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More Than a Destination: Contraceptive Decision Making as a Journey

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A B S T R A C T

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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Contraceptive use is a widely accepted means of reducing adverse health-related outcomes, from teen and unintended pregnancy to sexually transmitted infections (Dworsky & Courtney, 2010; Harper et al., 2013; Secura et al., 2014; Stevens-Simon & McAnarney, 2014). Dominant paradigms of contraceptive counseling promote an evidence-based approach (Harper et al., 2013) and development of "treatment" plans that anticipate behaviors and risks (Files et al., 2011). Contraceptive counseling aimed at increasing use of long-acting reversible contraception (LARC) is described as evidence-based, owing to its use of medically accurate data regarding contraception (Secura, Allsworth, Madden, Mullersman, & Peipert, 2010). LARCs, including intrauterine devices (IUDs) and implants, are highly effective at preventing pregnancy and a popular method among health care providers themselves (Stern et al., 2015). The most recent data show that 8.5% of contracepting U.S. women use LARC methods, with the highest rates of use among women aged 25 to 29 (11.4%), compared with women aged 15 to 19 (4.5%), aged 20 to 24 (8.3%), and aged 30 to 34 (10.3%) (Kavanaugh, Jerman, &, Finer, 2015). Among all contracepting women aged 15 to 44, 8.5% of Latina women use LARCs, compared with 8.3% of White women and 9.2% of Black women (Kavanaugh et al., 2015). Scholars note that overall LARC usage has increased in the last decade owing to the reduction of barriers such as cost, patient unfamiliarity, provider unfamiliarity,

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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 (Harper et al., 2013; Madden, Mullersman, Omvig, Secura, & Peipert, 2013). 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, undermining a foundational goal of health promotion (Dehlendorf, Henderson, et al., 2016). Particular attention must be paid to the contraceptive preferences of racialized groups considered at "high" risk of unintended pregnancy, such as Black and Latina women (Finer & Zolna, 2016), in light of historic and ongoing structural oppressions related to contraception and other health-related issues (Daniels & Schulz, 2006; Dehlendorf et al., 2013). For example, research indicates that patient mistrust of family planning care and health care is deeply tied to historic violence, such as the Tuskegee Syphilis Study, forced sterilization, and promotion of Norplant among poor women of color (Roberts, 1999; Sacks, 2015). Encouraging use of one method based on the association of a single patient with a particular population's behaviors may replicate patterns of oppression used to devalue women of color's fertility (Roberts, 1999). "LARC-first" for "high-risk" patients (e.g., young women, women of color) obscures the reality that many women, even with comprehensive counseling and no barriers, will not choose LARCs for a host of reasons that are neglected when method effectiveness is centered rather than patient preferences (Dehlendorf, Fox, Sobel, & Borrero, 2016; Giscombé & Lobel, 2005; Gomez, Fuentes, & Allina, 2014; Gubrium et al., 2016a).

The present qualitative analysis investigates the following questions regarding evidence and contraceptive decision making: How do women experience the definition of evidence these counseling protocols uptake? And where and how do women's experiences fit into these paradigms? This study is informed by calls to make contraceptive counseling more patient-centered and for a more holistic, life course approach to sexual and reproductive health (Bay-Cheng, Robinson, & Zucker, 2009; Dehlendorf et al., 2013; Gubrium et al., 2016b; Luke, Clark, & Zulu, 2011).

Methods

This analysis draws on semistructured, qualitative interview data from 38 young Black and Latina women in the San Francisco Bay Area, collected in 2013. The study's objective was to understand contraceptive decision-making processes and perspectives on IUDs among young women who identified with racial and ethnic groups 1) considered at high risk of unintended pregnancy (Finer & Zolna, 2016); and 2) who have historically experienced constraints to reproductive freedom, such as forced sterilization, denial of maternal and child health programs, or forced adoption (Briggs, 2003; Roberts, 1999). Study eligibility requirements included identifying as female; as Black, African-American, Latina, and/or Hispanic; being between the ages of 18 and 24; having had vaginal sex in the last 3 months; and not being pregnant or trying to become pregnant. Table 1 provides sample characteristics. Respondents were recruited via flyers at community colleges and organizations, and on Craigslist. A total of 192 women were screened via a survey completed online or over the telephone, and 63 met the eligibility criteria, with 38 ultimately participating in the study. Recruitment ceased when thematic saturation was achieved. The San Francisco State University Institutional Review Board approved the study protocol.

Participants provided written informed consent before the interview, completed a brief demographic survey, and received an incentive of $30. Interviews elicited an in-depth history of contraceptive decision-making processes, including initiation and discontinuation, and the context surrounding these decisions. All interviews were conducted in English. Interviewers included the last author (the study's principal investigator) and two masters-level research assistants. To attend to reflexivity,

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