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Family planning and contraceptive decision-making by economically disadvantaged, African-American women

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Abstract

Background—Significant racial disparities exist in the US unplanned pregnancy rate. We conducted a qualitative study using the theory of planned behavior as a framework to describe how low-income, African-American women approach family planning.

Study Design—Structured focus groups were held with adult, low-income, non-pregnant, African-American women in Connecticut. Data were collected using a standardized discussion guide, and audio-taped and transcribed. Four, independent researchers coded the transcripts using the constant comparative method. Codes were organized into over-arching themes.

Results—Contraceptive knowledge was limited with formal education often occurring after sexual debut. Attitudes about contraception were overtly negative with method effectiveness being judged by the experience of side effects. Family and friends strongly influence contraceptive decisions while male partners are primarily seen as a barrier. Contraceptive pills are perceived as readily accessible although compliance is considered a barrier.

Conclusions—Contraception education should occur before sexual debut, should involve trusted family and community members, and should positively frame issues in terms of achieving life goals.

1. Introduction

The burden of unplanned pregnancy is not experienced equally in the USA; unintended pregnancy occurs more often in African-American (69%) and Latina women (54%) as compared to Caucasians (40%) [1], particularly among those women who have low economic status [2]. Causes for these disparate rates are multi-factorial. The decision to choose and use more reliable contraceptive methods (progesterone implant, intrauterine device) differs between Caucasian and other racial/ethnic groups, with African Americans and Latina women more often choosing less reliable contraceptive options (condoms,

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withdrawal method) [3]. Limited access remains an important factor; even in situations where barriers to contraceptive method access are minimized, disparities persist in contraception failure rates within racial/ethnic groups [2] and socioeconomic status [4]. Moreover, more than half of women who have an unplanned pregnancy report use of contraception during the previous month or at the time of conception [3].

Successful family planning requires navigation through a complex series of decisions that are under the influence of sexuality, personal goals and beliefs, and family and community expectations. The theory of planned behavior [5] was developed to explain the positive and negative effects of these influences on behavioral intentions (Fig. 1). In this theory, three major domains influence a person's intention to perform a behavior, (1) beliefs and attitudes that performing the behavior will lead to the desired outcome, (2) the influence of major referents who contribute to subjective norms related to the behavior, and (3) the presence or absence of factors that influence one's perceived ability to perform the specified behavior. Being effectively informed is requisite to engaging in high quality decision-making, and as such, knowledge is the primary domain highlighted in this model. Each of the domains outlined in Fig.1 impact on women's decisions to use contraception.

Previous studies exploring the racial and socioeconomic differences in contraception use focus mainly on adolescents [6], and suggest that age, access to healthcare, and the ability to make healthcare decisions without informed consent influence successful use of contraception. Little is known about the experiences of adult women, for whom relevant factors may differ. Using the theory of planned behavior as a conceptual model, we conducted a qualitative study to describe how low-income, African-American women approach family planning and the contraceptive decision-making process.

2. Materials and methods

2.1 Study design

We performed a qualitative study using focus groups to obtain in-depth information about women's contraception decision-making process over their life course. The focus group approach was chosen because it is well suited to elicit shared experiences and group norms, as well as to reveal the variety of opinions within groups [7,8].

2.2 Participants

We held six focus groups in New Haven, CT, during March-December 2011 with groups ranging in participant number from 5 to 14 (Table 1). We recruited low income, sexually active, non-pregnant, English-speaking, African-American women between the ages of 18-49 years from a hospital-based health center serving primarily low income patients. We conducted focus groups until we obtained thematic saturation, or the point at which no new information was revealed.

2.3 Recruitment

We scheduled educational meetings with clerical/administrative staff, nursing, and care providers prior to recruitment to ensure a broad understanding of our research goals. Staff was encouraged to refer participants to this study about how people make decisions about birth control. They were asked not to discuss the specific aims of the project in order to avoid participant selection bias. We compensated participants with \$35 cash at the end of the 1 to 1.5 hour focus group in recognition of their time and contributions.

2.4 Focus groups

An African-American female (CC) with prior experience moderating focus groups led the sessions. In accordance with the IRB exemption protocol that we received prior to beginning this study, participants were asked to give informed verbal consent at the start of each focus group, were assured of confidentiality, and were asked to provide demographic and reproductive history information. To stimulate conversation, we used a predetermined set of open-ended questions and probes (Fig. 2). Focus groups were recorded, independently transcribed by a professional service, and checked for accuracy by research staff.

2.5 Analysis

We used standard qualitative analysis procedures [9] to systematically code and analyze our data using the constant comparative method. The research team created a codebook with operational definitions and refined it through an iterative process as coding progressed. Coding was performed by four independent coders representing unique cultural and professional backgrounds including public health, medicine, medical decision-making, family planning and obstetrics/gynecology. The codes were then used to organize the data into over-arching themes.

The multidisciplinary research team reviewed all coded transcripts and held regular meetings to resolve inconsistencies in interpretation. We maintained an audit trail [10-11] to track changes in details of code definitions, structures, and applications to different transcripts throughout the analytic process. We used qualitative analysis software (ATLAS.ti 6.2) to organize codes, facilitate data retrieval, and ensure consistent application of codes across all transcripts. After coding was completed and major themes were described, several focus group participants who previously volunteered and provided contact information reviewed the data to affirm the accuracy of the findings.

3. Results

3.1 Knowledge

For many women, sexual debut occurred prior to acquisition of adequate knowledge about contraception. The following quote depicts a woman's experience of an unplanned teen pregnancy.

"I didn't know anything about birth control when I was in high school. Me going to high school, I didn't even know I was pregnant. And I was still going through everything."

Most women in this study were not aware of the breadth of contraceptive options. Oral contraceptive pills were described as the prescription method most discussed, easiest to obtain, and the "expected" first option.

"That was the first one I heard of so that's what everybody was on. When I first heard of birth control everybody had the pills...they go in circles in different colors. That's what I first heard of when I first heard of birth control."

"It was like when I was younger it was birth control pills because that's what you use when you were young."

"I think that's what their study was basically on was the Pill. And that's what they offered, any doctor you go to was recommending birth control pills. It wasn't like the things that we had nowadays, it wasn't all that. It was basically the Pill. So, that's what everybody got - a packet of Pills."

The experience of an unplanned pregnancy activated many participants to learn about contraceptive options. Four women who experienced an unplanned pregnancy illustrated this widening of their perspective.

“I had my daughter the Friday I turned 19... I said okay, I can’t have the pills. Forget the pills. So I left the pills alone and then that’s what I asked my doctor. What’s the best thing for me to do so I can’t have another one? So, it was to use a Depo shot.”

“I chose birth control after I had an abortion. I’m not ready to have a baby.”

Participants expressed the desire for schools and other sources to improve family planning education and access for adolescents and younger women.

“I feel like this discussion should be with younger girls because they really need to hear a lot of these things that were discussed today. I talk to my daughters. I have a good communication with my daughters that openly tell me things. I thank God for that but I’m saying a lot of young girls don’t have people to go to, and I think this open discussion like this will be good for the younger girls also. I really do”

“A lot of teen pregnancy would be prevented if they had the opportunity to get on some birth control. If they can get highly educated about it [contraception] and ... and can make the decision, to me, oh, I guarantee you, most of that [teen pregnancy] will be cut in half if not more.”

3.2 Attitudes and beliefs

Attitudes about contraception were fairly negative. For many participants, choosing a birth control method was seen as a process of elimination; specific options were rejected based on the negative experiences or beliefs of the woman or by her close friends and family. These participants related their difficulty with method choice secondary to their concern over unwanted side effects.

“I don’t know because there are complications with doing birth controls. You get blood clots, it causes you to lose hair. That’s why it’s really kind of hard to choose because you don’t want none of those problems.”

“Well, I think it becomes harder with more choices because then the side effects become more intense.”

Among this group of women, there was a belief that a woman’s body had to “match” a contraceptive method in order for it to effectively prevent pregnancy. Participants explained this viewpoint in the following ways.

“So I feel the Depo’s not for everyone. Any kind of birth control is not for everybody. Everybody’s system is different.”

“It depends on your body. How your body takes to it. It doesn’t matter if you’re doing a patch, the pills, whatever.”

“I tried the pill so many times that my body just couldn’t get used to it. It didn’t agree with my body.”

“Like some women can take the pill and they’re fine with it. Some women can take the pill and they get sick from it.”

The differential experience of side effects was used as a determining factor for a method’s effectiveness. In the following quotation, a woman described dissatisfaction with a contraceptive method that was successful in preventing pregnancy but one she judged as ineffective.

“[I was using] the patch but then I just stopped using it. I just stopped because it was like breaking my skin off. I can’t say it wasn’t working because I didn’t get pregnant. I guess I don’t know. I felt like it wasn’t working”

Women held an overarching belief that pregnancy was not absolutely preventable. Family planning was seen as a way to slow down an inevitable process that is ultimately in the control of God or fate. Two participants related this belief in the following way:

“You can still get pregnant with birth control. That can happen. So, to me that’s slowing down the process of getting pregnant. It’s always a possible chance that you can get pregnant.”

“Like I said, if God wants you to have a baby, you will have a baby. So that’s just how it works.”

Frustration with ineffective contraception led some women to consider abstinence as the only truly effective family planning method. One woman expressed her belief that pregnancy was likely with any deviation from abstinence.

“The one thing with abstinence is that it’s easy and I don’t see where I can have a problem. Well, I can go for three or four years before I can [go without sex] and then every time I do it – a kid. I think that’s my abstinence knowing that every time you do it you are going to have another one.”

3.3 Subjective norms

Major referents that influenced contraceptive choice and use included family and close friends, the religious community and male partners. Many women relied on trusted family members for initial contraception decisions. One participant described actively researching contraceptive methods to determine the most appropriate contraception option but ultimately based her decision on the advice of family members.

“Oh this might be a bad one, but I actually went off, because I have sisters, so I went off of what they were using and their reactions to it, and that’s how I based my opinion. I did research to see, like, what are the pros and cons of each birth control method. That’s how I did it, but mostly I took the words of others and based my opinions on that”.

The following two participants utilized friends and relatives to decide on a method.

“It’s hard for a lot of people to go to their parents and I was one of them because my mother did not talk about it herself. ... So we found out mostly like from your friends, and so those would be the people that you talk to, your peers, other relatives.”

“I don’t know, I was older and I talked to my grandmother about what to use.”

From the perspective of the women in this study, sexually active teens required the involvement of an adult to effectively prevent pregnancy. This involvement took a variety of forms as expressed by the following women.

“Oh, I started to have the urge to want to be with someone else and I didn’t want to have any kids. That’s when I went to my mother and said I wanted to go on birth control.”

“My stepmother was adamant about me getting on birth control because I started staying out late and I wasn’t even having sex then.”

“I’ll tell you my daughter she’s eight and she’s very muscular. You think I’m not going to put her on birth control? She don’t have no choice.”

“I have an 11-year-old granddaughter who lives with me. She’s not having sex or anything and the reason is because I don’t let her go nowhere without me.”

Participants valued the support provided by family and the religious community and expressed concern over losing this support network in the event of an unplanned pregnancy. The following participant revealed her belief in the need to be able to raise a child independently.

“I was going to say maybe if you’re not sure you can do it on your own, you don’t do it because there isn’t never really support there. So if you can’t do it on your own, don’t do it”

Fear of losing this support motivated contraception use in the following participant.

“I live with my grandparents and it’s our house is full so it’s kind of, “God, if I get pregnant I might be kicked out.” So it was kind of that thing like that so I’m, “I hope not. I just hope not to be pregnant because I need a place to live.”

Although friends often played a helpful role in family planning decisions, peer pressure was also named as a factor that encouraged pregnancy and contraception non-use. In the experience of one woman who has since changed her mind, we see that teen pregnancy was desirable within her social network at school.

“When I was in high school, girls used to think being pregnant is a fashion statement. They see a couple of their friends pregnant and they want to get pregnant. Right now when I see others, I think “That is not cute.”

There was a range of expressed attitudes about the role of male partners. Positive partner involvement was seen in the setting of a mutual, romantic relationship, where shared family planning decisions were made as a couple. As these participants expressed:

“Some men do walk out and I’m very lucky because my college individual [boyfriend] is my husband, and not everybody is lucky to have that. So I just wanted to add that.”

“I think it was more effective, us talking about it and getting to really understand different birth control methods to prevent having more children.”

Many women described the responsibility for family planning and the repercussions of an unintended pregnancy as being primarily the woman’s duty. Two participants depicted this accountability for raising a child regardless of the involvement of a male partner.

“They’re my children. I’m going to be stuck with them--not stuck--but they’re my responsibilities. So it doesn’t matter whether he [partner] tells me.”

“A lot of young girls think the man that they -or the boy that they with— is going to be there. But in the long run when that baby come, he’s gone, gone, gone with somebody else.”

3.4. Perceived behavioral control

Many participants in this study felt empowered to make family planning decisions and believed that contraception was readily available.

“I actually, I thought about it beforehand so I used condoms and then once I became sexually active I did get on the birth control pill but I was aware of it and I didn’t want to have a child.”

"Yes, very easy because ... I know that Planned Parenthood or wherever you go ... they're all willing to give out birth control. So it's out there, if anybody is ever wanting any."

"Well, I thought about birth control initially when I first started having sex at sixteen. I was using condoms and at the time, there was a women's center and a few towns over from Maine that did not require parental consent to give out the birth control. And I would say seventeen when I went there and I took birth control Loestrin® for about eight years."

"You could get a condom. Every time you go the doctor, you just ask him if he has condoms. So, there's no excuse why the girls shouldn't have a condom, too".

"You control your body."

However, the focus groups revealed that limited access persists for some. Women shared their difficulty obtaining a desired method of contraception secondary to insurance and transportation issues.

"Fifteen months ago, whatever was when I went for like a different birth control because I was going to start Mirena®. Insurance wouldn't let me get it because it wasn't approved for like state insurance. So then by the time it was like, okay, it's approved now, it's like too late, you're pregnant. I'm like, oh yes, that's a little bit too late now."

"When I was a freshman in college, it was hard for me to go get to you because it's all the way up in Southington and I don't have a car. I had to take the van and that was not there all the time."

Lack of access to multiple options was particularly problematic for women who had difficulty using contraceptive pills effectively. Compliance with taking pills was seen as a barrier to successful family planning.

"Well this was after I had my first child and this was I used to think I could be able to handle taking it but I forget to take pills so that kind of threw me over that. That's what made me have my second child."

"I just know I miss pills. I don't like to take pills because I know I won't - if I had to take them everyday it's a problem because I'll forget."

In addition to lack of access, women expressed the belief that non-supportive family members can act as a barrier to effective contraception use.

"I don't know about everybody else but when I was growing up my mother was very judgmental...So it was like you couldn't go to her and talk to her about stuff without her accusing you or thinking you're doing it..."

"I felt as though if I wasn't scared to talk to my mama - because my mama is strict. If I wasn't scared to talk to my mother, I wouldn't have my oldest daughter."

The male partner was often described as a barrier to effective family planning. One woman expressed her belief that the majority of men do not worry about preventing a pregnancy.

"It's a percentage—but the highest percentage—it's the men that don't care. They just want to get in your drawers"

"I don't know but I'm in a relationship. I don't want to be pregnant or my partner wants me to be pregnant but I'm not ready to have a baby so I'm like... He said like, "Wow. I don't know. I'll go to somebody else who's willing to give me a baby."

Some women depicted an increased susceptibility of younger women to negative persuasion by a more experienced male who actively tried to curtail contraceptive use.

“The first time girls are thinking about it [using contraception] and if they don’t do it I feel like they’re more pressured in like maybe the guy, he’s more experienced. He’s like, “no, it’s your first time, you ain’t really going to get pregnant.”

Women described the male’s negative attitude towards using condoms and an accompanying lack of concern over using them correctly.

“Well, you want to have sex but you don’t want to get pregnant...so it was like you’re telling that person to, “please protect yourself so I can prevent myself from getting pregnant,” but it’s like it comes in one ear and go out the other. So it’s they heard what you said but it’s like they think you’re playing around. “We’re together. Why do we have to use a condom?”

Women expressed a general distrust in the quality and effectiveness of condoms.

“How long are you going to have this condom?” You should check that and the quality. I don’t know whether - but I know they’re selling condoms that are real cheap that are guaranteed to pop. So I think it’s the quality too. If you got to be on it - they think sex is just putting them on, getting it in, it’s over... but there’s like more to it than that.

4. Discussion

Successfully using contraception to prevent an unplanned pregnancy is a complex undertaking that requires alignment of multiple domains: knowledge about available methods, personal attitudes and beliefs, subjective norms, and a person’s ability to obtain and effectively use a birth control method. The results of our study describe the factors that influence each of these components for adult, low-income, African-American women living in New Haven, CT.

The shared experiences of our study participants highlight critical areas that may contribute to higher unintended pregnancy rates. Overall knowledge of contraception methods was limited to a few methods with formal education about contraception often occurring after a person’s sexual debut. The experience of an unplanned pregnancy often motivated a woman to explore a wider range of birth control options. Participants expressed overtly negative attitudes towards contraception, ultimately choosing the least harmful from a group of bad choices with real or perceived negative side effects. Maladaptive health beliefs lead women to equate effectiveness of a contraceptive method with the experience of side effects. Furthermore, the women in this study describe feeling sole responsibility to prevent a pregnancy.

Subjective norms for this group of women are created by important referents: family and friends play a critical role in initial contraceptive choice. The involvement of an adult is often credited for a teen’s success in preventing pregnancy. Concerns over loss of support from the family and community motivate contraception use. The view of male partners is mixed, although they are primarily seen as a barrier to effective contraception use. Women view contraception, particularly oral contraceptive pills, as readily accessible, although the ability to be compliant with this method is seen as a barrier to effective use.

This qualitative study is unique in several ways. Most studies looking at racial/ethnic and socioeconomic differences in contraception use have been performed in adolescents attending family planning or school-based clinics [6,12,13]. In contrast, we explore important family planning influences in adult, economically disadvantaged, African-

American women. Previous work focused primarily on hormonal and barrier method use [4,6] or was performed prior to the general availability of newer contraceptive delivery methods such as the vaginal ring, the hormonal patch or the levonorgestrel containing IUD [14]. From the perspective of a group of adult women, this study is one of the first that considers views on contraception over time, describes the impact of unplanned pregnancy on future contraception decisions, describes major motivators to use contraception, and explores important factors believed to help sexually active teens effectively delay pregnancy.

Some of our findings support the conclusions of previously performed research. This study affirms the important influence of parents and respected adult figures on family planning decisions [12,13]. Similar to a study of adolescent Latinas, we learned that younger African-American women rely on informal sources of information to make a contraceptive decision [15]. Although previously studied only in adolescent women, we also found general misinformation about side effects and a limited awareness of new contraceptive methods in urban African-American women [6]. Our work supports previous findings that women with ambivalent or fatalistic attitudes toward pregnancy may be less likely to effectively use contraceptives [16]. Dissimilar to previous studies, we did not find overt conspiracy beliefs showing distrust of contraception in general [17].

This study has a number of limitations that should be noted. Because our study population comes from a specific geographic area and represents low income women, our findings are not generalizable to the experience of African-American women from more diverse sociodemographic backgrounds. Also, given our primary recruitment from university-based health clinics, our study population may differentially represent those women who feel comfortable accessing health care services in general. One of the benefits of focus groups, however, is their ability to define the cultural and community beliefs that likely transcend decisions about where and if health care is received.

The findings from this study suggest that resources should be used to educate young women prior to their sexual debut – when they are the most vulnerable to having an unplanned pregnancy – in order to decrease misinformation about contraceptive methods and side effects, to reduce the feelings of singular responsibility regarding contraception, and to combat the negative beliefs regarding the inevitability of pregnancy. Our study supports using educational interventions that involve trusted adults from the community and peer educators to serve as family planning role models given the influence of family and trusted friends on initial contraceptive decisions. In light of the generally negative perception of all available birth control options, counseling by health care providers, education materials and programming should be framed as using contraception to achieve future life goals with a focus on the variety of options, their mechanism, and the likelihood of experiencing success instead of limiting the discussion to the possibility of side effects. Although the insight gained from the women in this study can help guide our efforts to decrease the rates of unintended pregnancy in low-income, African-American women, future research about the ways women from all racial/ethnic and socioeconomic groups choose and use contraception is needed if we hope to achieve equity in the ability for all people to achieve their personal and reproductive life goals.

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Fig. 1.
The theory of planned behavior describes the factors that influence a person's success in performing a specific behaviour

- Discussion guide:
1. If you have used a method of birth control in the past to prevent a pregnancy, what things have you tried?
    - o How did you make the decision to use that birth control method?
    - o Did you go to any person or place for advice?
    - o Was there any place or person you would never go to talk with about birth control? How come?
    - o Was there anything that made it difficult to decide on a birth control method?
  2. When did you first think about using birth control?
  3. When was the first time you actually used birth control?
    - o What was the reason for the time between?
    - o How did you go about deciding which method to use?
    - o What were the reasons you wanted to use birth control?
  4. Tell me how you went about figuring out when to start birth control and which method to use?
    - o If you are using a birth control method now, how did you decide on that method?
    - o Are you happy with what you are using right now? Why or Why not?
    - o Was it your first choice? If not, why did you switch to this method?
  6. Talk about a birth control method that worked well for you in the past.
  7. How much control do you feel like you have over using birth control?
    - o Do your partner's reaction/thoughts make a difference on your decision?
    - o What were the most important things about that method that made you choose it?
  8. If used correctly, do you think that every type of birth control works the same way for every woman?
    - o Why or why not?
  9. How do you decide if a birth control method works for you?

Fig. 2.
Focus group discussion guide.

Table 1 Descriptive characteristics for focus group participants (N=44)^a

characteristic	n	%
Highest level of education completed		
8 th grade or less	2	4.5
Some high school but did not graduate	13	29.5
High school graduate or GED	20	45.4
Some college or 2 year degree	6	13.6
College graduate	1	2.2
Occupation status ^b		
Wort full or part time	10	23.8
Retired	1	2.3
Unemployed	28	66.6
Disability	3	7.1
Health insurance status ^c		
Private	2	5.4
Medicare alone	3	8.1
Medicaid	31	83.7
None	1	2.7
Marital Status		
Single	35	79.5
Married/Partner	2	4.4
Widow	4	9.0
Separated/Divorced	2	4.4
Number of pregnancies		
0	3	6.8
1	11	25.0
2	8	18.1
3	6	13.6
>3	11	25.0
Number of pregnancies delivered		
0	6	13.6
1	9	20.4
2	13	4.4
3	7	15.9
>3	8	18.1

^aMean age of participants; 23.3 years old, range (16-49).^bData missing for two people.^cData missing for seven people.