In Their Own Words: Romantic Relationships and the Sexual Health of Young African American Women

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ABSTRACT

Objective. We assessed young African American women's understanding of "dual protection" (DP) (i.e., strategies that simultaneously protect against unintended pregnancies and sexually transmitted diseases [STDs]) and how relationship factors influence their use of DP methods.

Methods. We conducted 10 focus groups with African American women (n=51) aged 15–24 years in Atlanta, Georgia, to identify barriers to and facilitators of their DP use. Focus group participants also completed a brief self-administered questionnaire that assessed demographics and sexual behaviors. We analyzed focus group data by theme: relationships, planning for sex, pregnancy intentions, STD worries, the trade-off between pregnancy and STDs, attitudes toward condoms and contraceptives, and understanding of DP.

Results. From the questionnaire, 51% of participants reported that an STD would be the "worst thing that could happen," and 26% reported that being pregnant would be "terrible." Focus group data suggested that most participants understood what DP was but thought it was not always feasible. Relationship factors (e.g., trust, intimacy, length of relationship, and centrality) affected pregnancy intentions, STD concerns, and use of DP. Social influences (e.g., parents) and pregnancy and STD history also affected attitudes about pregnancy, STDs, and relationships.

Conclusions. Although participants identified risks associated with sex, a complex web of social and relationship factors influenced the extent to which they engaged in protective behavior. The extent to which relationship factors influence DP may reflect developmental tasks of adolescence and should be considered in any program promoting sexual health among young African American women.

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The sexual and reproductive health of adolescent girls and young women is a public health priority, with prevention efforts focusing on preventing unintended pregnancies and sexually transmitted diseases (STDs).[1,2] However, recent interventions have taken a more integrated approach by promoting dual protection (DP) against both unintended pregnancies and STDs while addressing social factors associated with sexual behaviors.[3–10]

The American Medical Association, the American Congress of Obstetricians and Gynecologists, and other health organizations recommend that sexual and reproductive health counseling highlight the benefits of DP strategies (such as pill or intrauterine device plus condom use, or consistent condom use). Although trends in the use of these strategies are promising, low levels of use among adolescents and young adults have prompted recommendations for tailoring DP to address epidemiologic and individual needs (e.g., consistent condom use for women who have high STD risk and live in areas of high STD prevalence) and the need for additional DP strategies (e.g., contraceptive use with mutual monogamy).[11–14]

The need for a broader contextual understanding of sexual risk and sexual protective behaviors has been noted, especially for adolescents whose developmental stage may shape their relationships and sexual experiences. A focus on sexual health highlights the need to integrate STD, human immunodeficiency virus (HIV), and pregnancy prevention efforts and to understand sexual behaviors within developmental, relationship, and community contexts.[15,16] Such an approach, which reflects the complex factors that shape people's sexuality, relationships, and sexual behavior,[17,18] is consistent with recent work concerning adolescents' sexual behavior. For example, a focus on risk taking discounts the tentative and experimental nature of adolescents' relationships and sexual behavior and, thus, may not account for how relationships influence STD risk and pregnancy, or how adolescents apply lessons learned from one relationship to subsequent relationships.[6,19]

Effectively addressing DP and sexual health among adolescent girls and young women requires moving beyond a risk perspective to better understand what young women desire from relationships, how these desires change over time, and how relationships shape pregnancy intentions, STD risk perceptions, and the trade-offs made between pregnancy and STD prevention.[20,21] Drawing primarily on focus group data, this study explored young women's relationship desires and characteristics, STD worries and the trade-off between becoming pregnant or acquiring an STD, and how these factors shape protective behaviors, including DP use.

METHODS

We conducted 10 focus group discussions with 51 young African American women aged 15–24 years. The discussions, along with in-depth interviews with providers and structured interviews with young women, were the first part of a larger study designed to identify barriers to and facilitators of DP use.

Procedure

We conducted the focus group discussions from August through September 2010 with young women recruited in waiting rooms at three reproductive health clinics in Atlanta, Georgia, that serve low-income teenagers and women. Eligible women self-identified as African American, were aged 15–24 years, were not pregnant, had intercourse with a male in the past three months, received services (e.g., contraceptive counseling, STD and pregnancy testing, or health education) at a study clinic in the past six months, and provided written informed consent. Groups were stratified by age (four groups of women aged 15–18 years [n=23] and six groups of women aged 19–24 years [n=28]) to assess how age influences DP use.

Prior to each focus group discussion, participants completed a brief 18-item written questionnaire about demographic information and their sexual/reproductive history. Two African American female researchers with extensive experience conducting in-depth interviews and focus group discussions with African American teenagers and young women co-facilitated the discussions, with a note-taker present. Facilitators built rapport, established ground rules, and set a positive tone to promote dialogue and minimize social distance between themselves and participants. Focus group discussions lasted approximately 90 minutes and were audiotaped and transcribed verbatim. Participants received lunch and a $25 gift card.

Measures

The focus group discussion guide addressed themes related to DP identified in the literature:[9,10] relationships; planning for protection; pregnancy intentions, STD worries, and the trade-off between the two; attitudes toward birth control and STD prevention; understanding of DP; and experiences at the clinic. The brief questionnaire included 18 items assessing recent sexual history, pregnancy history, and concerns about pregnancy and STDs.

Analysis

We analyzed focus group data using a summary-writing approach. Group facilitators wrote initial summaries based on field notes and audio recordings. Next, other

team members wrote more detailed summaries based on verbatim transcripts, compared their summaries to the facilitators' summaries, and reconciled any discrepancies. Both the facilitators and other team members summarized the major topics of discussion from transcript-based summaries, identified themes (i.e., relationships; planning; pregnancy intentions, STD worries, and the trade-off between the two; attitudes toward prevention; understanding of DP; and clinic experiences), and included representative quotes. Once major themes were identified by discussion topic, team members collated themes by hand across summaries and compared by age. We report distributions (by age) on select variables from the questionnaire and present themes relating to influences of social context and relationships on DP use.

RESULTS

Of the 51 focus group participants, more young women aged 15–18 years (n=19/23) were enrolled in school than those aged 19–24 years (n=11/28). Fewer women aged 15–18 years (n=8/23) reported a previous pregnancy than those aged 19–24 years (n=20/28). Most of the women (n=16/23 women aged 15–18 years, n=21/28 women aged 19–24 years) reported only one sex partner in the previous three months, and fewer than half of the women (n=9/23 women aged 15–18 years, n=7/28 women aged 19–24 years) reported using two contraceptive methods. Although few participants reported they were trying to have children, the majority (n=15/23 women aged 15–18 years, n=16/28 women aged 19–24 years) said they would "deal with a pregnancy" (e.g., have the baby and do their best to raise it) if it happened. When asked about acquiring an STD, 13 participants in each age group reported it would be the "worst thing that could happen" (Table).

Understanding of DP

Most participants were unfamiliar with the term "dual protection," but many used context clues to define the concept. One participant, for example, thought it meant "two different kinds of protection for you and him." However, few participants thought using DP would be feasible, particularly if it meant using birth control and condoms simultaneously or consistent condom use alone. Participants' concerns centered on the acceptability and meaning of pregnancy, condoms, and STD testing in their relationships. Participants' perceptions of these relationship issues were shaped broadly by their social context (e.g., norms and parental influence) (Figure).

Peer norms and family expectations

Participants generally described living in a sexualized social environment. The sexuality of music, their awareness of adults' sexual behavior (e.g., mothers with multiple partners), and the frequency of sex among peers contributed to beliefs held by most that sex and pregnancy are normal, if not expected, in trusting relationships and that STDs (including HIV) are prevalent but preventable. They also perceived that "everyone" was having sex and babies but thought childbearing for the sake of having a "cute" baby was unacceptable. They considered pregnancy to be less problematic than STDs, citing STD-related health concerns (e.g., taking medicine and the incurability of HIV and herpes), perceptions that people with STDs are viewed as "nasty," and the negative effects of STDs on current and future relationships (e.g., "[it] breaks your heart that he gave you an STD" and "men may not date someone who has had an STD"). Women in the older groups described pregnancy as being less regrettable and stigmatizing than getting STDs, citing a large number of peers with babies and their perception that men will date women with children.

Many participants were influenced by their parents' attitudes about sex. Some younger women described how seeing their mothers still having babies normalized pregnancy. Many in the younger group whose parents were supportive of contraceptive and condom use believed their parents would support them if they became pregnant. However, those whose parents disapproved of or "judged" their sexual activity and did not talk to them about sex or contraception were likely to seek information from their social network and to engage in sex despite their parents' disapproval.

Relationship influences

Relationship characteristics shaped participants' attitudes about pregnancy and STDs. Although facilitators asked about use of DP in casual and serious relationships, most young women talked spontaneously about a spectrum of relationship characteristics rather than a particular "type" of relationship. Trust (support/fidelity), intimacy, duration, and centrality (importance) were relationship characteristics that affected pregnancy intentions, concerns about STDs, and use of preventive behaviors, including DP.

Participants characterized casual relationships as typically being short-lived and lacking in trust, intimacy, and centrality, although some casual relationships could last for several months. When there was little desire to move a relationship forward with a casual partner, young women were less likely to want children and more likely to worry about STDs and pregnancy.

Table. Select characteristics of young African American women participating in sexual health focus groups, by age group: Atlanta, Georgia, August–September 2010

Characteristic	*Participants aged 15–18 years (n=23)*	*Participants aged 19–24 years (n=28)*
Demographic and sexual history	*Mean (SD)*	*Mean (SD)*
Age	16.9 (0.8)	21.5 (1.7)
Number of pregnancies[a]	0.6 (0.9)	1.4 (1.1)
Number of partners in the past three months[b]	1.5 (0.9)	2.5 (4.4)
Number of clinic visits per year[c]	2.8 (1.3)	3.3 (3.8)
Number of clinic visits for pregnancy concerns	0.7 (1.2)	1.6 (3.8)
Number of clinic visits for STD concerns	1.0 (1.1)	1.0 (1.6)
Number of clinic visits for other (not pregnancy or STD) concerns	0.6 (0.9)	1.7 (2.3)
	N *(percent)*	N *(percent)*
Currently enrolled in school	19 (82.6)	11 (39.3)
Have ever been pregnant[d]	8 (34.8)	20 (71.4)
Have children	5 (21.7)	18 (64.3)
One child	4 (17.4)	9 (32.1)
Two children	1 (4.3)	7 (25.0)
Three children	0 (0.0)	2 (7.1)
Had only one partner in the past three months	16 (69.6)	21 (75.0)
Pregnancy intentions, pregnancy concerns, and STD concerns		
Pregnancy intentions		
Trying/hoping to get pregnant	1 (4.3)	1 (3.6)
Mixed feelings	4 (17.4)	8 (28.6)
Trying/hoping not to get pregnant	18 (78.3)	19 (67.9)
Feelings if got pregnant right now		
Be happy	1 (4.3)	6 (21.4)
Not what want, but would deal with it	15 (65.2)	16 (57.1)
Would be terrible	7 (30.4)	6 (21.4)
Feelings if got STD right now		
Hassle, but not the worst thing	10 (43.5)	15 (53.6)
Worst thing that could happen	13 (56.5)	13 (46.4)
Contraceptive use during last sexual encounter		
Any contraceptive use[e]	17 (73.9)	20 (71.4)
Used dual methods	9 (39.1)	7 (25.0)
Used Depo-Provera	6 (26.1)	6 (21.4)
Used male condom	11 (47.8)	11 (39.3)
Used NuvaRing®	1 (4.3)	2 (7.1)
Used pill	8 (34.8)	3 (10.7)
Used IUD	0 (0.0)	4 (14.3)
Used female condom	0 (0.0)	1 (3.6)
Used Implanon®	1 (4.3)	0 (0.0)

[a]Range among women aged 15–18 years = 0–3; range among women aged 19–24 years = 0–3

[b]Range among women aged 15–18 years = 1–4; range among women aged 19–24 years = 1–20

[c]Range among women aged 15–18 years = 1–5; range among women aged 19–24 years = 0–20 (including one woman who received prenatal care in the previous year)

[d]Regardless of pregnancy outcome

[e]Young women could report using more than one method. No young women reported using the diaphragm or the patch.

SD = standard deviation

STD = sexually transmitted disease

IUD = intrauterine device

Figure. Influences on relationships and implications for dual protection use: examples from African American women aged 15–18 years and 19–24 years, Atlanta, Georgia, August–September 2010

Influences	*Relation to DP*	*Examples*	*Age similarities/ differences*
Social context:			
Norms: Everyone is having sex/ babies	Desire to get pregnant may take precedence over protection.	"Oh, but I want the babies." So you have that. Everybody wants to prevent STDs, but nobody wants to prevent pregnancy. . . . (participant aged 15–18 years)	Younger women discussed the pressures for having children more than older women.
Parental support	Parental communication and support for having children influences behaviors and pregnancy.	Some people, like parents, say, don't have sex. If you do, use condoms. They sit down and talk to their kid. (participant aged 19–24 years) But some females are lucky enough to have their parent in their home to help them out. But if they didn't have that helping hand, then they would see the inside part of the real struggle. . . . (participant aged 19–24 years)	Both age groups talked about the importance of parental support for pregnancy and STD prevention and having children.
STD and pregnancy worry:			
STDs are typically more worrisome than pregnancy.	Fear of STDs encourages condom use. Despite worry, sometimes condoms aren't used.	That's scary for me [getting an STD], so that's why I choose to protect myself. . . . (participant aged 19–24 years) In a casual relationship with someone . . . y'all might use condoms . . . [but] there's probably going to be some times where y'all feel like y'all don't want to use condoms. . . . (participant aged 15–18 years)	Younger women were more worried about pregnancy.
Pregnancy can be dealt with and has fewer negative implications.	STD prevention is more important than pregnancy prevention.	If you can't get rid of it [STD], you might as well just go on and prepare yourself to die. . . . With pregnancy, you can have the baby. You can put the baby in DFCS, or you can sign custody over to a family member that is willing to take care of the baby.… (participant aged 15–18 years) Boys will date you with a baby. . . . [with] STD, a lot of girls worry about being loved or being dated. But I know girls who got married who had babies out of wedlock. (participant aged 19–24 years)	Older women worried about STDs. Both age groups believed that pregnancy was easier to deal with than some STDs.
Relationships:			
Casual relationships	Condom use was expected in casual relationships.	Especially if you don't know them [you should use a condom]. Some people meet up just to have sex; yeah, they really need to keep some artillery [condom] in their purse. (participant aged 15–18 years)	Both age groups expected to use condoms to prevent STDs with someone they didn't know well.
Trust is key, but everybody messes with everybody.	Lack of trust may lead to testing.	Because me and my baby daddy go to the clinic all the time, because I don't trust no boy, no man. I don't care. I just don't trust them. (participant aged 15–18 years)	Given the prevalence of multiple partners, both age groups thought it naive to take trust for granted.
Child support expectations	Partner's ability to live up to child support expectations is risk for discontinuing birth control.	My boyfriend's 18. He does not have a job. He sits in my house all day and does not do anything. So him wanting a child is a no. . . . (participant aged 15–18 years)	Older women discussed child support expectations more than younger women.
		He just like, "I love you," and, "I'll take care of you. . . ." He actually does take care of me. . . . I was 15, so I believed him, and we took the condom off, and we had a baby, and ever since then we've been together." (participant aged 15–18 years)	Younger women talked about getting support from their families if they got pregnant.

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Figure (continued). Influences on relationships and implications for dual protection use: examples from African American women aged 15–18 years and 19–24 years, Atlanta, Georgia, August–September 2010

Influences	*Relation to DP*	*Examples*	*Age similarities/ differences*
Relationship length, trust, and expectations of fidelity	Condoms are discontinued as trust deepens. Reintroducing condoms signaled lack of trust in long-term relationships.	*Moderator: Why do they stop using condoms?* Speaker: I guess your relationship gets stronger and you start trusting each other more. You know this person ain't doing this. You know you ain't doing this. I guess you just decide. . . . (participant aged 19–24 years)	Older women talked more about long-term relationships, trust, fidelity, and challenges of introducing DP.
		Speaker: Like, if you haven't been using it [contraception or condoms] and you all of a sudden just bring it up because you want to start taking care of yourself, they'll feel like it's something wrong or like you stepping out on them or something like that. (participant aged 15–18 years)	Younger women discussed relationship dynamics less than older women. Most younger women thought introducing dual protection would be "easy."
	Discontinuing condoms and contraception was viewed as both essential and risky in long-term relationships.	*Moderator: Okay, so trust is an issue [with discontinuing protection from pregnancy and STDs]; so how do you know if you trust a partner?* Speaker 5: I mean you can't really trust nobody. Speaker 4: You don't know because you don't know. You can't trust it because you don't know what they doing. Speaker 2: But you should be able to trust yours, even though it's hard. Speaker 3: You're taking a risk, yeah. (participants aged 19–24 years)	
Balancing STD risk and trust	STD testing for trust and future test of fidelity	When you first get together with somebody and decide that you wanna have sex, you need to go get done tested before anything. . . . (participant aged 15–18 years)	Both age groups saw testing as a way to establish and maintain trust. Older women viewed testing as a means of establishing infidelity.
		I was like, we both getting tested. We both clean. That mean if I get something, it came from you, so you cheated. (participant aged 19–24 years)	
	Lack of trust leads to expectations for testing and/or condom use with outside partners.	I put it like this . . . if a male and a female go together, and he cheats on her with another girl, most likely he gonna use a condom unless he just that nasty. . . . (participant aged 19–24 years)	Both age groups expected their main partner to use condoms with side partners. Older women discussed the impact of side partners more.
Centrality of relationship	Serious relationship dynamics trump protection from pregnancy and STDs.	*Moderator: . . . other reasons it would be difficult [to use DP]?* Speaker 2: They in love. They trust that person. Speaker 1: It really can be trust, just trust. Speaker 2: Love and trust. . . . Speaker 1: And they've been together for a long time. . . . *Moderator: Would that make it easy or hard?* Speaker 4: Make it hard. . . . Because of the dude, the guy or whatever. If he don't want to, y'all been together for a couple of years or something, you get used to not wanting to [use protection]. (participants aged 19–24 years)	Both age groups felt that having unprotected sex maintained and perpetuated feelings of love and trust.
Length of relationship	Length of relationship decreases use of DP.	I was in a three-year relationship. The first year we didn't have sex. The second year we used [condoms] to have sex. Coming in the third year, I was like, "I know him, so I feel like we ain't gonna use no condoms or none of that because I know . . . he ain't got nothing, and I ain't got nothing, so why not? (participant aged 15–18 years)	Both age groups thought discontinuing both condoms and contraceptives to be a natural part of a long-term relationship.

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Figure (continued). Influences on relationships and implications for dual protection use: examples from African American women aged 15–18 years and 19–24 years, Atlanta, Georgia, August–September 2010

Influences	*Relation to DP*	*Examples*	*Age similarities/ differences*
Experience matters:			
Learning through experience	Personal experiences often prompt protective planning.	Well, I noticed after I had my first child, I didn't want no more. . . . I've got two, so I got smart after the second one. . . . (participant aged 19–24 years) Girl. My first one, it's hard. It's real hard. I had the one, I was just like, "Uh uh, I can't do it no more," and then . . . I got on Depo. . . . (participant aged 19–24 years)	Both age groups felt that learning through personal experience is the best teacher and acknowledged that learning through hindsight is not ideal but the most common reality.

DP = dual protection

STD = sexually transmitted disease

DFCS = Division of Family and Children Services

Participants generally thought suggesting and using condoms with casual partners would be acceptable to their partners because neither partner expected commitment or fidelity. They also thought dual method use would not be a problem, provided they had access to contraceptive methods.

Most respondents indicated that trust, intimacy, and centrality were critical components of a serious relationship. Trust was discussed relative to both pregnancy and STDs. Most participants agreed that the more trusting the relationship, the less problematic pregnancy became because children are an acceptable outcome in trusting relationships (e.g., pregnancy cements trust). However, because of uncertainty about partners' promises of financial and emotional support should pregnancy occur, participants generally viewed discontinuation of birth control as risky. One young woman who had a child expressed satisfaction that her decision to trust her partner's promise that he would be there for her and the baby was justified. Many others expressed disappointment in the lack of financial or emotional support provided by their partner or the partner of a friend.

Trusting a partner was perceived as inherently risky with regard to STDs in even the most intimate and central relationships, largely because most believed that "everyone cheats." Despite this pessimism, most also indicated that trusting partners was critical for maintaining relationships, and discontinuing condom use was viewed as a powerful symbol of trust. Women in both age groups mentioned how discontinuing condom use increased physical closeness and took their relationships to the next level. The resulting increase in intimacy often coincided with mutual expectations of fidelity. Occasionally, fidelity was assessed through STD testing. Although most participants acknowledged the need for testing to stop using condoms, few said they had been tested with their partners. Older participants described testing as a baseline measure of trust and evidence of infidelity in the future. Whether initial testing was done or not, reintroducing condoms or subsequent testing in trusting relationships raised questions of infidelity. As a result, participants were wary of introducing DP into trusting relationships.

Participants in both age groups generally agreed that the longer they were in a relationship, the less vigilant they became in protecting against pregnancy and STDs because their trust and expectations of fidelity and support for a child increased. Thus, most considered discontinuing condom use and other forms of contraception to be part of the natural trajectory for long-term relationships.

Participants in both age groups agreed that social acceptance of children in long-term relationships creates a supportive environment that leads some women (particularly younger women) to make decisions they may regret. Reasons for wanting a child included desires to achieve intimacy, stay together, or accommodate partner desires. Related to the need for intimacy, participants in both age groups described how children would love them or "make them happy." Although participants acknowledged that the appeal of children varies based on life circumstances, most agreed that acceptance and support from family and friends encourages early childbearing. One young woman described her decision to delay childbearing as "selfish."

Young women in both age groups described how the extent to which they cared about their partners shaped their relationship experiences: the more they cared

about and trusted their partners, the more they had to lose in their relationships. Some eased their feelings of vulnerability about their partners' fidelity and about becoming pregnant with STD testing and contraceptive use, particularly early in their relationships. Ultimately, though, many young women discontinued STD and/or pregnancy prevention efforts as a normal stage of their deepening relationship. In general, participants believed that most young women knew how to prevent pregnancy and STDs, but prioritized the desire to maintain a serious relationship over the desire to avoid pregnancy or an STD.

Life experience

Several women in both age groups suggested that personal experiences of pregnancy, parenting, or STDs altered their views on pregnancy and STD prevention. Young women's worries about pregnancy and STDs and their protective behaviors largely followed the patterns described previously (e.g., most used protective methods in casual relationships and in the beginning of serious relationships) until they became pregnant or had an STD. Pregnancy scares that resulted in confrontations with parents and partners altered how they weighed the costs and benefits of pregnancy. Although participants who had children loved them, these women wanted more financially and emotionally secure relationships, so many of them used hormonal contraception after giving birth. Likewise, an STD diagnosis prompted many participants to confront partners and insist on testing and/or condom use. Although there was considerable discussion about learning from others' experiences, the dominant view among both age groups was that it took a "special kind of person" (e.g., someone with goals) to learn from others' experiences.

DISCUSSION

Participants were aware that sexual activity put them at risk for both pregnancy and STDs. Although most had not heard the term "dual protection" before, they understood what it meant and believed it was a good idea. Their interest in practicing DP, however, was mitigated by social context and relationship factors, which shaped their pregnancy intentions, concerns about STDs, and sexual and protective behaviors. Their social environment included peer norms supportive of risk taking (e.g., peers had multiple partners or peers were having babies), parents who did not always support contraceptive use, and families ready to help raise a child—all of which have been linked to sexual and protective behaviors among younger women in other studies.[22] Likewise, the shift from more to less vigilance around unintended pregnancy and STD protection as relationships develop has been well documented.[8,23,24] Some participants were able to avoid early pregnancy and STDs, but many believed they would only learn to protect themselves through personal experience with these matters.

Coupled with the developmental tasks of adolescence and young adulthood, the social environment contributed to wanting children and downplaying STD risks, particularly in serious relationships. Although participants believed that condoms should be used in new or casual relationships, most reported not always using them in such relationships. Participants described the need to balance the risks of pregnancy and STDs while developing long-term relationships characterized by intimacy and trust. Although most women recognized the difficulty of caring for children and dealing with STDs, they weighed these against their relationship concerns and the potential support they would receive from family if they did have a child.

Such a calculus was reasonable to our participants who were, like most adolescents and young adults, learning how to develop intimate relationships. Given their nascent understanding of intimacy, many considered sex, discontinuing condom use, and pregnancy as signaling the increasing seriousness of their relationships. The importance participants placed on intimacy and the ways they defined it may help explain why they tolerated infidelity and limited partner support of a child. The ways adolescents judge actions have been associated with traits such as responsibility (capacity for behavior not unduly influenced by others), perspective (capacity to place decisions in temporal and social contexts), and temperance (capacity to regulate impulses).[25] Adolescents developing these traits are susceptible to peer pressure as they learn to form different kinds of relationships with peers and romantic partners. Seeing their peers have children may have led some of the young women to focus more on how a baby cements a relationship than on how to manage child rearing. Adolescents are present-oriented, which may explain why many of the young women spoke about pleasing partners or saving relationships rather than ensuring an STD-free future.

Participants demonstrated the capacity of young people to learn about intimacy and trust and to apply what they learned. Personal experience helped many of the young women realize that their own needs were just as important as their partners' needs. This realization led them to delay having additional children until they were more emotionally and financially stable and to prompt discussions with partners (and not make

assumptions) about fidelity, condom use, and STD testing.

It is clear that the young women prioritized their relationships over other concerns. Given their awareness of the social dynamics of relationships in their community, many understood the risks associated with having sex and took steps to mitigate that risk (e.g., condom and contraceptive use with new and casual partners, and STD testing). The importance of giving and getting love in romantic and mother-child relationships was substantial. Given a social environment in which children are sometimes the primary evidence of a committed and loving relationship, it was no surprise that motivation to avoid pregnancy and STDs was mixed.

Implications for public health practice

The young women in our sample reported constantly balancing their desire to establish and maintain an intimate relationship with efforts to minimize health risks associated with sexual activity. Although many interventions designed to encourage safe sexual practices address peer norms, they focus more on norms related to preventive strategies or health outcomes than on those related to relationships. To date, couple or relationship interventions have had limited success in promoting safe sexual practices and have not addressed the need of adolescents to form intimate and trusting relationships.[26,27] Additionally, sexual/reproductive health interventions rarely address expectations for healthy adolescent and young adult relationships.

Sexual and reproductive health interventions might draw on lessons learned from interventions to prevent dating violence or promote healthy relationships, including the importance of cultivating a healthy and self-assured character and of learning how to express emotions and desires for a more committed relationship in ways other than having a child or forgoing strategies to prevent STDs. To help young women navigate romantic relationships in a developmentally appropriate and healthier way, interventions should address these topics, as well as the social factors that shape how young women perceive pregnancy and STDs.

Limitations

Because focus group members were recruited from reproductive health clinics, they may have known more about issues related to pregnancy and STDs and may have been more sexually active than other women of the same age. As a result, our findings may not be generalizable to all African American women aged 15–24 years. However, given the sample consisted solely of African American females, we were able to focus on and explore within-group differences to a greater extent. Due to time constraints, the focus group discussion questions did not address the full range of potential relationship issues affecting respondents' sexual behavior and attitudes about contraceptives.

CONCLUSIONS

The extent to which young women are concerned about pregnancy and STDs and the strategies they used to prevent them were influenced by their social environment and desire for trusting, intimate relationships. Young women learning about and establishing relationships in an environment where trust is often violated and early childbearing is accepted may have difficulty establishing the intimate relationships they seek without putting themselves at high risk for pregnancy and STDs. Researchers and practitioners should continue to explore these issues and develop more holistic interventions to promote sexual and reproductive health among young women.

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REFERENCES

1. Cates JR, Herndon NL, Schulz SL, Darroch JE. Our voices, our lives, our futures: youth and sexually transmitted diseases. Chapel Hill (NC): University of North Carolina, School of Journalism and Mass Communication; 2004.
2. Centers for Disease Control and Prevention (US). Sexually transmitted disease surveillance 2010. Atlanta: CDC; 2011. Also available from: URL: http://www.cdc.gov/std/stats10/default.htm [cited 2012 Jan 17].
3. Bennett SE, Assefi NP. School-based teenage pregnancy prevention programs: a systematic review of randomized controlled trials. J Adolesc Health 2005;36:72-81.
4. Johnson BT, Carey MP, Marsh KL, Levin KD, Scott-Sheldon LA. Interventions to reduce sexual risk for the human immunodeficiency virus in adolescents, 1985–2000: a research synthesis. Arch Pediatr Adolesc Med 2003;157:381-8.
5. Kirby D, Laris BA, Rolleri L. Impact of sex and HIV education programs on sexual behaviors of youth in developing and developed countries. Family Health International youth research working paper no. 2 [cited 2012 Feb 29]. Available from: URL: http://www.fhi.org/NR/rdonlyres/e4al5tcjjlldpzwcaxy7ou23nqowdd2xwiznkarhhnptxto4252pgco54yf4cw7j5acujorebfvpug/sexedworkingpaperfinalenyt.pdf
6. Fortenberry JD. Adolescent sex and the rhetoric of risk. In: Romer D, editor. Reducing adolescent risk: toward an integrated approach. Thousand Oaks (CA): Sage Publications; 2003. p. 293-300.
7. Jemmott JB 3rd, Jemmott LS, Fong GT. Efficacy of a theory-based abstinence-only intervention over 24 months: a randomized controlled trial with young adolescents. Arch Pediatr Adolesc Med 2010;164:152-9.
8. O'Leary A. Are dual-method messages undermining STI/HIV prevention? Infect Dis Obstet Gynecol 2011:691210. Epub 2011 Nov 15.
9. Peipert J, Redding CA, Blume J, Allsworth JE, Iannuccillo K,

Lozowski F, et al. Design of a stage-matched intervention trial to increase dual method contraceptive use (Project PROTECT). Contemp Clin Trials 2007;28:626-37.
10. Exner TM, Mantell JE, Hoffman S, Adams-Skinner J, Stein ZA, Leu CS. Project REACH: a provider-delivered dual protection intervention for women using family planning services in New York City. AIDS Care 2011;23:467-75.
11. Mosher WD, Martinez GM, Chandra A, Abma JC, Willson SJ. Use of contraception and use of family planning services in the United States: 1982-2002. Adv Data 2004;(350):1-36.
12. Abma JC, Martinez GM, Copen CE. Teenagers in the United States: sexual activity, contraceptive use, and childbearing, national survey of family growth 2006–2008. Vital Health Stat 23 2010(30).
13. Cates W Jr, Steiner MJ. Dual protection against unintended pregnancy and sexually transmitted infections: what is the best contraceptive approach? Sex Transm Dis 2002;29:168-74.
14. Berer M. Dual protection: more needed than practised or understood. Reprod Health Matters 2006;14:162-70.
15. Centers for Disease Control and Prevention (US). A public health approach for advancing sexual health in the United States: rationale and options for implementation. Meeting report of an external consultation. Atlanta: CDC; 2010.
16. Department of Health and Human Services (US), Office of the Surgeon General. The Surgeon General's call to action to promote sexual health and responsible sexual behavior. Washington: HHS, Office of the Surgeon General; 2001. Also available from: URL: http://www.surgeongeneral.gov/library/calls/sexualhealth/call.pdf [cited 2012 Feb 29].
17. Robinson BB, Bockting WO, Rosser BR, Miner M, Coleman E. The Sexual Health Model: application of a sexological approach to HIV prevention. Health Educ Res 2002;17:43-57.
18. Runeborg A. Sexuality: a missing dimension in development. Stockholm: Swedish International Development Cooperation Agency; 2008. Also available from: URL: http://hivaidsclearinghouse.unesco.org/search/format_long.php?lang=en&ret=topics.php&fiche=4608 [cited 2012 Feb 29].
19. Stevens-Simon C, Sheeder J, Harter S. Teen contraceptive decisions: childbearing intentions are the tip of the iceberg. Women Health 2005;42:55-73.
20. Katz BP, Fortenberry JD, Zimet GD, Blythe MJ, Orr DP. Partner-specific relationship characteristics and condom use among people with sexually transmitted diseases. J Sex Res 2000;37:69-75.
21. Giordano PC, Manning WD, Longmore MA. Affairs of the heart: qualities of adolescent romantic relationships and sexual behavior. J Res Adolesc 2010;20:983-1013.
22. Kirby D. Emerging answers 2007: research findings on programs to reduce teen pregnancy and sexually transmitted diseases. Washington: The National Campaign to Prevent Teen and Unplanned Pregnancy; 2007.
23. Ott MA, Adler NE, Millstein SG, Tschann JM, Ellen JM. The trade-off between hormonal contraceptives and condoms among adolescents. Perspect Sex Reprod Health 2002;34:6-14.
24. Kusunoki Y, Upchurch D. Contraceptive method choice among youth in the United States: the importance of relationship context. Population Studies Center Research Report 08-655. Ann Arbor (MI): University of Michigan Institute for Social Research; 2008.
25. Steinberg L. Is decision making the right framework for research on adolescent risk taking? In: Romer D, editor. Reducing adolescent risk: toward an integrated approach. Thousand Oaks (CA): Sage Publications; 2003. p. 18-24.
26. Harvey SM, Kraft JM, West SG, Taylor AB, Pappas-DeLuca KA, Beckman LJ. Effects of a health behavior change model-based HIV/STI prevention intervention on condom use among heterosexual couples: a randomized trial. Health Educ Behav 2009;36:878-94.
27. El-Bassel N, Witte SS, Gilbert L, Wu E, Chang M, Hill J, et al. The efficacy of a relationship-based HIV/STD prevention program for heterosexual couples. Am J Public Health 2003;93:963-9.