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Reproductive Health Choices, Disparities, and Social Contexts of African American Adolescent Females Who Utilize School-based Health Centers

By

Gina Gabrielle Robinson-Osder

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

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in the

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of the

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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by

Gina Gabrielle Robinson-Osder

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> "*We are all inextricably bound by our childhood years spent together. The shared lessons, rituals, experiences, frustrations, and love laid the foundation for the people we are today*."
>
> Pamela Palmer—4th grade best friend

ABSTRACT

REPRODUCTIVE HEALTH CHOICES, DISPARITIES, AND SOCIAL CONTEXTS OF AFRICAN AMERICAN ADOLESCENT FEMALES WHO UTILIZE SCHOOL-BASED HEALTH CENTERS

Gina Gabrielle Robinson-Osder

African American adolescent females (AAAFs) continue to experience high rates of sexually transmitted infections, including chlamydia, gonorrhea, and HIV. African American and Hispanic adolescent females also continue to have higher birth rates compared to their White counterparts.

The risk markers of race and ethnicity correlate with fundamental determinants of health such as low socioeconomic status and limited access to health care. The prevalence of some risk factors can be addressed and even decreased through early prevention and lifestyle changes that are facilitated through services delivered at School-based Health Centers (SBHCs).

The purpose of this critical ethnography was to better understand the multifactorial contributors to AAAFs' reproductive health disparities. Aims included critically analyzing reproductive health decisions, use of SBHCs, peer influences and contextual factors in AAAF's lives. The study participants were 20 sexually active, self-identified AAAFs between 15-18 years old, from lower socioeconomic backgrounds as identified by their zip codes. Data collection included in-depth interviews and observations of social activities with participants. The data were iteratively coded for major themes and subcategories. Two major overarching themes regarding the sexual debut of these AAAFs were the intersection of reproductive health, sexual

behaviors, and developmental vulnerability in AAAFs, and the social contexts contributing to AAAFs' reproductive health disparities.

All of the AAAFs in this study reported being unprepared mentally, physically, and emotionally for their sexual debut. Developmental vulnerability was more apparent in the younger AAAFs. The young females, none of whom were on any form of birth control, lacked the cognitive development to negotiate their readiness to engage sexually with their older male partners, versus the older adolescents who had partners their own age, were on birth control, and better negotiated their sexual debut. Thirteen of the 20 AAAFs had mothers under the age of 18 years when they were born. Despite 17 of the 20 AAAFs being exposed to neighborhood violence, they were remarkably resilient.

All of the AAAFs in this study ultimately started on birth control methods provided through the SBHCs. The SBHCs provided access to confidential reproductive health care, health education, and counseling, and should be used to address vulnerabilities in younger AAAFs.

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CHAPTER I

INTRODUCTION

African American adolescent females (AAAFs), when compared to their white counterparts, experience disproportionately higher rates of unintended pregnancies, often experience delayed prenatal care, frequently have low birth weight infants, and have higher rates of sexually transmitted infections such as chlamydia, gonorrhea, and HIV/AIDS (Aronowitz, Todd, Agbeshire & Rennells, 2007; Guo, Wade, Pan & Keller, 2010; St. Lawrence, 1993; Coley & Aronson, 2013). In fact, disparities in birth outcomes of African Americans compared to Whites exist across all age groups; however, AAAFs have persistently higher rates of adverse birth outcomes such as low birth weight infants (LBWIs) and preterm infants (Coley & Aronson, 2013). These disparities often are enhanced and propagated by lack of access to health care services.

Access to comprehensive health care has been noted in the literature to improve health outcomes, such as decreasing risky behaviors and improving overall health for adolescents (Britto, Klostermann, Bonny, Altum & Hornung, 2001). Adolescents, especially those who are ethnic and racial minorities, often face a plethora of obstacles such as racism, socioeconomic status, lack of awareness about primary care, transportation issues when trying to access quality care, and concerns about confidentiality when trying to access quality health care (Britto et al., 2001). These issues manifest in both primary and reproductive health care outcomes. Adolescence is a transitional period when humans mature from childhood into adulthood, and it is imperative that we address inequities AAAFs face in primary care and reproductive health care accessed by AAAFs so that they can transition into healthy adults by establishing healthy habits

during adolescence. Drawing from the life course perspective to evaluate the long-term consequences of adolescents' health behavior trajectories, Frech (2012), posits that the health influences in the social context of these young adolescents early in the life course will continue to influence that individual over time.

African American adolescent females confront many obstacles accessing quality, confidential primary and reproductive health care (Council on School Health, 2012). School-based health centers (SBHCs) are one solution to help decrease adolescent health disparities, as they provide access to quality, confidential, comprehensive health education and prevention, primary health care, mental health, and sexual and reproductive health for youth (Gustafson, 2005). SBHCs are typically located on school campuses and, therefore, are conveniently accessible to children and adolescents (Gustafson, 2005). There is no out-of-pocket cost to students being treated at SBHCs and there are minimal wait times for services (Allison et al., 2007; Gustafson, 2005; Johnson & Hutcherson, 2006). Parents find SBHCs convenient and they also help decrease parents' time away from work (Brindis et al., 2003). By having the SBHCs on campus, the students can be treated and, in most cases, they can return back to the classroom (Pastore & Techow, 2004). Parents sign consent forms at the beginning of the school year so that their children have permission to be treated as needed.

School-based health centers are usually operated by a university medical center, children's hospital, or other health care facility and, for this study, the SBHCs are run by the Native American Health Center (NAHC) in Oakland, California. The SBHC includes a multi-disciplinary team of pediatric or family nurse practitioners, physicians, mental health care providers, substance abuse counselors, health educators, nurses, medical assistants, nutritionists,

and, in some locations, dental hygienists. The goal of the SBHC is to provide access to comprehensive health education and prevention, as well as primary medical, mental health, and reproductive health for youths (Gustafson, 2005).

Specific Aims

The purpose of this dissertation study was to explore the reproductive health needs of AAAFs and better understand the multifactorial reasons for their continued health disparities. Specific aims include:

1. To study the reproductive health and sexual experiences of AAAFs who seek services from SBHCs:

2. To describe and understand the decision-making processes of AAAFs in avoiding or seeking reproductive health care services at SBHCs:

3. To better understand sexual behavior and sexual choices of AAAFs who seek services from SBHCs; and

4. To describe contextual factors in the lives of AAAFs that may relate to their decision-making process about their reproductive health, sexual behaviors, and sexual choices.

The long-term goal of this study is to use this understanding to mitigate the health inequities faced by AAAFs by designing culturally appropriate and accessible interventions as well as influencing health and social policy to enhance their reproductive health.

This research study will address the gaps in the literature, and focus on AAAFs' perceptions and understanding of their reproductive health needs and sexual choices. Critical ethnographic methodology was chosen for this research study not only to describe the point of view of these young AAAFs, who seek reproductive health care at SBHCs, but also to better

examine and critique the political and socioeconomic issues that lead to oppression and power struggles for these young females. Using critical ethnography is a way that I as a researcher can assist to make known the stories of these young and vulnerable adolescent females. Critical ethnographers are known to “resist domestication” by uncovering the confines of suppressed and marginalized groups and freeing the voices of their participants, who are otherwise restrained (Madison, 2005; Thomas, 1993). Using critical ethnography will thus allow this research study to contribute to emancipatory knowledge and social justice (Madison, 2005). By understanding AAAFs' reproductive health needs from their point of view, I hope to evaluate on a more informed basis methods to mitigate the gap seen in their reproductive health disparities.

This research is important because I intend to focus on the ways to improve sexual and reproductive health for AAAFs. Past studies have reported education as a powerful vehicle linked to improving economic growth and better health outcomes for individuals. Focusing on ways to educate and promote sexual and reproductive health education for AAAFs is key to help reduce preventable adverse risk to this population of young females. According to the World Health Organization (2009), promoting safe and effective sexual and reproductive health should be initiated as a school curriculum-based intervention. These school curriculum interventions have been known to improve adolescents' critical and creative thinking and decision-making skill regarding their sexual and reproductive choices (Bearinger, Sieving, Ferguson, & Shama, 2007; Kirby & Laris, 2005; Keeton, Soleimanpour, & Brindis, 2012).

Significance and Background

African Americans are one of the largest groups in the United States (U.S.) to continue to experience higher rates of morbidity and mortality according to the U.S Department of Health

and Human Services, Office of Minority Health [USDHHSOMH] (USDHHSOMH, 2015). African American adolescent females will experience more illnesses, including hypertension, obesity and asthma at a rate that is at least five times higher than their white counterparts and they also have disproportionately higher incidence of death from those and other chronic diseases (Shavers, Shaker & Albert, 2002; USDHHSOMH, 2015). Obesity, sexually transmitted infections and cigarette smoking are only three among the many major risk factors that lead to preventable death among African Americans (AA) (Shavers et al., 2002; USDHHSOMH, 2015). The prevalence of many of these risk factors can be addressed and even decreased through early prevention efforts and lifestyle changes that are encouraged through health care services at SBHCs.

Adolescents, regardless of ethnicity, are a vulnerable population. They often face unique health risks and multiple barriers to accessing health care (Brindis & Sanghvi, 1997; Newacheck, Hung, Park, Brindis & Irwin, 2003; Silberg & Cantor, 2008). Adolescents have the lowest rate of primary care use when compared to other age groups (Nordin, Solberg & Parker, 2010). Studies of adolescent health care access and health care utilization services have found that the lower the family income, the less likely the adolescent will be seen by a primary care provider (Newacheck et al., 2003). Low socioeconomic status among AAAFs contributes to increased rates of teen pregnancy, early childbearing and sexually transmitted infections, including HIV/AIDS (Bauermeister, Zimmerman, Caldwell, Xue & Gee, 2010). Young single-mother households are less likely to increase their potential for lifetime earnings and are five times more likely to be poor (Cancian & Reed, 2009).

Adolescence is a crucial transitional time to establish healthy behaviors. In fact, good healthy habits when formed during this transitional period will carry into adulthood. It is also during this transitional period that adolescents develop sexual maturity, begin to think more independently, and are more sensitive to environmental inputs (Mulye et al., 2009). During this period, most adolescents begin taking greater responsibility for themselves and their actions, including diet and exercise (Mulye et al., 2009). Unfortunately, during this same period, there are also transitional markers that include high-risk behavior that can lead to increased rates of homicide, suicide, unintended injury, substance use, alcohol use, sexually transmitted infections, and teen pregnancies (Mulye et al., 2009).

The overall health of AAAFs can depend greatly on their behavior, including their sexual behavioral habits, which are often established during the adolescent period (Meschke, Bartholomae & Zentall, 2000). Risky sexual behavior is dependent upon timing of intercourse (early age before 15 years old is a risk factor), consistent contraceptive use, number of sexual partners, age of first pregnancy, and exposure to sexually transmitted infections, including HIV/AIDS (Meschke et al., 2000). The outcomes for these youth also varies by race, ethnicity, socioeconomic status, age, gender, family stability, and peer influence (Meschke et al., 2000). Among other factors, race/ethnicity can be an adverse determinant for health and well-being, health outcomes, and health parity and equity across the lifespan in the U.S. (Institute of Medicine, 2002; Williams, Neighbors & Jackson, 2003). Although inconclusive for sexual and reproductive health because of sparse literature, racial and ethnic health care disparities for youth 17 years and younger do exist in primary care and mental health independent of socioeconomic

status, particularly for African American (AA) youth (Elster, Jarosik, VanGeest & Fleming, 2003).

Providing health care access and quality confidential services to these adolescents can help them stay healthy and minimize preventable diseases (Britto et al., 2001). School-based health centers are a way to address an inequity by providing uninsured adolescents access to health and reproductive services.

CHAPTER II

REVIEW OF THE LITERATURE & THEORETICAL PERSPECTIVES

Relevant empirical literature regarding sexual and reproductive health, specifically of AAAFs, will be reviewed in this chapter. First, the background and significance for the need to understand AAAFs' sexual and reproductive health will be presented. Second, the literature search methodology will be described, followed by a critical review of relevant literature related to the determinants and consequences of AAAFs' sexual and reproductive health and the potential impact of SBHCs on AAAFs' sexual and reproductive health outcomes. A summary of the state of the science related to AAAFs' sexual and reproductive health will be provided. This chapter will also include a discussion about gaps in the current research and why this and additional research is needed to help address the sexual and reproductive health outcomes among AAAFs.

The second half of this chapter discusses the theoretical underpinnings regarding the theories used to support this research study. It also includes a critical review of two prominent theories that I believe have the potential to help understand the experiences and reproductive health needs of AAAFs; namely, Bronfenbrenner's (2005) Bio-ecological Theory and critical race theory, which were integrated into a framework to underpin this study that aimed to better understand AAAFs' reproductive needs (see Figure 3).

Background and Significance

In most western societies, the adolescent period consists typically of early adolescence (10-13 years), middle adolescence (14-17 years), late adolescence (18-21 years), and emerging adulthood (18-25 years) (Arnett, 2000). Adolescence represents a transition from childhood into

adulthood that involves biological, physical, psychological, cognitive, social, cultural, and environmental changes (Mulye et al., 2009). These changes can have profound effects on adolescents' judgment, decision-making, risk-taking behaviors, and other actions as they begin to assume greater responsibility (Steinberg, 2005, 2011). According to Mulye and colleagues (2009), these actions often include, but are not limited to, homicide, suicide, unintentional injury, drug, alcohol and other substance use. Adolescents also face untoward sexual and reproductive health, sexually transmitted infections (STIs), unintentional pregnancy, and risky lifestyles. These health behaviors, and health outcomes for youth also vary by race, ethnicity, socioeconomic status, age, gender, family stability, and peer influence. According to Steinberg (2005, 2011), in middle adolescence, youth are typically becoming more independent and interested in intimate relationships, which are on average frequently changing and of short duration, and in late adolescence, youth are typically more self-reliant and interested in long-term intimate relationships.

The primary event of puberty for females is menarche, the beginning of menstruation. African American females begin menarche, the ability to become fertile and reproduce, earlier than females of other ethnic and racial groups. This puts them at risk for untoward sexual and reproductive health behaviors during this uncertain transitional period of adolescent development (Reagan et al., 2012). Although there has been an overall decline in adolescent birth rates, the U.S. has the highest rate of pregnant teenagers among many western industrialized countries (CDC, 2012). In more recent birth statistics from 2014, the proportion of adolescent females ages 15 to 19 who gave birth were 34.9% Non-Hispanic Black, 17.3% Non-Hispanic White and 38% Hispanic (Hamilton, Martin, Osterman, Curtin, & Mathews, 2015). Risky sexual behavior is

dependent upon timing of first intercourse, contraceptive use, number of sexual partners, age of first pregnancy, and exposure to STIs (Kann et al., 2014).

According to the most current Youth Risk Behavior Surveillance statistics, in 2013, 46.8% of U.S. adolescents, 14 to 19 years in 9th to 12th grades, reported ever having sexual intercourse. Among females, 60.6% of Black and 49.2% of Hispanic youth reported ever having sexual intercourse as compared to 43.7% of White youth. For STIs, including chlamydia, gonorrhea, and human immunodeficiency virus (HIV) infection, AAAFs have the highest prevalence of STIs in comparison to other adolescent females (Kann et al., 2014).

Adolescents, especially ethnic and racial minority adolescents, often face a plethora of obstacles such as racism, socioeconomic factors and lack of awareness for primary care and transportation when trying to access quality, confidential primary and reproductive health care (Council on School Health, 2012). Established in the late 1960s and early 1970s in the U.S., SBHCs are one solution to help decrease adolescent health disparities by providing access to quality, confidential health care (Pastore & Techew, 2004). The goal of SBHCs is to provide access to comprehensive health education and prevention, primary health care, mental health, and sexual and reproductive health for youth (Gustafson, 2005). School-based health centers are usually operated by a university medical center, children's hospital, or other health care facility, and include a multidisciplinary team of pediatric or family nurse practitioners, physicians, mental health care providers, substance abuse counselors, health educators, nurses, medical assistants, nutritionists and, in some locations, dental hygienists.

School-based health centers are conveniently located on school campuses and, therefore, are easily accessible to youth, 95% of whom attend formal education in middle and high schools

(Gustafson, 2005). Typically, SBHCs services are free, have minimal service wait times, return students to class after receiving services, are convenient for parents, and decrease parental time away from work (Allison et al., 2007; Brindis et al., 2003; Johnson & Hutcherson, 2006). Parent's sign consent forms at the beginning of the school year so that their children have permission to be treated as needed. School-based health centers may be an important context for health care, especially for addressing the sexual and reproductive health of AAAFs, who often are at risk for not completing high school, live in low socioeconomic households, are uninsured or underinsured, along with other multiple economic, health and social issues (Strunk, 2008).

Search Strategy

A literature search of articles published between 2006 and 2016 was conducted using PubMed, PsychInfo, Sociological Abstracts, CINAHL, and Web of Science databases. The search occurred in several iterations, using various combinations of Boolean operators and MeSH terms: *African American* AND *adolescent/adolescence* AND *females/female* AND *risk/risk taking* AND *sexual behavior* AND *reproductive health.* The search yielded 44 records. To narrow further the search, the phrase 'NOT HIV' was added to the key terms, yielding 27 records. Nine records were eliminated because of duplication and four records were not relevant to the topic of sexual and reproductive health in AAAFs. The abstracts of the 14 remaining records were reviewed for relevancy. All 14 articles were selected for inclusion in the literature review. This search was repeated with the previous key terms and reproductive health disparities and yielded 17 more articles of which 4 were reviewed for this paper. In connection with my preparation of this paper, over 400 additional articles and texts were reviewed on health and reproductive disparities. Key articles, particularly, the ones related to health disparities, were

retained because of their seminal relevance and contribution that continue to be critical to the literature related to the sexual and reproductive health of AAAFs.

Studies for this review were selected based on level of evidence that was at minimum generated from descriptive, cross-sectional studies. Integrated/systematic reviews or meta-analyses were not selected for review. A study was selected for review if it addressed reproductive or sexual health and/or school-based health centers and included AAAFs as part of the sample. Reproductive or sexual health for adolescent population includes unintended pregnancy, STIs, contraception, and number of sex partners. All of the studies reviewed were conducted in the U.S. and in the English language. If a study did not meet these inclusion criteria, it was excluded from the review. One qualitative study was chosen for review because of its rigor in design and because the study included both African American adolescent females and males. No critical ethnographic research studies related to the sexual and reproductive health of AAAFs were located during the search.

Literature Review

The literature review is divided into the following two sections: (a) sexual behavior of AAAFs, and (b) access to and utilization of SBHCs among AAAFs.

Sexual Behaviors of African American Adolescent Females

Sexual thrill seeking (Spitalnick et al., 2007), stage of adolescence (Sales et al., 2012), and age of sex partner (Bauermeister et al., 2010; DiClemente et al., 2001) are major determinants of sexual activity in adolescence, particularly for AAAFs. Cognitive or brain development and maturity are hallmark processes as adolescents gain the ability to problem-solve, think long-term, and grapple with moral dilemmas (Steinberg, 2011). The brain develops

in the frontal lobe, which is key to regulating and evaluating behaviors, emotions, perceptions, risk-taking, and reward seeking. In addition, there are changes in arousal and motivation that are triggered by puberty, resulting in a disjunction between adolescents' affective experiences and their ability to regulate their arousal and motivation behaviors.

Spitalnick and colleagues (2007) conducted a cross-sectional study to examine the relationship between sexual sensation seeking and sexual risk-taking behavior among 715 sexually active, unmarried AAAFs, aged 15 to 21 years, who were not pregnant and were in juvenile detention. Sexual sensation seeking is the propensity to engage in new and different sexual experiences in order to attain heightened sexual excitement. Other study variables assessed were age, perception of peer norms of sexual behavior, and sexual risks (frequency of intercourse, condom use, and number of partners). Statistically significant associations were found between sexual sensation seeking and sexual risks. Higher sexual sensation seeking was related to more lifetime sexual partners, more frequent sexual intercourse, higher perception of peer norms, and lower condom use and other forms of contraception. Regression analyses indicated sexual sensation seeking was the only factor that explained a statistically significant amount of variance related to sexual risks. Study findings suggest sexual sensation seeking is an important predictor of sexual risk-taking behavior among AAAFs that may put them at risk for unintentional pregnancies, STIs, and other adverse sexual and reproductive health outcomes.

Voisin, Tan, and DiClemente (2013) conducted a longitudinal study to examine the relationship between sexual sensation seeking and STIs among 715 sexually active AAAFs living in Atlanta, Georgia. With a mean age of 17.8 years, the sample ranged in age from 15 to 21 years and were not married nor pregnant. Participants were randomly assigned to an

intervention group that received STI prevention services or a control group that received HIV care for 1 year. Study variables were assessed at 6 and 12 months; the retention rate was 83%. Data collection was conducted using audio computer-assisted self-interview survey. There were no statistically significant differences between the control and intervention groups. When controlling for age, peer norms, school enrollment, and employment, both groups had decreased sexual partner communication, decreased self-efficacy to not have sex, and fear of condom negotiation. Low condom use was related to more sexual sensation behavior in both groups, putting participants at risk for unprotected sexual behavior and STIs. Study findings were similar to Spitalnick and colleagues' (2007) cross-sectional study findings.

Ritchwood and colleagues (2014) conducted a study to examine the influence of sexual sensation seeking behavior on the precursors of unprotected intercourse and number of male sex partners among 446 AAAFs who were sexually active with male partners at least more than 2 years older than they were. Participants ranged from 14 to 20 years old with a mean age of 17.6 years. Eight percent of participants used condoms during the past 6 months and 12.8% over the lifetime. Greater sexual sensation seeking behavior and less sexual enjoyment was significantly associated with decreased condom use; and, higher sexual sensation seeking behaviors was significantly associated with more male sexual partners. Participants with older male partners reported significantly lower condom use and those with younger sexual partners reported significantly lower sexual sensation seeking behavior and higher condom use.

DiClemente and colleagues (2011) also found a relationship between sexual risk-taking behaviors of 522 AAAFs and having older sex partners and STIs in a cross-sectional study. Participants were recruited from neighborhoods with high unemployment rates, substance abuse,

violence, and STIs. The mean age of the sample was 16 years with a range of 14 to 18 years. Self-reported questionnaires were administered in a group setting with a trained African American female research assistant. Study variables assessed were perceptions of their male partners, male partners' reactions to condom use, and AAAFs' perceived ability to negotiate condom use with their male partners. Results indicated AAAFs with older partners were significantly more likely to report fear of negative partner reaction to the request for condom use. Participants reported never using a condom and no vaginal protection during intercourse and those with older sex partners were 1.6 times and 2.2 times more likely to report unprotected vaginal sex over the previous 30 days and 6-month period, respectively. Sixty-three percent of participants had sex partners at least two years older than they were, had unprotected vaginal sex, and experienced partner-related barriers to condom use.

Sales and colleagues (2012) conducted a cross-sectional study to explore developmental stages of adolescence for sexual behaviors, sexual communication skills, psychosocial development, condom use, self-efficacy, self-esteem, impulsivity, and knowledge about STIs among sexually experienced younger (14-17 years) versus older (18-20 years) AAAFs. The sample was comprised of 701 AAAFs who had vaginal intercourse without a condom at least once during the past six months. The mean age was 17.6 years. The younger age group consisted of 318 AAAFs with a mean age of 16.1 years. The older age groups consisted of 383 AAAFs with a mean age of 18.9 years. Most of the participants were full-time students (65%), had graduated or were no longer attending school (34%), lived in a "mother only" household (43%), and were in a current relationship (80%).

A female research assistant recruited and enrolled participants (Sales et al., 2012). Data were collected using an audio computer-assisted self-interview survey that took 60 minutes to complete. After completing the survey, participants obtained a self-collected vaginal swab specimen to test for STIs. Trained instructors taught participants how to obtain and handle vaginal swabs. Statistically significant differences were found between younger and older adolescents. Younger AAAFs lived in family households that received more public assistance as compared to older AAAFs family households. Younger AAAFs were significantly more likely to test positive for STIs, whereas older AAAFs were more likely to have a past history of STIs. Younger AAAFs experienced lower partner communication, less confidence to negotiate condom use, and less knowledge about STIs as compared to older AAAFs, who reported more frequency of sexual intercourse and unprotected sexual intercourse. Among older AAAFs, STIs were significantly associated with number of male sex partners, past history of STIs, and high impulsivity. Younger AAAFs reported significantly more conversations about sex with their parents as compared to older AAAFs. Among the total sample, 17% tested positive for chlamydia, 6% tested positive for gonorrhea, and 12% tested positive for trichomoniasis. Younger AAAFs tested positive for chlamydia and gonorrhea in higher levels as compared to older AAAFs. Study findings suggest that age appropriate preventions are warranted, particularly for younger adolescents prior to sexual engagement. Whether the age of the sex partner makes a difference was not explored.

Bauermeister and colleagues (2010) conducted an 8-year longitudinal prospective study of adolescents, 14 to 25 years old, considered at-risk for school dropout, defined as a grade point average less than 3.0 during 8th grade, as they transitioned from middle adolescence to young

adulthood. The researchers examined sexual risk-taking behavior of 562 African American adolescents in the 9th grade who did not have emotional impairments or developmental issues. Half the sample were females. Variables assessed were age of sexual partner, self-acceptance, substance use, number of hours worked, and sexual risk-taking behavior. Female adolescents reported significantly older sex partners across the stages of adolescence as compared to male adolescents. In addition, female adolescents with significantly higher self-acceptance had a same-aged or younger-aged sexual partner, those who dropped out of high school reported significantly lower self-acceptance and having older sex partners, and working many hours was significantly correlated with having older sex partners. Study findings suggest that this sample of AAAFs were most vulnerable particularly when they had older sex partners. Specifically, adolescent females were at a disadvantage with sexual power dynamics, such as condom use negotiation, and, therefore, had little leverage to negotiate with their older sex partners, increasing their risk for STIs and unintended pregnancy. Findings were similar for African American adolescent males, but AAAFs were more at risk. Increasing self-acceptance may be a protective factor as adolescent's transition to adulthood.

Previously discussed studies have reported that older male sexual intercourse partners with younger AAAFs were less likely to use condoms consistently and, therefore, placed them at higher risk for STIs and unplanned pregnancies (Bauermeister et al., 2010; Sales et al., 2012). To further investigate the effects of age difference of male sexual intercourse partners with younger adolescent females, Volpe and colleagues (2013) conducted a cross-sectional descriptive study that examined the age difference of male sexual partners as a prediction of relationship power, intimate partner violence, and condom use among adolescent females. The sample of 150

sexually active, adolescent females, grades nine through 12, were recruited from a school-based health center in the Northeastern US. The mean age of the sample was 16.1 years with a range of 14 to 18 years. The mean age of the male sexual partner was 17.8 years. The majority of the participants were AAAFs (75%) and 80% were of lower socioeconomic status.

The results indicated 24% of the sample had used condoms consistently over the past 3 months, 18% of participants reported minor intimate partner violence and 18% of them reported severe physical intimate partner violence, and 47% of participants reported minor psychological intimate partner violence and 35% of them reported severe psychological intimate partner violence (Volpe et al., 2013). Increased physical and psychological intimate partner violence was significantly associated with lower condom use. The correlation between younger females and older male sexual partners was statistically significant; however, there was no statistical significance for effect of age difference with male sexual partner and consistent condom use. The researchers' conclusions were that the age differences for adolescent females with older male sexual partners showed a power difference which could lead to the younger females using condoms inconsistently. Other researchers have found similar findings of older male sexual partners with younger adolescent females and inconsistent condom use, increased lifetime number of male sexual intercourse partners, increased risk of STIs, and increased unintended pregnancies (Senn & Carey, 2011).

There are consequences associated with AAAFs who have high levels of sexual risk-taking experiences. Bachanas and colleagues (2002) conducted a quasi-experimental study to investigate potential risks, such as depression, behavioral conduct problems, self-efficacy to practice safe sex, and substance use, on high-risk sexual behavior in a sample of 158, inner-city,

low-income AAAFs. The mean age of the sample was 15.7 years with a range of 12 to 19 years. Participants were recruited from a primary care clinic that provided birth control, family planning, pregnancy prevention, and treatment for sexually transmitted infections. Twenty-nine percent of participants lived with another family member or grandparent, 84% of them attended school, 10% of them were in special education classes, 57% of them reported consensual sexual intercourse at 14 years old or younger, and 46% of them reported at least one STI within the past 12 months. Study questionnaires were administered by a trained research assistant not associated with the clinic.

Findings indicated age was significantly associated with risky sexual behavior (Bachanas et al., 2002). Seventy-eight percent of the participants reported unprotected vaginal intercourse at least once, 40% of them had at least one STI in the past year, 14% of them had a current STI, and 23% of them had been pregnant at least once. Substance use was found to be a significant, independent predictor of risky sexual behavior. Depression and perception of peer norms accounted for 26% of the explained variance in risky sexual behavior. Statistically significant predictors of risky sexual behavior were substance use, perception of peer norms, and young age of consensual sexual encounters.

Akers and colleagues (2012) conducted a qualitative study in rural North Carolina to explore 37 African American adolescents' perspectives and comprehension of primary prevention strategies to reduce STIs. The researchers were interested specifically in five core sexual and reproductive health primary prevention strategies: abstinence, low-risk sex partners, consistent condom use, avoiding multiple sexual partners, and sexual history discussion with sex partners. Recruitment occurred from a community-based organization for youth. The sample

consisted of 20 females and 17 males, 15 to 17 years old with a mean age of 15.7 years. The mean age at first intercourse was 13.8 years. Sixty-six percent of the sample was sexually active, 85% of females reported using birth control and 60% of the sample reported condom use, with more males (100%) as compared to females (23%) reporting condom use. One African American and one White, non-Hispanic female graduate student moderators conducted four focus groups of seven to 10 participants: two groups with males and two groups with females. A vignette was read aloud to each group followed by structured probes to explore participants' knowledge about barriers to prevent STIs. Three-step coding, content analysis, and constant comparison methodologies were used to analyze data. All of the participants were familiar with and understood the five STI primary prevention strategies. Three major themes emerged: (a) sexual intercourse during adolescence is normative and abstinence is unrealistic; (b) adherence to the five STI primary prevention strategies depends on their sex partner's adherence; and (c) prevention of STIs was not at the forefront of adolescents' thinking as it relates to sexual relations.

School-based Health Centers

School-based health centers have been shown to be effective in providing access to health care as well as sexual and reproductive health for underserved adolescents. Minguez and colleagues (2015) conducted a quasi-experimental research study to compare adolescents attending two urban public high schools: one with an SBHC (n = 1,365) and the other one without an SBHC (n = 711). Both schools were in lower income areas and were comprised of predominantly ethnic minority students in grades nine through 12. In the intervention school, 88% of students were Latinos and 47% were females; in the control school, 68% of students

were Latinos and 38% were females. A 45-minute self-administered questionnaire was completed by students during one class period and focused on four areas: (1) willingness to use an SBHC for reproductive health care, (2) receipt of classroom education and health care provider counseling, (3) use of contraception, and (4) source of contraception. Students in the intervention school (81%) reported they would be significantly more likely to use an SBHC versus 35% of students in the control school.

Santelli and colleagues (2003) examined adolescent reproductive health service utilization in SBHCs from 1998 to 1999. The mailed survey included 225 questions about SBHC characteristics, student demographics, staffing and operations, health services, policies, quality assurance, and technical assistance needs. A clinician working at each SBHC completed the survey, which took about 30 minutes to complete. Among 1,415 SBHCs identified, 846 returned the survey for a response rate of 60%. Fifty-five percent of the SBHCs were urban, 33% of them were rural, and 12% were suburban. The SBHCs were located in high schools (57%), middle schools (18%), elementary/middle schools (10%), middle/high schools (6%), and elementary/high schools (9%). Typical services provided by 55% to 82% of SBHCs were counseling, pregnancy testing, birth control follow-up, diagnosis and treatment of STIs, and HIV testing. Referral services ranged from 3% to 28%. Although a majority of SBHCs provided access to sexual and reproductive health services, there were marked differences. Suburban SBHCs did not offer basic sexual and reproductive health services such as gynecological exams, diagnosis and treatment of STIs, and pregnancy testing. Rural SBHCs were least likely to allow adolescents access to family planning because of state minor consent laws and institutional policies. Forty percent of SBHCs allowed independent access to family planning. A majority of

the SBHCs were located in inner city areas where the majority of ethnic/racial minority adolescents are typically concentrated.

Using the North Carolina Adolescent Health Survey, Coyne-Beasley and colleagues (2003) conducted a cross-sectional study to examine the willingness of 949 sexually active students to seek and utilize sexual and reproductive health at seven SBHCs located in rural North Carolina where pregnancy rates and STIs among adolescents were higher than other states. The survey was administered in classrooms within a 45-minute time period. Participants were students attending two middle schools and five high schools. The sample was comprised of 52% females, 52% African Americans, 37% Whites, non-Hispanic, and 8% Native Americans. The mean age of the sample was 15.5 years. Seventeen percent of adolescents reported their mother's educational level was less than high school and 40% received low cost or free lunch. Median age at first coitus was 13 years; 32% of the sample had sexual intercourse one to four times a month, and 17% of them several times a week; and, 48% of the sample always used birth control and 22% of them did not use any birth control. Condom use was the most common birth control (83%) and 19% of females and 24% of males had never used birth control. Eighteen percent of females had been pregnant and 10% of males had gotten someone pregnant.

Sixty-nine percent of participants were enrolled in or had planned to enroll in SBHCs (Coyne-Beasley et al., 2003). Seventy-five percent of them had utilized SBHCs at least once during the past 12 months, 48% reported they would utilize SBHCs for sexual and reproductive health and 58% to obtain information about STIs and unplanned pregnancies. Statistically significant gender differences were found for utilization of SBHCs for sexual and reproductive health services. Twenty-six percent of females as compared to 14% of males used SBHCs for

STIs, 29% of females and 10% of males used SBHCs for pregnancy, and 80% of females and 47% of males used SBHCs for general sexual and reproductive health issues.

Braun and Provost (2010) conducted a descriptive, cross-sectional study to assess factors associated with chlamydia infection among 3,022 adolescent females who had received chlamydia testing during a visit for sexual and reproductive health services at SBHCs. The sample was categorized into three age groups: 15-17 years (60%), 18-19 years (18%) and 20-25 years (12%). The proportion of chlamydia infection was 13% for African Americans, 8.6% for Pacific Islanders, 7.6% for Asians, and 5% for Whites, non-Hispanic. Findings suggest AAAFs are at increased risk for chlamydia infection and SBHCs can be an effective setting to address their sexual and reproductive health needs. Ethier and colleagues (2011) also found that adolescents who utilize SBHC services had better sexual and reproductive health outcomes as compared to adolescents who did not utilize SBHC services in 12 high schools located in Los Angeles, a large urban city. The sample consisted of 2,600 (44%) students, 1,226 males and 1,374 females, who reporting having had sexual intercourse. Half of the schools had large ethnic/racial minority populations. Thirteen percent of the sample was African Americans, 77% were Latinos, 3.4% were Whites, non-Hispanic, and 5.6% were of other ethnic/racial groups. Among AAAFs, 15% had no access to health care services and 14% had access to SBHCs. Adolescent females without access to SBHCs were least likely to have had testing for STIs and pregnancy, to have used hormonal contraceptives at last sexual intercourse, and to have used emergency contraception if needed after the last sexual intercourse. Sexually active adolescent females were more likely to utilize SBHCs services as compared to adolescent males.

Summary and Conclusions

African American adolescent females are the most vulnerable population among adolescent females for poor sexual and reproductive health outcomes. They tend to seek sexual sensation behaviors, putting them at greater risk for STIs and unintended pregnancies, for which they have significantly higher rates. Their sexual debut tends to be earlier and with older sex partners with whom they lack self-efficacy and/or are unable or unwilling to negotiate condom use, creating a power imbalance and putting them at risk for physical and sexual intimate partner violence and unintended pregnancies. In addition, they have more sexual partners and unprotected vaginal intercourse. African American adolescent females are likely to believe sexual intercourse during adolescence is normative and abstinence is unrealistic. Therefore, AAAFs who participate in safer sexual behavior may depend on their sex partner's adherence to safe sex practices. In addition, the risk of acquiring an STI is not always at the forefront of their sexual relation considerations. Findings from the literature suggest pragmatic interventions with AAAFs need to occur prior to middle adolescence to minimize negative consequences of poor sexual and reproductive health decision-making in the earlier phases of adolescence. Despite their low percentage as participants in study samples, there is strong scientific evidence in this review that support the use of SBHCs to address the sexual and reproductive health needs of AAAFs.

The studies reviewed had relatively adequate to large sample sizes considering that AAAFs can be a hard-to-reach population for research participation. None of the studies were randomized-controlled trials, which would have strengthened the internal validity of the studies reviewed. With the exception of one study, the studies were comprised of non-probability,

convenience samples. Recruitment mainly occurred at low-income neighborhood clinics. A majority of researchers used self-report surveys to collect sensitive and confidential data from adolescents. Social desirability and response bias associated with self-report surveys involving adolescent samples have been shown to be limited if adolescents have not been informed and assured of confidentiality (Kelly, Soler-Hampejsek, Mensch, & Hewett, 2013). A race- and/or gender-concordant data collection approach between the interviewer and participants was utilized in many studies. Trained research personnel were on-site to answer participants' questions and to address literacy issues. The audio computer-assisted self-interview for data collection was used to minimize issues of literacy, confidentiality and race-concordance.

Gaps and Directions for Further Research

Many of the studies in the literature review were quantitative. Quantitative research methodology offers the researcher a way to capture large sample sizes of participants' responses, which allows the researcher to quantify data generated from the study and to generalize findings beyond the study sample. While quantitative studies often offer the advantage of external validity, the nature of understanding phenomena is typically captured using questions with closed-ended responses without the richness of participants' perspectives. Qualitative methodology allows the researcher to ask more in-depth and complex questions related to human behaviors, beliefs, values and motivations behind thoughts and opinions. Therefore, qualitative studies may help provide a better understanding of the determinants of sexual behaviors, judgment and decision-making processes of AAAFs as they transition through the stages of adolescence to adulthood.

Despite strengths and weaknesses, what is clear from the literature is that AAAFs continue to face not only persistent health disparities, but also disproportionately widening health disparities in sexual and reproductive health as compared to adolescent females of other ethnic and racial populations. By choosing a qualitative methodology, such as critical ethnography, I was able to provide a more in-depth understanding of the sexual decision-making processes of AAAFs as well as other contributing factors, such as socioeconomics, peer, familial, environmental and other contextual assets and risks, and availability, access and utilization of SBHCs. Through critical ethnography, this researcher not only feels a compelling sense of commitment and duty to uncover AAAFs' stories that explain their sexual and reproductive health disparities, but also to be able to contribute to health equity by understanding the social, cultural, and political power structures that contribute to health disparities by exploring beneath the surface of "what is" and "what needs" to change. There are few critical ethnographic studies about AAAFs' sexual and reproductive needs. Therefore, conducting a critical ethnographic study, developmentally and culturally appropriate interventions have been identified and educational programs can be designed for this specific population.

Theoretical Underpinnings

Theory is an important part of research and can lead the investigator to discover new areas of research that can be further developed (Tudge, Mokrova, Hatfield & Karnik, 2009). Theory is designed to provide a unique framework to express ideas of a phenomenon (Walker & Avant, 2011). Theory represents reality and it gives researchers "a common scientific language" (Tudge et al., 2009, p. 198). Theory guides empirical studies and is used to establish precise and parsimonious examples of the real world (Walker & Avant, 2011). Through theory analysis, the

strengths and weaknesses of theories can be analyzed objectively, which may lead to new insights and new studies of interest (Walker & Avant, 2011).

The continual growth, development, and nature of nursing science depends on the relationship between theory, practice, and research (Meleis, 2012). Nursing theorists, practitioners, and researchers all share the goal to understand the health care needs of people (patients) and their communities (Meleis, 2012). These practitioners, theorists, and researchers all want to be able to enhance their patients' sense of well-being by promoting healthy lifestyle choices, facilitating transitional periods of growth and development, and also to help increase access to high quality, affordable health care (Meleis, 2012).

Nursing science aims to develop theories that will describe, explain and understand “the nature of phenomena” both directly and indirectly related to nursing care (Meleis, 2012, p. 391). Theories provide a rationale and a guide for health care models and support to other aspects of phenomena. Theory provides a framework in the health care system that looks at patterns of both healthy, therapeutic relationships, and unhealthy, non-therapeutic relationships. Meleis (2012) describes nursing as a human science, which also includes time, history, environment, social and human conditions, and human rights (Meleis, 2012). According to Meleis (2012), “these aims for the development of theories in human science are congruent with the aims of other human sciences that are focused on human beings and their lives” (p.391).

The two theories that were examined for this dissertation were Bronfenbrenner's (1994, 2005) Bio-ecological Theory and Delgado & Stefancic’s (2011) critical race theory.

Bio-ecological Theory of Human Development

Urie Bronfenbrenner's (2005) Bio-ecological Theory of Human Development is a theory that can underpin our understanding of AAAFs' developmental needs. This theory emphasizes the interrelationship of various processes and their contextual variations over time (Bronfenbrenner & Morris, 1998; Darling, 2007). Bronfenbrenner and Morris (1998) defined development as "the phenomenon of continuity and change in the bio-psychological characteristics of human beings over the life course" (p. 793). Therefore, by understanding AAAFs' bio-psychological characteristics of development, more emphasis can be placed on improving their environment, in addition to improving their best health practices from adolescence into adulthood.

Bronfenbrenner is best known for his ecological systems theory (Bronfenbrenner, 1994, 2005; Harkonen, 2007). Bronfenbrenner (1994) posited how the ecological systems were conceived as nested systems. He initially proposed four concepts of the child in context: microsystem, mesosystem, exosystem, and macrosystem – he later added a fifth system called chronosystem (Bronfenbrenner, 1994, 2005; Harkonen, 2007; Tudge et al., 2009). Bronfenbrenner's (2005) ecological systems theory was later renamed the Bio-ecological Theory of Human Development (Bronfenbrenner, 2005; Harkonen, 2007; Tudge et al., 2009). Bronfenbrenner (1998) further developed the *Process-Person-Context-Time model* (PPCT) that would later become the "essence" of his Bio-ecological Theory of Human Development (Bronfenbrenner, 2005; Tudge et al., 2009).

Bronfenbrenner's 1979 work, *The Ecology of Human Development*, focuses on how humans develop in their environments. According to Harkonen (2007), Bronfenbrenner's (1979)

theory was also "suited" for describing human socialization, for example, the growth and development of children was imperative to be nurtured in their environment for them to grow into contributing members of society (p. 2). Bronfenbrenner (1979) defines human development as "the process through which the growing person acquires more extended differentiated and valid conception of the ecological environment and becomes motivated and able to engage in activities that reveal the properties of, sustain, or restructure that environment at levels of similar or greater complexity in form and content" (p. 27).

Bronfenbrenner (1979, 2005) was concerned with developmental processes of human development from infancy to adulthood. During the 1960s and 1970s, most psychology observations with children were done in a controlled environment, which was an artificial clinical setting (Bronfenbrenner, 1977). However, Bronfenbrenner focused on contextual variations in human development, thus moving developmental psychology forward from "the science of the strange behavior of children in strange situations with strange adults for the briefest possible periods of time" (Bronfenbrenner, 1977, p. 513). Bronfenbrenner (1979, 2005) underscored the principle of development in context and undertook naturalistic observation; for example, he studied children in their natural settings. As a result of his research, Bronfenbrenner (2005) became one of the world's leading authorities in developmental psychology (Bronfenbrenner, 2005; Harkonen, 2007).

Bronfenbrenner (1979, 2005) described his ecology systems as layers of context being similar to the nesting of Russian dolls, where the smallest center doll represents the child inside a bigger doll and that doll inside another larger doll and so forth. Bronfenbrenner (2005) diagrammed the ecological systems theory of human development with the child in the center

surrounded by concentric circles, each representing the context of the child's environment (see Figure 1). Bronfenbrenner (2005) explained how the ecological environment was conceived as nested systems. The relationship within the layers of the structures and the relationship of the structures between the layers are key to Bronfenbrenner's theory and are represented by the arrows in Figure 1 (Harkonen, 2007). The microsystem includes immediate family, daycare, schoolteachers, peers, relatives, play areas, spiritual groups and distant environmental components (Bronfenbrenner, 1979, 1994, 2005).

The *Microsystem*, the center of the nested system, is the smallest of the contexts and the child/individual is at the center (Bronfenbrenner, 1977, 1979, 1994, 2005; Harkonen, 2007). The microsystem is where the developing individual spends most of her time; for example, home, school or daycare (Bronfenbrenner, 1977, 1979, 1994, 2005). Anything in this area has an immediate and direct effect on the child (Bronfenbrenner, 1977, 1979, 1994, 2005). This is where the child maintains direct contact and has relationships with immediate caregivers, including parents. The interactions between children and their immediate caregivers are bi-directional (Bronfenbrenner, 1977, 1979, 1994, 2005; Harkonen, 2007). The child is also able to influence the parents' beliefs and behaviors by the way he or she responds to the parents, and the parents also influence the behavior and beliefs of the child (Bronfenbrenner, 1979, 1994, 2005). The child's biological composition affects their well-being in the world and can, to some degree, affect how the immediate interactions are affected (Bronfenbrenner, 1979, 1994, 2005).

In the *microsystem*, the developing child and caregiver have the strongest interaction, which is bi-directional and a powerful influence on the child (Bronfenbrenner, 1977, 1994, 2005; Harkonen, 2007). The *microsystem* is a pattern of interpersonal relationships that include

activities and socialization that are experienced by the developing individual in a "face to face" environment (Bronfenbrenner, 1994; Harkonen, 2007). The microsystem contains within its immediate environment *proximal processes* that operate "to produce and sustain the individual's development, but their power to do so depends on the content and structure of the microsystems" (Bronfenbrenner, 1994, p. 39). The microsystem is the center of the next layer, the Mesosystem.

The *mesosystem* is the second system context and it is described as including the microsystem and it connects the child's immediate settings and surroundings (Bronfenbrenner, 1979, 1994, 2005). Here, processes take place "between two or more settings" containing the developing child; for example, home environment and school, and school and workplace (Bronfenbrenner, 1994, p. 40). The mesosystem includes the parents, caregivers, and any interactions between home and school surroundings (Bronfenbrenner, 1994; Harkonen, 2007). Family and school processes have more influence on the individual than do socioeconomic status and race (Bronfenbrenner, 1994). This has been researched and documented in the literature for over a decade and many studies have concluded that the parent/child bond is strongest in an optimal family (both mother and father) and when parents and teachers work in unison when teaching the child (Bronfenbrenner, 1994).

The *exosystem* is the third system context, which includes the "linkages and processes" (Bronfenbrenner, 1994, p. 40). These linkages and processes take place between two or more environments in which at least one of these environments does not contain the developing child/individual (Bronfenbrenner, 1994). Although the child/individual is not contained in this environment, he or she can be indirectly affected (Bronfenbrenner, 1994). There are events that can occur that will indirectly influence the processes and, subsequently, this will have an effect

on the developing child/individual (Bronfenbrenner, 1994). Most of the research in this area was documented in the early 1980s and focused on three main exosystems; namely, the parents' work place, family social networks, and the neighborhoods-community context (Bronfenbrenner, 1994).

The *macrosystem* is second to the outermost system and includes the overarching pattern of microsystems, mesosystems and exosystems. This context includes values, cultures, laws, and customs (Bronfenbrenner, 1994). This area also includes the ideology of the culture, lifestyles, and hazards in which the child lives (Bronfenbrenner, 1994). Bronfenbrenner (1994) referred to macrosystems as a societal blueprint for cultures, which goes beyond simply being labeled as class and culture. Instead, it extends to social and psychological features at the macro-level and subsequently affects certain conditions and processes which exist in the microsystem.

The *chronosystem* is the outermost and the last system context that was developed by Bronfenbrenner (1977). It includes environmental events and historical events in the life of the child (Bronfenbrenner, 1994, 2005). These systems are not static – they are ever-changing between the child, peers, institutions, and ecological environments (Bronfenbrenner, 1994, 2005; Harkonen, 2007). The chronosystem circumscribes changes over time, including both characteristic changes of the individual such as age, as well as changes in environment, including family structures, SES, job changes and employment (Bronfenbrenner, 1994). This early version of Bronfenbrenner's (1994) theory is what is referenced in the literature as the Systems Theory. A later version of Bronfenbrenner's (2005) Bio-ecological Theory includes both the systems theory and the developed discussion of the process-person-context-time model (PPCT).

In Bronfenbrenner's 2005 text, *Making Human Beings Human*, he defines *development* as "the phenomenon of continuity and change in the bio-psychological characteristics of human beings both as individuals and as groups. The phenomenon extends over the life course across successive generations and through historical time, both past and present" (p. 3). The Bio-ecological Theory is also described as having an emphasis on the child's biology as the "primary micro-environment that is the fuel for development" and it also stresses the "quality and context of the child's surroundings" (Harkonen, 2007, p. 2). Bronfenbrenner posits that since the child is in constant growth (physical) and cognitive development, the interactions with his or her surroundings can be complex (Harkonen, 2007).

The Bio-ecological Theory is marked by a theoretical focus that embraces the dynamics of individuals who not only are influenced by others (peers) and institutions of their ecology, but also their own individual effects on their environmental ecology (Bronfenbrenner, 2005). Bronfenbrenner (2005) concluded that our society has a major influence on a child's development and this influence became the principal basis to his Bio-ecological Theory (Bronfenbrenner, 2005).

Within the Bio-ecological Theory, basic processes of human development may be summarized and cultivated with the child/individual in the center, how the family, community and environment affect the individual, and how the individual affects the environment (Bronfenbrenner, 2005). Bronfenbrenner (2005) describes the socialization of the child in context, where the child is studied in the context of family, community, and larger social environment.

In this second period of Bronfenbrenner's writings on human development, he argues that his earlier writing on the theory of ecology of human development had always and explicitly stressed “person-content interrelatedness” and, therefore, he did not focus “exclusively on contextual factors” (Tudge et al., 2009, p. 199). In Bronfenbrenner's later writings, he stressed the concern with the *processes* of the individual's development (Tudge et al., 2009). He explained in his early writings that “process” could explain the connection between context and the developmental outcomes of an individual (Tudge et al., 2009). In the 1990s, Bronfenbrenner defined *proximal processes* as being essential in human development (Bronfenbrenner, 1994; Tudge et al., 2009). In addition, his Process-Person-Context-Time (PPCT) Model became known as the key of the Bio-ecological Theory (Tudge et al., 2009). According to Tudge et al. (2009), Bronfenbrenner's theory in its “mature form” includes both Systems Theory and interrelations among the PPCT concepts (p. 199-200).

The four defining concepts of the PPCT bio-ecological model are explained below. According to Bronfenbrenner and Morris (1998), in the early development of the Bio-ecological Theory its interdisciplinary and integrative focus on the “age periods of childhood and adolescents” lead to its application use in youth policy programs and family development programs as well (p. 794).

Process

The first concept, *process*, is important in development and is referred to as *Proximal Process*. Bronfenbrenner (1995) defines *proximal processes* of the bio-ecological model with two propositions. In the first proposition, he describes the life course of human development as something that takes place in time through the process of interactions with an evolving “bio-

psychological human organism" and the objects and symbols in that person's immediate environment (Bronfenbrenner, 1995; Tudge et al., 2009, p. 200). This interaction must continue to occur over an extended period of time to be effective. Interactions that happen in the immediate environment are referred to as "proximal processes" (Bronfenbrenner, 1995). Bronfenbrenner (1995) gives examples of proximal processes as "parent-child," "child-child interaction," "group" or "solitary activities," "learning new skills," "studying," and "performing complex skills" (Bronfenbrenner, 2005).

Bronfenbrenner explains the second proposition as "the form, power, content and direction of the proximal processes, effecting development vary systematically as a joint function of the bio-psychological characteristics of the developing person: of the environment, both immediate and more remote, in which the processes are taking place and the nature of the developmental outcomes under consideration" (Tudge et al., 2009, p. 200). Both propositions are subjected to empirical testing when they are presented as concrete hypotheses (Bronfenbrenner, 1995). Therefore, the PPCT model is a research design that has an investigational form of specific hypotheses that permit a simultaneous investigation (Bronfenbrenner, 1995).

Person

The second concept is person. Here, Bronfenbrenner (1995, 2005) looked mainly at the personal characteristics of an individual (although he did acknowledge to some extent the importance of genetics and biology of the person) and how those characteristics have an effect on their social interactions with others (Tudge et al., 2009). The characteristics that he listed were of three types, which he called Demand, Resource, and Force. *Demand* is referred to as a

“personal stimulus” such as physical appearance, age, gender, and skin color (Tudge et al., 2009). This personal stimulus may invoke or even influence situations or interactions because of immediate “expectations formed” (Tudge et al., 2009, p. 200). *Resource* characteristics are not as apparent as Demand characteristics although, in some instances, they can be induced from those Demand characteristics that are seen. *Resource* relates to emotions and past experiences, social skills, food and housing access, and reflects social and material resources (Tudge et al., 2009). The last characteristic is termed *Force*. Bronfenbrenner explained that Force has to do with a person's temperament, motivation, and persistence (Tudge et al., 2009).

Context

The third concept is *Context*. The Context or environment includes four systems, which are interrelated. Bronfenbrenner names these systems the microsystem, mesosystem, exosystems and macrosystem (see above). Bronfenbrenner (2005) then later added a fifth system, the Chronosystem. These were all discussed above.

Time

Time is the last concept in the PPCT model. Time is important in Bronfenbrenner's (2005) theory because he viewed it as “constituting micro-time” (“what is occurring during the course of a specific activity or interaction”; Tudge et al., 2009, p. 201), meso-time (activities occurring with consistency in the individual's environment) and macro-time (chrono-system in which there are varying degrees of developmental processes (Tudge et al., 2009). The Chronosystem is based on certain historical events that occur in the developing person at different ages. Time and timing are equally important in the PPCT model because of “relative constancy” and “change” (Tudge et al., 2009). This becomes apparent when thinking about the

types of activities and interactions of the developing person or the different types of micro-systems in which they live.

After reviewing Bronfenbrenner's (2005) Bio-ecological Theory one can see how his theory continued to evolve. Bronfenbrenner was reflective and observant in his research and concluded that both individual and environment affect one another in a dynamic bidirectional way. His theory can be utilized effectively to research AAAFs who seek reproductive health care services at SBHCs because the Bio-ecological Theory is important in this research to explain human development in context.

Bio-ecological Theory Applied to the Study of African American Adolescent Females

According to Bronfenbrenner (2005), the development of the child depends on the child's biology, genetic make-up, and immediate environment, including primary care givers. Bronfenbrenner has argued that child problems are both "more prevalent and more severe in poor quality environments"; therefore, the need of parental attention for guidance is imperative (Darling, 2007, p. 209). Parental responsiveness can "disrupt negative processes" that are observed in low SES environments (Darling, 2007, p. 209). Many young AAAFs who live in low SES neighborhoods and single parent households and are exposed to environments with limited resources and unsafe neighborhoods. This may put them at heightened vulnerability to poor health care access and health outcomes. Bronfenbrenner's theory proposes that the proximal processes used to promote development are most effective if the child has many resources in combination with positive parental guidance (Darling, 2007). School-based health centers operate in the microsystem under Bronfenbrenner's theory and provide a unique resource to such AAAFs with limited parental guidance and living in low SES environments. Oftentimes,

young AAAFs seeking reproductive health care services at the SBHCs find the access to their health care needs met in a confidential and safe environment (Pastore & Techow, 2004; Gustafson, 2005). The SBHC also provides an environment that reinforces health education and promotes safe sex and other health care practices (Britto, Klostermann, Bonny, Altum & Hornung, 2001; Brindis et al., 2003; Gustafson, 2005). Many of the SBHCs are located in underserved areas where the adolescents attend school and thus can counteract some of the systems issues that put young people at risk (Pastore & Techow, 2004). A potentially poignant and important component of Bronfenbrenner's theories is race. It pervades Bronfenbrenner's systems (see Figure 3). Accordingly, to help inform a better understanding of AAAFs health care disparities, critical race theory is another valuable theoretical school of thought.

Critical Race Theory

Another important theory utilized when researching AAAFs was critical race theory (CRT). Critical race theory describes itself more as a movement, which is comprised of a group of intellectuals, activists, and scholars who are interested in understanding and changing the relationship among race, racism, and power in the United States (U.S.) (Delgado & Stefancic, 2011). Critical race theory evolved from previous movements of Critical Legal Studies (CLS) and radical feminism (Delgado & Stefancic, 2011). Critical race theory provides a critical analysis of race and racism from a legal point of view (Delgado & Stefancic, 2011). Critical race theory is based on the laws in America from pre- and post-civil rights eras and it questions liberal order, equality, theory, legal reasoning, and neutral principles of constitutional law (Delgado & Stefancic, 2011, p.3). Critical race theory extracts from philosophies and theories of Antonio Gramsci, Michel Foucault, Jacques Derrida, Sojourner Truth, Frederick Douglass,

W.E.B. DuBois, Cesar Chavez, and Martin Luther King, Jr., among other luminaries (Delgado & Stefancic, 2011). The Black Power and Chicano movements from the 1960s also heavily influenced the CRT movement, whose goal was to address and correct "historical wrongs" (Delgado & Stefancic, 2011, p. 5).

Critical race theory began its development in the mid-1970s with early works from Derrick Bell and Alan Freeman, CRT founders who were interested in the process of racial reform in the U.S. They posited that the civil rights movement of the 1960s had stalled and that there were notable setbacks for blacks and other minorities (Delgado & Stefancic, 2011). Bell and Freeman also proposed that new theories and strategies were needed to fight new, more subtle forms of racism (Delgado & Stefancic, 2001). Derrick Bell, Alan Freeman, and Richard Delgado are the early authors, lawyers, activists, and scholars of CRT and they were later joined by Kimberly Crenshaw, Mari Matsuda, and Patricia Williams (Delgado & Stefancic, 2011). Collectively, these authors were interested in making changes to America's race relationships and power (Delgado & Stefancic, 2001). These early authors were collectively referred to as a "community of scholars who were inventing a language and creating literature" on race and historical race relations "central to the laws and policies" in the U.S. (Delgado & Stefancic, 2001, p. xix-xx). Over the past decade, CRT has spread out to new subgroups, which include Asian American jurisprudence, Latino Critical (LatCrt), and queer-Crt, and all of these subgroups are interested in improving race relationships, mitigating racism, and improving power struggles that face many minorities living in the U.S. (Delgado & Stefancic, 2012).

Critical race theory is important because it not only attempts to comprehend social situations but also sets out to change them (Delgado & Stefancic, 2001). The intent of CRT is to

be conscious of society's organization of racial disparities and to alter race-based issues for the better (Delgado & Stefancic, 2001). It highlights the relevance of contemporary discourse on race and racism in the U.S. (Crenshaw, 2011). It is important to contemplate this critical theory in tandem with a more mainstream developmental theory, as the impact of race on health disparities must be highlighted.

The basic tenets of CRT are many; however, there are four major concepts (also referred to as themes or tenets in CRT movement language) that will be examined in this paper: (1) legal story-telling or narrative analysis, (2) race as a social construct, (3) racism is ordinary and not aberrant, and (4) intersectionality.

Legal Story-telling and Narratives

The first hallmark of CRT is legal story-telling and narrative analysis. This concept is built on the day-to-day experiences of how race is viewed in America (Delgado & Stefancic, 2012). The narratives and legal story-telling are drawn from a historical base of slave narratives and African American and Native American oral storytellers (Delgado & Stefancic, 2012). These narratives are often used to make the legal cases more personal to be able to connect on a more human level (Delgado & Stefancic, 2012). Story-telling is a powerful way to give a minority community a voice (Delgado & Stefancic, 2012). The value of narratives for marginalized persons was explained by Jean-Francois Lyotard's concept *differend* (Delgado & Stefancic, 2012), which is explained as a conflict of injustice between two groups (one group in power and the other in a subordinate position). Here, the subordinate group is unable to use language to articulate how the other group, usually the one in power, has wronged them. As a result, justice for the subordinate group is deprived because the language used by the subordinate

group inadequately conveys their grievance in the language the system would understand. The narratives therefore provide the language to connect the gaps that give rise to the differend (Delgado & Stefancic, 2012).

Race as a Social Construct

Another tenet or concept in CRT is race as a social construct. CRT scholars are divided on certain issues regarding race, racism, and discrimination. For example, the "idealist" school of thought proposes that race is a social construct and that it has no biological basis in reality (Delgado & Stefancic, 2001). Therefore, if race is socially constructed, then by simply changing our attitudes and social teachings regarding racism, then the idea of race is something that can be undone (Delgado & Stefancic, 2001). The idealist also proposes that racism and discrimination "are matters of thinking, mental categorization, attitudes and discourse" (Delgado & Stefancic, 2001, p. 17). Consequently, by simply changing the negative images, words, and societal attitudes towards people of color—for example, "that certain people are less intelligent" or hard-working than others—then race-based attitudes in society would begin to change (Delgado & Stefancic, 2001, p. 17). These *social construction* theorists argue that race is simply a byproduct of our society—a "social thought" and construction—and that it is manipulated "when convenient" for political and economic gains (Delgado & Stefancic, 2011, p. 17).

The opposing school of thought, the *realist* or *economic determinist* believes that "racism" is a way our society designates "privilege and status" (Delgado & Stefancic, 2011, p. 17). It allows "racial hierarchies," with those at the top of the racial hierarchy receiving the "tangible benefits" of better schools, improvements to neighborhoods, and access to health care and medical specialists (Delgado & Stefancic, 2011, p. 17). The realists propose that slavery in

the U.S. reflected deeper, underlying shifts in racial prejudice. They explain that, prior to slavery in the U.S., many Europeans recognized certain African civilizations for their advanced mathematicians and astronomers whose knowledge greatly predated that of the Europeans (Delgado & Stefancic, 2001).

Racism is Ordinary

Another theme CRT examines is "that racism is ordinary, not aberrational" (Delgado & Stefancic, 2001, p. 20). This means that for people of color living in American society, racism is a common, everyday occurrence that most minorities experience. This "ordinariness" means that the frequency of racism among people of color is such that it would be difficult to "cure or address" because it happens so frequently that people have become conditioned to believing it is a normal, acceptable way of life (Delgado & Stefancic, 2001, p. 7). Proponents of this perspective argue that espousing "color blindness" (defined as the treatment of every individual the same regardless of his or her race or skin color) could only be an effective remedy to highly egregious forms of racism and discrimination (Delgado & Stefancic, 2001, p. 7). In addition, there has been a growing interest in the existing empirical research on how racism and discrimination affect health outcomes (Ahmed, Mohammed & Williams, 2007; Williams, Neighbors & Jackson, 2003).

Intersectionality

Intersectionality is a term first used by Kimberly Crenshaw in 1989 and it is defined as an examination of race, class, sex, sexual orientation, and national origin and how "their combination plays out in various settings" (Delgado & Stefancic, 2001, p. 51). These classifications are viewed as separate, disadvantaging factors (Delgado & Stefancic, 2001).

When an individual occupies two or more of these classifications, it is called an intersection of recognized position of oppression (Delgado & Stefancic, 2001). Intersectionality has its roots in sociology and black feminist sociology. It is a term used to describe individuals with their multiple "social identities" (Delgado & Stefancic, 2001, p. 51).

Patricia Hill Collins (2000), a professor in sociology at the University of Maryland, further developed the concept of intersectionality. Collins is best known for her ideas of intersectionality and the matrix of domination (Collins, 2000). Intersectionality, according to Collins, is defined as "a particular way to understand social location in terms of crisscross systems of oppression" (2000, p. 299). Specifically, intersectionality is an analysis claiming that systems of race, social class, gender, sexuality, ethnicity, nationality and age form mutually constructing features of social organization, which shape Black women's experiences and, in turn, are shaped by Black women (Collins, 2000, p. 299).

Collins (2000) defines oppression as "any unjust situation where, systematically and over a long period of time, one group denies another group access to the resources of society. Race, class, gender, sexuality, nationality, age and ethnicity among others constitute major forms of oppression in the U.S." (p. 4). Collins explains that the culture in the U.S. allows for "racist and sexist ideologies to permeate the social structure" to such an extent (that which is so large) that it becomes the norm rather than the exception (Collins, 2000, p. 4). Therefore, many negative stereotypes that have been attached to African American or Black women have been noted to be "fundamental to African American women's oppression" (Collins, 2000, p. 4).

Application of CRT to the Study of African American Adolescent Females

Critical race theory (2001, 2011) is important to review in the context of AAAFs and reproductive health care needs because AAAFs are at greater risk for sexually transmitted diseases, low birth weight delivery and, overall, African Americans continue to have the highest morbidity and mortality of all minorities living in the U.S. (Geiger, 2006). By studying race as a social determinant to health, we can look for ways to start closing the gap of health disparities. Thus far, the gaps have been resistant to change and profound poor health outcomes for African Americans have persisted. Race and racism, more than low SES, have continued to affect the health outcomes of all minorities, most particularly, the African American community (Geiger, 2006).

Summary

After carefully reviewing these two theories, it is apparent that both were useful to study AAAFs' reproductive health care needs in SBHCs. First, Bronfenbrenner's (2005) Bio-ecological Theory is important because it places the child in context by laying a foundation of the developing individual in the more natural setting of the child's own environment. Here, the child is at the center of his/her environment with a series of "concentric circles" representing the various nested systems, of micro, meso, exo, macro, and chrono-systems. Each of these systems is important to the developing child at the center of them. There are arrows linking to and across context and systems. For example, the arrows in Figure 1 show home, school, and neighborhood and connect family to school. Everything in the developing child's world is interrelated and bound by context and culture over time. The developing child is active and affects the environment as much as the environment has an effect on the growing individual; responses are

evoked from both children to parents and from parents to child. Environmental influences on child development are key in Bronfenbrenner's (2005) Bio-ecological Theory.

Critical race theory (2011) is named a "theory" although it is not clearly identifiable as such for scientific purposes. It is a movement in the law which studies race, racism, and discrimination in an attempt to understand and improve minorities' social situations. Critical race theory "sets out not only to ascertain how society organizes itself along racial lines and hierarchies, but to transform it for the better" (Delgado & Stefancic, 2001, p. 3). It can be used to enhance or transform other theories by putting the phenomena into a wider social context that is inclusive of social belief systems, perspectives and movements, history and ordinary social practices like racism.

Integration of Bio-ecological and Critical Race Theories

Bronfenbrenner's Bio-ecological Theory (2005) is comprehensive in its presentation of the innumerable factors and relationships that the developing child encounters. Bronfenbrenner's ecological systems framework (see Figure 1 and Figure 2) below can be further enhanced by moving race to the forefront as a major social construct of influence and demonstrating the principle of intersectionality as race intersects with each system. This author revised Bronfenbrenner's original diagram (see Figure 3) below by explicitly adding the concept of race as conceptualized in CRT (2001, 2002) as an arrow cutting across all of the systems. This arrow in the revised diagram represents the pre-eminence of race as a social determinant of health across all systems. Although within CRT race is defined as a social construct, in the scientific literature, there is growing evidence that race plays a critical role in an array of health outcomes (Ahmed et al., 2007; Williams et al., 2003). The frequent byproducts of race, racism, and

discrimination are noted in the literature to be real and to have adverse consequences to health, especially for African Americans living in the U.S. (Ahmed et al., 2007). In fact, racism and discrimination are acknowledged in the research literature and recognized by the Institute of Medicine (IOM) not only to be harmful, but as a major contributor to disproportionate morbidity and mortality for African Americans and other minorities living in the U.S. (Ahmed et al., 2007).

Within the revised diagram, it is posited that the intersection of race and the microsystems and mesosystems have immediate impact on the child situated in the center. This point is briefly illustrated. For a young, urban AAAF, it is likely that her first encounter with the effects of race, racism, and discrimination occurred when she was in-utero. As an African American infant, if she had received any prenatal care at all, her mother was 2.3 times more likely to have had delayed prenatal care until her third trimester compared to a white mother. In addition, AAAFs who subsequently became mothers, compared to white adolescents, are three times as likely to have a high mortality rate, secondary to complications resulting from being born a low birth weight infant (LBWI) (Coley & Aronson, 2013).

These examples demonstrate how the African American infant's microsystem will be impacted by longer hospitalizations and caused additional stress in her home and her immediate care may have extended from her parent(s) to other family members. Her exosystem will also be impacted by race: for example, as an AAAF, she will also have a high chance of living in a segregated neighborhood, being from a single-parent household, and having limited access to curative and preventable health care in her neighborhood (Baffour & Chonody, 2009). The effects of race in her neighborhood will affect her resources, social welfare, and work

opportunities (Baffour & Chonody, 2009). As an AAAF, she will experience these health care disparities over her life course over time chronosystem (Ahmed et al., 2007).

Because racial disparities in health, along with SES, are known to affect the distribution of health and resulting disease, race is a critical consideration in the research on the health needs of AAAFs. Racial disparities contribute to a striking pattern of earlier onset and more chronic and severe diseases for minorities when compared to whites, with grave morbidity and mortality patterns (Geiger, 2006). Ahmed, Mohammed and Williams (2007) define racism as “an organized system undergirded by an ideology of inferiority that categorizes populations into races, assigns hierarchical status to these 'racial' groups and uses this ranking to preferentially allocate societal goods and resources to those that are regarded as inherently superior” (p. 318). Therefore, AAAFs living in low SES neighborhoods are especially vulnerable and an integration of these theories provides us with a better framework for understanding why.

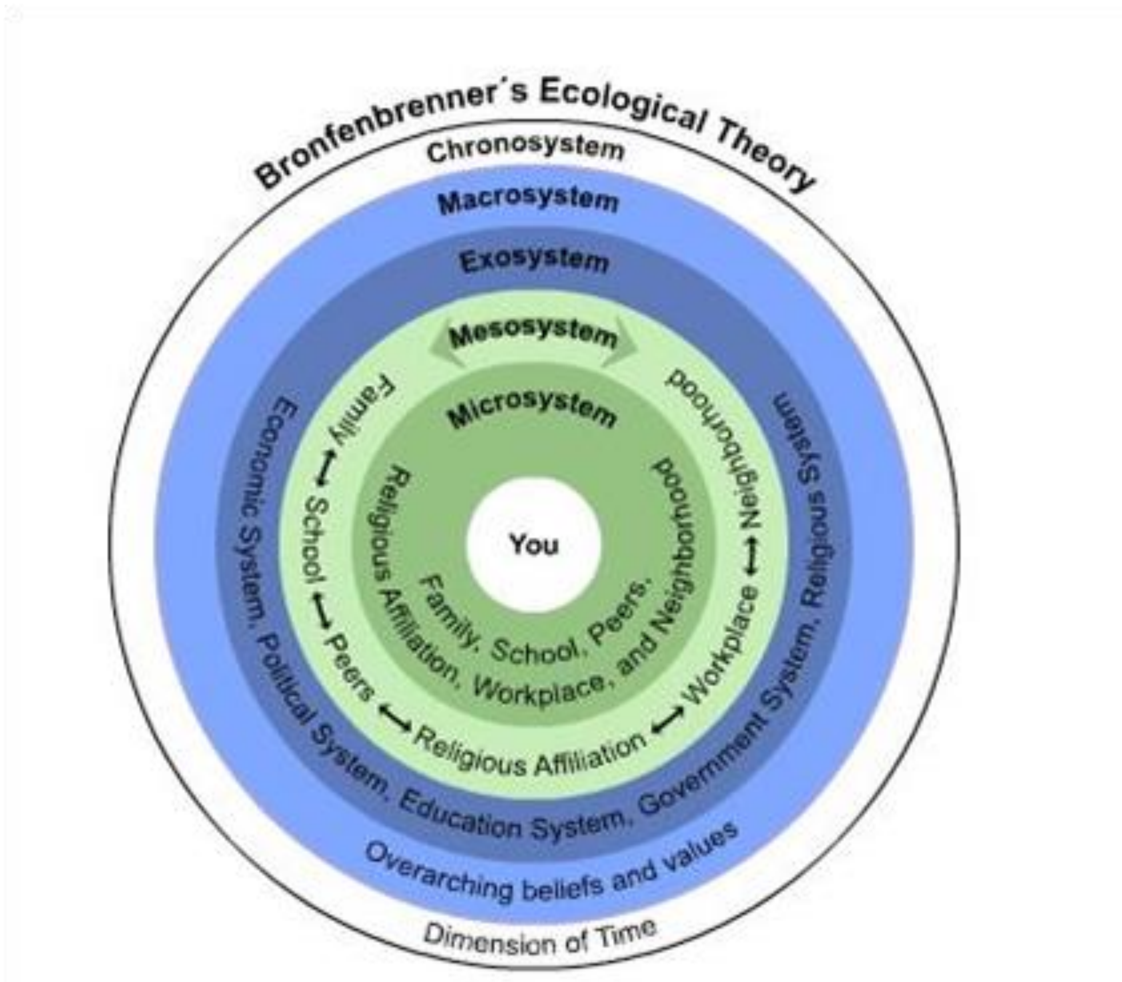
By integrating Bronfenbrenner's (2005) Bio-ecological and Delgado & Stefancic's (2001, 2012) Critical Race theories, race is brought to the forefront as a paramount construct – to be underscored as a key condition with great impact on all systems levels for developing AAAFs (see Figure 3). Moreover, consistent with Bio-ecological Theory, Critical race theory's tenet of intersectionality or the deep interrelatedness of one's identities (Collins, 2000) lends another important emphasis. The integration of race and bio-ecological theory may effectively serve as both theoretical and philosophical underpinnings to our understanding of AAAF health. When considering the reproductive health needs and disparities of many AAAFs, race (and by default intersectionality) becomes a critical social determinant of health and health inequities. Stated slightly differently, as the U.S. continues to grow in diversity, there will also be a growing

recognition of the complexity of the multiple axes of social identities and how they intersect. It is at this intersection that we as nurse researchers need to conduct a critical examination to better understand how these intersections influence the health and welfare of AAAFs, as well as the general population in need of health care.

Conclusion

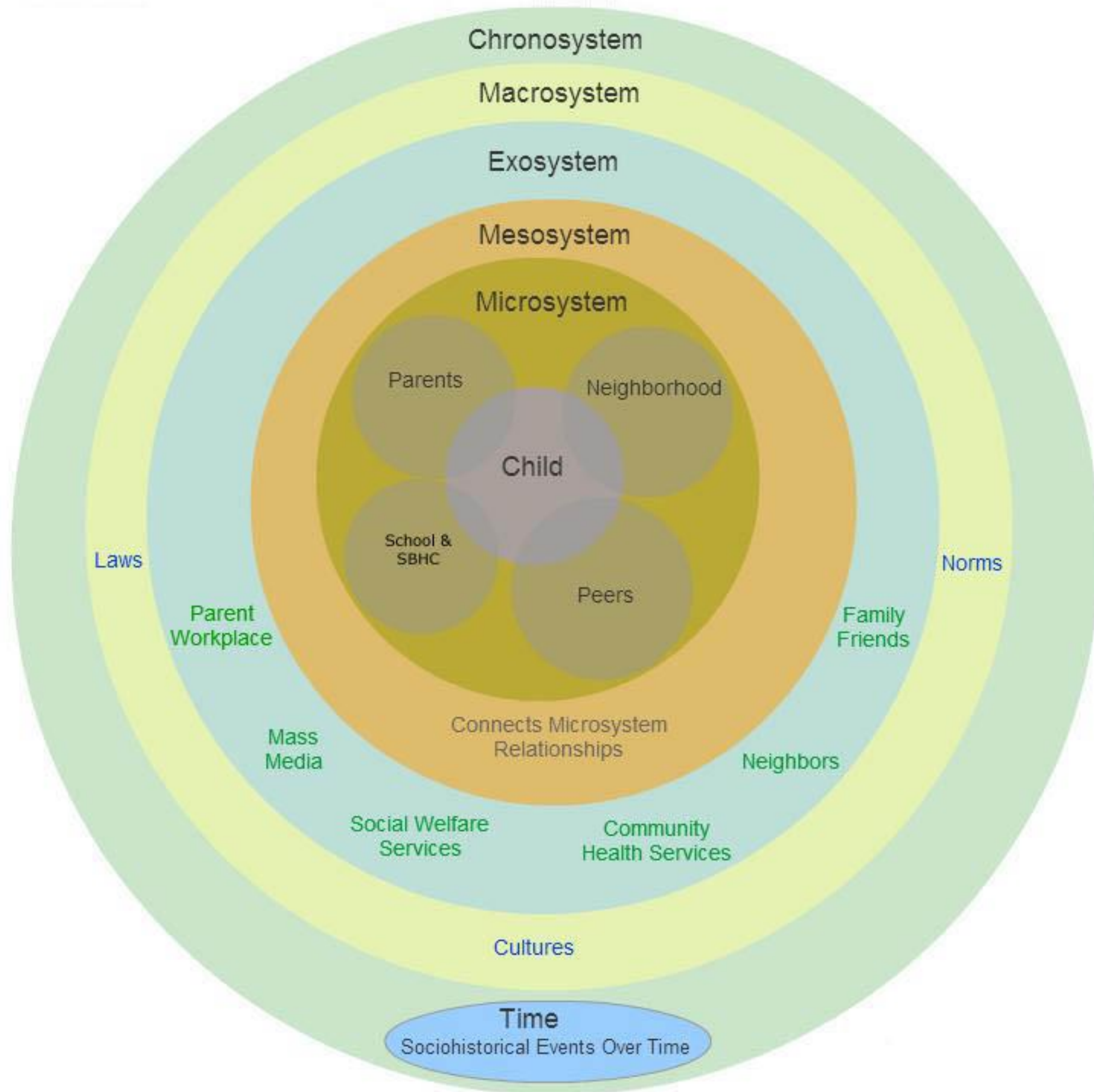
Theory can provide multiple ways to understand the influences upon an individual's life and how their context shapes their development. Theory can lead the investigator to new areas of research and it can provide a framework to critically examine the phenomenon under study (Meleis, 2012). By critically examining Bronfenbrenner's (2005) Bio-ecological Theory of and CRT (2001, 2012), it becomes evident how both theories can be useful in providing a framework to enhance research on the reproductive health needs of AAAFs. By looking at the adolescent female in context, one can see how important the ecological systems are to the developing child. Since the microsystem is the most influential, it is important to therefore stress the parental or primary caregiver bond or engage the child's microsystem in a positive way. Racism and discrimination intersecting any of these ecological systems can have a devastating effect on the developing AAAF. In fact, racial categorizations in the U.S. continue to be present and to reflective of systems of oppression (Ahmed, et al., 2007). The intersectionality of race, ethnicity, social class, gender, sexuality, nationality, and age, integrated with a general understanding of Bio-ecological Theory, allows us to critically examine multiple contributing factors to health disparities among this vulnerable group of AAAFs. By acknowledging and understanding these social inequalities, we can move forward towards ideally eradicating or at least to mitigate inequalities for all human beings.

Figure 1. Bronfenbrenner's Bio-ecological Systems Theory Diagram



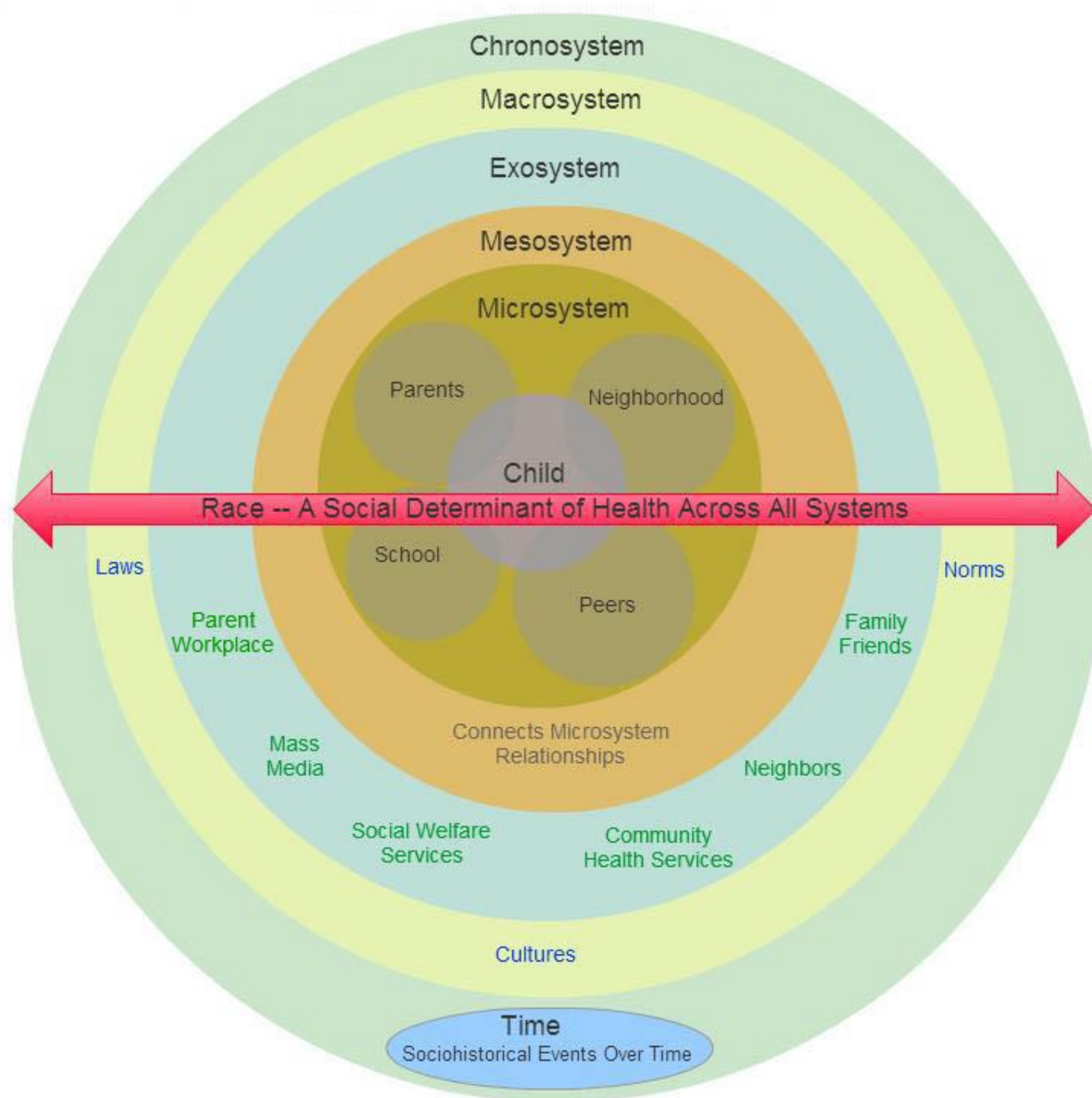
Bronfenbrenner's bioecological systems theory diagram retrieved from the Internet
http://search.yahoo.com/search;_ylt=A0oGdV8VX39RQg4Aq8tXNyoA?p=chrono%20systems%20diagram&fr2=sb-top&fr=my-myy

Figure 2. Bronfenbrenner's Bio-ecological Theory of Human Development Systems Venn Diagram Reconstructed by Gina Robinson



Bronfenbrenner's Bio-ecological Theory of Human Development Systems Venn diagram reconstructed by Gina Robinson

Figure 3. Integration of Bronfenbrenner's Bio-ecological Theory of Human Development Systems and Critical Race Theory reconstructed by Gina Robinson



Integration of Bronfenbrenner's Bio-ecological Theory of Human Development Systems and Critical Race Theory reconstructed by Gina Robinson.

CHAPTER III

METHODOLOGY

Chapters I and II provided the foundation of the social context for AAAFs. In chapter III I will review traditional ethnography, the distinction between it and critical ethnography, and why the latter was chosen to guide this study. I then will describe the critical ethnography procedures I used to complete this study.

Traditional Ethnography

Traditional ethnography, critical ethnography, qualitative inquiry, and fieldwork are all part of social research methodology rooted in anthropology and are part of a long research tradition in sociology (Hammersley & Atkinson, 2007; Creswell, 2007).

The word ethnography comes from the Greek word *ethos*, which Madden (2010) defines as writing about a group of people and their culture. Ethnography is a qualitative social research science which sets out to broaden our understanding of *otherness*, to push us past ourselves so that we may also develop an understanding of what it is like to live in another culture (Jessor, Colby & Shweder, 1996). Ethnography refers to fieldwork, interviewing, observations, and other means of gathering data in the real world (Willis, 2007). Often, ethnography and fieldwork are used synonymously (Willis, 2007). Holloway and Wheeler (2002) define ethnography as "a method within the anthropological tradition that gives a direct description of a culture" (p. 135).

Ethnography is unique in its way of studying human behavior through a cultural lens, to interpret and better understand a cultural group's norms and routines (Holloway & Wheeler, 2002). Ethnography is produced as a non-fictional text account of a group of people and their cultural way of being (Madden, 2010; Holloway & Wheeler, 2002).

Critical Ethnography

Critical ethnography, like ethnography, originated from anthropology, history, education, philosophy, and from a long tradition in the social sciences (Thomas, 1993). Critical ethnography is a reflective way to examine social realities through culture, knowledge, and action (Thomas, 1993). It has a strong ethical responsibility, an obliged sense of duty, and a commitment to deal with the unfair processes and injustices often found within a specific lived domain (Madison, 2005). Here, the researcher has a strong sense of moral obligations to make contributions toward change for equity and examines closely those in power and control (Madison, 2005). Critical ethnographers not only describe and analyze a situation, but they also examine and criticize it and look for hidden agendas, power differentials, and those situations that can be repressive, constraining, or inhibiting (Thomas, 1993).

The purpose of using a critical ethnography design in this study was to explore and describe the experience or phenomenon of AAAFs living in urban areas and their perceptions about seeking reproductive health care services at SBHCs. As noted earlier, AAAFs continue to be the population most vulnerable to poor reproductive health outcomes when compared to their white counterparts (Bauermeister, Zimmerman, Caldwell, Xue & Gee, 2010; Ritchwood, Penn, DiClemente, Rose, Sales, 2014). Historically, African Americans have a unique and rich culture of survival during the most tumultuous times in America when medical care was legally segregated and not readily available to them. African Americans have endured disproportionate levels of poverty, racism, and diverse changes over the past several decades (Aronowitz, Todd,

Agbeshire & Rennells, 2007). This unfortunate history has affected cultural perceptions of African Americans about health care access and efficacy. Critical ethnography provided a unique way to study the social contexts of the AAAF study participants. Employing critical ethnography to conduct interviews and participant observations was a way to enhance the understanding of AAAFs' culture and facilitate the provision of health care by contextualizing their beliefs, behaviors and feelings (Hammersley & Atkinson, 2007).

There have been numerous quantitative studies on the utilization of SBHCs, but there are limited studies on how health care is perceived by AAAFs (Silberg & Cantor, 2008). Increased knowledge about the perceptions of AAAFs can provide health care providers with insight into the needs of this population so that appropriate education and prevention strategies can be addressed. This critical ethnographic study provided a rich cultural aspect and an in-depth understanding of AAAFs' decision-making process regarding their reproductive health and using the SBHC. Critical qualitative methodology was a way to also look at the relationship in society between power and truth. This was a good starting point to study AAAFs' reproductive health issues and their use of reproductive health care through SBHCs. This study provided me with new insight into an under-represented group in the research literature, being both African American and adolescent females (Branson, Davis & Butler, 2007).

Ethnography and social science research are a way to acknowledge social issues; however, critical ethnography goes beyond just an acknowledgment—it is a political mandate for change (Thomas, 1993). Critical ethnography gives a voice to marginalized, oppressed social groups. It is an ethnographic approach that confronts and challenges the implicit assumptions that generally underlie research. It not only deconstructs these biases, but also positions the

researcher firmly into methodology. Researcher perspectives and biases are acknowledged as well as their influence on analysis and findings. The purpose of critical ethnography is to disrupt ordinary power relations and challenge inequalities.

Qualitative social research provides a method to study humans in their natural environments in a way that quantitative methods cannot express (Carspecken, 1996). Critical qualitative social research is one method used to investigate human beings and their social conditions. Critical ethnography is initiated by an ethical responsibility to address social injustices within a specific, particular area of life (Madison, 2005). In critical ethnography, the researcher is drawn in by a sense of moral principles and compassion, resulting in a duty to make changes to foster equity in the lives of those who face disparities (Madison, 2005). In other words, critical ethnographers feel an obligation to contribute towards improving poor conditions and to make life equitable for all human beings, not just those who are privileged (Madison, 2005). The critical ethnographer feels morally obligated to make changes to improve conditions and equity (Madison, 2005).

Critical ethnography helps us to develop a larger capacity to expand our vision and auditory and tactile senses. It also challenges our ethical commitments by reinforcing our development and action in a political agenda (Thomas, 1993, p. 2). Implicit assumptions are required to be questioned through this critical scholarship (Thomas, 1993). According to Thomas (1993), "critical ethnographers describe, analyze and open to scrutiny otherwise hidden agendas, power centers and assumptions that inhibit, repress and constrain" (p. 3).

Although critical and traditional ethnography share some basic fundamental characteristics, the lines of distinction are oftentimes confusing. This is because ethnography in

itself is known to be traditionally associated with a "potential critical mandate" and, therefore, it becomes difficult to tease out a "well-done ethnographic study from critical scholarship" (Thomas, 1993, p. 3). The basic fundamental characteristics of ethnography and critical ethnography include qualitative data interpretation, ethnographic methods, analysis, and symbolic interactions with the "preference for developing grounded theory" (Thomas, 1993, p. 3). The distinguishing characteristics of critical ethnography include a reflective inquiry and challenging methodology aimed at eventual policy changes to improve the lives of the underrepresented. Critical ethnography is not just criticism; it includes conventional ethnography with a "political purpose" (Thomas, 1993, p. 5).

Critical ethnography has an additional research obligation not only to speak on behalf of participants, but also to empower them by giving them 'more authority' through expression in their own voices (Thomas, 1993, p. 4). This additional obligation invokes action and social consciousness in attempts for social change (Thomas, 1993, p. 4). Critical ethnography is more than the study of oppressed and marginalized people; it also has an emancipatory goal to reduce social domination of repressed groups (Thomas, 1993). According to Thomas (1993), emancipation is a process of setting free those who have been marginalized. Thomas (1993) adds that repression is a constraint on thoughts and actions. Therefore, critical ethnography becomes both "hermeneutic and emancipatory" (Thomas, 1993, p. 4). Ethnography hermeneutics defined by Thomas (1993) is the understanding, or preventing the misunderstanding, of the translation of what we see as cultural symbols from our subject to interpret to our research audience (p. 5). Therefore, critical ethnography is a way to reveal societal dominations and constraints on other cultures.

Ethnography is thought to be the best situated of the social sciences to uncover deep below the surface meaning of social phenomena (Thomas, 1993). For example, critical ethnography recognizes that "power" is symbolic and that "institutions of power" are what often dictate behavior, limit access, and acknowledge membership and this, in turn, affects the everyday social life of societies (Thomas, 1993, p.7). In critical research, the critical ethnographer resists and unveils this "symbolic power" to un-restrict the voice of their participants (Thomas, 1993, p. 7). Critical ethnography reflects research scholarship in a way that uncovers extensive, unequal societal controls, power inequity, and the exploitation over others (Thomas, 1993).

Critical ethnographers are known to "resist domestication" (Thomas, 1993; Madison, 2007). "Domestication" is defined as a means of prohibiting growth and power (Madison, 2007, p. 6). Marginalized participants' lives may reflect domestication or experiences that are oftentimes constrained and, therefore, the critical ethnographer brings to light conditions out of reach, to work towards more equitable powers for their participants (Madison, 2007). Thomas (1993) states that ethnography perhaps is most valuable research in "digging" below the surface of social lives (p. 6). After all, it is the "institutions of power" that affect cultures and attitudes and behavioral responses (Thomas, 2007, p. 6). Critical ethnographers set out to reveal how restrictive these "institutional powers can be" (Thomas, 2007, p. 6) and then propose social change to ameliorate these inequities.

Critical Ethnographic Methods

To supplement the traditional ethnographic methods of participant observation, interviews, and thick description, critical ethnography incorporates important practices, such as reflexivity and positionality.

Reflexivity

Reflexivity is an important and critical concept of social research and is a tenet of the critical ethnographic method; it includes the researchers participating in the social world and reflecting on the outcomes of that participation (Hammersley & Atkinson, 2007). Nazaruk (2011) described reflexivity as a "process of reflection" and the reflection is on the self "as the object" (p. 73). The act of being reflective in anthropological discourse and critical ethnography is imperative to the researcher because being reflective will hopefully acknowledge the researcher's awareness to be able to produce "discriminating and defensible interpretations" of their research (Foley, 2002, p. 473). Reflexivity is a way to look for the ultimate truth (Nazaruk, 2011). Research scientists, literary writers, social cultural scientists, and philosophers have all participated in reflexive thoughts during the postmodern times of the 20th century (Nazaruk, 2011). In fact, the post-structuralists take part in reflexivity with their critique of modernism (Nazaruk, 2011, p. 76). Reflexivity is a way of expressing our innermost thoughts, in a "Nietschean perspective our consciousness" (Nazaruk, 2011, p. 81).

Reflexivity for the critical researcher is the way to be reflective. This process produces self-awareness; by turning one's gaze upon the self, it becomes a way to reflect as the *other* (Foley, 2002). By turning back to look at one's own cultural experiences and assumptions during the research, it allows the researcher to see how their experiences affect their understanding of

the research problem, the questions asked, the observations made, and their interpretation of the data. The researcher is reflective through memo writings. Reflexivity is the researcher's own experience of cultures and her understanding of what it might be like to be the *other*.

Positionality

Critical ethnographers are known to focus on social change, but these researchers have also been criticized for not acknowledging their own position in their research (Madison, 2007). Positionality is the critical ethnographer's acknowledgment of their own position of privilege, power, and biases and how these affect the researcher's own position in their study (Madison, 2007). Critical ethnographers must recognize the impact that they as researchers have when representing their participants because, even as researchers attempt to give voice for their participants, there still remains a domination factor from the researcher (Madison, 2007).

Positionality is established as being a vital requirement for critical ethnographers, as important as having a dialogue with their participants (Others) (Madison, 2007). One's position as a critical ethnographer remains of the utmost importance when entering the world of the other (Madison, 2007). The conversations between the researcher and the other must continue to flow and to be ongoing. Here, a dialogue is “the quintessential encounter with the other” (Madison, 2007, p. 9). There are three ways to use positionality in qualitative research. First, the ventriloquist: here, the ethnographer must be “invisible” in the transcription of the information being taken in. Only the facts given by the subjects are the main focus and the researchers themselves should not be included in the text. Second, the positionality of voices: the voice of the subject must be heard in a way that brings forth the *others* experiences and these experiences should be the main focus of the writings. Third is the activism stance. This is where the

researcher will take up a clear position and advocate for change and alternative interventions (Madison, 2005). These steps are repeated throughout the participant observations and interviews.

My Reflexivity and Positionality as the Researcher

After reviewing the national databases regarding the health disparities of AAAFs, I immediately thought that I was uniquely qualified and very interested to look deeper into this phenomenon, through the lens of a researcher. As a health care provider and African American female, I was naturally drawn to conduct research on the African American female population. Conducting ethnographic research on an adolescent population, although not difficult for me, did have its challenges. Being an African American female is not an automatic entrée into the adolescent world of AAAFs willing to volunteer to be a study participant. Adolescents have their own social groups that they protectively screen for entry. In other words as an adult provider-researcher, it did not matter how up to date I was with the popular language, styles, or shared ethnic background, I am still not a teenager!

Gaining entrée into the field of adolescent research required a guide—a member from the adolescent world, someone who could vouch for me. In my case, it was the adolescent daughter of a good friend of mine. I also interviewed a young woman who was interested in the study, but could not participate because she was not sexually active; however, I was gratified when she told me that I was cool and that she would bring her friends when I was scheduled to be at the SBHC to collect data. Thereafter, each time I went to that SBHC, students were lined up to volunteer to participate. We often needed to reschedule them. The power of a teenager operating in her own microsystem! I also was fortunate to have a 99% show rate for 2 of the SBHCs, both due to

having a key informant. The third SBHC proved more challenging to recruit participants from, perhaps because the school was moved one mile away from the SBHC.

As an African American female, researcher, and health care worker, I was honored to be accepted into the worlds of the AAAFs who kindly volunteered to participate in my study. The subject matter of this research involves highly sensitive, confidential, and sometimes embarrassing topics and gaining trust from my participants was both high praise and motivating. As is the role of the critical ethnographer, I have conducted research that captures, memorializes, and amplifies the unique voices of these young females who continue to face reproductive health care disparities.

Conducting a critical ethnography research study allowed me to provide a forum for AAAFs to openly share and reflect on their sexual debut. My study provided a safe and comfortable environment for these AAAFs to reflect on and learn from their reproductive health experiences, choices, and outcomes.

Description of the Research Setting

My research study took place in a natural setting. It was conducted in three SBHCs, all chosen for their demographics, locations, and accessibility, and each run by the Native American Health Center (NAHC) in Oakland, California. Figure 4 below sets forth the student enrollment demographics for each SBHC.

The three sites chosen for this study, and other established SBHCs run by the NAHC, provide health care to vulnerable populations of students mainly located in low socioeconomic status areas. The mission statement for NAHC is "to provide comprehensive services to improve the health and well-being of American Indians, Native Alaskans, and residents of the

surrounding communities with respect for cultural and linguistic differences" (Native American Health Center Mission Statement).

The SBHCs provided private office space to conduct one-on-one interviews. This helped to ensure the privacy of this study's AAAF participants. Participant observations took place in the settings of SBHC waiting rooms, outside the school campus as the AAAFs walked to and from school, off-campus sandwich and coffee shops, school bus stops, outdoor malls near school, and at school events, including Homecoming Week, Spirit Week, and a basketball game.

Figure 4. Student Enrollment Demographics For Dissertation Study SBHCs

SBHC	Demographics

High School A

2013-14 Student Enrollment by Group	
Group	**Percent of Total Enrollment**
Black or African American	19.1
American Indian or Alaska Native	0.3
Asian	23.9
Filipino	13.7
Hispanic or Latino	17.5
Native Hawaiian/Pacific Islander	1.4
White	18.4
Two or More Races	5.7
Socioeconomically Disadvantaged	47.5
English Learners	18.2
Students with Disabilities	10.9

High School B

Student Enrollment

Group	Enrollment
Number of students	1,793
Black or African American	35.4%
American Indian or Alaska Native	0.5%
Asian	19.1%
Filipino	1.4%
Hispanic or Latino	31.8%
Native Hawaiian or Pacific Islander	1.7%
White	8.4%
Two or More Races	0.8%
Socioeconomically Disadvantaged	74.9%
English Learners	25.4%
Students with Disabilities	12.7%

High School C

2013-14 Student Enrollment by Group	
Group	**Percent of Total Enrollment**
Black or African American	25.6
American Indian or Alaska Native	1.2
Asian	6.4
Filipino	8.7
Hispanic or Latino	27.9
Native Hawaiian/Pacific Islander	2.9
White	23.8
Two or More Races	3.5
Socioeconomically Disadvantaged	54.7
English Learners	15.7
Students with Disabilities	19.8

Sample

This study's sample consisted of purposive sampling of 20 AAAFs who sought reproductive health care at certain SBHCs in Northern California. The inclusion criteria were adolescent females who:

1. Self-identified as AAAFs, who were heterosexual or bi-sexual who have had intercourse with males. The focus included risk factors more common to women having male sexual partners (e.g., early and unintended pregnancy, chlamydia and HIV/AIDS);
2. Were 15-18 years old;
3. Were able to read and understand the English language because the consent forms and interview was conducted, in English; and
4. Were or have been sexually active within the previous 6 months.

Exclusion criteria included non-African American adolescent females, non-English speaking AAAFs, and those AAAFs outside the desired age range of 15-18 years old, and AAAFs who had no history of sexual activity. The participants were recruited from and interviewed at three Northern California SBHCs where I had negotiated access to and also obtained support from the director of adolescent health through the Native American Health Center in Oakland, California. The three SBHCs chosen for this research study included those high schools located in areas where the SBHCs serve students who are sometimes marginalized due to their lower SES and minority status. The participants chosen for this research study included a lower SES population.

Human Subjects Assurance

The Committee on Human Research (CHR) at the University of California, San Francisco approved the previous pilot study for this research project. Any modifications for this research

dissertation were based on the proposal and the revised study aims. There is always potential harm in research studies that include human participants. For example, this study could have been time consuming and may have involved asking questions that might make the participants feel uncomfortable. The AAAFs were informed that I am a Mandated Reporter and, as such, I am required to report any suicidal ideations and any sexual, physical, or other types of abuse suspected or observed. In addition, I was required to report any evidence of neglect and knowledge of any incidents or risk of serious harm to self and/or others. (None was evident in this study).

All participants were able to read and sign a consent form in English prior to their enrollment. The consent forms included the rights of human research participants as volunteers and the consent also informed the participants of their right to confidentiality and privacy along with their right to discontinue with their participation at any time during the study.

Data Collection Method Techniques

Interviews

As the researcher for this study, I created an interview guide which was reviewed and revised based on the recent scientific literature review (see Appendix 2). The interview guide was influenced by my preliminary analysis of the pilot data by creating a more informed and specific set of questions intended to capture more specific replies about reproductive health issues. The interview guide also directed the research study to gain a “thick description” of the experiences and perceptions of AAAFs' reproductive health care needs (Fetterman, 2010; Holloway & Wheeler, 2002). I also took detailed field notes, resulting in “Thick description”, which is described in the ethnographic literature as a rich and comprehensive detail of long,

often-redundant note entries during fieldwork (Fetterman, 2010). The notes were then later edited for presentation. The goal of thick description is to draw the reader in to feel the emotions and perceptions that impact the participants (Holloway & Wheeler, 2002). Thick description is also a way to produce a concise, thorough, highly descriptive reality, without using every word collected in the field (Fetterman, 2010). The data collected in this study was used to address the aims of the study. In-depth semi-structured interviews were conducted for approximately one hour. After the first interviews were listened to and transcribed, depending on the data collected, a second 30-60 minute follow-up interview was conducted to further discuss preliminary analysis with participants. In some cases I used triangulation, which is an ethnographic technique used to test participants' data against each other in order to support preliminary analysis and to validate data collected (Fetterman, 2010). By using the semi-structured interview technique, this allowed me to have a one-on-one interaction with the participant, which can give a more natural conversation appearance and still guide the study (Gulati, Paterson, Medves & Luce-Kapler, 2011). The use of conversation-style interviewing is a good way to share and discuss personal information such as reproductive health issues and to increase AAAFs' comfort and participation.

Participant Observations

Participant observation is a hallmark method of data collections for critical ethnographers (Madden, 2010). For this study, participant observation took place at the SBHCs, during interviews and pre-interview sessions in the clinic waiting rooms. As the primary investigator for this research project, I also informed the participants of my goal to better understand the social life and activities of AAAFs, mainly through their interactions with their friends and family. I also asked each participant to allow me to accompany her on a social outing which was

usually an after school or sports event. Each participant observation was individually negotiated with participants to assure their comfort and confidentiality and, therefore, each observation was unique. The observations were recorded as fieldnotes and a field note observation guide was followed (see Appendix B). The participants were aware of the observations during the informed consent process. Participant observation is a key methodological approach to ethnography and an important part of data collection in which I as the researcher utilized my whole set of senses to capture rich data (Madden, 2010). The goal of the participant observation was to gain access to the AAAFs' social group, in addition to observe behaviors and cultures of these young females and also to observe how these females interact with both male and female peers. This involvement allowed me a better understanding of AAAFs' microenvironments and culture in order to better inform their actions regarding reproductive health needs. Hours of field work and notes were written for this study regarding participant observations. Participating in adolescent females' daily activities was exhilarating, entertaining, and exhausting all at the same time. Maintaining a degree professional distance between me and the AAAFs allowed me to observe them and to take notes (collect data) from my position as an observer. Participant observation helped me to better understand adolescent language and patterns of behavior. Some of my own limitations were time constraints.

Procedure

Study participant recruitment was facilitated through the posting of flyers outside the SBHCs. Clinic staff was trained to identify potential participant volunteers and direct them to the posted flyers, which set forth inclusion criteria and contact phone numbers. Potential study

participant volunteers arrived at their respective SBHCs at the times coordinated by the SBHC staff. I interviewed them to ascertain whether they met my study's inclusion criteria.

As the researcher for this study, I was available at the selected SBHC sites in a private office for formal screening of potential participants and to enroll them into the study if they agreed to participate. I met with all of the eligible volunteer AAAFs. In addition, my cell phone number was available on the flyers and with the SBHC staff. The SBHC staff also assisted the participants to a private office room where the interviews took place. Those AAAFs who met the eligibility criteria as posted clearly on the flyer under inclusion criteria were then further screened using the screening guide (see Appendix 3). The participants read the informed consent, and full description of the study's risks and benefits, and then any remaining questions were answered before the participants signed the informed consent. Only the adolescents participating in the study needed to sign an informed consent since the study is focused on sensitive services for adolescents which, under California reproductive health law, is confidential and requires only minor consent (and not parental consent). Once the consent was signed for those AAAFs who meet the inclusion criteria, the adolescents underwent one-on-one interviews with me as the researcher (see Appendix 2 for the interview guide). The participants were also informed that they may be called back for a second interview if needed and were each given a $10 gift card upon completion of the study. The participants were informed that they could also refer other AAAFs who attend the SBHC; this is referred to as snowball sampling.

Demographic information was obtained. All transcripts and fieldnotes were de-identified and kept in a secured, locked area. Any identifying data was limited to last name or initials and

limited to phone numbers and/or email addresses and this information was kept separate from the data collected on the participants.

Data Analysis

Critical ethnography methodology techniques were followed to collect and analyze data. Critical analysis included both the participant's (AAAFs') and the researcher's perspectives. The AAAF's perspective came from her words and actions and included her attitude, cultural behavior, and beliefs. The AAAF's perspective gave a description from a group member's perspective about AAAFs' culture and the social situation in which they live and make reproductive health decisions and choices. The researcher's perspective was documented in the form of reflexive memos, which is defined in ethnography as a process of self-reflection and self-disclosure (Madden, 2010). Reflexivity is a way for researchers to self-identify their own assumptions, cultural biases, and beliefs. Reflexivity was also a way for me to be self-revealing to document how my own assumptions might impact the study.

The data for this study were derived from face–to-face individual in-depth interviews with 20 AAAFs who were sexually active. Participant observation was conducted with several key informants, and memos, reflective journals field notes, and summaries all comprised the data sets. After collecting the data through fieldnotes of events, reflections, attitudes, memos, and observations, the notes were then reviewed in a recursive and iterative way. I also constructed a matrix of major concepts and events to compare across participants, adding analysis as the study proceeded. This process of data analysis began from the time I entered into the field and continued throughout this study.

Since this was a sensitive topic about sexual reproductive health, this researcher first had to gain the trust of the participants by providing anonymity, privacy, and confidentiality. The interviews were digitally recorded and transcribed without any participant attributes. I digitally recorded the interviews to capture the essence of the AAAFs' view and to be able to transcribe the words verbatim to help enrich the authenticity of the study.

All of the transcripts were read several times to familiarize myself with the data and to look for any patterns of similarities or differences. Once the data became more familiar, the transcripts were then re-read for open coding. The software program Atlas.ti was used to code and organize the data. Once each transcript was coded, then all of the transcripts were compared to one another to look for patterns of relationships. All of the similarly coded lines were then reviewed side–by-side and memoranda were written for each relevant concept. The relevancy of the concepts was decided by words or phrases that were repetitious, frequently used, and by this study's theories used. Since the topic of this study was about AAAFs reproductive health needs, many concepts in this study were related to developmental age of the young females' first sexual intercourse, and the use or non-use of birth control. Once the codes were reviewed and compared, they were then put into larger categories and from these categories salient themes, were developed.

During thematic analysis, the procedures recommended by DeSantis and Ugariza (2000) were used. Themes were extracted from the litany of data collected in this study, including fieldnotes, memos, and categories of codes. These data captured the experience of the study's AAAF participants, painting a verbal portrait of the essential experience of these AAAFs (DeSantis & Ugariza, 2000). After developing categories from initial codes, I used an iterative

process to analyze information within the categories and developed a set of major categories which were related to two major overarching themes, as described in Chapters 4 and 5.

This data analysis process also included an inductive and recursive process of patterns and themes that continued to evolve throughout the study. The analysis process included triangulation, which was used to further support the information collected from participants' interviews and from participant observations; this was important to increase the qualitative validity of the study's findings.

Through participant observation, data was collected in the form of extensive field notes. For the reflexive process, I kept a journal and wrote memos to capture my feelings, important themes, and assumptions that might have influenced this study.

Rigor

Rigor is essential in all research studies to ensure validity (Whittemore, Chase & Mandle, 2001). Using qualitative inquiries requires a distinct set of rigorous criteria on which to base validity and reliability, which differ from quantitative research standards. Rigor was maintained throughout this study from the beginning by maintaining and confirming the data for credibility, authenticity, criticality, and integrity. The Whittemore, Chase and Mandle (2001) article was used as a guide on how to maintain a rigorous qualitative study.

Credibility, authenticity, criticality, and integrity are considered the primary criteria on which to base validity of a qualitative study (Whittemore, Chase & Mandle, 2001). Credibility is the accuracy of the data being presented in a believable way. Digital recordings of the interviews were transcribed verbatim to obtain the rich data directly from the participants' voices. Quotes from these transcriptions were included in the text. Authenticity linked closely to

credibility includes not only the emic's perspective, but also that which is also confirmed and verified through thick description and triangulation of the data that was collected and reviewed until I reached saturation. The second interview along with participant observations helped to verify the data. According to Whittemore and colleagues (2001), both criticality and authenticity were referred to by Maxwell (1996) as the descriptive and interpretive validity necessary to establish rigor in the qualitative designs. Criticality offers critical appraisal and trustworthiness. The integrity of this study included recursive and repetitive checks of the AAAFs' perspective; this was done through the interviews, and participant observation. This was done when I presented the preliminary analysis to the participants in a second interview to ensure that I had understood their words and ideas. Open-ended questions allowed the participants to give their perspectives of their experience. Reflexivity, along with criticality, was another way to give my perspective and feelings towards the study on a daily basis, in addition to addressing my own biases. Reflexivity also contributed to increasing the study's validity.

Conclusion

Qualitative research sets out to capture human behavior and culture in a way that cannot be completely fulfilled through quantitative design. Qualitative research enriches our understanding of the other, both culturally and individually. The qualitative design critical ethnography was chosen for this study to explore and describe the phenomenon of AAAFs' reproductive health needs and their perception about seeking reproductive health care services at school-based health centers.

Critical ethnography methodology is important in studying AAAFs because this approach is concerned with social inequities such as health disparities, which this particular group

historically has faced and which continue to be well-documented and persistent. Critical ethnography researches social change by examining social structure, power and culture. Institutions of power such as schools, health clinics and other major institutions have disproportionately disenfranchised African Americans. By researching through participant observation and interviews at school-based health centers, the aim is to understand why these young African American adolescents continue to face health disparities.

Critical ethnography sets out not only to describe social circumstances but also to refine social theory and to give their participants voice. Critical ethnographers are challenged to provide accurate and adequate representation of the experiences of their participants. This is important for these researchers because the solution to the problems uncovered in a community must be deciphered by and accepted according to the community's values. The critical ethnographer must be reflexive of her limitations as a cultural interpreter and to examine power, assumptions, privileges, and biases. Critical ethnographers also must be able to reflect and reject the power structures encompassing their subjects. The critical ethnographer can create an accurate text of what the others' issues are about. Critical ethnographers are positioned in a way that they have an ethical responsibility to bring to light unfairness and obscure operations of unequal power. The impetus using critical ethnography in studying African American adolescent females' reproductive health needs is to look at sensitive issues that surround reproductive health in this community and to challenge policy barriers that these young women continue to face.

CHAPTER IV

RESULTS

The purpose of this critical ethnographic study was to explore and understand the reproductive health needs of African American adolescent females (AAAFs), who bear a disproportionate burden of health disparities among the female adolescent population in the United States (U.S.) (Aronowitz, Todd, Agbeshire & Rennels, 2007; CDC, 2011). The information presented in this chapter is the result of individual, face-to-face interviews with 20 AAAFs, participant observations in the field with selected participants, reflective journals, memos, field notes, and summaries.

Socio-demographic Profile of Participants

Ranging from 15 to 18 years, the average age of the sample of 20 AAAFs was 16.6 years. The sample was divided into younger participants (15 to 16 years) and older participants (17 to 18 years old). There were 9 younger participants and 11 older participants. There were 4 participants who identified as bisexual, another 4 as biracial, and 1 as Puerto Rican. All of the AAAFs were enrolled in a public high school, were sexually active, and had utilized the services of the school's health center. Several participants had visited the clinic for pregnancy testing and no participant had delivered a child. One participant had a confirmed pregnancy at the time of the second interview. Two participants had been previously pregnant at ages 14 and 15, respectively; both participants had abortions about one month prior to being interviewed. Of the 20 participants, 1 participant lived with her biological mother and father, 1 participant lived with her mother and stepfather, another participant lived with her mother and her mother’s female

partner, and all the other participants lived in single-parent/guardian households comprised of mothers, fathers, grandmothers, an aunt, and a female foster care guardian.

Intersection of Reproductive Health, Sexual Behaviors, and Developmental Vulnerability in African American Adolescent Females

The first over-arching theme that I constructed from the data collected from the AAAFs in this study was the *intersection of reproductive health, sexual behaviors, and developmental vulnerability*. Within the context of the results of this study, developmental vulnerability was defined as a feature of adolescence that may put a youth, particularly in early adolescence, at higher risk for a negative outcome. Components of developmental vulnerability that are supported by the literature include immature cognitive development, inability to regulate emotions, lack of sense of self and control over one's life and decisions, and present orientation (Steinberg, 2011).

Several major categories were subsumed under the study results' over-arching theme that represents a composite of the sexual experiences, reproductive health needs, and developmental vulnerability of AAAFs. The categories were: (a) love, regrets and redoes: reflections of the first sexual experience; (b) virginity as a "special virtue" and a sexual contradiction; (c) lack of agency – "it just happened"; (d) leaving it to others to be "smart" about safe sex; (e) the contraceptive conundrum; and (f) influence of school based health centers (SBHCs) on reproductive health. According to DeSantis and Ugarriza (2000), themes are important in qualitative research because they "capture and unify the nature of the experience [into a] meaningful whole" (p. 356) to provide a better understanding of participants' experiences.

Love, Regrets, and Redo's: Reflections on the First Sexual Experience

Developmental vulnerability as it relates to the participants' first sexual experience was evident in the data. All but 3 participants reported they were not prepared mentally, physically, or emotionally for their first sexual intercourse, which often was unplanned. In this study, sexual experience or intercourse referred to vaginal intercourse. Eighteen of the 20 AAAFs reported their first sexual experience was not what they had imagined. Although 19 of 20 participants used condoms during the first sexual intercourse, it was their male partners who supplied the condoms.

Differences in cognitive development by age of the first sexual intercourse were noticeable among participants in this study. A majority of participants who had their first sexual intercourse at a younger age (13-16) reported that they had romanticized about and had a crush on their first male sexual partner, who was often 3 or more years older. Shortly after having the first sexual experience, and during the encounter for some of them, a majority of younger participants reported feelings of physical pain, remorse, and regrets for succumbing to peer pressure to have unplanned sex, particularly when they were not physically, psychologically, and emotionally ready. Their romantic notions of love and sex clashed harshly with the reality of their first sexual experience. A participant who was 14 years old at the time of her first sexual experience lied about her age to her male partner, who was several years older, because she was infatuated – "in love" – with him. In the quote below, she explained that romanticizing about love and relationships, but not necessarily in a sexual way, guided her decision to engage in her first sexual experience. This participant was not expecting to have sexual intercourse, but she did and she was disappointed.

> I was really young … a freshman. I was 14. And the guy was older. I had lied to him about my age and I was really like in love with him, but he knew I was young. He just didn't know like how young. Uh, I think he was like 20. He wasn't like – like 35 but like he was still really old. I was so in love. I really thought I was in love with him but I obviously wasn't. "But I just wanna be with you," and then he was like, "Well, you're still young. You gotta do this, this and this and we can't be in a relationship." I said, "But you can have the" – we had already had sex, so I was like, "you can have sex with me but you can't date me?" Like I didn't think, that doesn't make any sense [P5].

Another participant, who was also 14 years old at the time of her first sexual experience, imagined her first sexual intercourse would be similar to what occurs in romantic movies. Her first sexual experience, however, was different from her preconceived notions and expectations of lovemaking. Slapping her hands on her thighs and almost jumping from a seated position to emphasize her point about the disconnect between movies and reality regarding sex, she explained:

> It was terrible. I mean whoever's on the other side listening to this, do not have sex. It was terrible. It was so bad. Like it was like the, um, the first time it was terrible. It hurt so bad. Like, oh my god! Like this is not what it looks like on the movies! Like the movies make it seem like so superb and like, oh you have to do it. Oh my god. But it was terrible. Second time – even worse. I was just like, "What is going on?" (laughing) What is going on?" But, yeah, it was terrible the first few times [P13].

Thirteen years was the youngest age that a participant had her first sexual intercourse. After her mother and grandmother died within a short time of each other, this participant went to live with her father, with whom she did not have a close relationship. Prior to their current living situation, she had never lived with her father nor was he an active parent in her life. The death of her mother and grandmother was a major, unexpected life transition. As a young teen, at 13 years old, and living in a new environment, she welcomed with excitement the much-desired attention of an older boy living in the same neighborhood as her father. Eventually, she felt

pressured to have sex with him even though she was not ready for her first sexual experience. She emphatically regretted her first sexual experience. Her mother and grandmother had not given her the "sex talk" because they felt that she was too young, nor had her father spoken with her about romance, love, crushes, boys, or sex. She explained:

> Um, he was cute … a gentleman, sweet-talked me a lot … Say, everyday he'd see me, he would say, "Oh, you're beautiful..." I got all excited so I liked him more. The first time it [sex] was pressuring. I felt like I was pressured into it... I wasn't in a serious relationship with the boy who took my virginity. Um, it was more like, he begged for it pretty much and, you know, I just felt really pressured and then when it did happen, then I guess everybody knew about it so it was just like a terrible experience for me the first time. So yeah … it was more like, just go with it. No, I was not prepared for that first time. I regret doin' it [P12].

In the category *love, regrets and redos: reflections of the first sexual experience*, regret was the prevailing sentiment for all of the participants who had first sexual intercourse at a younger age. All of these young AAAFs wished they had postponed their initial sexual encounters. One of these participants said, "yeah, that was the worst experience of my life … I just think that, honestly, I was peer-pressured and I think like, you know, I was ready but then I wasn't" [P7]. Another young participant [P4] recalling her first sexual encounter described it as "horrible." Like the other young females, she too felt like she was not prepared yet, but she went along with her male partners sexual advances. "My first time was horrible, because like it wasn't the person that I wanted it to be…the end. It just wasn't, it wasn't how I thought it was gonna be…" [P4].

In contrast to participants who had their first sexual intercourse at younger ages (age 13-16), participants who were older (age 17-18) when they had their first sexual intercourse reported being more prepared and ready for the first sexual intercourse. This age difference in the decision to have the first sexual intercourse suggests that cognitive readiness for sexual

experiences may be related to developmental processes, which in turn may explain age differences in sexual readiness and preparedness. Participants who were older at the time of the first sexual intercourse reported being in a relationship longer with male partners, discussed safe sex practices with their male partners, and insisted that male partners wear a condom. In addition to condom use, 2 of the older AAAFs used other forms of birth control. Although the first sexual intercourse did not meet a majority of these participants' expectations, they seemed more in control of the situation and seemed to have responded differently to their experiences compared to participants who were younger when they first had sexual intercourse.

For example a participant who was 17 years old at the time of her first sexual intercourse had been friends for 2 years with her male sexual partner and had dated him for 4 months. She reported feeling comfortable around him. One night after a date, they returned to his mother's house where he attempted to initiate sex. Because she felt uncomfortable, she refused his sexual advances and went home. The next day, however, she felt comfortable and wanted to have sex. The quote below is a description of the events leading up to, and around her first sexual experience:

> It was not what I expected. At first like I was really uncomfortable and I told him to stop and then like the next day, I was like, “okay, I been knowing you for two years so why not.” I just felt bold and I just did it and then that was the only time. And like it started to hurt, so I just told him to stop and like he was “okay” and then, I was like “okay.” And then we just sat there and talked [P10].

Eighteen years was the oldest age that a participant had her first sexual intercourse. Unlike the younger participants, she prepared for the first sexual experience by talking with her older sister and insisting that her male sexual partner use a condom to minimize the risks of

pregnancy and sexually transmitted infections. A description of her experience is detailed in the following quote:

> I wasn't prepared because I didn't think like it was going to happen, but he was [prepared], because he lost his virginity way before me so it was just like, "Okay, I've talked to my big sister about it" – well my foster, my older foster sister and she was just like, "if you're not prepared and he is but he doesn't wanna use one [condom], make sure that you use one or you just say no." So I just like remember what all she told me for like if I'm about to have my first-time experience, what to do and how to do it, don't come off as like rude, just say it in a polite way. If it doesn't quite get through the first time, then that's when I actually have to push and be like, "no" [P8].

The AAAFs who were older at first sexual intercourse (17-18 years old), although not prepared for their first sexual experience, were able to verbalize their feelings and thoughts to their sexual partner, thus allowing them time to be better prepared.

Love, regrets and redos, reflected the thoughts of the first sexual intercourse and illustrated the difference in the developmental responses to participants' first sexual intercourse. For the younger participants in this study, their romantic notions were not consistent with their ideal reality. In addition to adolescents' cognitive development challenges, these teens are also learning how to socialize in male and female roles (Childs, White, Hataway, Moneyham, & Galoso, 2012). Similar to the findings in this study, Childs and colleagues (2012) conducted a research study that included AAAFs and romantic relationships. These researchers reported that the social development of younger adolescent females tends to seek "closeness in relationships" while adolescent males are socialized to avoid romantic moments and instead focus on the act of sexual intercourse (Childs et al., 2012 p.11).

Virginity as a "Special Virtue" and a Sexual Contradiction

The category *virginity as a special virtue and a sexual contradiction* represents the varied meanings, complexity, and contradictions of virginity among the study participants, regardless of whether they had engaged in sexual intercourse recently or were sexually active currently. For a few participants who had had sexual intercourse, they viewed losing one's virginity as whether they had been sexually satisfied, which was often reported as an unmet expectation by participants. If they were not sexually satisfied, some participants despite already having had sexual intercourse still considered themselves virgins. They similarly disregarded their second and subsequent sexual experiences that also did not meet their satisfaction threshold as their first sexual intercourse; they continued to view themselves as virgins. Below is a quote from a participant describing virginity as a sexual contradiction.

> [Sex] wasn't planned. I wasn't even for it, but he's like "I'll just put it in and take it out," and I was like, "okay." And then it [orgasm] didn't – it didn't happen. I was kinda mad but I mean it didn't really hurt. It didn't feel like I lost my virginity so I was like "okay well, you don't count" [P9].

A majority of participants, however, described virginity as a special virtue, although they believed that losing one's virginity during adolescence is a milestone similar to turning 16 or "Sweet 16," as some participants described it. One participant [P20] who had her first sexual intercourse on her 16th birthday, and was in what she described as "a caring relationship", described virginity as "something that people hold. It's like their – I'm not sure if that's the right word, but it's kinda like a part of their virtue" [P20].

A participant who was 14 years old when she had the first sexual experience gave a technical description of virginity. At the time of her first sexual intercourse, she was not close to her male partner but she conceded to his request to have sexual intercourse. She said: "Your

virginity is like before you have sex, when you're like – never had like a penis inside a vagina" [P9].

The additional quotes below are representative of the salient views of virginity by a majority of the study participants, who believed that virginity is something special and that relinquishing it should be reserved for when one is physically, psychologically, emotionally, and developmentally prepared:

> I don't know. Because some people, it's not important, some people it is important, and I can't just, I don't want to, I don't wanna just sit here and say, well it's important and – cause people wanna like do what they wanna do anyways. It is important – I feel like, it's special [P15].
>
> "I think … keep it until like you find someone that you really wanna like give your virginity to, but if you lose it before then, then no one's gonna hurt you for it or harm you for it" [P9].
>
> "Even now, to this day, I still wish that I could've like, could be a virgin. I like wish I was a virgin, I guess" [P5].
>
> I really did not wanna lose my virginity because that was my prize possession; but I was young and, well, a couple months ago, like not a couple months but a while ago, and I can say that I was so young, I just like, time to mature, so I just lived in the fast lane and I felt like I was in love, moving too fast and that's why I'm trying to keep it, um, trying to keep focus in this new relationship and not let that happen. After that, I just never wanted to do it until later on because that's something I could'a cherished until I was married and I didn't decide that [P16].

In this study all of the participants agreed that virginity is something special, however the definition of virginity varied. These findings were also similar to other studies in which adolescent females varied in their definition of virginity (Childs, et al., 2012; Haglund, 2003). These misconceptions of virginity are of concern to health care providers because these AAAFs are at the greatest risk for STIs.

Lack of Agency – "It Just Happened"

Within the context of the results of this study, I defined the category, *lack of agency – it just happened,* as a description of AAAFs' propensity to passively let things happen to them without making a conscious choice or having active involvement in their sexual decision-making. Almost all of the participants made the statement "it just happened" when asked about their sexual experiences, releasing responsibility and ownership from self, and shifting it to their sexual partner. A majority of participants, especially younger participants, were not on birth control, were not ready or prepared for the first sexual intercourse, relied on the male sexual partner to supply and use condoms, were unable to talk about safe sex with sexual partners, and were unable to negotiate a "no" response if she did not want to have sex with a partner. Unlike younger participants, older participants were more able to successfully postpone sex with partners until they were ready to have sex or negotiate condom use with the sexual partner. One older participant explained:

> He was like, "I don't want no kids right now … really just wanna be safe", and how – he told me how he went to like the doctor's and he decided to take the HIV test. He told me about that and I was like yeah, – we just talked about that stuff [P10].

A majority of participants were resigned to believe that sex was something that was going to happen, regardless, and it was better to "just get it over with." The following quotes from participants summarize this prevailing sentiment among this sample of AAAFs:

> I don't think I was ready for it [sex] but it happened and it was something I'm glad I kinda got over, like I just got it over with – so this happened, I was like okay, whatever. That's what that was? Okay – like wow …. We used a condom. Like we used protection so we were prepared but I wasn't like really expecting that. It wasn't planned, you know? [P11]

> Yeah. It just happened. It was like surprising! I didn't think he would like rush into that, you know, that he would like, okay, she wants to wait, so I understand but, it did lead to kissing and you know kissing leads to sex and so it just happened so fast that I couldn't remember but all I remember is a little pain [P18].

When participants were asked what factors prevented them from delaying their first sexual experience, many of them cited spontaneity and inability to refuse the request of the sexual partner, particularly if they had been dating and enjoying the relationship for an extended period. In the quote below, a participant explained how her feelings prevailed over her cognition of wanting to wait to have sex.

> Um, if you're kissing and you're feeling the love and you're feeling in the moment, sometimes, especially when you're sexually active, you get this tingly feeling in your heart and your stomach like oh my gosh, like your heart is saying like, "do it, do it, do it!" but your stomach's like, "no, don't do it!" but like, you always go for your heart, like you know it always tells you something and it just happens [P18].

Another participant also addressed this emotional, developmental, and hormonal vulnerability and confusion that often occurs during adolescence.

> I was not prepared, yeah. No. I don't think I was – I mean, who is at 15? Like no one's worried about like sex or – well now they are in this generation and in upcoming time they are worried about sex, but when I was 15 and in my mind, I wasn't worried about that. I was worried about going to school … worried about if I was gonna be late, you know, but I was not prepared [for sex]. I think I wasn't prepared mentally for the, the, the depth of the relationship after you have sex … like there's emotions released into that you just don't know how to explain so I, I don't think I was prepared for that emotionally or mentally [P11].

Many participants could not overcome the emotions and feelings they had, one participant explains below;

> Like when you're in the heat of the moment, just like you don't really like acknowledge like, oh, like let's get a condom. You know, you just do it, so that's really what happens. It's not like, oh, we're like avoiding it – it's just – yeah.

Many of them expressed that they should have delayed engaging in the first sexual experience by a year or two, imagining that the sexual experience would have been better.

> Um, probably time – more time. Like a year or two. That probably would have helped but the, I mean we're fine now but it probably would'a helped me, you know with myself, in understanding myself" [P11].

Lack of adult supervision was also a contributing factor for the initiation into these AAAFs first sexual experience. All of the participants reported being alone in a parent or guardian's home with the sexual partner at the time sex occurred. Activities prior to the sexual experience included watching movies or playing video games. "I was at his house. We were watching TV … just started kissing and then it led on from there" [P14].

> [Sighs] We were on my way to my grandmother's house and we were having a lotta fun watching movies and it just happened but … I didn't want it to happen but cause I always told myself I would never do that 'til marriage. I'm not gonna get caught up in it. And it's weird how I fell into what I was trying to avoid [P16].

> "Like I went over there. We were watching movies or whatever and then it just like happened. But he didn't even expect for it to happen" [P5].

> We went out to eat, somewhere to get something to eat and then I came over to his house and his mom, like they was all over and then they left to go to a party and then we was just there … so it just happened [P10].

Leaving it to Others to be "Smart" about Safe Sex

Three of 20 participants reported they were on a birth control method at the time of their first sexual intercourse; all 3 were older participants. All but 1 of the study participants' male partners used condoms for the first sexual intercourse. Participants' descriptions of safe sex as being protection from unwanted pregnancies and sexually transmitted infections were similar. The following quotes are representative of a majority of participants' perspectives on safe sex:

> Safe sex means going about things in the right way, using protection … protection from being pregnant if you feel you're not ready or from diseases that may be out there. You're basically being smart [P17].

> Make sure you use condoms; you use birth control and, if you can, stay abstinent. If you can. If you really feel like you're at that point, then at least be protected so you won't have to face a lifelong problem [P16].

Although not the prevailing perspective, a few participants believed that only abstinence guarantees safe sex. One participant said:

> Safe sex really means don't have sex at all. Because there's no – there's nothing really you – if you don't have sex, that's the safest thing ever. But if you are having sex, all I can say is use a condom and make sure … the girl has some type of birth control, talk about it before like, you know, if that's what you really want and if y'all can't get to a mutual understanding then you're dumb to be having sex [P7].

Although participants were cognitively aware and verbalized the importance of having safe sex, they often deferred implementation of safe sex practices to their sexual partners.

> I mean I guess we don't really talk about like safe sex cause we don't really use protection but, cause I'm on birth control but, I mean, we – we should still use protection. You should do that regardless but, I don't know, I don't know [P11].

As mentioned previously, older participants negotiated safe sex practices better than younger participants did. One of the older participants explained,

> I tell him everything I need – like he knows everything we need to do to make sure we're safe when we do decide to start, um, engaging in sexual activity. I tell him to make sure when we do feel like that, we need condoms ready. I need to already have been on birth control for a few months just so we know, just to be sure and make sure we have a plan just in case like I were to get pregnant or something, we have something ahead of us so we won't be stuck [P16].

For some participants, "trust" was a form of safe sex as it relates to sexually transmitted infections. For many participants, condom use was essential for the first sexual intercourse; over time, however, if they trusted the sexual partner and both of them viewed their relationship as

exclusive, condom use ceased regardless of whether another form of birth control was used to prevent pregnancy. The following quote from a participant who reported she has never tested positive for a sexually transmitted infection illustrates this perspective: “I don't use condoms but I guess my protection is trust because, um, I trust my partner” [P11]. Other researchers found that adolescent females trusting their male partners put them at increased risk for STIs, including HIV. This is because their male partners did not necessarily share the same commitment and definition of the concept of trust (Brawner, Gomes, Jemmott, Deatrick, & Coleman, 2012; Towner, Dolcini, & Harper, 2015).

When participants were asked about how they learned about safe sex, some of them reported they had sex education classes at school; others learned from older sisters or sexually active peers. Many participants reported safe sex was not a topic that was frequently talked about at home. Some participants “felt funny” talking about sex with their mothers; others reported their mothers did not want to discuss sex with them for fear it would encourage them to become sexually active. A participant explained:

> My mom never told me about it ‘cause she wants me to stay a virgin until I die. Um, my auntie kinda told me about it. She was like when you do have sex, just make sure you use protection [P9].

According to the literature, family communication, and in particular conversations with mothers, are the primary sources of sexual information (DiClemente, Wingood, Crosby, Cobb, Harrington, & Davies, 2001; Kapungu et al., 2010). Other researchers have also reported that in addition to parental guidance, other sources of sexual education, which can influence sexual risk, come from peers, and schools and school-based health centers. The following quotes represent participants' exposure to sex education and decision-making related to safe sex:

> We took sex ed. in 7th grade because I guess some people were having sex so they taught us about it and like how babies are born and what you should do during sex and so I just learned a whole lesson about it in school [P9].
>
> The little clinics will come to our school and like, you know, talk about birth control and then mom was trying to get me on it and I'm like no. But then, like, as I got older, well if I'm gonna be, you know, sexually active, I need to make sure … just in case, even though we are using condoms, make sure that I take care of myself so I kinda just really thought about it and just took it upon myself to take it [P7].

The Contraceptive Conundrum

The contraception conundrum describes the pathway leading to reproductive health and birth control that these AAAFs took after their first sexual experience. In their reflections on their first sexual intercourse, none of these females were prepared for intercourse and, with the exception of 3(out of 11) older females, most were not on a birth control method. Although the majority of these AAAFs stated that they regretted their first sexual intercourse, all of them did remain sexually active. At some point during this time period from their first initial sexual intercourse to present, these females realized that they were going to continue to have intercourse and that they needed to be protected from early pregnancy and STIs. The exact moment and cause for this realization is not entirely clear, and varied between participants. In this study AAAFs' peers were not very influential in this important decision; many of the AAAFs appeared to make their own decisions, though for some there was a strong maternal push towards birth control. Interestingly, many of those mothers who did insist that their daughter go on birth control had themselves become pregnant during their teenage years. Other similarly situated mothers, however, avoided having this discussion with their daughters fearing it would encourage their daughters to engage in sex.

When these participants were asked “what made you decide to go on birth control?” Their answers varied tremendously. One young female was 14 years old when she had her first sexual intercourse and, although her partner had used condoms, this use proved to be inconsistent; as a result she became pregnant at 14 years old. However, unlike her mother who also was pregnant with her at age 14, she was not allowed to keep the baby because her father had custody of her, and she did not tell her mother that she was pregnant, mainly because she was afraid to disappoint her. This same participant reports that she was 15 years old when she first started oral contraceptive pills (OCPs). This was one of the options she was given after her abortion. She stated that she went on the pill for the following reasons:

> ‘Cause I don’t wanna be pregnant yet. I am too young to have kids…Uh cause I’m—I want kids but right now I prob’ly can wait ‘til I’m like 17, 18 to have a kid. I don’t want to go through nine months of labor. I been seein’ pregnant people a lot and they look like it hurts. Say they havin’ cramps and yeah, it just looks like it hurts [P21].

This participant had lived with her mother and grandmother most of her life until she was 14 years old, when her father obtained legal custody of her. She was not happy to go to live with someone that she never knew while growing up, but she had no choice. She states that her mother and grandmother always reinforced that she should always stay on the “right path” and not get pregnant at an early age, like her mother did. Although this young female was good at reiterating her mother’s and grandmother’s wishes, she did not seem to really digest the message that they were trying to get across. When she was asked about how she was doing with the OCP, she stated, “okay, I just like lose count…like I lose track of ‘em.” She was not interested in the other methods of birth control, such as the shot, implant ring, patch, or IUD, “’cause I don’t want nothing going inside of me.” When asked if she had the safe sex talk with her mother or anyone in her family, she answered no. However, when she did become pregnant, she was able to

confide in her 19 year-old sister who also recently had an abortion. Both girls recently moved in with their father. And it was her older sister who took her to Planned Parenthood to confirm her pregnancy, and to provide her with reassurance and support when she had her abortion.

Similarly, another participant in this study also had her first sexual experience with her male partner providing and using condoms. Unlike the first participant, however, this female was older at 16 years old and had the sex talk (safe sex practices) with her mother prior to her having intercourse. She was not on any birth control, although her male partner did provide and use condoms. This participant reports that although she knew that safe sex meant, “not getting pregnant—like at all” it took her several months to go on birth control after she had a pregnancy scare. She stated:

> After I lost my virginity and after like five months, six months came around and I was like okay, we stopped using the condoms and then like I came to the clinic one my mom got me on birth control but birth control didn't make me feel right – like it made me feel sick so I stopped taking birth control and I tried the NuvaRing and the NuvaRing made me feel sick so they put the [implant] in my arm and that made – it has no effect to me, so that's what we use [P1].

For this AAAF, her mother played a supportive role in her decision to use birth control, and to try various methods until she found one that worked for her. Mothers who had conversations with their daughters regarding safe sex and not getting pregnant also seemed to provide strong advocacy for their daughter’s birth control acceptance.

Another female who was older had a very different conversation with her mother regarding birth control and safe sex practices, eventually taking control of her own contraceptive decisions. As a result of her having a boyfriend, her mother initiated her on birth control, prior to her first sexual experience. She states that as soon as she had a boyfriend her mother took her to get on the pill:

> Um, I did – well my mom wanted me on birth control originally cause I had a boyfriend. She's like, you gotta get on birth control. But she put me on the pill and she wanted me to go back on the pill and I didn't. So I decided that I wanted to go on the IUD because I was – I thought it was more responsible for me and I knew I wasn't gonna be able to take the pills every day at the same time so that's what I did. That's what I chose [P11].

Mother–daughter conversations regarding birth control provided to some degree a protective factor for the AAAFs to be more persistent in seeking out a birth control method, and being more persistent in finding a birth control method that works for her. Not all of the females, however, were able to talk with a parent about birth control or safe sex. After the AAAFs in this study lost their virginity, they made their decision to continue to be sexually active and to seek birth control methods. One participant states:

> Like after I lost my virginity, the first thing I knew – like I'm gonna get on birth control even though I did it once, it was like I know I have to do this for myself. And I haven't really talked to her [my mother] lately about it. I just been talkin' to her about my senior year and what I wanna do when I go to college. I haven't really brought up that yet. But that's mainly what we talk about and my goals …

Another young female reported that she does not talk much with either of her parents. She lives with her father and he works nights and goes to school during the day. She reports that everybody has their own life and no time for her, so she has her own life and no time for them. She is independent and when she was asked how she made the decision to use birth control after her first sexual experience, she explained:

> It's not big decisions. It's life. It's realistic stuff that could happen. If you're gonna be having sex with somebody, you can get pregnant. Hello. Like that's what you're a woman for. You're meant to made babies – make babies so it's like you know the consequences of your actions. So if I know I'm gonna be havin' sex, I don't wanna slip up and get pregnant. So I'm gonna get on birth control, I'd rather talk to her and tell her [my mom] – I'd rather tell her that I have birth control than to have a baby on the way, so. And a baby's like $80,000 to take care of now! Like who has that money? Like I still gotta buy Uggs and North Face and get my hair done every two weeks so, no. I don't have time for that [P13].

The majority of these young females were determined not to get pregnant. Most of them started on birth control after they had their first unplanned intercourse. For AAAFs who were unable to discuss safe sex or losing their virginity with their mothers, some turned to extended family and peers; the majority of these young females used the services of the SBHCs to provide them with access to free comprehensive health and reproductive care.

Influence of School-based Health Centers on Reproductive Health

The SBHC was a place participants frequented, mainly because they were, or wanted to become, sexually active. The SBHC, which was the setting for this study's participant recruitment and data collection, was located on the school campus. The SBHC provided health education, primary health care, including dental, trauma-informed care, sex education, and a confidential environment that addressed the needs of adolescents. Services were provided on either a scheduled or walk-in basis. Students could come in between classes so that class attendance would not be affected. The SBHC was adolescent friendly. When an adolescent forgot or was late for an appointment, which was typical, the SBHC would accommodate them.

All of the participants in this study used the SBHC for their reproductive health needs, including birth control, STI testing, and other health services. Convenience, confidentiality, sexual health information, physical, mental, and reproductive health, and no fees were the primary reasons participants sought services at the SBHC. In addition, all of the participants reported they liked the SBHC's staff and they believed that the staff and health care providers were interested in them personally and as a group of AAAFs. Participants reported feeling safe and confident to discuss anything of concern with the SBHC's staff, who they described as non-judgmental. In the quotes below, participants explained their reasons for seeking services at the

SBHC. “I love it. And it's free. I think it's awesome” [P9]. “It's actually closer and my doctor's like all the way in Berkeley. So, yeah. It's just more convenient for me” [P7].

> “I look for, uh, STDs, stuff about STDs and how to prevent it and how to help it if you do catch one. And I come here for physicals and just to have someone to talk to sometimes” [P4].
>
> I feel good because there's a center full of people – adults that actually care about children. They're willing to like listen to like whatever's going on and help you out because the majority of the teachers, like, they just go – “Oh, okay.” It'll be like, “Take your seat and all.” I'm like, “Dude, you're not even listening, you're not even understanding what I'm talking about” … I feel like you guys [the School-based Health Center staff] have a lot to offer when it comes to us being teens and needing someone there to actually listen to what's going on with us. And like actually being our supporters if your parents aren't or if we can't go to them [P8].
>
> I feel like they play a huge role because when it comes to us as teenagers being you, we make careless decisions that put us in sometimes situations where we never thought we would be in. So I feel they play a huge role with that and they help us realize that sometimes being protected and like knowing about our self and what our body is going through, it can bring us a long way [P16].

Other participants expressed that they feel more independence, confidentiality, and comfortable using the school-based health center instead of relying on parents/guardians.

> One, I didn't want my mom to know. And two, like it was easier. And it's not just that – like, um, I was going to come here for my physical but I'd actually got an appointment earlier at my doctor's but it's easier access. It's way easier than waiting for an appointment to get a physical when I need a physical cause physicals only last here for the season of the sport so we have to get a whole new one and, yeah, so it's just easier access [P4].
>
> I feel like it's efficient and it's easier. I don't really have to go through my mom to get health, um, what is it? Well, I don't have to go to my mom to go to a health physician. Like I can do this on my own … I feel it's helping me with my independence, you know, if I need to take care of myself, I'm gonna go do it myself, you know, cause I'm in charge of me and no one else is, so that's one of the reasons why I come here [P11].

In this study the SBHC provided confidential, convenient, and no fee for service to young

adolescents. The SBHC is a place where adolescents can be independent, often learning to make responsible decisions, acquire health knowledge, and learn how to be safe with all aspects of their health.

> I come here because I'm on birth control and I really – when I started birth control after I lost my virginity, I felt like it was a good thing. I felt like I'm a young lady, I don't wanna have any kids and even though I didn't want to, it was like a big step up for me cause I know I'm safe and I know it won't save me from STDs but to still use protection and stuff. It's like, it just taught me like I can come here when I need someone to talk to.

Summary

The overarching theme for chapter IV, *Intersection of reproductive health, sexual behavior and developmental vulnerability,* encompasses and unites the major categories of findings of this chapter: (a) love, regrets, and redo's: reflections of the first sexual experience, (b) virginity is a "special virtue" and a sexual contradiction, (c) lack of agency—"it just happened," (d) leaving it to others to be "smart" about safe sex, (e) the contraceptive conundrum, and (f) influence of school-based health centers on reproductive health. These AAAFs were set (located) at a place of a widening intersection of reproductive health disparities. These disparities include higher rates of sexually transmitted infections such as chlamydia and HIV, in addition to increased rates of unintended pregnancies (Aronowitz et al., 2007; Coley & Aronson, 2013; Guo et al., 2010; St. Lawrence, 1993).

Developmental vulnerability is an important characteristic of adolescence during which the adolescent is undergoing a developmental phase of transitioning from child to adult. This transitional period is significant because the adolescent is undergoing brain development including behavioral, emotional, and cognitive changes, in addition to the initiation of puberty which signals the development of the reproductive system and primary and secondary sexual

characteristics (Pinyerd & Zipf, 2005). All of these changes during adolescence contribute to the adolescent's developmental vulnerability.

The consequences of the interplay of developmental vulnerability, sexual behavior, and reproductive health are evident when examining the decisions made by the study's participants, and how those decisions varied according to their age and corresponding maturity level. For example, none of the adolescent females interviewed stated that they were prepared for their first sexual experience. Younger adolescents stated that they were not prepared physically, emotionally, or cognitively. All but three of the adolescent females had not been prescribed birth control methods and reported they relied on their male partners to provide condoms and to initiate their use. One young female [P11], age 15 when she was faced with her first "unexpected" sexual situation, reported not using any barrier protection, nor other birth control method since it [sex] was already happening. Neither she nor her male partner was prepared for the potential consequences of sexually transmitted infection, or unintended pregnancy. This participant [P11] stated that she used "trust" as a form of protection. She trusted that her male partner did not have any STIs, and trusted that he would be there for other potential consequences, such as pregnancy, that might arise from the sexual encounter.

The older participants demonstrated increased maturity in their actions; for example, 3 of 11 were on birth control prior to their first sexual encounter and others had also insisted that their male partners use condoms at the time of their first sexual experience. And although these females also stated that they had not specifically planned their first sexual encounter, prior to that experience more reported having had conversations with their male partners about safe sex, which allowed them time to decide and use additional birth control methods during that first

encounter.

Overall, the lack of preparation, and the level of emotional response to their first sexual intercourse, were related to the age of the participants and demonstrated the vulnerability of all adolescents, but particularly those who are very young.

Although the majority of these females stated that they regretted their first sexual experience they all also continued to have intercourse and subsequently made the decision to start birth control. Chapter IV highlights the sexual choices and outcomes of AAAFs who seek reproductive health care services at SBHCs. These adolescent females are at a vulnerable stage in the life span where they are still developing cognitive skills and learning how to make decisions independent of their parents.

CHAPTER V

RESULTS

Social Contexts That Contribute to African American Adolescent Females' Reproductive Health Disparities

In this chapter, the results of the second overarching theme, *social contexts that contribute to AAAFs' reproductive health disparities,* are discussed. This theme is defined as the contextual aspects that may influence AAAFs' sexual decision-making. According to the literature "adolescent sexual development unfolds in a context that includes the family and the community in which the young person lives and interacts, and development is shaped by the meaning that youth make of their experiences" (Choby et al., 2012, p.1). Family dynamics therefore are an important and relevant aspect of sexual development, as are community norms, and neighborhood safety. Early sexual intercourse for example, has been linked to residing in unsafe neighborhoods (Choby et al., 2012). All 20 of the AAAFs who participated in this study were sexually active and lived in lower socioeconomic neighborhoods; the majority of them were raised in a single-parent household and often with extended family. Following iterative coding of the data, the following major categories comprised the overarching theme for this chapter: (a) family and peer modeling for pregnancy and parenting; (b) adverse contexts for living; and (c) resilience.

The first category, *family and peer modeling for pregnancy and parenting*, denotes modeling by parents, other family members, and peers that may contribute to AAAFs' sexual decision-making. For AAAFs in this study, a role model was someone who set an example of how to live and behave as a mature individual, adult, or parent. The second category, *adverse contexts for living*, refers to AAAFs' exposure to various forms of violence, discrimination, and

poverty, and how these exposures impacted their life choices. The third category, *resilience*, refers to AAAFs' positive outlooks on life, despite their adverse experiences.

Many of the participants (13/20) lived in single parent or guardian homes headed by a matriarchal figure – a great grandmother, grandmother, mother, foster mother, or an aunt. One participant lived with her biological mother, father, and younger sister; three lived with their mothers and stepfathers; and three others lived with their biological fathers.

Family and Peer Modeling for Pregnancy and Parenting Mothers as Role Models

The influence of parental connectedness or closeness during adolescence has been documented in established literature (Markham et al., 2003). In the current study the role models are highly revered persons who on some level, share their beliefs, values and model a behavior that is often emulated by the youth (Bryant, & Zimmerman, 2003). Although there was a sense of mother-child closeness among participants when they were younger, every participant reported having mixed emotions about the relationship with their mothers that included apathy, love, respect, admiration, and a deep understanding of their mothers wanting something better for their children. Here is an example of a participant who has a strained relationship with her birth mother. This participant chose to continue to live with her grandmother, although her birth mother decided to move over 40 miles away:

> I see her [my mom] almost [everyday], well, I don't really see her as much, but I talk to her every day. So, we talk about stuff and our relationship wasn't as good but, it got better and we're more understanding. Like, you know, yeah. At the end of the day, I know she's my mom before my friend [P 7].

Advice given by the young mothers of the participants sometimes seemed to contradict their own actions, creating conflict in the AAAFs' mother-daughter relationship. For example, while these young adolescents' mothers admonished some of the study participants "not to come

home pregnant," many were young mothers themselves. For example, 13/20 of the participant's mothers had children when they were 18 years or younger, with the youngest (4 mothers) giving birth when they were 14 or 15 years old.

Many of these young mothers of the participants lived with and were still being cared for by their own mothers (the participants' grandmothers), who also played a significant role in helping to raise both the participants and their mothers. These participants received varying degrees of positive advice from their mothers: to do better with their lives, to do the right thing, and to stay on the right path. Every participant reported that, no matter what the relationship with her mother, the mother wanted her to achieve higher goals without the struggles of being a young, single mother. However, even among participants who were very close with their mothers, the majority of these young females did not want to talk about sex or losing their virginity with their mother. A participant explained:

> My relationship with my mom, it's good. Like I thought – well, I didn't tell her that I lost my virginity cause I'm scared cause I know – she was pregnant with me when she was 19 or 18. And I know that she did not finish high school but she got her GED when she came to California … so I know that she does not want to hear that right now [P10].

There were two participants in this study who were previously pregnant. Each had an abortion. Age 14 was the youngest age when a participant was pregnant. This participant was less mature cognitively than were other participants. She had an abortion about one month prior to the interview. She reported that her mother was pregnant with her at age 14 – the same age that the participant became pregnant. Although she reported a good relationship with her mother, she chose not to confide in her mother when she was pregnant because she did not want

to disappoint her mother by repeating the cycle of pregnancy and its associated consequences as an unwed teenager. She explained:

> I can't tell my mom. My mom doesn't know what's going on. She'd be mad. 'Cause my mom had me when she was 14. Yeah. And I'm 15 so she don't want me like going down the wrong path that she went through, when she was 14 and she had me. I'm trying to be on the right path and wait to have a baby [P21].

Although this participant verbalized an understanding of what her mother was trying to teach her, the real impact of being an unwed teenage mother did not resonate with her. She said, "I really wanted to have that baby, 'cause I really like kids and I know how to take care of a baby…cause I take care of my godson and he's one now, so yeah I know how to do that," but her older sister took her to get an abortion. Neither her father, with whom she lived, nor boyfriend wanted her to have the baby. She was initially disappointed that she couldn't keep the baby, citing that her mom got to keep her, but her boyfriend was not ready to be a father and told her so. During the interview, the participant became very emotional; she paused, looked down, twisted her bubble gum wrapper and in a very soft voice (almost a whisper), stated "I am too young to have kids … I want kids but not right now, I probably can wait 'til I'm like 17, 18 to have a kid." For this young participant, she truly did not understand the consequences of being a teen mother.

Unlike the previous participant who was pregnant at 14 years, an older participant who was pregnant at 16 years had a different response to the consequences of being a young teen parent; she heeded her mother's advice. The quote below by this older participant represents the views of most participants to postpone having a baby until well after they graduate from high school.

> My mom told me that I couldn't keep it. She was like, you can't keep it, you can't afford it, you can't keep it. It's not gonna help you. You're too young, you know. She told me that young moms can't prosper and she just wanted me to have like a normal teenage life without the drama of a child and a baby daddy and all that stuff; and my boyfriend left it up to me. He was like, you choose what you wanna do 'cause it's your body. So like I, I had two supportive people in my life. You know, my mom's older than me. She knows more than me. She knows what's better for me. I was only 16, you know … A child is not something I'm willing to take on – not even now if I turned 18, I probably wouldn't have a kid. Um, probably if I was even 20, I wouldn't so I, I have no intentions of having any at all – well now, you know. Maybe later. Really later [P11].

As demonstrated in the quotes above, participants who were pregnant responded differently to pregnancy based on their age and cognitive understanding of the responsibilities that come with being a teen parent. Many participants' mothers were young mothers (13/20) and a majority of participants heeded their mothers' advice about being a teen parent, regardless of whether the relationship with the mother was close or distant. The quote below is from a participant who had a distant relationship with her mother, but she respected her mother's opinions and advice.

> Yeah we don't have a really close relationship but that's my mom, I respect her and everything … like I text her every day … like mom, what's up, blah, blah, blah cause I'll stay with my dad and like I jump back and forth [P13].

When asked about role models, every participant discussed the presence or absence of her mother in her life. One 18-year-old participant reported she was living with her maternal grandmother, with whom she had a close relationship, because the relationship with her mother was strained. The participant's mother was pregnant with her at age 17 and her father has never been a part of her life. Despite having a strained relationship with her mother, the participant respected her mother who struggled and made sacrifices for her sister and her. She explained:

> My role model I think would be my mom. I never said this but, I think it would be my mom because like she took care of two kids when she was young. My

> mom was real young so she was able to take care of us with no help and stuff and like she finished high school, you know, she works in, she's a nurse and stuff so I think she's a very strong woman and I respect her for that [P7].

Another participant lived with her foster mother and was placed in foster care after her father was shot in front of their house when she was six-years old. Her birth mother had 6 children with her father, all of whom were raised in foster care. The participant expressed strong admiration for her foster mother:

> My role model is my foster mom. Because she's very strong and independent. I've seen her go through so many things and like still stand and go to work. She won't break down in front of me, but when she's in her room, I can hear her stressed out and crying because certain things that she has [to] hold on her shoulders [P8].

One participant's closest relationship was with her great grandmother, who died when she was 12 years old. As a child, this participant was nurtured and cared for by her great grandmother and the great grandmother raised her and her mother like they were sisters. After her great grandmother died, she lived with her mother. Initially, living with her birth mother was difficult. She said:

> I don't have a role model really. I mean my biggest role model to really like not lie or anything like, is my mom because she does do a lot even though I am mean to her and I sometimes act like I don't care and I just do it cause, I don't know, sometimes I just feel like, well, she's been mean to me maybe sometimes she deserves to be mean too but I do it at the wrong times. Like I swear I do. And sometimes she just misunderstands me and I don't try to be mean. But she puts up with me and, and she just make me feel like if – she was pregnant with me and she could get good grades, then I feel like I can get good grades and do what I'm supposed to do cause I have nothing to worry about and she had a lot to worry about. She had to take care of me and everything else. I mean when I first thought about it like, not – as I was growing up I just felt like well you can't be mad at me ‘cause I get bad grades. Like you always had help. Like somebody was always helping you, taking care of you. But I failed to realize that I'm the reason why people were helping her, taking care of her. It's 'cause I was there [P15].

This young participant (age 15) was still making adjustments while living with her mother. She subsequently came to understand why her mother needed a lot of support.

Extended Family as Role Models

For several decades, with the changing demographic and socioeconomic status, for many African Americans and other ethnic minority families living in the U.S. the nuclear family have not been the "statistical norm" (Grossman, Tracy, Richer, & Erkut, 2015). Instead, adolescents have often relied on non-traditional communities and family networks, including *Fictive Kin*, *Kin Folks*, and *Extended Family*, to fill in the gaps of socialization, and support. Fictive Kin includes non-blood relatives (non consanguinal), or non- family related through marriage (affinal) (Grossman et al., 2015). Kin Folks are therefore related through bloodline or through marriage. Extended family is the combination of both historic terms, and includes binding together family networks to help support and rear children and adolescents (Grossman et al., 2015).

In this study extended family members were central to participants' lives and provided influential, positive social support for these young AAAFs. Having at least one adult role model within a family was reported as having a profound effect on the overall wellbeing of urban African American youth (Bryant & Zimmerman, 2003). An integral part of the socialization of adolescents lays in the relationships they have within their extended families. These relationships are particularly important for urban African American adolescents (Bryant, & Zimmerman, 2003). Researchers have found that role models during adolescence foster identity development and resilience (Bryant & Zimmerman, 2003). Role models can include multiple relationships with extended family members. Here is an example from one study participant:

> My role model – I would have to say, I have actually – I would have to say my god-mommy is my role model, because she reminds me a little bit of my granny. She's just so

> spiritual and stuff and also, my granny and my sister. [Because] my god-mommy is that type of person to, even though she's going through a lot and she feels like she probably hit rock bottom, she always, she always like, uh, she doesn't show it. She makes everybody – she puts everybody before herself. And sometimes that's not a good thing but when she knows somebody really needs her, she's always there to be there for them and she just stays strong and she gets through it all. My sister, she, she's similar and she has a daughter and, you know, it's not really easy because she had a daughter pretty young and she really didn't get a chance to but she's pickin' up her life, you know. She's getting her a job and havin' a place to live with her daughter and she just – being a good mother for her daughter. And, uh, my granny because how she was able to keep the family all as one even though there was probably huge arguments, she would just be the one to bring them back together [P20].

This participant's role models encompassed faith, strength, endurance, persistence, and a sense of family. Positive role models, even extended family role models, can also help these young adolescent females to de-stress and to continue to persevere in the face of adverse conditions. Immediate and extended family members often played an important role for these young AAAFs. In addition to her mother, another participant described the close bonds that she had with her grandmother, whom she viewed also as a role model. In this study the most revered figures were all related to the maternal parent.

> My mama is my role model because I can look up to her and she motivates me to do the right thing. Same thing with my granny. Like they want me to be on the right path and not be on the wrong path. They want me to get an education and not to be on the streets … so they're my motivation [P21].

For this young female the "right thing" and "the right path" are similar – not to have a baby at 14 or 15 years old like her mother, because of the challenges and difficulties that her mother faced. For this participant "the right path" was defined as staying focused to get good grades and complete high school, not get pregnant, and follow in her mothers' path. She states that she is motivated to do better than her mother, because that is what both her mother and grandmother want for her and this is reiterated to her frequently.

Other significant role models are often found in the immediate family. Participants identified aunts as role models, too. Even though one participant did not have a great relationship with her mother, she considered her maternal aunt, with whom she lived, and her mother as role models. For this adolescent her aunt served the role of surrogate mother, mainly because the participant and her biological mother had a strained relationship. This participant explains:

> [My role model], I would say my auntie and my mother. My mother – why? Because she is not only like not in my life like that, but she's teaching me to be a better mother than she was. To be there for her child every time she need it. And my auntie, she's just on top of things. She doesn't drink, smoke, anything. She's a role model for me because she's showing me how to campaign, loyal work and different all types of work even though sometimes I don't wanna do it but I know it's important to learn so she teaches me a lot of things [P18].

All of the participants acknowledged struggles and triumphs of the women they identified as making an impression in their lives. The godmothers, grandmothers, and aunts all have contributed to co-parenting, nurturing, and advising these young females. These extended family members have been known to provide traditional and significant roles in socialization for African American youth (Bryant & Zimmerman, 2003). African American and other American families, who have faced economic, social, and housing adversity, have relied historically on extended families to provide additional support to their children. Extended families are diverse and flexible during economically challenging times and also provide housing support and protection for children during marital or employment instability. Extended families are a way to pool resources and a way to keep families together. (Bryant & Zimmerman, 2003; Brown, Cohon, & Wheeler, 2002).

Grandmothers as Role Models with Special Bonds

Of all of the extended family members with significant positive impacts on the participants in this study, grandmothers stood out. The most special bond for participants were with their maternal grandmothers and, in one case, a maternal great grandmother. Grandmothers were often the most stable, reliable, and positive figures in the participants' lives. These matriarchal figures were strong, fierce, and loving, and they seemed to have left an indelible positive mark on the participants. Many participants, particularly those with young mothers, spent their primary years with maternal grandmothers and these matriarchal figures often provided a role of surrogate parenting. A participant explained:

> My great-grandmother—my mom's grandmother. She took care of me; it made me feel like she was the mom and like me and my mom were sisters. Like that's how I feel. Once she passed away, it felt like reality kicked in. Like this is my mom, I gotta' listen to her. Can't run to nobody and be like hey I don't like this. Can you tell her not to do this? Can't do that anymore. I guess that was like a difficult thing for me transitioning in here 'cause it was really difficult. It still is difficult. Like I have no one to run to [P15].

Another participant spoke fondly of her deceased grandmother and the strength and importance of their bond and how she made her feel.

> My grandmother was like my mom. That was like the mommy you want to have. Always there. She'll cuss you out all up and down the street but that's the mom you always have. At the end of the day it's like shut up grandma. Like why you yelling like? It was funny … She was awesome … really sweet. She'll cuss you out and do a hecka' stuff and then still be like you hungry? What you wanna' eat? Like … (laughing). So, I mean, she was awesome. She was really nice. She, um, what was she? She was always caring, always even if she didn't like you, even if you did get into an argument with her, she would still offer you a place to stay if you didn't have a place to stay. She's from the South so she's very – what is that word – hospitality? [P13]

The quotes provided are representative descriptions of participants' affection for and bond with their grandmothers. Many participants described their grandmothers as being nurturing,

caring, and someone who enforced a sense of family cohesiveness. In this study, many participants had at some point in their life lived with their grandmothers. Here is one of several examples:

> I used to live with my grandmother. I call her Granny but, uh, before she died, she was honestly like everything I could ever ask for. She raised all of me and my cousins and my sisters like in one little household and she was just the best. She also took all of her grandchildren in and just raised us all and had us really connect with each other because we are family. She made sure that we were all together. She was just amazing. Everybody loved her [P20].

These participants' grandmothers provided them with a sense of family cohesiveness that it seemed like only their grandmothers could, giving them much-needed consistency and stability in their young lives. For African Americans, extended families have always played an important role. That is because of the flexibility and adaptability in the extended family unit that has been able to provide family support through difficult times (Brown, Cohon, & Wheeler, 2002).

Fathers as Role Models

There were only 4/20 participants who described their father-daughter relationship as stable and loving. For these four young females who had the opportunity to spend quality time with their fathers, they also were able to benefit from their paternal advice and male perspective.

> Well, [my father] actually I feel like the biggest lesson he always taught me that I was really hold onto is, is that he taught me that some guys just like – it's kinda weird, it's a weird saying like when it comes to relationships and stuff, he says some guys don't look for a relationship and they just wanna kinda hit it and quit it. And then he was all like, you should be aware because guys do think about "why buy the cow when you could just get the milk for free." And he was just like, "so you don't give out any milk …" [P20].

The remaining 16 participants, however, described the father-daughter relationship as non-existent, noncommittal, and often awkward. The African American fathers in this study have not all met the needs of the remaining 16 participants. For these young females, at various times in

their young lives they had reached out to their fathers, but their specific and basic needs were not fulfilled. As a result these AAAFs chose to distance themselves from the disappointments, and unfulfilled needs, experienced from their paternal relationships. As one study participant stated:

> My biological father … he's like in and out of my life basically… so I don't really try to … I don't know how to explain it but like I don't go out of my way even to try and get my biological father's attention because, um, he hasn't been there for so long [P17].
>
> Me and his [my father's] relationship is really weird. Um, we never had that close connection like I really love him, but I don't like him. We are cordial to the point where we could live together, ya know? And, um, let's say when I was younger, when I moved with my dad, pretty much he just been living off women. So everywhere he went, I went. So, when he moved and broke up with that one [woman], I have to leave with him. Basically I been moving from female to female getting used to new personalities and stuff. So me and him never had that, ya know, father/daughter connection. We just like, um, ya know, short conversations. It was always awkward around him [P12].

For this young participant, her relationship with her father began immediately after the death of her maternal grandmother. She states that her mother and her maternal grandmother initially raised her until her mother's death when, she was 7 years old. She then continued to live with her grandmother, and at 12 years old her grandmother died from lung cancer, and she was immediately sent to live with her biological father, whom she never knew growing up. This transition was difficult and painful for her; she remembered that her mother's last request to her own family was to not have her child live with her father since he never participated in her life. That request, however, was not honored.

Her father had never raised or cared for any children prior to her moving in with him, and he was frequently living between his mother's house or with his latest girlfriend. This environment was difficult for this young participant to adapt to, because of the

instability. She was also often left alone. She was the youngest of the participants to engage in sexual intercourse, at age 13.

Another participant tried to reach out to her birth father, only to be disappointed. She felt that her father did not care enough for her, he was not there for financial support, or conversation, and when he did not console her when she was injured in the hospital, she resolved to create emotional distance from him. She stated:

> My father doesn't want to be a part of my life. He tries to interact with me but it's not all there. He just, he doesn't know how to take care of a child. He has two so it makes no sense but he doesn't buy anything for me. He's never there, never calls me to see if I'm okay. I told you I got hit by a car. He didn't even call. Uh, the next day he's just like, oh, well maybe you should be much safer next time. I'm like, so you're not gonna ask if I'm okay? So, after that, that's when our relationship – I just didn't talk to him ever again [P16].

The absence of fathers in the lives of these young AAAFs can be emotionally shattering, and many who had strained relationships with their fathers decided to emotionally detach themselves from the disappointment that their fathers brought.

Peers as Role Models

Peers are important during adolescence, primarily because of the amount of time adolescents spend with each other as compared with the amount of time they spend with their parents (Steinberg, 2011). This was true for participants in this study, who viewed relationships with friends as comfortable and important to them as was their positive maternal influences. “I don't feel comfortable telling my parents or family everything.” The quotes below are representative of peers' influence on participants.

> I have to say my relationship with my little sister and my relationship with my friends. I feel like those are the main relationships that I'm like focused on. I don't know because I feel like they play a big role in my life, like they help me out with a lot of things and they help me realize things that I don't realize at the

> moment. They help me keep – like stay on track sometimes like if I fall but the majority of the time it's just like I look to them for advice when I'm feeling a little down or I can't seem to get something right [P8].
>
> I probably say my important relationships would be with my boyfriend and my friends because those are people who keep me sane around my mom and just like with life and like my stresses, my issues and things that, I don't know, they make. They're the people who make me happy and they're there for me and since I don't have family here, they're like my family so I rely on them a lot. Like for anything if I need anything … and they're always there so that's why they're important to me [P11].

Other studies report, "that perceived values of friends regarding sex have a stronger direct relationship with sexual initiation than do friends reported attitudes about sex" (Sleving et al., 2006, p. 13).

> Like me and my friend, well, she's like my best friend, we umm lost our virginities [at the same time] and then we took Plan B just to like be safe on the safe side and stuff. So, Kim and Jessica and Jamie, we talked to them and then, okay. So on the side of my house there's like this trash can but you could see it out of my window and I guess my mom thought like we were tryin' to like be sneaky and throw stuff away so she went down there and found it, so she took me out to eat and was like, when did you and Manuel start having sex? And I was like, (whispers) oh God. I was gonna tell her when I was like 18 but (laughs)....

Other studies have reported that significant social influences include those of parents, siblings, boyfriends, and friends. According to Sleving and colleagues (2006) "the most powerful sources of social influence are parents, siblings, sexual partners, and friends" (p. 13). Although during adolescence peer groups are important for further developing socialization, early bonds with significant adults, parents grandparents, or other significant family or extended family also remain strong. And in this study as reported in chapter IV for some of the younger adolescents, there was a heavy sense of "peer pressure" by their male partners, which also led to early initiation of sexual intercourse.

Adverse Contexts for Living

Violence, poverty and racism are all adverse contexts that can have a profound effect on the health and well-being of children and adolescents (Leventhal & Brook-Gunn, 2000). A majority of participants reported exposure to various forms of violence. Four participants' fathers were deceased; three of the four fathers' deaths were due to violence related to gunshot wounds and one father died in his sleep. Two participants had no memory of the gunshot incidents because they were 3 years old or younger. One participant, however, recalled how her father's death changed her life. At the time of the incident, she was 6 years old and was at her aunt's birthday party during which her father was shot 6 times by a friend. After the event, she and her 5 siblings were sent to foster care because their mother was unable to cope with her father's death. Her recollection of the incident is described in the quote below.

> My dad, um, was killed when I was 6 years old. Um well, his, I won't say his best friend. I don't know what they were but they were friends; they were close and, um, on my aunt's birthday, they were celebrating. I guess he decided to leave the house and he went across the apartment complex to the other ones and he cheated on my mom with his friend's fiancée and I guess he, they got caught and, um, they fought, uh, twice and then, well police said that's what was said and then the next, when they were going on to fight the next time, um, he shot him six times and that was it [P8].

Violence in the broader community was another adverse context. In the following quote, a participant described her exposure to neighborhood violence during an overnight stay with her father, who was at work when the incident occurred. She was home alone.

> It's Oakland. It's a bad neighborhood. I mean it was just recently shooting I think it was what, last Sunday? Yeah! I heard like six shots. Like boom, boom, boom, boom – no, I think it was like eight. I don't know. It was a lot though. And then my dog was like – arrrrhhhh and like rubbing his ears and I was like wow, this is really intense. I just stayed in my bed. What can I do? I'm not gonna freak out. I mean it's not nothing to be scared of as long as it's not coming my way and it sounded like it was far away anyway. I was alone with my dog [P13].

A majority of participants seemed to have an unfazed attitude when recalling their common experiences with violence. For many participants, the occurrence of some degree of violence seemed to be commonplace. A participant explained,

> It's kinda sad how used to gunshots I am. I'm sitting down with my baby brother playing a game and we hear gunshots. I'm just like, oh okay, well, mom always told me to just like turn off the light and shut the windows and just go in there with my baby brother and that'd just be it. [We don't duck or get under the bed]. We just sit there and just play the game until we make sure we don't hear anymore and then like 5 minutes later I go back in my room and just turn on the light and open the windows all over again [P20].

Racial discrimination was another adverse context described by a few of the participants. One participant said racial discrimination was one reason that she moved from Texas to California. She felt she was treated unfairly at her high school in Texas because of her race.

> I didn't like the schooling. They was racist and I'd rather be out here [California]. It was like more Caucasian people [in Texas] than Blacks. The teachers was like, you know, semi-racist. You could tell, but they're trying not to show it. I just didn't like it … I really don't know how to explain it cause, like, say certain stuff like it's not equal. Say if I was to do something or whatever, they'd make a big deal out of it but if like their same color did it, they be like oh, like they don't care. So, you know, it was just stuff that I didn't like … I see how people felt back in the day cause it don't feel right and it's not fair [P17].

One participant noted that when she lived in Chicago, the police and poverty were ever-present in her neighborhood but, since moving to California, she no longer had this perspective. She said,

> [In Chicago], I thought I lived in a pretty good neighborhood. I lived next to a school. I remember there was a lot of police cars and there were some poor buildings, like apartment buildings. I remember that. There was a lot of poverty where I lived … towards the downtown … like the Navy Pier … a lot of poverty, um, a lot of violence, a lot of police. School reminded me of a prison kind of 'cause it was huge and there's police, um, cameras on each end. I was shocked that they needed that much precaution; it was an elementary school. It wasn't a high school [P11].

Despite the adverse contexts of violence and racism experienced by the AAAF participants in this study, and the readily self-evident substantial challenges those adverse contexts present in the lives of these young AAAFs, their resilience was remarkable.

Resilience

Resilience is defined as "overcoming the negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risk" (Fergus & Zimmerman, 2005, p. 399). Resilience theory is focused on the strengths of the individual and not on their shortcomings or deficits. The focus is on healthy development despite adverse risk exposure (Fergus & Zimmerman, 2005).

There are two components of resilience theory. Either a positive result is produced, or an adverse outcome is diminished; both are risk and promotive factors (Fergus & Zimmerman, 2005). Promotive factors necessary to help mitigate the adversarial effects of risk include assets or resources. Assets are defined as "self-efficacy" or the internal drive or make-up of the individual that are positive and come from within (Fergues & Zimmerman, 2005). Resources are defined as external positive factors, any of which help the individual to overcome risk. Resources include the social context and its effects on the adolescent's growth and development including their health (Fergus & Zimmerman, 2005).

Despite personal, familial, social, and contextual adversity, every participant in this study exhibited resilience in terms of having a positive outlook about life, setting future goals, and forgiving self and others. Despite having to repeat a grade early in life because of family events

that occurred and were out of her control, a participant, who was a senior in high school, explained:

> I'm really proud of myself 'cause I didn't think I was gonna make it this far. School was always like a challenge for me. I always like learning but it was kinda hard when I got to high school. It was like so much work from going to a charter school; it was very small, classes were small. Then I came to [California] and everything was different – people, you're learning faster. I'm proud of myself right now. I'm very independent. Hardworking. I'm the oldest out of four … and I'm preparing myself for college next year [P10].

All of the participants aspired to higher education; they expressed a desire to attend college after high school. A representative quote is below:

> I hope to be on the right track with school, like with my units and my class courses when I get to college … The right track is basically not being in bad hands and not putting myself in dangerous situations where I know in the long run I'm gonna have to suffer the consequences that are gonna push back my decisions and my goals for my future [P8].

For this participant [P8] the right track with school refers to getting good grades to pass all of her classes and to acquire enough units to graduate from high school. She is hopeful that her grades are also good enough to get into college. She would later explain that her "the right track" meant not getting caught up in bad or risky situations, having a bad boyfriend, and avoiding early pregnancy, drugs, or anything else that would prevent her from achieving her goals.

Other participants expressed the importance of making good choices and decisions in life. They observed and were told by their mothers about life's consequences due to poor decision-making. In the following quote, a participant described the impact of her mother's incarceration on her life from a resilience perspective.

> When I was a child, I remember when I was eight; she [my mother] was incarcerated due to bad decisions that she had made to try to provide for me and

> our other family. She's a strong woman who, you know, doesn't really give up. I got strength out of the situation but I also learned, you know, to what path not to go down and she's stressed that to me a lot, you know, about making the right decisions and things like that … I wanna go straight to a four-year, um, major in psychology and later on go to law school [P17].

Summary

Chapter V reports the results of the second overarching theme, *social contexts that contribute to participating AAAFs' reproductive health disparities.* In chapter IV the theme of developmental vulnerability documented a key characteristic of adolescent development that emerged from and was supported by the data. In the continuum of human development, Bronfenbrenner's Bio-ecological Theory of Human Development describes how the individual's biological characteristics as well as their environmental context can have a profound effect on that individual's development (Huston & Bentley, 2010). The AAAF participants in this study are nested in their environment, which is a dynamic state (Huston & Bentley, 2010). These contextual aspects are any experiences or transactions that will affect the adolescent's development and influence AAAFs' sexual decision-making (Huston& Bentley, 2010).

In this study, the developing AAAFs' microsystem also included mothers, fathers, great grandmothers, grandmothers, aunts, and a foster mother. Those adolescent females who had very young mothers age <15 years old, spent the majority of their time with a grandmother, or great-grandmother. This is because their very young mothers were still completing high-school and continuing to undergo their own developmental growth and cognitive development. Filling that parental void often were the participants extended family members.

In the category of Family and Peer Modeling for Pregnancy and Parenting, the participants in this study reported that no matter what their relationships were with their mothers,

all of the mothers wanted their daughters to achieve higher goals then they did and without the struggles of being a young single mother. This was even more evident with the very young mothers of the adolescent females in their statements. While the adolescent females' understanding of their mother's concerns was accepted by all of the AAAFs in this study, the degree of their cognitive understanding was influenced by the development stage of each respective adolescent. For example, with the youngest female who was pregnant at 14 years old, she could repeat what she knew her mother wanted for her to be on the "right track," however she also had the conflict of wanting her baby at 14 years old. By comparison, the older adolescents took heed of their mothers' advice to not go down the same road that she did, because it was difficult and that same road would hold her back from achieving better things.

Mothers of this study's participants set the examples and the tone for these young females, and despite their sometimes-strained relationships with their mothers, all of the mothers were acknowledged, and respected for their struggles, and the sacrifices that they made for their children. Extended family members were, as noted above, central to participants' lives and provided influential, positive social support for participants as foster parents, aunts, godmothers, and grandmothers. Every participant had a special bond and unwavering love for their (usually maternal) grandmother, and in most cases the grandmother served as a surrogate mother who nurtured, cared for, and instilled a sense of family cohesiveness.

Only four father-daughter relationships were described as being stable and loving. These 4 fathers were able to provide their male perspective, including through dating advice to their daughters. For all African American youth, especially females, supportive fathers are a protective factor in their lives who contribute to their resiliency. The majority of the participants

(16/20), however, described their relationships with their fathers as non-existent, strained, and non-committal.

In this study many of the AAAFs confided in their friends, who also played an important, influential role in the lives of these young AAAFs. During adolescence, peer friendships developed and played an important role in adolescent development and also provided emotional support.

Almost all of the adolescent females in this study were exposed to violence, poverty, racism, and living in single parent homes. The extent of violence experienced in the young lives of these AAAF participants included the shootings of fathers, friends, or other family members and the common sound of gunfire at night. Several of these adolescents felt that violence was the norm in their neighborhood. The physical environment is important for the development of children and adolescents and this environment is known to be dynamic and can have a direct (microsystems) or indirect (exo systems and macro systems) effect on the individuals in this study (Bronfenbrenner & Morris, 1998, 2006). Their microsystems include single parent households, which was the majority in this study, thirteen of which were female-headed households. Neighborhoods and schools are also included in the microsystem and in this study almost all of the AAAFs were exposed to violence in their neighborhoods. Despite the challenges of their living situations, and their experiences with difficult environmental adverse impacts, all of the AAAFS in this study were remarkably resilient. They all (20/20) had goals, hopes, and aspirations to stay on “the right track,” to finish and graduate from high school, and to attend college and to avoid early pregnancy as advised by their mothers.

CHAPTER VI

DISCUSSION / CONCLUSION

I set out to study the reproductive health and sexual experiences of AAAFs. The specific aims of the study were to investigate and better understand the reproductive health experiences of AAAFs, including their decision-making processes in avoiding, delaying, or seeking reproductive health care services, to better understand peer and other contextual influences on sexual behaviors, and sexual choices of AAAFs who sought services at SBHCs.

In chapter IV, the overarching theme that was constructed from the data collected from the AAAFs in this study was the *intersection of reproductive health, sexual behaviors, and developmental vulnerability*. First, reproductive health and developmental vulnerability appear to be inextricably linked in understanding AAAFs' sexual behaviors and choices. In addition, the intersectionality of age, gender, and race/ethnicity seems to contribute to health disparities in the AAAF population due to their young age of sexual intercourse debut, and disproportionately higher rates of unintended pregnancies and reported sexually transmitted infections, such as chlamydia, gonorrhea, and HIV (Bearinger, Sieving, Ferguson, & Sharma, 2007; Bose, 2012; Coley, Nichols, Rulison, Aronson, Bown-Jeffy, & Morrison, 2015; DiClemente, Salazar, & Crosby, 2007; Manlove, & Fish, Moore, 2015; Pete, & DeSantis, 1990).

Developmental vulnerability as it relates to the participants' first sexual intercourse experience was evident in the data regarding younger versus older adolescents. In this study, developmental vulnerability was found in the younger group of AAAFs; notably, 13 and 14 year

olds, who all reported that, although they consensually agreed to their first sexual intercourse, they were not "prepared" mentally, physically, or emotionally. This finding is consistent with those of Steinberg (2005, 2011), who found that risk-taking and sensation seeking are very influential during puberty. This is because during adolescence, in addition to the onset of puberty, several biological processes, including brain and cognitive development, are all maturing at various rates, exposing the adolescent to a vulnerable period of making adjustments and decisions (Steinberg, 2005).

Adolescence is divided into three stages; early or younger adolescence, middle, and late adolescence. Younger adolescents (12-14) undergo heightened "emotional arousability, sensation seeking," and immediate pleasure rewards (Steinberg, 2005, p.70). This can overlap into middle adolescence (15-16) regarding affect and behavior regulation, and enhance vulnerability to risk-taking. In late adolescence (17-18), more regulatory competence begins to occur due to the maturing brain—specifically the frontal lobes (Steinberg, 2005, 2011). Consistent with the findings of Steinberg (2005, 2011), in this study, adolescents who reported first sexual intercourse during younger or middle adolescence regretted their initial sexual intercourse. These same young females also all reported that they wished they had waited until they were older to have made this decision and many felt that their first intercourse resulted from peer pressure from their older male suitors. "I just think that, honestly, I think I was peer pressured and I was ready but then I wasn't" [P7]. Other researchers have reported that first sexual intercourse was determined in part by the adolescents' social groups, neighborhood norms, and parental beliefs (Sieving, Eisenberg, Pettingell, & Skay, 2006).

In adolescent research a broad range of peer influences, or peer pressures, have been well documented, including initiating adolescent substance use, delinquency, risky sexual behaviors, and early sexual initiation (Sieving, Eisenberg, Pettingell, & Skay, 2006). Other studies have reported that adolescents engage in early sexual intercourse because many of these youths are unsupervised. Many times unsupervised youth living in high-risk neighborhoods are more likely exposed to drugs, violence, and early sexual intercourse, and other behaviors that are counterproductive. This is because families that live in low-income disadvantaged neighborhoods are also faced with less resources, and single-parent families have longer periods of unemployment and often low educational attainment especially for young single adolescent mothers who do not graduate from high school (McBride Murry, Berkel, Gaylord-Harden, Copeland-Linder, & Nation, 2011; Rankin & Quane, 2002). Adolescence is a critical stage of life, and neighborhood peer pressures can rival that of parental guidance and authority (McBride Murry et al., 2011; Rankin & Quane, 2002). Youth residing in high-risk poor neighborhoods are placed in a challenging environment and are frequently exposed to being socialized by older peers (McBride Murry et al., 2011).

In my study, the participants 15 years and younger, reported that, although they had strong romantic ideations and had "a crush" on their first male sexual partner, they still felt pressure to have intercourse, mainly from these same older male partners. One participant stated that she might as well just get sex over with, because it was inevitable. Many participants also reported that, although they liked the initial attention from their male suitors, they were not "prepared" for intercourse, nor did they feel ready for the emotions that they felt afterwards. One participant summarized:

> I don't think that I was prepared at all…I mean who is at 15? I wasn't prepared mentally for the depth of the relationship after you have sex, like there's emotions released into that you don't know how to explain so I, I don't think I was prepared for that emotionally or mentally [P11].

In my study the age imbalance of the participants and their older male suitors is consistent with earlier research. DiClemente and colleagues (2001) found that AAAFs living in low socioeconomic neighborhoods with increased violence and unemployment often chose sexual intercourse partners that were 2 or more years older than themselves. This age difference creates a power imbalance, which can lead to peer pressure and early sexual intercourse (DiClemente et al., 2001). In my study the majority of participants (60%) reported their first sexual debut at 15 years old and younger. All of these participants reported that, although sex took them by surprise, they were ok to go along with it, even though they did not feel prepared. The participants who were 14 years old and younger, consistent with earlier research findings, also reported their first male partners were at least 2 or more years older.

My study's findings regarding vulnerability of younger aged participants being at increased risk for having sex before they were ready was similar to Bachanas and colleagues' (2002) research on sexually active AAAFs. They reported that young (age14 years old) and very young (12-13 years old) adolescents were vulnerable because they were not developmentally equipped to understand how to communicate with their male partners, use condoms, or postpone sexual intercourse until they could practice safe sex (Bachanas et al., 2002). In addition, multiple studies, including the Youth Risk Surveillance Survey (2013) (Centers for Disease Control and Prevention [CDC], 2013), also reported that younger age (<14) adolescent females, especially AAAFs, are at risk for having more sexual partners, and contracting STIs, such as chlamydia, gonorrhea, syphilis, and HIV/AIDs, and having unintended pregnancies (Bachanas

et al., 2002; Buhi, & Goodson, 2007; CDC, 2013; Kapungu, 2010; Kaestle, Halpern, Miller, & Ford, 2005). In my study there were only two older adolescent females who reported that they were able to talk with their male partners and insist on condom use and safe sex precautions during their first sexual intercourse. The remaining adolescent females did not talk about safe sex with their male partners.

In addition to not being prepared to have sex, participants in my study, in particular those who were 13-16 years old, were not on any prescribed birth control at the time of sexual initiation. All of the AAAFs in my study relied heavily on their male partners to provide and to use condoms. And although all of the participants could recite what safe sex meant, the younger adolescents did not actually practice safe sex measures, relying instead on the judgment of their sexual partners. The younger AAAFs sexual encounters were more emotionally charged, seeking an immediate romantic gratification. Many of the findings are, as noted, consistent with earlier research studies. A unique aspect of my research, however, is how open the AAAFs were with me, as a minority researcher with whom they appeared to relate which allowed me to evidence through this study their otherwise unheard voices and lend a human perspective to their struggles.

One of the youngest participants shared with me her emotional response to her first sexual debut as:

> If you're kissing and you're feeling the love and you're feeling in the moment, sometimes, especially when you're sexually active, you get this tingly feeling in your heart and your stomach like oh my gosh, like your heart is sayin' like, “do it, do it, do it” but your stomach's like no, don't do it but like, you always go for your heart [P18].

In the context of condom usage, there was only one young female and her partner who did not use any form of birth control or protection against STIs. She stated, “it was just like we just got caught up in the moment and we just had [no condoms]. Well, I just, I don’t know, it just happened” [P20]. She was also the only participant to state that she used “trust” as a form of protection. This form of protection as described by this female was “trusting that he does not have anything,” meaning that they as a couple are exclusive and he is not “fooling around” with anyone else. She believed that “trust” would cause her partner to support her if she became pregnant and had a baby. Other researchers similarly report that trust in adolescent relationships was not only very important, but if the adolescent was in a steady partner relationship, some females used trust as a form of STI protection for the same reasons articulated above (Childs et al., 2012; Pete, & DeSantis, 1990; Roberts & Kennedy, 2006; Roye, & Seals, 2001).

In discussing the deleterious effects that young age sexual intercourse debut has on AAAFs, one must analyze the trends in their sexual health behavior. The seminal study, titled *First Intercourse Among Young Americans,* conducted by Zelnik and Shah (1983), surveyed Black and White males and females, 15 to 21 years, about the age of first sexual intercourse. The mean age of, 50% of adolescent females living in the metropolitan area of the U.S. first intercourse was 16.2 years. Among the sample of 938 adolescent females, 459 females were Black and 479 females were White. Among females who had their first sexual intercourse at age 15 or younger, 36.7% were Black, and 18.9% were White. These same researchers reported that there was a disparate proportion in age at first sexual intercourse by race, which decreased dramatically with older age. Among the 15 to 17 year old age group, 61.8% of White females and 55.8% of Black females reported their first sexual intercourse. This inverse downward trend

increased even more between Black and White females who initiated intercourse at 18 years and older. Among adolescent females, 18 years and older, 6.4% of Blacks and 19.2 % Whites had their first sexual intercourse experience.

Zelnik and Shah (1983) also found that Black female adolescents reported the age of their first sexual partner as 3 years older on average. Although the Zelnik and Shah (1983) study was completed over 30 years ago, not much has changed in the key components of first experiences among adolescents such as young age, older partners, and being unprepared for first sexual intercourse. Other researchers have noted higher risk outcomes for early adolescent intercourse (Khurana, Romer, Betancourt, Brodsky, Giannetta, & Hurt (2012). Young age of initial sexual intercourse has been associated with higher probability for STIs and there is a racial ethnic difference (Kaestle, Halpern, Miller & Ford, 2005). Kaestle and colleagues (2005), found that 70% of Whites reported 44% of STIs, while 15% of Blacks reported 50% of the STI burden. As with the findings of Zelnik and Shah (1983) over three decades earlier, Kaestle and colleagues (2005) and Khurana and colleagues (2012) found that younger adolescents were more vulnerable and likely to have a higher risk for STIs, compared to older adolescents. In a recent U.S. survey regarding adolescents' sexual behavior, the Youth Risk Behavior Surveillance Summaries (YRBSS)—United States, 2014), researchers reported that 46.8% of all adolescents (9th-12th graders), approximately 14-18 years old reported having had intercourse (Kann et al., 2014). The prevalence of sexual intercourse was higher among males as compared to females, and higher among African American females when compared to White females, at (53.4%) and (45.3%), respectively (Kann et al., 2014).

The power shift that occurs as adolescent females age and mature, and are better able to negotiate terms with older sexual intercourse partners, was also found in the research of Senn & Carey (2011). They concluded that the younger female "may not develop the self-efficacy" nor the ability to negotiate safe sexual habits which include condom use (Senn & Carey, 2011, p. 64). Older sexual partners pose a sexual risk to younger females due to the power imbalance.

In my study there were two AAAFs who had their first sexual intercourse at older ages relative to the other study participants—at 17 and 18, respectively. Although these participants too were "not prepared" for the moment of their first sexual intercourse experience, both were able to negotiate on their terms to postpone sexual intercourse until they felt ready. Consequently they reported being more prepared at their subsequent, first sexual experience, at which time they were using a prescribed method of birth control, and had insisted that their sexual partners wear condoms. Consistent with this study's findings, Kaestle and colleagues (2005) found that female adolescents who had their first sexual intercourse at an older age, 17 years and older, were more likely to use condoms, and were better able to negotiate safe sexual intercourse with their sexual partners as compared to younger adolescents.

The Meaning of Virginity for AAAFs

An interesting area that also emerged from my research and proved similar to other studies on AAAFs was their perspective on virginity. The heading *virginity as a special virtue and a sexual contradiction* represents the participants' definitions of virginity, and the varied meanings, complexity, and contradictions they all have. Every participant in my study believed that virginity was special and important, however, there were sexual contradictions regarding the varied meanings, definitions, and the degrees of complexity given to the meaning of virginity.

Regardless of whether they had engaged in sexual intercourse or were currently sexually active, some of the participants defined virginity as being sexually satisfied. In other words, if she was not sexually *satisfied,* she did not count her sexual intercourse as loss of virginity. One participant explained that after her first intercourse "it didn't feel like I lost my virginity, so I was like okay well, you don't count" [P9].

The majority of the participants in my study agreed that virginity was a special virtue, one that should not be lightly given away; yet, according to the participants, all 20 of whom were sexually active females, losing one's virginity during adolescence is a rite of passage even if, as noted, earlier, some felt it was something that you might as well get it over with" [P7]. Having sexual intercourse was an expectation for this group of young females. Other researchers have reported that living in low SES neighborhoods and violent areas have been known to increase AAAFs' early sexual initiation (Leventhal & Brooks-Gunn, 2004). This early sexual initiation for some AAAFs comes as a result of fear that they themselves may have a short life expectancy; however, this purported belief that is found in other literature (Choby et al., 2012), was not explored in this study.

The inconsistent definitions of virginity found in my study can pose concerns for health care providers. For AAAFs who believe that being sexually active only means being sexually satisfied, despite having vaginal intercourse, and who also dismiss oral or anal sex as qualifying for being sexually active, they are at greater risk for STIs (Childs et al., 2012). Childs, and colleagues (2012) similarly reported on AAAFs' misconception of what they considered to be sexually active. In their study, Childs and colleagues (2012) found that some of the participants did not believe that oral or anal sex was considered a loss of virginity, although a majority of the

participants did understand that virginity meant not engaging in oral, anal, or vaginal intercourse. There continues to be a misconception among AAAFs regarding virginity and what constitutes being sexually active.

Lack of Agency "It Just Happened"

Regardless of the age when the AAAFs in this study had their first sexual experience, or what their definition of virginity was, another significant finding was that all of the participants (20/20) reported their first sexual intercourse "just happened." This was defined as a lack of agency in which the majority of these young females passively let sex just happen. In addition to this lack of agency, all of the females in this study were unsupervised by an adult for the time period immediately prior to their first sexual intercourse. According to Buhi & Goodson (2007), an increase in parental monitoring added protective effects on sexual initiation for adolescents. The clinical implications of this is that community education directed at the parents of AAAFs might prove to be a useful tool to mitigate the well-documented risk to AAAFs of unwanted pregnancies and higher incidents of STIs.

The Contraceptive Conundrum

For this group of AAAF participants, many of the females reported that safe sex was not discussed much, if at all, at home. Some participants "felt funny" initiating the sex talk, and others reported that their mothers did not bring up the subject of sex, for fear that it might encourage their daughters to become sexually active. There were, however, two AAAFs in this study who did benefit from safe sex discussions with their mothers. For these two females, their mothers had discussed birth control and safe sex prior to their first sexual intercourse and both mothers insisted that their daughters start on the birth control pill. Another of the females was

younger at age 15 [P1], and although her first sexual intercourse partner did wear a condom during their first sexual intercourse, on subsequent times condom use was not consistent. For this participant [P1], she did not start the birth control pill until she had a pregnancy scare several months into their relationship. Her mother was also a strong advocate for her to start the birth control pill. This was an important finding, because when this participant started on the pill, it did not make her feel well, so instead of discontinuing birth control all together, this participant was persistent in trying the various methods that the SBHC provided, and came to an independent informed choice about her preferred method of birth control and both her mother and partner were supportive. For this AAAF, having an informed dialog with her mother, sexual partner, and the SBHC staff proved helpful and effective.

The second participant who also had a frank conversation with her mother was also a young adolescent (age 15). Unlike the first participant [P1], this participant [P11] was started on the birth control pill by her mother, when she had announced that she had a boyfriend. However, she was inconsistent in taking her pill and she did become pregnant and had an abortion. For this participant [P11], after her abortion she decided on her own to come to the SBHC to change her method of birth control to a different birth control method that she did not have to think about daily, the IUD.

Both of these participants (P1 and P11) benefitted from initial conversations with their mothers about being sexually active and as a result, both started on the birth control pill. Each of them thereafter was comfortable with exploring alternative methods of birth control that they preferred. Other researchers have found that parental communication regarding sexual health can be beneficial to African American adolescents, and in fact family communication has been

reported as being critical to prevent sexual risk-taking for AAAFs (DiClemente et al., 2001; Kapungu et al., 2010; Khurana, & Cooksey, 2012; Widman, Choukas-Bradley, Helms, Golin, & Prinstein, 2014). Maternal communication with adolescent females similarly has been found to be a protective factor towards the practice of safer sex (Teitelman, Ratcliffe, & Cederbaum, 2008).

Although 19/20 of the AAAFs in my study had partners who used condoms during their first sexual intercourse, they generally did not seek reproductive health care until after their sexual debut. Several girls experienced pregnancy scares, or fears of STIs, or acknowledged the realization that they were going to continue to be sexually active, which drew them to the SBHC for reproductive health care. Even without an anxiety- provoking event, over time all of the AAAFs in my study started on various birth control methods at their own pace, after they themselves realized that they were going to be sexually active, despite, their initial unpreparedness.

Influence of SBHCs on AAAFs' Reproductive Health

School-based health centers have operated for over 40 years and have provided evidence-based practice and comprehensive health care services delivered by a multidisciplinary team to children and adolescents (Keeton, Soleimanpour, Brindis, 2012). School-based health centers are a way for youth to overcome the barriers of transportation and cost, and address the lack of or limited community clinics (Mason-Jones, Crisp, Momberg, Koech, De Koker, & Mathews, 2012). They are conveniently located on the school grounds, thus making them accessible to youth, and they help fill the void on topics many parents appear unable, unwilling, or uncomfortable to discuss, like reproductive health issues. The participants in this study all

reported that the services provided by the SBHC were confidential, convenient, and the reproductive health care was supportive and addressed their needs in a timely manner. In addition to sexual health information, physical, and mental health is also provided by the SBHCs with no fees, and they also include primary preventive services (Soleimanpour, Geierstanger, Kaller, McCarter, & Brindis, 2010). These were some of the primary reasons participants sought services at the SBHC. Smith, Novello, and Chacko (2011) reported that having the SBHC on-site helped to reduce pregnancy rates when compared to the referral system for off-site health care for adolescents. Thus, having SBHCs on school campuses can be efficacious to address and mitigate pregnancy and STI risks for adolescents.

School-based health centers located at schools in neighborhoods that are low income and susceptible to high violence can serve as a positive factor towards resilience as they have been found to improve the overall health status of youth and health and education achievement has been found to be closely related to resilience and wellbeing in the literature (Mason-Jones, Crisp, Momberg, Koech, De Koker, & Mathews, 2012). The SBHCs provide a positive support system for learning about safe sexual intercourse, long acting reversible contraceptives (LARC), pregnancy testing, Plan B, and STI testing, treatment, and counseling. This accessibility and knowledge also contributes to AAAFs informed decision-making process and resiliency.

Social Contexts and AAAFs' Health Disparities

The second overarching theme in this study is *social contexts that contribute to participating AAAFs' reproductive health disparities.* Chapter IV documents the theme of developmental vulnerability as an important characteristic of adolescent development that was constructed from and was supported by the data. In the continuum of human development,

Bronfenbrenner's Bio-ecological Theory of Human Development is key in understanding the individual's growth and development, including biological characteristics as well as their environmental context, which can have a profound effect on that individual's development (Huston & Bentley, 2010). The system theories are discussed in detail in chapter II, however the microsystem is briefly reviewed here for its importance to social contexts. Stephens, Phillips, & Few (2009) describe Bronfenbrenner's theory as "relevant for examining African American female adolescents sexuality" because of the inclusion of the individual, and their environment (p.161). The social context environment, or community factors, include neighborhood violence, poverty, low SES, and low education attainment all of which have been linked to young age of first sexual intercourse, inconsistent condom use, and increase in STIs among AAAFs (Choby et al., 2012; Kogan et al., 2010). In addition, neighborhood violence has been linked to increased stress, difficulty in concentration, contributing to compromising future goals, and early sexual initiation (Kogan et al., 2010). Lower SES neighborhoods place AAAFs at higher risk for earlier age sexual engagement, peer pressures, older sexual partners, and academic challenges (Choby et al., 2012; Kogan et al., 2010).

In my study, the developing AAAFs' microsystem included their immediate social environment and families, including their mothers, fathers, great grandmothers, grandmothers, aunts, foster mothers, guardians, peers and school (Stephens et al., 2009). The microsystems are interpersonal relations set in an intimately related setting which includes the developing individual (Bronfenbrenner, 2005). These systems are also bidirectional, meaning that not only does the child, in this case the AAAF, affect her family and environment, but the AAAF's "parents influence her beliefs and behavior just as she influences the behavior and beliefs of the

parent" (Stephens et al., 2009, p.169). According to these same researchers, these bidirectional bonds are strong and they have a great effect on the AAAFs' "behavioral outcomes, particularly as they relate to sexual socialization" (Stephens et al., 2009, p. 169). This is because the parent (caregiver) lays the primary foundations for the child's value systems and beliefs (Stanton, Li, Pack, Cottrell, Harris & Burns, 2002; Stephens et al., 2009).

I noted these microsystem influences in the category of family and peer modeling for pregnancy and parenting. The majority of these young females lived in a single-parent, matriarchal-headed household (13 out of 20). These same 13 females all had young teenage mothers who were 18 and younger at the time of that they delivered their first child. All 13 of these participants were raised primarily by their grandmothers, or great-great grandmother for one participant. Many of the participants had strained relationships with their mothers, however most of them reported that no matter what their relationships were with their mothers, all of the mothers in this study wanted their daughters (the participants) to achieve higher goals then they did, and without the struggles of being a young single mother. Although these participants respected their mothers, they also reported that their grandmothers made them feel very special.

The majority of the participants also reported not having a conversation about safe sex with their mothers or grandmothers. For most of the AAAFs who did have such a discussion with their mothers, they reported it was a one-way dialog, from mother to daughter that mainly included the admonishment "not to come home pregnant." This one-way dialog was often left up to interpretation by the AAAF. For example, one of the younger participants [P21] was pregnant at age 14, and got an abortion. She was confused as to why she could not keep her baby, "'cause my mom had me when she was 14, yeah, but, I guess that I am too young to have a baby, I could wait

'til I'm 17 or 18" [P21]. This statement by this young female is full of conflict. Although she could reiterate the words that her mother had spoken to her to "stay on the right track" and "do not get pregnant," she also expressed feelings of remorse and lack of understanding about why she could not keep her baby when her mother kept her. This was reported in a somber tone, and withdrawn body language as she reported proudly how her mother was her same age when she was delivered. She added, "I am the first grandchild of my granny, we have a special bond because she raised me and I am her first grandchild" [P21]. Past studies have reported that the birth rate of adolescent females who are the daughters of adolescent mothers were at least two times more likely to have an early pregnancy than those of daughters whose mothers were age 20 or older when they had their first birth (Kah & Anderson, 1992; Manlove, 1997).

In a related study by East, Reyes & Horn (2007), the researchers concluded that, although having a mother who had an early teenage birth yields an increased risk for her adolescent female daughter to also have an early pregnancy, with an odds ratio of 1.12, having both the mother and an older sister in the same family with an early pregnancy yielded an odds ratio of 5.08, whereas a sister only in the same family was an odds ratio of 4.79. Although East et al., (2007) reported higher odds ratios for sisters in the same family and both mothers and sisters, the reality of intergenerational cycle of teenage motherhood is just as profound when there is a young teenage mother and her adolescent daughter (Meade, Karshaw, & Ickovics, 2008).

To some extent participant 21 in my study was being exposed to "norms for early parenthood" (East et al., 2007, p.108). African American adolescent females born to adolescent mothers are placed at greater risk for early pregnancy, marital instability, limited education, and a disadvantaged home environment often leading to lower SES, and job insecurity (East et al., 2007).

This intergenerational early childbearing therefore can be seen as a bidirectional event. In this situation the young adolescent mother can inadvertently model behavior perceived by her daughter to be acceptable, including young age sexual intercourse and the likely consequences of pregnancy. In my study, although there were more than half (13/20 adolescent mothers (who were 18 or younger) at the time of their first delivery, there was no information asked about the child bearing of other siblings.

The experience and perception of participant 21 contrasted sharply with two older participants in my study who did have conversations with their mothers about safe sexual intercourse. The two older participants clearly benefited from those conversations. As a result, they were able to postpone their first initial sexual intercourse and they were also able to talk with their male partners about condom use. This finding in my study supported previous research that concluded that parents who communicate with their AAAFs about safe sex measures increased their daughters' likelihood that they would also have the safe sex conversation with her male partners and use condoms during sexual intercourse (DiClemente et al., 2001; Hutchinson, Jermmott, Jermmott, Braverman, & Fong, 2003; Kapungu et al., 2010). Teitelman, Ratcliffe, & Cederbaum (2008) reported that minority adolescent females, African American and Hispanic, age 15-19 years old who had discussed "sexual pressure from dating partners, or resisting sexual pressure" from their male dating partners were twice as likely as their peers to report consistent condom use or be abstinent (p.8). Not only are conversations with adolescents important, but also are how parental figures clarify acceptable and expected actions and behaviors as they lead to "sexual health messages" (Stephens et al., 2009, p 169).

Some of the fathers of these young AAAFs also played a role in their developmental context. In my study there were only four AAAFs who reported spending time with and having a good relationship with their birth fathers. These young participants benefited from father-daughter conversations regarding safe sex and boyfriends. Their fathers were able to provide their male perspective, including their thoughts on dating, and additional advice to their daughters. Teitelman and colleagues (2008) also reported that, although there was no significant influence with adolescent females (both African American or Hispanic) regarding paternal communications about HIV/ or STI preventions, these same conversations with their fathers did yield a five times greater likelihood of these adolescent females practicing consistent condom use or abstinence with their male dating partners. Other researchers found that findings from father-hood scholarship in African American communities was often negatively portrayed, and that more current studies need to be conducted to better understand AAAFs' daughter–father relationships (Coley, 2003). The remaining 16/20 of the AAAFs in this study did not have contact with their birth fathers.

Peer Influence

In my study many of the AAAFs confided in their friends, who also played an important and influential role in the lives of these young AAAFs, and they also provided emotional support. Oftentimes adolescents' sources of sexual information come from their peer social group (Haglund, 2003; Kapungu et al., 2010). This information from their peers is often inaccurate and can be misleading. Although other studies report that adolescents tend to conform to their peers regarding risky behavior (Sieving et al., 2006), in this study the consistent findings related to lack of preparation for sexual intercourse, and early entrée into sexual

intercourse came mainly in the form of “peer pressure” from their older male sexual partners. One participant [P1] made a pact with her best girlfriend to lose their virginities at the same time, however the remainder of the AAAFs in this study all felt “peer pressure” from their male partners.

Neighborhood Violence Exposure

Using Bronfenbrenner’s systems theory, microsystems are influenced by the neighborhoods in which the AAAFs spend their time. In the section *adverse contexts for living*, this refers to the neighborhood in which these females walked home, lived, and spent the most time outside of school. Past researchers have well documented the effects of poor neighborhoods on children and youth (Leventhal & Brooks-Gunn, 2000; McBride Murry et al., 2011). Inner city dwellings and urban areas typically have high concentrations of poverty, in particular for minorities and African Americans (Leventhal & Brooks-Gunn, 2000; McBride Murry et al., 2011). There were 17/20 AAAFs in this study who reported that they were exposed to violence, mainly neighborhood shootings, and the frequent sounds of gunfire at night, and an amazingly high 25% (5/20) of these same females experienced their fathers being shot in front of their homes. The majority of neighborhoods with high crimes and shootings are low SES minority neighborhoods. The socioeconomic status of minority neighborhoods is also likely to include single-parent households, low-educational attainment, low income, and material deprivation (Huston & Bentley, 2010; Rankin & Quane, 2002). Neighborhood violence also has been linked to AAAFs early entrée into sexual intercourse (Choby, Dolcini, Catania, Boyer, & Harper, 2012; Leventhal & Brooks-Gunn, 2000). Almost all of the adolescent females in this study were exposed to violence, poverty, racism, and lived in single parent homes. The majority

of these females reported that violence was the norm in their neighborhood. One participant laughed off this continuous exposure to violence. She stated "I'm just so use to it [the gun sounds], I know that's really sad." The AAAFs in this study also reported that living in their neighborhood was just part of living in the inner city.

Many of these AAAFs also spent a considerable amount of time home alone. Although self-confinement at home has been found in the literature to reduce the AAAFs' time spent in their inner-city community (Choby et al., 2012), perhaps decreasing exposure to violence, the lack of parental monitoring also increased risks for young adolescents regarding early first sexual intercourse. All of the AAAFs in this study were alone and thus unsupervised with their sexual partners on the day or night of their first sexual intercourse, usually in the partner's home. Other researchers have also concluded that parental monitoring is a main mediating effect of neighborhoods (Kapungu et al., 2010; Leventhal & Brooks-Gunn, 2000; Rankin & Quane, 2002).

Resilience

Resilience was a major finding in my study. Fergus and Zimmerman (2005) defined resilience as "overcoming the negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risk" (p. 399). The most positive finding in my study was that resilience was found among all of the AAAF participants.

Despite early entrée into sexual intercourse, being unprepared, living in a single-family household, having minimal or non-existent relationship with their fathers, and living in violent, low SES neighborhoods, all of the AAAFs in my study set as goals to

go to college and to strive for their independence. All of the participants (20/20), had goals, hopes, and aspirations to stay on “the right track,” to finish and graduate from high school, to attend college, and to avoid early pregnancy.

Resilience theory is focused on the strengths of the individual and not on her shortcomings or deficits. The focus is on healthy development despite adverse risk exposure (Fergus & Zimmerman, 2005). Resilience is a construct that is “dynamic, multidimensional, and it includes a bidirectional interaction comprising of the developing individual and their environment within contexts” (American Psychological Association Task Force on Resilience and Strength in Black Children and Adolescents, [APATF], 2008, p. 21)

Implications for Practice

Implications for nursing practice from my study include assessment of all AAAFs, with specific targeting of young adolescent females (12 to 14 year olds), for both risk and protective factors against early sexual debut, including teaching safe sex measures (preferably before first sexual intercourse). Parents should be taught about known statistical risk factors facing their daughters and methods to discuss and mitigate those risks, as well as how to talk openly, appropriately and comfortably about sex.

Other researchers have concluded that families and primary care givers play a pivotal role in a child’s development, including safe sexual practices (Rankin & Quane, 2002). More family-based interventions, including community outreach, should be done to encourage greater parent-child communication about safety and safe sexual practices (Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003). Maternal involvement—specifically mother and daughter

communication about safe sex, can affect AAAFs' sexual behavior in a positive way to create stronger positive efficacy towards condom use, birth control, and safe sex (Hutchinson et al., 2003).

Providers at SBHCs are also well positioned to provide interventions that include education about safe sex and that focus on academic achievement, and focus groups for both young male and female pre-adolescents, and to assist educators or health care policy makers with new guidelines for health and wellbeing, including safe sex practices, condom availability, use, and birth control methods. The providers can also initiate mentorship empowerment groups to supplement education about safe reproductive health and to cultivate positive future goals and planning.

Although statistically it has been reported that there is an overall decrease in U.S. adolescents' sexual activity, and pregnancies, U.S. adolescents continue to lead most western industrialized countries in high adolescent births and sexually transmitted infections (CDC, 2014; Meade et al., 2008).

Social Justice

Now is the time to reflect deeply on the research and to take strong action towards a new reproductive health reform. No longer can we afford to leave early sexual behavior to chance. We must begin by acknowledging the fact that we as human beings are also sexual beings and as such this sexual biological process also begins for most during adolescence. We therefore need to be realistic, pragmatic, and prudent about effectively using evidence-based health wellness and prevention programs and meaningful education. In my study SBHCs have been shown to be

a vital and critical link to provide developmentally appropriate services to youth, on the school campus where these AAAFs spend their time (Keeton, Soieimanpour, & Brindis, 2012).

Standard health and sexual education policies are needed in urban and inner city public schools, as well as mandatory health and safety and sexual education. The participants in this study all attended public schools and less than half of these students reported receiving any form of sex education. The majority also did not receive sex education or learn about safe sex at home.

With little to no education occurring in Bronfenbrenner's macrosystem of the AAAFs, how can we as a society reasonably expect to mitigate the historic, generationally repeating higher incidents of unplanned pregnancies and disproportionate rates of STIs suffered by this vulnerable population? By standardizing and improving safe health education and sexual practices before sexual debut, these adolescents are likely to benefit substantially, and reproductive health will be improved for AAAFs. We need to be more proactive regarding sexual and reproductive health for adolescents working upstream to prevent known sexually transmitted infections and unintended pregnancies, instead of continuing to wait defeated downstream picking out the bodies from the water.

Critical race theory and critical ethnography both highlight the significance of contemporary race and racism discourse in the U.S. We need to improve educational policies for minority health education and adolescent sexual health. I will start with the dissemination of my findings by letting the voices of these AAAFs be heard through publication and national conferences. If we are looking at theory as a way to provide a framework in the health care system that looks at patterns of both healthy therapeutic relationships and unhealthy, non-

therapeutic relationships as mentioned earlier in chapter II, then these theories should be congruent with other aspects of social research such as human capital.

Limitations

Data was self-reported, which carries some degree of bias from being influenced by social desirability. One way this was addressed was through conducting individual, confidential face-to-face interviews, rather than other methods, such as focus groups.

As a minority researcher I likely brought to some degree my own personal biases, including heightened concerns while reading multiple studies relating to disparity outcomes of AAAFs. I felt compelled to highlight positive aspects to show another dimension to these young AAAFs, for example, their amazing resiliency. And although I was accepted as a researcher wanting to know more about the lives and first sexual intercourse for these AAAFs, to some degree was I accepted so much so that the majority of the participants were recruited as a snowball effect. There was a power difference between myself and these young AAAFs overall and they allowed me to ask very personal questions to which they were willing to provide me candid answers. As the interviews were private and confidential, I believe that this also helped to decrease peer pressure in answering questions.

Future studies

Additional qualitative research including African American male partners' perceptions of safe sex practices and condom use should be the next step. By learning more about the decision-making processes of African American male adolescents, their views toward safe sexual intercourse and consistent condom use would benefit the sexual health for adolescents and contribute towards improving reproductive health outcomes for AAAFs. In addition, by

conducting a critical ethnographic study including African American male sexual intercourse partners, this study should include their views on family, marriage, child rearing, and education, and long-range goals.

Additional qualitative studies should also include the primary family caregivers, including their views, beliefs, and attitudes towards teaching their children about sexual development, safe sex, and reproductive health. There is a good deal of literature that reports parental communication regarding safe sexual experience as a protective factor towards safe sex for AAAFs (Golin & Prinstein, 2014; Hutchinson et al., 2003; Kapungu et al., 2010), and further understanding about parental perspectives could facilitate the development of assistive strategies & mitigate health disparities.

Another research plan would be to conduct a mixed method study including qualitative ethnographic study along with quantitative study to further explore and link the in-depth decision-making processes, attitudes, and beliefs, to the number of STIs, teen unintended pregnancies, births, and abortions with the same cohort of AAAFs, over a period of time (1 year). In addition to looking at the bioecological systems theory, it would be useful to add a survey such as Adverse Childhood Experiences (ACEs), and the CRAFFT Screening Test (for substance related risks), to highlight and support the oral data collected.

Conclusion

In this qualitative study critical ethnography was used to better understand and describe AAAFs' "cultural place," social contexts and their influence on their everyday lives, and to report their decision-making processes (Jessor, Colby & Shweder, 1996, p.307). Critical ethnography is an important research method used to study the development of AAAFs in their

environment, and therefore it can ensure that the "cultural place" will be also incorporated to a better understanding (Jessor et al., p. 302).

The concept of critical ethnography emphasizes the phenomenon "in the context in which it occurred" (Oladele, Richter, Clark, & Laing, 2012, p.17) by using critical ethnography the accounts of the stories of these AAAFs could be accurately reported and unlike only quantitative studies, which look at the statistical facts, this study puts a voice to the lives and perceptions of these AAAFs. In critical ethnography, the researcher's ability to report accurate representation of the participants is vital (Oladele et al., 2012). This is imperative because by identifying the problem with young aged, unprepared sexual intercourse leading to increased STIs and unintended pregnancies, better solutions can be can be encouraged.

The richness of this study's data was accomplished through triangulation and included the memos, fieldnotes, participant observations, and data transcripts for one-to-one interviews. This unique study contributes to the existing literature by expanding the knowledge about these young and vulnerable AAAFs first sexual intercourse.

Despite the improvements in minority health care over the past several decades, African Americans continue to experience health care disparities with poor health outcomes. With increased reports of early sexual debut for AAAFs, and increased rates of early pregnancies, STIs, and HIV growing fast among African American women who are in heterosexual relationships, all of these factors contribute to the increase risk for AAAFs and widen disparities. This study, like previous studies reported in the literature, describes how younger adolescents are at greater risk of STIs and unintended pregnancies (and increased risk in the number of sexual partners) due to immature cognitive ability to understand the true consequences of unprepared

sexual intercourse. The findings from my study stress the continual need to address AAAFs' socio-ecological contexts on multiple levels and to provide neighborhood and family interventions and educational outreach, including through provisions of better educational programs and public health policies aimed to improve reproductive health. The critical ethnographic approach I used in this research demands action by the researcher to advocate for the participants. I plan to actuate this responsibility as the researcher by disseminating my findings through publications and national conferences, and by raising awareness of these important issues in the hopes of affecting a meaningful change to these persistent disparities at a local level in affected communities of color through SBHCs.

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Appendices

Appendix 1

CHR Letter

Human Research Protection Program Committee on Human Research

Notification of Expedited Review Approval

Principal Investigator Co-Principal Investigator
Roberta S Rehm, RN, PhD, FAAN Gina Robinson

Type of Submission: Submission Correction for Continuing Review Submission Form **Study Title:** What are the experiences and perceptions of African American adolescent females who seek reproductive health care services at school-based health centers?

IRB #: 10-01278
Reference #: 152929

Committee of Record: Laurel Heights Panel

Study Risk Assignment: Minimal

Approval Date: 12/10/2015 **Expiration Date:** 01/02/2019

Regulatory Determinations Pertaining to this Approval:

This submission was eligible for expedited review as: Category 8(c): Renewal of inactive research protocols or protocols that are essentially complete: where the remaining research activities are limited to data analysis

IRB Comments:

All changes to a study must receive CHR approval before they are implemented. Follow the modification request instructions. The only exception to the requirement for prior CHR review and approval is when the changes are necessary to eliminate apparent immediate hazards to the subject (45 CFR 46.103.b.4, 21 CFR 56.108.a). In such cases, report the actions taken by following these instructions.

Expiration Notice: The iRIS system will generate an email notification eight weeks prior to the expiration of this study's approval. However, it is your responsibility to ensure that an application for

continuing review approval has been submitted by the required time. In addition, you are required to submit a study closeout report at the completion of the project.

Approved Documents: To obtain a list of documents that were approved with this submission, follow these steps: Go to My Studies and open the study – Click on Submissions History – Go to Completed Submissions – Locate this submission and click on the Details button to view a list of submitted documents and their outcomes.

For a list of all currently approved documents, follow these steps: Go to My Studies and open the study – Click on Informed Consent to obtain a list of approved consent documents and Other Study Documents for a list of other approved documents.

San Francisco Veterans Affairs Medical Center (SFVAMC): If the SFVAMC is engaged in this research, you
must secure approval of the VA Research & Development Committee in addition to CHR approval and follow all applicable VA and other federal requirements. The CHR website has more information.

Appendix 2

Interview Guide

Thank you for agreeing to talk with me today. As I mentioned, the purpose of this study is to understand and describe the experiences of African American adolescent females who seek reproductive health care services at school-based health centers (SBHCs).

There are no right or wrong answers. I am really interested in what you think and your experiences that you had coming to the SBHC. In fact from the time to time I will ask you to give me an example of what you have experienced so that I understand what you mean. I understand that reproductive health can be a very personal matter, please let me know if at any time you feel uncomfortable or need to take a break.

Do you have any questions for me?

The following questions may be asked of the participants.

Pre-Interview Stage: Ok let's get started

1. Please tell me about yourself: Who do you live with? Who makes up your immediate family? How many adults live in your household?

- Do you live with your mother, father, grandmother, (maternal/paternal), foster care?

-How much time a day do you spend with the adults with whom you live?

-What adult do you confide in the most? Parents, teachers, relatives, peers (i.e. best friend/s) other members of your community?

2. Describe who is in the house when you get home from school

3. Can you tell me who is your role model and why?

4. What do you like to do best outside of school?

-Tell me a story of what you like to do in your free time outside of school

- What do you hope to do after high school graduation?

-What future goals do you have, after graduation in 5 years, 10 years?

-Tell me a story about someone you know that went to college, work

-general health, reproductive, counseling, nutrition, etc.?

5. What music do you like to listen to? What movies do you find entertaining? What video games do you like to play?

6. Can you describe what your neighborhood is like?

-Houses, apartments, condos, urban, noisy, quiet, music playing, other frequent noises, is there violence in your neighborhood, gun shots, shootings, violence?

7. Can you tell me about the important relationships that you have in your life? (i.e. mother, father, siblings, other blood relatives, best friends, boyfriends)

- tell me about how you decide on what kind of relationships that you are going to have with a boy? (i.e. boyfriend vs sex "friend" vs friend not sexual)?

8. Tell me about your first sexual experience

-how old were you?

-was this something that was planned? Did it just happen?

-Looking back do you think that you were prepared?

9. What about now, how have your sexual experiences changed over time?

-How do you negotiate safe sex with your partner?

10. How many sexual partners have you had?

11. How do you decide on what boys that you are going to have sex with?

-How do you make the decision to have sex with someone? Do you think about it first, do you talk about with your partner or best friend?

12. Tell me what a committed boyfriend- girlfriend relationship is like? What does that mean to you?

13. Can you describe what an un-committed sexual relationship is like? What does that mean to you?

14. What does safe reproductive health (sex) mean to you? How do you negotiate safe sex practices? In your relationships who initiates safe sex practices, i.e. condom use, or birth control methods? Do you or your partner?

15. Do you feel that there is someone in your life that can tell you about how to be healthy and experience safe sex practices? 6. Tell me about what brings you to seek health care services at the SBHC?

16. Who influences you the most when making big decisions? Family, friends, others, media?

17. When you come to the SBHC what type of services do you look for?

-General health, reproductive, counseling, nutrition, etc.?

18. How do you protect yourself from sexual transmitted infections?

-Does your partner use condoms why, why not?

- Have you ever been treated for an STI?

19. Can you please tell me about what kind of grades you are getting in school?

-What subjects do you find the most challenging? -Why?

-Please tell me about your favorite school experience

-If you could take a class on anything you want what would that class be?

-What subject would you want to learn more about and why?

-Who would you get to teach that class? Anybody you want.

20. Do you have any questions for me?

Appendix 3

Screening Guide

Please place an X mark on the chosen questions below.

1. Do you describe yourself as African American? Yes____ No_______

2. How old are you? 15____ 16_____ 17_____ 18______

3. Have you been sexually active with a male within the past year? Yes____No____

Appendix 4

CHR Flyer

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO RESEARCH STUDY

Want to be part of a research study?

Are you an African American teenager girl?

We want to know what it is like to use school-based health care

You are eligible for this study if you:

- Are an African American girl
- Speak English
- Are between 15-18 years old
- Have used the School-based Health Center

About The Study:

- The study will take 1-1.5 hours
- Participation is strictly voluntary
- You will be privately interviewed 1-2 times by Ms. Robinson
- You will be asked to complete a short survey (Demographic Sheet)
- Your responses are completely confidential

If you are interested, please contact the health care staff

If you are eligible and complete the survey you will receive a $10 Gift card to Starbucks or Subway or Jamba Juice

Publishing Agreement

It is the policy of the University to encourage the distribution of all theses, dissertations, and manuscripts. Copies of all UCSF theses, dissertations, and manuscripts will be routed to the library via the Graduate Division. The library will make all theses, dissertations, and manuscripts accessible to the public and will preserve these to the best of their abilities, in perpetuity.

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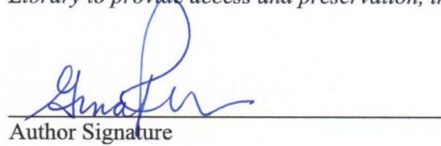

Author Signature

30 May 2016
Date