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The association of attitudes about contraceptives with contraceptive use in a random sample of Colorado women

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ABSTRACT

Context: Research regarding unintended pregnancy often focuses on how women make decisions about whether or not to use contraceptives, and structural barriers to contraception. Less research examines how multidimensional attitudinal characteristics may be associated with effective contraceptive use.
Methods: In fall 2007, we conducted a random telephone survey of 801 sexually active women in Colorado to assess associations of the attitudinal dimensions of Planning, Partner Communication, and Stigma and Misinformation with contraceptive use. We also examine demographic differences on hypothesized predictors.
Results: Stigma and Misinformation is higher in Latina women, women on Medicaid or with no insurance, women with less than a college degree, and women living in small towns or rural areas. Partner Communication attitudes are most positive among those with a bachelor's degree, and those with less than a high school degree, while they are most negative among those living in small towns and rural areas. In multivariate analysis, planning to use contraceptives is associated with greater likelihood of more effective contraceptive use. Higher levels of planning and partner communication are associated with greater likelihood of any contraceptive use.
Discussion: In addition to addressing structural barriers to contraception, interventions to address the need to plan for contraception are vital to mitigate the high prevalence of unintended pregnancies in the United States.

The United States has the highest unintended pregnancy rate of all industrialized nations reporting these statistics (Mishell, 2000; Peipert, Madden, Allsworth, & Secura, 2012). The most recent statistics put the U.S. unintended pregnancy rate at about half of all pregnancies (Finer & Zolna, 2014), with just under half of those ending in abortion (Finer & Zolna, 2014). Unintended pregnancies are most common in young, low-income, uneducated, or unmarried women (Finer & Henshaw, 2006) – all groups that tend to have fewer resources to deal with an unintended pregnancy or infant. Children born to women at risk for unintended pregnancy will face greater social and economic disadvantages, and an increased likelihood of mental, physical, and psychosocial challenges (Logan, Holcombe, Manlove, & Ryan, 2007). Latina women experience high levels of unintended pregnancy (Finer & Henshaw, 2006) and are among the group least likely to use contraceptives (Raine, Minnis, & Padian, 2003). Therefore, a better understanding of motivations

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for contraceptive use among this group specifically is needed.

Necessary precursors for unintended pregnancy prevention are avoidance of sexual activity without use of contraception, and use of effective methods of contraception (Kaye, Suellentrop, & Sloup, 2009). However, structural barriers such as high unemployment, rapid population growth, low socioeconomic status, high levels of religious affiliation, cost and access to services, and lack of insurance coverage (Culwell & Feinglass, 2007a, 2007b; Frost, Singh, & Finer, 2007) also effect contraceptive use. Less is known regarding multidimensional attitudes toward contraception which may interfere with use of effective contraceptive methods. However, previous research suggests several components worthy of further study such as the influence of a partner (James-Hawkins, 2015; Sable, Libbus, & Chiu, 2000), perceptions that contraceptives make sex unpleasurable, unspontaneous, unnatural, or foreign and invasive (Ayoola, Nettleman, & Brewer, 2007), viewing birth control as a hassle or feeling that it takes too much planning (Barber, Gatny, Kusunoki, & Yarger, 2010), wanting to hide sexual activity from others (Ayoola et al., 2007), fear of stigma (Banker, Kaestle, & Allen, 2010; Berntson, Hoffman, & Luff, 2014; James-Hawkins, 2015), and finally, misunderstanding the effectiveness of contraception (Kaye et al., 2009; Roberts & Noyes, 2009; Woodsong, Shedlin, & Koo, 2004). All of these attitudinal components may affect contraceptive behavior, yet they have never been systematically examined in multivariate analysis predicting contraceptive use.

We address this gap in the research by assessing associations of attitudinal components of contraception, perceived severity of an unintended pregnancy (Campo, Askelson, Spies, & Losch, 2012), and external barriers to contraceptive use (Peipert et al., 2012; Secura, Allsworth, Madden, Mullersman, & Peipert, 2010) with contraceptive behavior. Specific attitudinal components included are stigma and misinformation about contraceptives (Banker et al., 2010; Berntson et al., 2014; James-Hawkins, 2015), partner communication about contraceptives (Cox, Posner, & Sangi-Haghpeykar, 2010; Davies et al., 2006; James-Hawkins, 2015), and planning to use contraceptives (Wilder et al., 2009). We use a representative sample of women who are heterosexually active, and may be using contraceptives but are still at risk for experiencing an unintended pregnancy, given high failure rates of some contraceptive methods.

1. Methods

We report on a telephone survey of a random sample of adult women in the State of Colorado who are at risk of experiencing an unintended pregnancy. The telephone survey was conducted by NARAL Pro-Choice Colorado Foundation as part of the Prevention First Colorado program. To ensure unintended pregnancy risk, eligibility criteria include women who: (1) are not pregnant or trying to get pregnant at the time of the survey, (2) believe that neither they, nor their partner are surgically sterile, and (3) have had sex with a man at least once in the 12 months prior to the survey. Eligible respondents are identified by screening households using a list-assisted random-digit sample of telephone numbers in Colorado. Quota sampling is used to oversample Latina women as the largest racial/ethnic minority group in the State of Colorado. A total of 22,000 telephone numbers are screened for inclusion in the study. Of these 39% are disconnected or business numbers, 13% refuse on initial contact, 9% have no eligible household member, 3% have eligible household members but refuse to participate, and 9% terminate the call during the screening questions. Three call backs are made before a number is dropped. Of the 2,165 calls made to households identified as eligible during the screening process, 37% of qualifying households ($N = 801$) complete the survey. Only female interviewers are used and each is bilingual so the surveys can be conducted in either Spanish (13%) or English (87%) as the respondent desires. Verbal consent is obtained at the beginning of the call. On average, the survey takes just under thirteen minutes to complete.

1.1. Measures

1.1.1. Contraceptive attitudes scale

A 22-item Contraceptive Attitudes Scale, created for this study, includes subscales of Planning ($\alpha = .70$), Partner Communication ($\alpha = .75$), and Stigma and Misinformation ($\alpha = .69$). The Cronbach's alpha levels reported assess each subscale's internal reliability, indicating a high level of intercorrelation among items. Scale items are generated as a result of a review of the literature suggesting primary psychosocial concepts associated with both contraceptive use and unintended pregnancy (Ayoola et al., 2007; Sable et al., 2000), and comprehensive pilot testing with two previous samples of 1,016 women in waiting rooms of Colorado clinics and 528 women responding to an online survey. Response options are on a one-to-five scale ranging from "strongly disagree" to "strongly agree." Example items include "I make sure I always have birth control with me" (Planning), "I am willing to discuss birth control with my partner before sex" (Partner Communication), and "Only sluts plan for birth control" (Stigma and Misinformation). An exploratory factor analysis is conducted, using a varimax rotation to maximize distinction of items' loadings on extracted factors. Analysis confirms the three-factor structure, although we eliminate one item that does not load highly on any factor and one item that loads equally on two factors (see Table 1). Higher scores on the Planning scale indicate higher levels of planning to use contraceptives. Higher scores on the Partner Communication scale indicate greater willingness on the part of the respondent to communicate with their partners about contraceptives. Finally, higher scores on the Stigma and Misinformation scale indicate a higher level of stigma and misinformation about contraceptives.

1.1.2. Perceived severity of pregnancy

Two questions are averaged to assess perceived severity or negative impact of pregnancy as used in previous research (Kost, Singh, Vaughan, Trussell, & Bankole, 2008). The questions are, "How important is it to you to NOT get pregnant right now?" rated as "Not at all important" to "Very important", and "How would you feel if you found out