More Than a Destination: Contraceptive Decision Making as a Journey

Margaret Mary Downey, MSW, Stephanie Arteaga, MPH, Elodia Villaseñor, MPH, Anu Manchikanti Gomez, PhD*

Sexual Health and Reproductive Equity Program, School of Social Welfare, University of California, Berkeley, Berkeley, California

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Abstract

Background: Contraceptive use is widely recognized as a means of reducing adverse health-related outcomes. However, dominant paradigms of contraceptive counseling may rely on a narrow definition of “evidence” (i.e., scientifically accurate but exclusive of individual women’s experiences). Given increased enthusiasm for long-acting, reversible contraceptive methods, such paradigms may reinforce counseling that overprivileges effectiveness, particularly for groups considered at high risk of unintended pregnancy. This study investigates where and how women’s experiences fit into the definition of evidence these counseling protocols use.

Methods: Using a qualitative approach, this analysis draws on semistructured interviews with 38 young (ages 18–24) Black and Latina women. We use a qualitative content analysis approach, with coding categories derived directly from the textual data.

Findings: Our analysis suggests that contraceptive decision making is an iterative, relational, reflective journey. Throughout contraceptive histories, participants described experiences evolving to create a foundation from which decision-making power was drawn. The same contraceptive-related decisions were revisited repeatedly, with knowledge accrued along the way. The cumulative experience of using, assigning meanings to, and developing values around contraception meant that young women experienced contraceptive decision making as a dynamic process.

Implications for Practice: This journey creates a rich body of evidence that informs contraceptive decision making. To provide appropriate, acceptable, patient-centered family planning care, providers must engage with evidence grounded in women’s expertise on their contraceptive use in addition to medically accurate data on method effectiveness, side effects, and contraindications.

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and insurance restrictions (American College of Obstetricians and Gynecologists, 2009; Bearak, Finer, Jerman, & Kavanaugh, 2016; Harper et al., 2013). With nearly one-half of pregnancies (45%) in the United States classified as unintended, LARC promotion in particular is presented as a key solution to this issue and its related costs (Finer & Zolna, 2016). Unintended pregnancy rates are disproportionately high among young, Black, Latina, and poor women (Finer & Zolna, 2016). These populations are deemed at “high risk” for unintended pregnancy and targeted for LARC promotion (Secura et al., 2010). However, when epidemiological data and method effectiveness are the primary evidence, many women’s needs are neglected, resulting in a “one-size-fits-all technological solution” to an issue that is highly personal, contextual, and evolves over time (Foster, 2016). Contraceptive decision making in particular is often portrayed as only a “woman’s” issue, without acknowledging the role and positionality of male partners (Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013). As Cookson (2005) observes, scientific research is just one factor alongside experience, anecdote, opinion, and political, economic, legal, or ethical constraints—that impacts health care decisions.

A rich body of literature around evidence-based medicine highlights the tension between scientific data and patient experiences, raising questions about whose evidence is centered and how it is valued (Greenhalgh, Howick, & Maskrey, 2014; Sim, 2016; Timmerman & Berg, 2010). As illustrated in Martin’s (2001) classic text The Woman in the Body, women express “scientific” knowledge in one reproductive health domain and “personal” knowledge in another, suggesting they actively resist a solely “scientific” view, not because they do not understand it, but in part because they find it irrelevant to their experience. In Martin’s study, women who embraced a solely “scientific” view (of menstruation) were left alienated from their bodies’ functions and changes.

Many evidence-based approaches to contraception rely on normative understandings of “correct” and “consistent” usage, with evidence typically conceived of as empirical research (Halpern, Lopez, Grimes, Stockton, & Gallo, 2013; Harper et al., 2013; Stanback, Steiner, Dorflinger, Solo, & Cates, 2015). Increasingly, correct and consistent usage refers to choosing a highly effective method, continuing use throughout one’s sexual history, and using a method precisely as prescribed by a family planning provider. For young women in particular, operating outside the dominant evidence-based paradigm is framed as risky or troubling (Barcelos & Gubrium, 2014; Elliott, 2014; Jaccard & Levitz, 2013; Logan, Holcombe, Manlove, & Ryan, 2007).

Contraceptive decision making is a highly contextual process: women engage factors such as side effects, personal values, relationship status, and/or preference for types of medication (Arteaga & Gomez, 2016; Dehlendorf, Henderson, et al., 2016; Dehlendorf et al., 2013; Manning, Longmore, & Giordano, 2000). With the recent emphasis on LARC, method effectiveness may be the primary factor guiding contraceptive counseling. For example, in tiered effectiveness counseling approaches, in which women are presented information on methods in order of effectiveness, LARCs are presented first, regardless of women’s preferences, priorities, and experiences. With the recent emphasis on LARC, method effectiveness may be the primary factor guiding contraceptive counseling. For example, in tiered effectiveness counseling approaches, in which women are presented information on methods in order of effectiveness, LARCs are presented first, regardless of women’s preferences, priorities, and experiences (Henderson, et al., 2016; Dehlendorf, Scheinberg, et al., 2016). Counseling that privileges this type of evidence or is perceived by the patient as one-sided may result in patients feeling stigmatized, isolated, and reluctant to seek care, under-
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