Original Study

Adolescent and Young Women's Contraceptive Decision-Making Processes: Choosing “The Best Method for Her”

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A B S T R A C T

Purpose: To evaluate influences on adolescent and young women's contraceptive decision-making processes.
Methods: We conducted 21 individual interviews with women who presented to an adolescent-focused Title X family planning clinic seeking a new contraceptive method. Data were collected using a semi-structured interview guide, audio-taped and transcribed. Three researchers independently coded the transcripts using grounded theory; codes were organized into overarching themes and discrepancies were resolved.
Results: After identification of themes, we organized the conceptual framework of the decision-making process using the transtheoretical model of behavior change in which participants move through 4 stages: (1) contemplation, (2) preparation, (3) action, and (4) maintenance. When contemplating contraception, most of our participants were highly motivated to avoid pregnancy. During preparation, participants gathered information related to their contraceptive concerns. Participants cited peers as primary informants and healthcare providers as experts in the field. Participants integrated information received with their personal concerns about contraception initiation; the most common concerns were effectiveness, method duration, convenience, and side effects. When participants acted on choosing a contraceptive method they described how it fit their individual needs. They considered their contraceptive experiences unique and not necessarily applicable to others. During maintenance, they acted as informants for other peers, but most commonly expressed that each individual must choose “the best method for her.”
Conclusions: When adolescent and young women select a contraceptive method they balance the benefits and risks of available methods portrayed by peers and provider in the context of their personal concerns. Peer influence appeared to be greatest when participants shared contraceptive concerns and goals.
Key Words: Adolescent, Contraceptive uptake, Decision making, Qualitative

Implications and Contribution

Adolescent and young adult women engage in an autonomous contraceptive decision making process that is partially influenced by peers and physicians. Peer influence is primarily based on shared contraceptive goals, while providers are important for myth clarification and education.

Introduction

Adolescent and young adult women (ages 14-24) have the highest rates of unintended pregnancy in the US.[1] Although data from Cycle 7 of the National Survey of Family Growth (NSFG) showed that 86% of never married females aged 15-19 reported using at least 1 contraceptive method at last sex, the methods most commonly chosen were condoms (52.0%) and the oral contraceptive pill (30.5%).[2] Usage of the most effective methods such as the intrauterine device (IUD) and implant was not specifically reported in the NSFG; however, Finer et al. reported that only 4.5% of adolescents, who used birth control used a long-acting reversible contraceptive (LARC) method between 2007-2009.[3]

Major obstacles to LARC uptake for adolescents and young adult women appear to be cost, awareness, and provider barriers.[4] A recent study in St. Louis demonstrated that when such barriers were removed, the majority of adolescents chose a LARC method.[5,6] This study also demonstrated participants who chose short-acting contraceptive (SARC) methods were 20 times more likely to have a contraceptive failure than those who used LARC methods. Furthermore, participants less than 21 years of age who used pills, patch, or ring had almost twice the risk of unintended pregnancy as older women who used the same methods.[6] Thus, it appears that greater uptake of LARC methods by adolescents and young adult women may decrease unintended pregnancy rates.

Factors that lead to LARC initiation in this population remain obscure. In a study of predictors of IUD initiation among adolescents and young adult women presenting to our adolescent focused Title X clinic in Colorado, Schaefer et al. found that the strongest association was having a friend who uses the method and likes it.[7] Similarly, a survey of contraceptive users in St. Louis demonstrated that having heard a positive experience appeared to affect contraceptive uptake.[8] In contrast, prior qualitative studies in women

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aged 18 and older have reported the influence of the social network on women's contraceptive decision making process to be primarily negative and a source of common myths and misperceptions.[9,10] Given the lack of understanding of how adolescents and young adult women choose contraception, our specific goal was to explore their decision-making processes and the role played by peer influence using qualitative interviews.

Methods

We obtained Institutional Review Board approval at the Colorado Multiple Institutional Review Board to conduct this study at the Children's Hospital Colorado Adolescent Family Planning Clinic. This is an adolescent focused Title X clinic that offers free and confidential contraceptive services to patients aged 12-24 and is primarily staffed by nurse practitioners and physicians.

Participants

At our adolescent-focused Title X Family Planning Clinic, we approached all English-speaking adolescents and young adult women (aged 14-24) who were initiating or switching contraception for participation in our study. The research assistant explained the nature of the study and that participation would be voluntary. Interested participants provided informed consent and after their contraceptive visit with a provider they participated in a semi-structured interview. We used purposive sampling to ensure interviews with users of both long- and short-acting methods, and with women of varied ages and ethnicity. After interview completion, participants were given a $20 gift card. Participants were enrolled until thematic saturation was reached.

Data Collection

Interviews were conducted in a private room. In 5 of the 21 interviews, a female friend or sister of the participant was present at the request of the participant. The research assistant used a semi-structured interview guide to lead the discussion. She explained to participants that their names and any names of friends, partners or family members would be de-identified in the transcription process. Questions about past contraception use, reasons why they chose a new form of contraception and outside sources that helped them make their decisions were included in the guide. We further asked how they discuss contraception with their friends and what they deemed important contraceptive information to pass on to their friends. Following interviews, the research assistant wrote about any unique observations. Interviews were audio recorded and subsequently transcribed and de-identified by the research assistant.

Data Analyses

The de-identified transcripts were independently coded by 3 investigators (JM, MP, MG) using grounded theory techniques. Grounded theory is a qualitative research design in which the inquirer generates a general explanation (theory) of a process, action, or interaction shaped by the views of participants.[11] We engaged in an iterative and comparative form of analysis to allow themes to emerge.[11] Open coding (level I) consisted of line-by-line examination of transcripts and identification of specific factors that influence contraception uptake; these factors were used as codes. During axial coding (level II), we examined open codes to understand the role it played with adolescents and young adult women's contraceptive decision-making processes. We then used selective coding (level III) to merge findings. Next, we created data display tables to visually understand our results and created a conceptual framework based on the theory that emerged. We subsequently re-reviewed transcripts to ensure theoretical consistency. Contributions of the 5 friends or sisters of the primary participants were also evaluated and coded, and considered in the development of the overarching conceptual framework.

Credibility

We took various steps to ensure the validity and reliability of this study including triangulating data, memo writing, and using multiple coders.[12] Since validity can be influenced by researcher bias, the coders clarified their own biases by memo-writing while coding interviews. We improved reliability by having multiple transcript coders; in cases where disagreement occurred, reasons for codes were discussed until agreed upon.

Results

We conducted 21 interviews between November-December 2012, at which time we felt we had reached thematic saturation. We had a racially and ethnically diverse group of participants; 41% were Non-Hispanic White, 36% were Hispanic, 9% were Non-Hispanic Asian, and 14% were

Table 1
Demographic Characteristics of Study Participants

Participant	Age (y)	Race/Ethnicity	Gravidity	Parity	Contraceptive Method Chosen
1	18	Non-Hispanic White	0	0	Implant
2	21	Hispanic	0	0	Implant
3	16	Non-Hispanic Asian	0	0	Implant
4	21	Non-Hispanic White	1	1	LNG-IUS
5	21	Hispanic	0	0	DMPA
6	19	Non-Hispanic Asian	0	0	Ring
7	17	Non-Hispanic White	0	0	Implant
8	17	Hispanic	0	0	DMPA
9	19	Non-Hispanic African American	0	0	DMPA
10	17	Non-Hispanic African American	0	0	OCP
11	17	Non-Hispanic White	0	0	Implant
12	15	Hispanic	0	0	Implant
13	22	Non-Hispanic White	0	0	LNG-IUS
14	17	Hispanic	0	0	Implant
15	17	Hispanic	0	0	DMPA
16	21	Hispanic	3	2	Implant
17	19	Non-Hispanic Black	0	0	OCP
18	23	Non-Hispanic White	1	1	Implant
19	21	Non-Hispanic White	0	0	Implant
20	22	Non-Hispanic White	0	0	LNG-IUS
21	15	Hispanic	0	0	Implant

DMPA, Depot medroxyprogesterone acetate injectable; Implant, Etonorgestrel implant; LNG-IUS, Levonorgestrel Intrauterine System; OCP, Oral contraceptive pills; Ring, Contraceptive vaginal ring.