Original article

How can Primary Care Physicians Best Support Contraceptive Decision Making? A Qualitative Study Exploring the Perspectives of Baltimore Latinas

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Abstract

Objectives: U.S. Latinas experience disproportionately high rates of unintended pregnancy and low rates of consistent contraception use. Not well known are Latinas' perspectives about how primary care physicians (PCPs) might facilitate or deter contraceptive decision making. The theory of planned behavior has been used previously to explain contraceptive behaviors. This study used the theory of planned behavior as a guide to help describe Latinas' perspectives regarding specific factors that influence their contraceptive decision making and to describe their perspectives about the role of PCPs in the decision making.

Study Design and Methods: We conducted focus groups (n = 3) and interviews (n = 8) of Latinas ages 15 to 24 years, recruited from urban primary care sites in Baltimore, Maryland. Concepts from the theory of planned behavior were used to develop a coding scheme and guide identification of themes.

Results: Sixteen Latinas participated; all were immigrants.

Themes: The desire to avoid unintended pregnancy is dominant and, not surprisingly, is the main driver of contraceptive intentions. The role of PCPs in contraceptive decision making is to build strong patient relationships through heightened communication and trust. PCPs should develop trust and foster communication by using a shared decision-making approach in contraceptive counseling. Religious norms rarely operate as barriers to contraceptive use, yet positive reinforcement from family, friends, and schools is viewed as supportive.

Conclusions and Implications: For this group of young, immigrant Latinas, there is a pervasive desire for effective communication and trusting relationships with PCPs. Findings suggest that providers can facilitate contraceptive decision making for this population by using a shared decision-making approach to contraceptive counseling.

Recent estimates indicate that nearly than one-half of all pregnancies are unintended, and rates continue to be highest among poor, minority women (Finer & Zolna, 2016). Among the poorest women, Latinas are the most likely group to experience unintended pregnancy and unintended birth (Finer & Zolna, 2011). Unintended births can diminish opportunities for young women to fulfill educational goals (Gipson, Koenig, & Hindin, 2008), and effects are more severe for racial and ethnic minority groups (Finer & Zolna, 2011; Kost & Henshaw, 2014; Mosher & Jones, 2010). Latino immigrants are the fastest growing ethnic group in the United States (Martin et al., 2012; U.S. Census Bureau, Population Division, 2012), and in Baltimore, Maryland (Rawlings-Blake, & Barbot, 2011). In Baltimore, more than 50% of Latinos are low income and have less than a high school education (Baltimore City Health Department, 2011), placing them and their families at high risk for unintended pregnancy.

Many Latinas use contraception inconsistently or not at all (Garcés-Palacio, Altarac, & Scarinci, 2008; Masinter, Feinglass, & Simon, 2013; Rivera, Méndez, Gueye, & Bachmann, 2007;...
Sterling & Sadler, 2009). Reasons associated with low rates of use or inconsistent use among Latinas include limited knowledge about contraceptive options (Craig, Dehlendorf, Borrero, Harper, & Rocca, 2014), misinformation about contraception (Gilliam, Warden, Goldstein, & Tapia, 2004; Reed, England, Littlejohn, Bass, & Cauldillo, 2014; Rocca & Harper, 2012), concerns about side effects (Aarons & Jenkins, 2002; Gilliam et al., 2004; Reed et al., 2014), and inaccurate reasoning about pregnancy risk (Masinter et al., 2013; Reed et al., 2014). There is also evidence that Latinas’ contraceptive decisions are often influenced by their families (Aarons & Jenkins, 2002; Yee & Simon, 2010) and male partners (Schwartz, Brindis, Ralph, & Biggs, 2011; Yee & Simon, 2010). Last, recent research has shown that Latinas report greater odds of being discouraged from childbearing by their providers compared with White women (Downing, LaVeist, & Bullock, 2007). Such perceptions of discouragement to have children might lead to subsequent feelings of pressure from providers to use contraception in general.

Immigrant Latinas in particular may have distinct perceptions about contraception (different from those of non-immigrant Latinas) because of factors related to their immigration status and experiences. The immigration process, along with experiences of perceived discrimination, can adversely affect health and well-being among Latino immigrants (Ajon & Becerra, 2013). Additionally, perceptions about access to care and quality of care can vary among Latino immigrant subgroups, and the mere trait of being an immigrant can impact perceptions of health and health care experiences (Abraido-Lanza, Cespdes, Daya, Flores, & White, 2011; Becerra, Androff, Messing, Castillo, & Cimino, 2015; Martinez Tyson, Arriola, & Corvin, 2016).

The Role of Primary Care in Facilitating Contraceptive Decision Making

Strong primary care has been linked with improved preventive behaviors (Starfield, Gervas, & Mangin, 2012), and primary care physicians (PCPs) are often involved in contraceptive counseling, positively impacting use (Lee, Parisi, Akers, Borrero, & Schwarz, 2011). Additionally, Latinas have previously reported a preference for receiving reproductive care at general health care facilities (Becker & Tsui, 2008). Perhaps even more impactful is the fact that patients who report higher ratings of trust in and communication with their PCPs, demonstrate improved outcomes (Safran et al., 1998; Safran et al., 2006). Among Latinos, inadequate provider communication (Sterling & Sadler, 2009) and suboptimal trust (Davis, Bynum, Katz, Buchanan, & Green, 2012) have been cited as barriers to care. Further, research has also shown that miscommunication between women and their health care providers deters effective contraceptive use (Isacs & Creinin, 2003), whereas high-quality communication between a patient and her provider has been associated with continued method use and use of highly effective methods (Dehlendorf et al., 2016). Optimal PCP communication and trust during contraceptive counseling sessions may also help PCPs to understand their Latina patients’ perspectives regarding contraception to improve and enhance decision making.

We set out to identify factors that influence contraceptive decision making among Latinas in Baltimore. We also specifically sought to understand how trust and communication with PCPs impacts their contraceptive decision making.

Material and Methods

Theoretical Framework for Understanding Contraceptive Behavior

The theory of planned behavior (TPB; Glanz, Rimer, & Viswanath, 2008) was used to guide development of the discussion guide and to frame our understanding of contraceptive behavior (Glanz et al., 2008). The TPB posits that motivations to carry out health behaviors are related to behavioral intentions and that both motivations and intentions predict performance of the behavior (Ajzen & Fishbein, 1972; Glanz et al., 2008). Motivators include attitudes, beliefs, normative beliefs, subjective norms, control beliefs, and perceived behavior control (Ajzen, 2002; Glanz et al., 2008). A key motivator is perceived behavioral control, defined as a person’s perceptions about her ability to perform a given behavior (Ajzen, 2002; Ajzen & Fishbein, 1972). Research has found that the TPB accounts for approximately one-third of the variation in intentions and behavior and that perceived behavioral control accounts for a significant variance independent of the TPB (Armitage & Conner, 2001). The authors hypothesized that effective communication and trust between a woman and her PCP during contraceptive counseling might serve to increase her sense of perceived behavioral control (Figure 1).

Study design, study setting, sample, and recruitment

Focus groups and semistructured interviews were conducted in Baltimore, Maryland. Participants were recruited from two federally qualified health centers that provide primary care to a majority low-income population of minority patients. Purposive sampling (Maxwell, 2012) was used to recruit participants who self-identified as Latina, were ages 15 to 24 years, and were not pregnant or intending to become pregnant at the time of the interview. This age range represents the group with the highest rates of unintended pregnancy and the worst outcomes (Finer & Zolna, 2016; Masinter, Fenglass, & Simon, 2013). Initially, researchers planned to conduct focus groups only; however, after several months of recruitment, it became clear that scheduling conflicts, transportation issues, and family/work responsibilities posed significant barriers to some participants’ ability to commit to focus group meeting times. Additionally, some focus group participants seemed uncomfortable discussing sensitive topics in the presence of other participants and were often less vocal; at times, they were overshadowed by more vocal participants. To address these practical and study design issues (Krueger & Casey, 2014), researchers also conducted individual semistructured interviews.
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