Sexual & Reproductive Healthcare 8 (2016) 19–24

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.srhcjournal.org

The perceived role of clinicians in pregnancy prevention among young Black women

Meredith G. Manze [a,*], Lois McCloskey [b], Barbara G. Bokhour [b,c], Michael K. Paasche-Orlow [d], Victoria A. Parker [b]

[a] CUNY Graduate School of Public Health & Health Policy, New York, NY, USA
[b] Boston University School of Public Health, Boston, MA, USA
[c] Center for Healthcare Organization and Implementation Research, ENRM Veterans Affairs Medical Center, Bedford, MA, USA
[d] Section of General Internal Medicine, Boston Medical Center, Boston University School of Medicine, Boston, MA, USA

ARTICLE INFO

Article history:
Received 25 June 2015
Revised 14 December 2015
Accepted 31 January 2016

Keywords:
Adolescent
Contraception
Health care
Health communication
Pregnancy
Qualitative research

ABSTRACT

Objective: The purpose of this study is to identify young Black women's attitudes toward clinicians and understand how they affect contraceptive behavior.
Study design and main outcome measures: We conducted semi-structured qualitative interviews with women aged 18–23 who self-identified as Black or African-American and analyzed data using techniques informed by grounded theory. Initial codes were grouped thematically, and these themes into larger concepts.
Results: Participants discussed two salient concepts related to pregnancy prevention: (1) sexual responsibility and self-efficacy and (2) the perceived limited role of health care clinicians. Women portrayed themselves as in control of their contraceptive decision-making and practices. Many viewed their life plan, to finish school and gain financial stability, as crucial to their resolve to use contraception. Participants gathered information from various sources to make their own independent decision about which method, if any, was most appropriate for their needs. Most had limited expectations of clinicians and considered in-depth conversations about details of contraceptive use to be irrelevant and unnecessary.
Conclusion: These findings help understand factors contributing to contraceptive decision-making. The patient–clinician interaction is a necessary focus of future research to improve sexual health discussions and understand if and what aspects of this interaction can influence behavior.

Introduction

Researchers and policy makers have focused much attention on the sequelae and prevention of teenage pregnancy, but far less attention on young adults (ages 18–24), the age group with the highest rates of unintended pregnancy (88 and 104 per 1000 women aged 15–44 for 18–19 year olds and 20–24 year olds, respectively) [1]. Young Black women are particularly at risk for higher rates of unwanted pregnancy and lower use of contraception at last intercourse (15–24 years old, sexually active within the last 3 months) compared to their White counterparts [2]. Consistent and correct use of effective contraception prevents unintended pregnancy [3]; clinicians can play a pivotal role in educating women about contraception and help to increase both contraception knowledge and use [4–7]. As patients must acquire prescriptions for various methods of contraception from their clinicians, discussions about sexual health issues are a natural occurrence in these clinical encounters; however, little is known about the content and quality of these conversations and how patients perceive the importance of interactions with clinicians about contraception.

Many types of clinicians deliver pregnancy prevention care, including pediatric, family medicine, internal medicine and obstetrics-gynecology physicians, nurse practitioners, certified nurse-midwives, and physician assistants. Researchers have documented differences in the content and frequency of contraceptive counseling, prescribing habits, beliefs about patients' problems with contraceptive usage and services across clinician types [8]. This lack of consistency can result in patients being misinformed or inadequately informed about contraceptive methods. Young adult women may also have limited access to reproductive health care during their transition from pediatric to adult primary care [9].

In addition, medical mistrust and perceived discrimination may influence the interaction between women of color and health care clinicians. Racial/ethnic disparities in health and health care are well established [10]. Less is known, however, about perceived discrimination in sexual health care among young women of color [11]. There is a disconcerting history in the U.S. of controlling the

Note: Work was done partially when corresponding author was a student at Boston University School of Public Health, Boston, MA.

* Corresponding author. 2180 Third Avenue, Room 523, New York, NY 10035, Tel.: 212 396 7736.
E-mail address: meredith.manze@hunter.cuny.edu (M.G. Manze).

http://dx.doi.org/10.1016/j.srhc.2016.01.003
1877-5756/

reproductive rights of Black and African American women, from the time of slavery until as recently as the 1970s [12]. The Reproductive Justice (RJ) movement has grown in this century in response to the inequities experienced by women of color [13]. RJ is "the human right to have children, not have children, and parent the children we have in safe and healthy environments [and]… to bodily autonomy from any form of reproductive oppression." [13] This movement recognizes the intersection of race, gender and class in reproductive health and calls for a new framework, beyond the scope of the "pro-choice" movement, which is focused on the ultimate health and well-being of women and their families. RJ is informed by the historic and persistent ill effects of reproductive oppression and the awareness that unequal opportunities for social mobility play a key role in health. Health services and advocacy for equality are fundamental tenants to the continued promotion and achievement of RJ [14].

The historical reproductive control of women of color that led to this movement may also be responsible for increased mistrust of the medical system and of birth control in particular [15,16]. One study of low income women found that Black women were more likely to report being pressured by their clinicians to use contraceptives, compared to Whites [11]. A series of studies found that many African Americans who received family planning care felt discriminated against and held conspiracy beliefs about birth control [16]. These beliefs were associated with their perception of their clinicians, negative attitudes toward contraception, and type of contraceptive usage (where women who used contraception were less likely to use a method that must be obtained from a clinician) [15,16]. How discrimination in the health care setting or mistrust of clinicians among younger Black women may affect contraceptive decisions has not yet been examined in the recent public health literature. Using an RJ framework, we explored how the history of and potential current day reproductive oppression and discrimination impacts young women's perceived control of their reproductive lives.

This study was designed based on the Donabedian model of quality of care that proposes three broad domains predict quality of care: structure, process and outcomes [17]. Linking process measures, such as characteristics of the patient–clinician interaction, to outcomes in health services is useful in allowing for quality assessment and identifying processes that necessitate improvement. Applying this model to our study, patient, clinician and system characteristics all influence the patient–clinician interaction. Patient sociodemographic factors, such as race/ethnicity, may contribute to the effectiveness of communication between patients and clinicians [18], and whether or not the patient receives contraceptive counseling. The presence and effectiveness of this counseling, and the patient's perception of this discussion, can influence a patient's knowledge, attitudes and beliefs regarding contraception and pregnancy prevention. This can then influence patients' safe sex behaviors, such as using safe and effective contraception to prevent unintended pregnancy. Becker et al. have assessed how quality of family care has been conceptualized and measured. They found that quality was viewed as multidimensional and suggest a framework that incorporates (among other things) communication, client-centeredness, technical competence and offering a range of services and choices. We have incorporated these domains into our framework of quality for pregnancy prevention, including communication, information provision and patient–clinician interactions [19].

Few studies have focused on patient perceptions of pregnancy prevention and family planning care among young adult women, those most at risk for unintended pregnancies. Each woman may have distinct reasons embedded in cultural, religious, familial or historical roots affecting their contraceptive attitudes and decision-making [15,20]. Our study addresses this gap and seeks to understand what influences young Black women's contraceptive decisions. Contraceptive behavior is multi-dimensional and has many other influences outside of health care, including family, peers and information from the Internet, which can affect health beliefs, knowledge, attitudes and use [20,21]. Thus, our study also allows for discussion of these influences. These objectives serve the study aim of improving our understanding of factors related to attitudes and decision-making about contraceptive and sexual behavior among a population at risk of unintended pregnancy. This study was exploratory, employing qualitative methods to allow participants' views to emerge in their own terms.

Methods

Sample and recruitment

We employed a purposeful sampling method. The inclusion criteria for enrollment included: being female, aged 18–25 years, self-identified as Black or African American and fluent in English. Participants were recruited primarily through another focus group study; flyers were also posted throughout the metropolitan area, including clinics affiliated with a safety-net hospital and local stores. The first author conducted all interviews and completed all informed consent processes. Twenty-seven women expressed interest in this study. Fifteen women, self-identified as Black or African American, ages 18–23, were eligible and participated.

Data collection

We designed and refined a semi-structured interview guide through pilot testing. Questions were informed by the conceptual framework, described above, specifically focused on addressing gaps in the literature related to the patient–clinician interaction. To avoid asking leading questions, we did not directly query for perceived discrimination in care. The guide began with questions regarding participants' feelings about contraception and pregnancy prevention, including their opinions about how well birth control works and preferences for various methods, and then proceeded to ask about interactions with their clinicians in general, and about sexual health care specifically. All interviews were audio recorded. Participants received a $10 gift card for their time and participation. The semi-structured, qualitative interviews occurred from February to July 2010. The majority of the interviewers were held in the administrative space at a large, urban safety-net hospital, with one occurring at a local eatery. The interview times ranged from 16 to 41 minutes. This study was approved by the Boston University Institutional Review Board (IRB).

Analysis

We transcribed all interviews verbatim and analyzed the data using grounded theory techniques. Grounded theory is a qualitative research method in which theories are derived through inductive analysis, based on themes that emerge from the data [22]. We read transcripts repeatedly prior to coding. First, we employed line-by-line coding and created codes that conceptually described the data. Initial codes were grouped thematically, a process known as axial coding [22]. We then analyzed the relationships among the themes, grouping them into larger concepts, focusing particularly on ways in which women portrayed themselves and their interactions with clinicians. We analyzed the transcripts throughout the enrollment process, to begin to identify themes. Our initial research question was related to perceived discrimination in family planning care. However, over the course of the interviews and analysis, this issue was not mentioned in depth so our research interest changed to focus on the themes that emerged from the data. Themes were also reviewed by education level (not shown). All participant names reported are pseudonyms. Qualitative analysis was facilitated by