannot be trusted		
Raine et al. (2010)	Condoms are for STI prevention Don't want to use condoms Alcohol/drugs interfered with judgment "Lost in the moment" (p. 381) Limited knowledge Weight gain Safety concerns	Need pregnancy prevention if having sex with a causal partner	Condoms not necessary in committed relationships, lack of risk for STIs "sooner or later you are going to take it off [condom]" (p. 380) Little to no conversation about contraception Woman expected not to get pregnant/use birth control	Concerns about female partner "poking holes in condoms" (p. 380) Worried partners forgot to take pills		
Roye and Seals (2001)	"On the pill and can't get pregnant" (p. 82) "Don't want to use" (p. 82) "It just happen" (p. 82) "He didn't have any" (p. 82) Irritation from condoms Quick sexual encounter Condoms expensive Hard to carry around Condoms break a lot Embarrassing to get them	Condoms used to prevent STD and pregnancy while not on pill "Habit" Pregnancy/STD scare Friend had an STD	"Because I feel I can trust my partner, or at least I hope I can" (p. 82) "I was with my boyfriend" (p. 82)		Communication with parents "Parents should be friends to their kids; and that way they can be open to them more instead of just going out there and being sneaky" (p. 83)	
Spear (2004)	"I thought I couldn't get pregnant" (p. 341) "I wasn't really thinking about doing it" (p. 340) Ambivalent regarding pregnancy		"He loves me to death, and I love him too" (p. 340)	Tricked by boyfriend and got pregnant "Baby's father told me he don't like to use	"My dad was never there for me; he left when I was 6 years old" (p. 340)	"Mom said 'I know you're doing it (having sex)' and she told me about birth control" (p. 340)

	Pregnancy result of not using birth control		condoms, so I told him I could get on the pill. But I didn't take 'em; I'd forget; I'd be busy…" (p. 340)		Needed guidance and approval from parents especially mothers
Wilson et al. (2011)	"Before I got pregnant I didn't really think that it would happen to me." (p. 232) Never used contraception; Side effects resulted in switch/discontinuation "Body did not agree with it" (p. 234) Forgot to take the pill Just happened Ran out of condoms Limited knowledge & awareness about resources for contraception Misconceptions about side effects and health Loss of insurance caused loss of care Guidelines about contraceptive use caused teen to stop depo Unprepared, could not imagine sex postpartum	Wake up call, vulnerable to pregnancy "One is enough. Like, I learned my lesson." (p. 234) Knowledge/access to contraception improved after birth Received counseling pre and postpartum Social service program education Happy with contraceptive choice post-partum IUD easy to use Asked clinician for the pill		"My mama don't believe in birth control" (p. 232) "I thought it was really embarrassing, so…I didn't want to talk to my mom about getting help for… birth control pills or anything like that" (p. 232) "I haven't really talked to my mom she just tells me to take care" (p. 235) Mom dismissed need for contraception	Postpartum parental communication facilitated about sex and contraception

to use condoms if they were "cheaper and if it was not so embarrassing for either partner to go and get them" (Roye & Seals, 2001, p. 83). Cost was the largest obstacle to adolescents getting an intrauterine device (Gilliam et al., 2004). Access and the use of health care services dropped significantly after the birth of the baby because of the loss of insurance coverage for the mother at 2-months postpartum and subsequently limited access to contraception for teen mothers (Wilson et al., 2011).

Positive Influences: Motivators

The motivation to use condoms and contraception was concentrated in three different subthemes that included a commitment to avoid pregnancy and STIs, convenience, and lessons learned from personal experiences. Many described the wish to be different than those around them and the benefits of remaining abstinent throughout adolescence (Martyn & Hutchinson, 2001).

Commitment to prevent pregnancy and STIs. It was very clear that many teens were aware of the potential dangers of unprotected sex and actively engaged in strategies to protect themselves.

> I feel like this…the female wears the pants because when you think about it…I mean, it's her decision to open her legs alright come on…she control what she want to do. Even if you doin' it cause you want to, you can still [make] him wear a condom or not. And if he can't get one, he won't get none. (Gilliam et al., 2009, p. 100)

These girls expressed their decisions to remain abstinent by making it clear to partners "I am a virgin, I'm not going to have sex. If you can't deal with that, then you can move on" (Martyn & Hutchinson, 2001, p. 249). "I just felt like if you don't want any kids, you shouldn't have sex. [I] just say no" (Martyn & Hutchinson, 2001, p. 249). Others knew that even if they had had unprotected sex, post-coital contraceptive options existed;

> I mean you got emergency contraception. If this boy… release sperm inside you…you can go to the clinic that very next day and be on it. You got within 72 hours… some-thin' like that. You can work hard within them 72 hours. (Gilliam et al., 2009, p. 101)

Cowley, Farley, and Beamis (2002) found that adolescent women used condoms to postpone pregnancy because of living situations that would not be favorable to parenthood and during the recovery from health concerns that could impact future fertility. One teen described the contraceptive counseling she received from the hospital following the birth of her baby and her decision to start the oral contraceptive pill; "They [health care providers] were just saying about the pill, the shot, like just different methods. And I just asked, 'Could I get the pill?' And they just prescribed the pill" Female, age 16 (Wilson et al., 2011, p. 234).

The desire to have a better life and postpone or prevent childbearing was a significant motivator to use contraception and condoms for many teens.

> Well I mean if you don't use a condom you can get a disease from the other person, or worse, you can end up having a baby. Then it is most likely you won't have a future because you'll have someone to take care of now. And it's good to use a condom 'cause you can prevent all of that from happening and you can keep your life going forward instead of putting it on pause. Female, age 16. (Mendez, 2011, p. 60)

Another expressed, "I don't think [teen pregnancy] is cute. A lot of people think it's cute, but I think it is a waste of your time. I really think you are destroying your life" (Martyn & Hutchinson, 2001, p. 246). The desire to stay in school was a motivation to avoid pregnancy (Martyn & Hutchinson, 2001). Others described their choice to delay pregnancy was rooted in a desire to give their future child(ren) more. "I want my child to not want for anything because love these days is not enough. Love can't put food on the table and clothes on the back" (Martyn & Hutchinson, 2001, p. 246). Another female adolescent described her partner's desire to delay parenthood until his goals for the future were realized. "He wants to wait, after he graduates from... [college], and that'll be 5 years from now. I'd rather wait until both of us decide, or else all of a sudden he's not happy about it and neither am I" (Martyn et al., 2002, p. 158).

Male adolescents used condoms primarily for the prevention of STIs, especially in casual relationships (Raine et al., 2010). "Talk about one-night stands and all of that. If you are talking about just getting with a girl, I'd use a condom for sure. No STDs, no….I mean, I'm not trying to catch no STD" Male, age 20 (Raine et al., 2010, p. 379). In relationships, described as 'friends with benefits', males expressed strong motivation to avoid an unintended pregnancy.

> One disadvantage…the most important one, I guess, is pregnancy. Because if you're with a friend with rights…I suppose you don't want her to become pregnant, since you are not going to make the relationship an official one. Mainly, what you need for this [pregnancy] to happen is love and this is just sex. Male, age 19. (Raine et al., 2010, p. 380)

Convenience. The importance of having access to contraception was a significant motivator for many adolescents. Teens also simply stated that the primary motivator for using condoms was "we had them" (Roye & Seals, 2001, p. 83). Girls described protecting themselves by using condoms in between the use of other contraceptive methods "because I was not on the pill yet and I did not want to get pregnant" and because "if I didn't have any other type of birth control" (Roye & Seals, 2001, p. 83). A postpartum adolescent explained that "[the IUD] is really easy because all you have to do is go for one appointment and get it inserted….you don't have to mess with it" Female, age 17 (Wilson et al., 2011, p. 235).

Lessons learned. Teens described situations, either personal or those of friends, that served as a motivator to use condoms and/or contraception. Male partners who were

inconsistent or ambivalent about condom use provided a significant reason for girls to use other birth control methods to prevent an unintended pregnancy (Gilliam et al., 2004; Kendall et al., 2005). The scare of a pregnancy (Gilliam et al., 2004) served as motivation to stop using the withdrawal method for contraception and use other, more reliable methods (Horner et al., 2009). The experiences of friends also impacted teens choices about safer sex; "Well I have a friend that got an STD, you know a close friend" (Roye & Seals, 2001, p. 83). A teen mother described that she was not ready for another child and thus used contraception: "I think I'd kill myself…I'm not ready for it. Like I'm not financially ready, mentally ready, physically ready. No way. Like I'm just not ready. One is enough. Like, I learned my lesson" Age 17 (Wilson et al, 2011, p. 234). The teens offered that they needed more personalized education about pregnancy and STI prevention and suggested "to have a lot of movies and stuff like that in the school auditorium. And show all the bad parts…really graphic. But makes them realize that this is out there and it can happen to you" (Roye & Seals, 2001, p. 83).

Partner

The relationship between partners influenced contraceptive decisions. Trust in a relationship negatively influenced contraceptive and condom use. Conversely, distrust of a partner because of fears of a partner tampering with or not using a condom, the desire of a partner to have a child, casual sexual relationships, and mutual decision-making motivated contraceptive and condom use.

Negative influences: Trust

Adolescents in relationships with a partner they trust were likely to engage in unprotected sex for a variety of reasons. Teens explained that requests to have a male partner use a condom can undermine the trust in a relationship especially if condom use had been optional in the past (Aarons & Jenkins, 2002; Kendall et al., 2005). They explained "because I feel I can trust my partner, or at least I hope I can" (Roye & Seals, 2001, p. 82) and "I didn't have anything to worry about at that time because I was with my boyfriend" (Roye & Seals, 2001, p. 82). Girls found it difficult to negotiate condom use with a partner and often would forego condom use for fear of conflict or that the relationship would end (Kendall et al., 2005). Some felt pressured to not use condoms as a sign of fidelity and trust in a relationship; "When you always say put on a condom and you have been going together for like 2 years [boys say], 'put on a condom? What, you don't trust me or something?'" (Aarons & Jenkins, 2002, p. 18). For some couples, withdrawal was purposively selected as an expression of "negotiated safety" (Horner et al., 2009, p. 783) and signified a trusted and committed relationship. In addition, successful use of withdrawal earned a male adolescent "the right to go without condoms" (Horner et al., 2009, p. 784). Both male and female adolescents reported that they were unsure if condoms were necessary and advocated for the use of withdrawal instead (Gilliam et al., 2004).

Relationships for male and female adolescents evolved over time and the commitment or desire to avoid pregnancy and the perceived risk of STIs diminished. A 21 year-old male adolescent explained how he became a father twice:

> That's how it happen with me after like about a good 6 or 7 months and I know I'm going to be with that woman and I'm not cheating and she's not cheating. I mean sooner or later you're going to take it off. I don't know nobody that been with their woman for more than 2 years and they're still using condoms unless they're really determined to have no baby. (Raine et al., 2010, p. 380)

Positive Influences: Distrust

Distrust. A lack of trust of a partner for male and female adolescents served as a driving force for condom and contraceptive use. Girls expressed feeling pressured to have sex without condoms because their male partners did not like to use them or reported a lack of sensation (Gilliam et al., 2009; Horner et al., 2009) and also that their male partners did not think it was their responsibility to prevent pregnancy.

> Well like some boys, they just get a woman pregnant, they don't really care. And they should like, if they don't want a baby then they should use a condom and the woman herself should make sure the male uses a condom…if she doesn't want to get pregnant. Male, age 15. (Mendez, 2011, p. 62)

Adolescent females were more likely to use condoms if they were having sex with more than one partner, thought their partner was cheating on them (Roye & Seals, 2001), "because I did not know the person that well," (Roye & Seals, 2001, p. 83), needed time to explore concerns about a relationship before a pregnancy (Cowley et al., 2002), or felt their partner could not 'pull out' in time (Horner et al., 2009).

Female adolescents described situations in which males tamper with condoms to trap them with pregnancy (Gilliam et al., 2009; Kendall et al., 2005; Spear, 2004). "Well some people I know they think that the condom is not safe because they believe that they boyfriends be putting holes in them and try to use them and they be wondering why they come up become pregnant" (Gilliam et al., 2009, p. 101). Teens also described situations in which male partners pretended to have a condom on during sex (Gilliam et al., 2009; Kendall et al., 2005).

> Some boys do it cause they think they're slick, so they act like they got on a condom and frickin' without the condom and um release them self in there and did it on purpose, 'cause they tell you later 'I want a baby.' What's that got to do with me? (Gilliam et al., 2009, p. 101)

Males also distrusted the motives of their female partners and felt condoms could be tampered with and explained

> That means you've got to bring your own condoms 'cause if she's like really trying to have your baby and

> she doesn't care how she has it, you got to bring your own condoms so she's not poking holes in yours. Male, age 21. (Raine et al., 2010, p. 380)

Males expressed concern about the truthfulness of their partners contraception use. "What about the broad that lies to you? She says she is on birth control but you find out…" (Aarons & Jenkins, 2002, p. 19). Another male teen explained "it's your fault, you see what I am sayin'? If the girl tells you [she's] on birth control, man you can't trust man. You can't go by what they say, man" (Aarons & Jenkins, 2002, p. 19) and felt it was the responsibility of both partners; "the girl because she is the one that gets pregnant and the boy because he should protect his best interests in case the partner is untrustworthy" (Aarons & Jenkins, 2002, p. 19).

Mutual decision-making. Adolescents explained that if they were able to discuss contraception and safer sex with a partner they were more likely to use a condom or contraception. "We decided [to use condoms] it was mutual" (Martyn & Hutchinson, 2001, p. 249). To prove to each other and themselves that everything was okay in the relationship, "we'd go get tested and make sure both of us were fine. I knew I was with him and because we were together so much I really wonder how he could be with anybody else" (Martyn & Hutchinson, 2001, p. 250).

Family

Similar to the themes of self and partner, positive and negative influences were found related to parents and other important adults in the adolescent's life. Negative influences focused on the silence that was created from parents not discussing sexual activity and contraception and resulted in teens describing having no one to talk to about these issues, being fearful of parents discovering their contraception use and confused by the mixed messages they experienced from parents. Supportive family members, who were able to communicate with teens and offer useful advice, provided a positive influence and access to contraception.

Negative Influences: Silence

No one to talk to. "Some people's mothers aren't there for them. They don't have anyone to talk to. Some people's parents are so strict and so set and [the parent's say] 'this is the way it's going to be'" (Aarons & Jenkins, 2002, p. 20). Teens described their parents as strict and unapproachable "out of touch with reality [and] more likely to scold rather than counsel or advise" (Aarons & Jenkins, 2002, p. 20).

> Your parents never really talk to you about birth control. You know, because if your parents are very traditionally Mexican, the birth control is wrong and sex itself is bad when you are young and not married… (Gilliam et al., 2004, p. 282)

Adolescent males lamented, "parents will wait until you already know these things and then they will tell you" (Aarons & Jenkins, 2002, p. 20). "I haven't talked to my mom [about contraceptives]…she just tells me to take care" Female, age 17 (Wilson et al., 2011, p. 235) implying that her mother had some knowledge that her daughter was sexually active but was unable or unwilling to discuss contraception with her. Female teens expressed that the over protectiveness of their parents got in the way of discussions about sex. Teens in many of the studies reported the need to conceal or hide their sexual activity from their parents and that contraceptive methods that could be found by a parent placed them at risk for discovery. "Yeah, I know my mamma's goin' through my stuff" (Gilliam et al., 2009, p. 100). The possibility of being found out therefore prevented the use of condoms, oral contraceptive pills, contraceptive patch, or vaginal ring. Many teens expressed that their parents never talked to them about relationships or sexual activity.

> My father never talked to me. But I knew where he stood. I was like if I get pregnant while I am in high school, I already know my dad is not going to go for that. My dad is about six-three and about 300 pounds so…it wasn't like fear or anything, but it's like when he said something there was no back talk or no 'Well why I can't do this…and why'….no. When he said no you can't do it that was the end of it. Same way with my mom. (Martyn & Hutchinson, 2001, p. 247)

A 15 year-old female teen simply stated "My mama don't believe in birth control" (Wilson et al., 2011, p. 232). A teen echoed this statement, however, the disapproval of birth control stemmed from the belief that it caused medical problems and associated medical costs.

> Our parents don't agree with us using birth control for the simple fact of all the problems you have to go through with it. The news media talking about cancer and all that stuff...We ain't got money for all these medical problems, so you better off with a condom. (Aarons & Jenkins, 2002, p. 18)

A explained the potential impact her mother's silence could have had on her life.

> My mother never really sat me down and talked about it. So I had to learn from my peers. And now that I am an adult, I kind of regret that, because I know that I would have made better decisions as a teenager. I think I was lucky not to get pregnant. (Martyn et al., 2002, p. 157)

Mixed messages. Silence regarding expectations about sexual behavior was further affected by mixed messages from parents and lack of supervision (Aarons & Jenkins, 2002; Mendez, 2011).

> Their parents are responsible for letting them go out and not knowing where they're at, what they're doing, not caring…A lot of moms, their [teenage daughter's] boyfriends come in the house, like what's that? Like they come in. Oh, y'all could go upstairs…I don't think

> that's a way of treating their daughter, especially a daughter. Female, age 15. (Mendez, 2011, p. 72)

Some teens also reported a double standard; boys were expected to be dating and engaging in sexual relationships and girls were to remain virgins until marriage (Aarons & Jenkins, 2002). The adolescents felt that parents should talk to their teens "'cause your kids, you need to talk to 'em, say well, I can probably help you with condoms, but I don't want you to have sex and stuff like that— Female, age 14" (Mendez, 2011, p. 71). Some took it even farther stating "the parents should give them to the girl. The parents don't have to be responsible, but it is better for them to like know what is going on and help their children" Male, age 16 (Mendez, 2011, p. 71).

Embarrassment on behalf of the teen or parent often stifled communication; "But you know, I thought it was embarrassing, so….I didn't want to go to my mom about getting help for birth control pills or anything like that" Female, age 17 (Wilson et al., 2011, p. 232). Even teens who were able to begin conversations with their mother and tell them that they needed contraception, were met with their mother dismissing their request but then forbidding the teen from leaving the house without it; "this didn't make sense to me…so I went and got some" (Wilson et al., 2011, p. 235).

Positive Influences: Support

Supportive adults. Support from family members, most often mothers and grandmothers, provided education and opportunities for access to health care services, both essential in preventing unintended pregnancies and STIs. Adolescents expressed that "parents should be friends to their kids and that way they can open up to them and tell them more instead of just going out there and being sneaky" (Roye & Seals, 2001, p. 83). Mothers that were viewed as a support provided information about contraception and pregnancy prevention (Aarons & Jenkins, 2002), were open, talked about sex proactively, began conversations when their teens were young, and provided their daughters with a reason to delay sexual activity (Aarons & Jenkins, 2002).

> My mother is very open. She has been that way forever [because she herself was a teenage mother]. That's why I didn't rush out to have sex. Some girls really rushed… Where I was elementary girls [aged 12 and below] were having sex. (Aarons & Jenkins, 2002, p. 20)

For some adolescents, the decision to avoid a pregnancy was made for them;

> I actually didn't make the decision [to avoid early childbearing]. My grandmother made the decision…she told me [to start birth control] even before I actually started [having sex]. But she didn't stop the sex part, but the child part she could. (Martyn et al., 2002, p. 157)

Families also instilled teens with religious beliefs that helped them to make decisions; female teens described their belief in God as a "moral compass" to be used in times they were off track (Martyn & Hutchinson, 2001). Parents also expressed clear expectations (Aarons & Jenkins, 2002). My mother and father always said they'd kill us if we brought children into the house, had a baby" (Martyn & Hutchinson, 2001, p. 247). Other family members assisted in reinforcing parental messages. "[My aunt] she was the one that who always told us, "Don't have sex, you can't do this, she was the one who said if you have a child, she'll kill you, she's the one who instilled that fear in us" (Martyn & Hutchinson, 2001, p. 247).

Important advice. The use of contraception often resulted from conversations they had with an important person in their life like a mother, aunt or relative (Cowley et al., 2002). Mothers provided advice "my momma told me, like, if a male pull out their penis…My momma say you should always say no, 'cause you can catch something. You never know what that male got on him or nothing like that" Female, age 18 (Horner et al., 2009; p. 785). When parents were not available to teens, many sought other, more approachable and available adults, like older siblings, aunts, grandmothers, or health teachers as sources of support and information (Aarons & Jenkins, 2002; Horner et al., 2009). Teen mothers expressed that the pregnancy had the unintended benefit of facilitating conversations about sex and contraception that had not been possible prior to the pregnancy (Wilson et al., 2011).

Discussion

Adolescents' contraceptive decision-making is driven by numerous positive and negative influences that can be categorized into three themes: self, partner and family. Factors related to each may influence decisions about contraceptive use at different times and in different ways with results that can either positively or negatively affect the adolescent's future.

A lack of planning or anticipation for sexual encounters was a common finding in this study (Gilliam et al., 2004, 2009; Martyn et al., 2002; Roye & Seals, 2001; Wilson et al., 2011) and may be a consequence of the still developing prefrontal cortex that is responsible for planning, impulse control, decision-making, and the ability to weigh the potential consequences of behavior throughout adolescence (Giedd, 2004). Developmentally, the imaginary audience may play a significant role for teens seeking contraceptive services and fuel fears about their confidentiality being broken by health care providers, insurance agencies, or even while seeking care or buying condoms in the community (Elkind, 1967). In addition, many teens forego contraception use because of the cost or lack of insurance (Ford et al., 1999; McKee & Fletcher, 2006). Even condoms, that are generally thought to be inexpensive and easily accessible, were perceived to be difficult to access and viewed as expensive. A pregnancy provided entrée into the health care system for the first time for some teens. However, access to care and

contraception was short lived because of the loss of insurance postpartum (Gilliam et al., 2004) and likely contributes to the large number of subsequent births that occur to adolescent mothers (Klerman, 2004).

Bell (2009) describes embarrassment as "a deeply unpleasant experience for everyone and people (young and old) are motived to avoid it" (p. 379). The results of this study are consistent with Bell's findings that a fear of embarrassment and concerns about how one will be viewed by others inhibits condom use despite knowing the importance of safer sex. Embarrassment was found throughout the themes and had a significant impact on teens accessing contraception through health care agencies or buying condoms in the community (Roye & Seals, 2001). Parents were viewed as being "too embarrassed" to talk to their adolescents about sexual decision-making and contraception (Gilliam et al., 2004). Teens also expressed embarrassment related to approaching parents and other adults for contraception (Wilson et al., 2011). This has important implications for how condoms and contraception are made available to adolescents and assisting parents to have conversations with their teens.

Ambivalence regarding pregnancy and parenthood and the belief that a male partner desires a baby are well documented in the literature as risk-factors for future teen pregnancy (Cowley & Farley, 2001; Jaccard et al., 2003). Teens that are ambivalent about pregnancy are less likely to use contraception than those that have negative views about pregnancy (Brücker, Martin, & Bearman, 2004; Jaccard et al., 2003). Conversely, teens that have a negative opinion about pregnancy or express a strong desire to prevent a pregnancy are more likely to avoid sexual activity or use contraception (Bartz, Shew, Ofner, & Fortenberry, 2007; Brücker et al., 2004; Martyn & Hutchinson, 2001).

Conversations between partners regarding contraceptive use were rarely reported. Male adolescents often placed the responsibility for birth control and/or condoms on their female partners and trusted that the female partner and they were on the same page regarding these decisions (Gilliam et al., 2004; Mendez, 2011; Raine et al., 2010; Spear, 2004). The use of condoms was perceived as evidence of a lack of trust with the potential to cause an argument or jeopardize a relationship and some girls preferred to risk a pregnancy rather than confront their partner (Aarons & Jenkins, 2002; Gilliam et al., 2004; Horner et al., 2009; Kendall et al., 2005; Raine et al., 2010). There were teens in these studies that reported mutual decision-making as a positive influence on condom use. Clinicians can assist male and female adolescents to have discussions about the use of contraceptives and condoms. In addition, available methods, proper use, and possible side effects can be discussed with all teens. These findings suggest that female teens need to be empowered to make contraceptive decisions based on what they want, not as an indication of how much they love or trust a partner.

Adolescents articulated their desire for guidance and support from parents and other adults (Aarons & Jenkins, 2002; Gilliam et al., 2004; Mendez, 2011; Roye & Seals, 2001; Spear, 2004; Wilson et al., 2011). Clear parental expectations regarding condom and contraceptive use, as well as strong messages to delay sexual activity and child bearing, can have positive effects on preventing teen pregnancy and supporting the completion of high school for female adolescents (Albert, 2004; McNeely et al., 2002). However, embarrassment was found to inhibit conversations between teens and parents (Gilliam et al., 2004; Wilson et al., 2011). Thus, educating and empowering parents to have these conversations with their teens can be critical to adolescent decision-making. Further, this review revealed many examples of teens suggesting that school can be an effective place for health education; parents can provide an important voice in changing school curriculum to include comprehensive sexuality education (Gilliam et al., 2004; Mendez, 2011; Roye & Seals, 2001).

It was apparent that the influence of health care providers was minimal. The few teens who mentioned the health care system or providers painted a view of distrust related to confidentiality and lack of accessibility that may have contributed to teens not having timely access to a contraceptive method and STI prevention education (Gilliam et al., 2004; 2009). Lack of factual knowledge about contraception fueled fears about safety, efficacy, side effects, and potential medical complications, and ultimately drove some teens to switch methods or not use contraception at all (Aarons & Jenkins, 2002; Clark et al., 2006; Gilliam et al., 2004, 2009; Kendall et al., 2005; Raine et al., 2010; Roye & Seals, 2001; Spear, 2004; Wilson et al., 2011). These results suggest that health care providers need to seize any and all opportunities to listen to what teens have heard from friends and family and have conversations with adolescents regarding safer sex and contraceptive use. Health care professionals should provide factual information and capitalize on the positive influences and mitigate identified negative influences on contraceptive decision-making.

Limitations

Meta-ethnography is an interpretive process and is dependent on the interpretations of the researchers of the studies included in this study as well as the interpretations of the author (Noblit & Hare, 1988). Only the published qualitative data from each study were available for analysis. A more in depth interpretation may have been gained if the author had analyzed the original data from each of the studies (Noblit & Hare, 1988).

Conclusion

This meta-ethnographic study provides important insight into the multiple influences on male and female adolescent

contraceptive decisions. Armed with this information, health care providers will be better able to assist adolescents to identify the positive influences and help them to avoid negative factors which contribute to the large number of unintended pregnancies and STIs during adolescence.

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