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Understanding contraceptive needs of women who inject drugs in Orange County: A qualitative study

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Abstract

Objectives: Women with opioid use disorder experience higher rates of unintended pregnancy compared with the general US population. Our aim was to examine the factors that may affect access to desired contraception for women who use injection drugs.

Methods: Using purposive sampling, we conducted semi-structured interviews pertaining to contraceptive use with 14 women ages 18–44 who were current users of injection drugs living in Orange County, CA between March-December 2019. Interviews were transcribed, coded and analyzed using grounded theory.

Results: Participants discussed logistical barriers, including homelessness and lack of transportation, as well as perceived barriers, such as a belief in the inability to become pregnant while using drugs, that affect access to contraceptive care. Women also discussed the factors that motivate them to use contraception despite these barriers, including the desire for sobriety prior to becoming pregnant and fear of harming a fetus while using substances. Some participants expressed feeling uncomfortable disclosing substance use to their healthcare providers out of concern for stigmatization. Several points of access for contraceptive care were elucidated, including visits for primary and postpartum care, as well as in carceral spaces. Finally, participants expressed a desire to obtain contraceptive services at a local syringe exchange program due to trusting relationships with providers and increased ease of access.

Conclusions: Our findings highlight several causative factors for the unmet contraceptive need among women who use injection drugs, and suggest that syringe exchange programs represent a unique access point for the provision of contraceptive care for this population.

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Keywords

syringe exchange; IV drug use; contraception; homeless

Introduction

Women with opioid use disorder are more likely to experience unintended pregnancy compared with women in the general US population. [1] In 2011, 45% of all pregnancies in the US were unintended [2], while 86% of pregnancies among women with opioid use disorder were unintended. [1] Prior research suggests several reasons for this disparity. Women with substance use disorder may be less likely to use contraception, and those who use contraception often rely on less effective methods such as condoms. [3,4] Women's perceptions about contraception may also be influenced by misinformation about substance use causing the inability to become pregnant. [5] A recent study done in Michigan, in which women in treatment for substance use disorders were interviewed about barriers to contraceptive care, demonstrated that this population also faces competing priorities, transportation issues, lack of education surrounding sexual and reproductive health care, and a fear of stigma and law enforcement.[6]

Given the high prevalence of unintended pregnancy and barriers to the use of effective contraception use among women with substance use disorders, it is essential to identify access points to contraceptive services for this population. While some access points fall within the medical establishment, such as postpartum care [7], prior studies have highlighted the importance of potentially integrating family planning services into settings that do not usually incorporate women's health services like substance use treatment programs. [1,5,8,9]

Syringe exchange programs (SEPs) represent another unique access point, particularly for women who use injection drugs and are not in treatment for substance use. Prior research has outlined how SEPs could potentially be utilized by medical providers to increase access to general preventive health services for this high-risk population. [10] There has been limited research done regarding provision of contraception at SEPs. Findings from a recent study of an SEP in Santa Ana, California show a high prevalence of unintended pregnancy and a low prevalence of contraceptive use, and that contraception provision at an SEP would be acceptable to clients. The researchers also found that the contraceptive methods preferred by participants were long acting reversible contraception (LARC) and condoms. [11]

The aim of this study is to further examine factors affecting access to desired contraception for women who use injection drugs, elicit information regarding common points of access to contraception for this population, determine the factors that shape their contraceptive preferences, and conduct a nuanced exploration into why a local SEP would be an acceptable source of contraceptive services. Qualitative methods were chosen to allow for an in-depth look at these complex issues.

Materials and Methods

Data collection

This study was approved by the University of California, Irvine Institutional Review Board. Participants were selected using purposive sampling methods, enrolled in the study and interviewed from March to December 2019. Recruitment occurred during community outreach and naloxone distribution hours with a volunteer-run non-profit SEP based in Santa Ana, California. Eligible participants included women ages 18–45 who used injection drugs, spoke either English or Spanish, and were not trying to become pregnant. Fourteen participants were enrolled and interviewed. This small sample size resulted from the county's halting of the SEP's syringe exchange operations at the time of participant enrollment, which meant that recruitment was limited to backpack outreach and naloxone distribution. Participants received a $40 bus pass as a gift for their participation. All interviews were conducted in English.

All interviewers were female, had extensive experience as volunteers at the SEP working with clients and had completed a BA (OF, MVL) or MA (DA) at the time of the interviews. Two interviewers (OF, DA) had prior experience with qualitative research, and all three received training in qualitative interview techniques from the senior researchers (RP, HTB). Interviews were conducted in the field immediately following recruitment to maximize convenience for participants. Interview topics were identified by the research team, and included experiences with contraception, the impact of substance use on contraceptive use, past experiences with health care providers and desirability of obtaining contraceptive care at an SEP.

The interviews were conducted using a semi-structured interview guide for consistency across topics while allowing researchers to probe when unanticipated subjects of interest arose. Interviews lasted from 8–30 minutes, with a mean of about 14 minutes. In accordance with the principles of grounded theory, data were intermittently analyzed during the collection process and iterative changes were made to the interview instrument based on these preliminary analyses. [12] These mid-collection changes allow researchers to explore themes unanticipated at the project's outset, producing data grounded in the experiences and views of the study participants and more accurately depicting their reality. [12,13]

Analysis

Interviews were digitally audio-recorded, professionally transcribed, and analyzed using ATLAS.ti v 8.4.4, a qualitative data analysis software program (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany). Analysis was guided by the constant comparative method wherein the data are inductively coded and grouped into larger conceptual categories; codes are continually refined as new data are analyzed and new concepts emerge. [13] Three members of the study team independently coded transcripts (OF, DA, MVL), then reviewed their coding strategies and reached a consensus. [13] Grounded theory was applied to the final codes and the patterns that emerged. [14]

Results

Demographics

Participants included 14 women between the ages of 23–39 (mean 30 years old). All participants spoke English. Table 1 describes the demographic characteristics of participants.

Emergent Themes

Factors affecting access to contraception: Logistical barriers—Drug use itself was discussed as a barrier to contraceptive care. Some participants stated that contraception is simply not a priority during periods of substance use.

> Honestly, when you're using drugs, it's kind of in the back of your mind for the most part...you think that would be a priority… −29-year-old, White and Hispanic

Participants identified homelessness as a compounding factor, in that it creates additional challenges, including keeping track of appointments and belongings, and safely storing certain types of contraception. Lack of transportation was mentioned as another barrier that physically prevents women from getting to appointments, and makes obtaining medical care a more time-consuming and stressful endeavor.

> Just lack of transportation and I mean, living outside right now. It's not the easiest to get around. So you know, I'm trying to do that, figure that out right now. −32-year-old, White

> There's the ride situation, there's the appointment…I can't keep any appointments. I never know what time it is…I could get a watch but everything I have is, even if it's jewelry or clothes, things that are on me, I can't keep hold of them. −29-year-old, White and Hispanic

One participant explained that these logistical barriers make condom use more appealing, because condoms are more widely accessible. Finally, lack of insurance was discussed as a financial barrier to contraception.

Factors affecting access to contraception: Perceived barriers—Participants repeatedly reported a belief in the inability to become pregnant while actively using substances, stating they did not need contraception during periods of substance use for this reason. Several of the participants discussed experiencing amenorrhea or oligomenorrhea while using substances, then the return of regular menstruation during periods of sobriety.

> Being on heroin and injecting it, I don't have periods…So I think it's less of a chance for me to become pregnant. −26-year-old, White

> I went to rehab last year like six times. When I went to rehab and I was sober even for a little bit, my period would instantly come back. Instantly. And as soon as I touched drugs…You know how some people get pregnant on drugs? I don't think that's possible for me. −27-year-old, Hispanic

Finally, several women described perceiving themselves as being too passive, or unable to take positive action, as a barrier to obtaining contraception. This was described by

participants as “laziness,” even after discussing logistical barriers that are objectively difficult to surmount.

> Just the fact that I don’t have a car…I mean, I guess if I really want…I guess it’s just laziness. If I really wanted to, I guess I could get there, but you know. −39-year-old, German and Mexican

> Being homeless. And just laziness. And just carelessness, like not being responsible. −37-year-old, White and Asian

Factors that motivate the use of contraception—Despite the aforementioned barriers, participants reported being highly motivated to use contraception to prevent pregnancy for multiple reasons. Several women wanted to make lifestyle changes before becoming pregnant, such as attaining sobriety, stable housing and employment. Women also discussed fear of harming a fetus while using substances as a motivation to use contraception.

> Everything. Just be more stable. Have a good job. And to be clean. −32-year-old, German and Puerto-Rican

> When I’m not living under the freeway. When I’m more stable in life…I would like to be sober eventually. −32-year-old, White

> I don’t want to have a baby out here…on drugs. I don’t want to, you know, hurt a baby. −39-year-old, German and Mexican

Finally, few participants discussed the desire to prevent menstruation through the use of contraceptive methods that cause amenorrhea, and eliminate the cost of feminine hygiene supplies.

> I don’t even have that much sex…I like it ‘cause I don’t have my period. It’s like, have to get tampons and stuff. Being a girl is costly, you know. It’s costly. It’s like, I don’t have a lot of money. −28-year-old, White

Experiences with contraception—Factors that contributed to positive past experiences with contraception included ease of use, such as not needing to remember to take a daily pill.

> [The arm implant is] simple. Don’t have to take it every day. −23-year-old, Hispanic

Factors that contributed to negative past experiences included forgetting to use the contraceptive method appropriately, difficulty storing contraception, and contraceptive method failure resulting in unplanned pregnancy.

> Participant: *I didn’t like [the pill]. Just ‘cause having to remember every single day…it really is kind of a lot to remember…Clearly it’s not gonna happen.* Interviewer: *So were you on the pill when-* Participant: *When I got pregnant with her, yeah. −28-year-old, White*

Disclosing substance use in healthcare settings—Participants discussed past experiences disclosing substance use to their healthcare providers. Factors contributing to discomfort around disclosing drug use included fear of judgment that would result in poor care, being treated like a "drug-seeking" patient, and fear of losing custody of their children.

> They just always criticize and look at you like you're less of a person or something…Like there's something wrong with you or they don't want to give you the care that they give other patients. −26-year-old, White

> When I went there it was about the fact that I was pregnant…There was always this big gnawing feeling in the back of my head like, they're gonna test you, and you're gonna be dirty. −29-year-old, White and Hispanic

Conversely, some participants felt that discussing substance use with their healthcare providers was essential for obtaining the best care for themselves and for their families.

One participant stated that she only felt comfortable talking about her substance use with her healthcare provider when she was in jail, where the provider already knew about it. Another participant reported being more comfortable discussing substance use with healthcare providers who have a background in addiction medicine.

Provider bias limiting contraceptive method choice—Participants discussed whether or not they had experienced perceived coercion on the part of healthcare providers during contraceptive counseling. While most participants did not report coercion, some felt that their providers may not have provided access to the full range of contraceptive options. This led at least one participant to end her relationship with her provider.

> I told them I didn't want to be on [depo provera] anymore. And they were like, well that's what's best for you. So I eventually just stopped. I just stopped going and I stopped being on it because they didn't want to offer me a different birth control. −32-year-old, White

> The IUD definitely…It wasn't like, forced, but it was like, you're gonna want this…I never said oh no, let me try something else. It was like…almost seemed like, oh it's what everybody else does. −29-year-old, White and Hispanic

Access points for contraception—Participants discussed having accessed contraception from multiple sources within the healthcare setting, including post-delivery in an obstetrical setting, post-pregnancy termination, through primary care offices and at Planned Parenthood. Participants also described alternative points of access, the most common being carceral spaces. Women reported having received various types of contraception, including LARC and birth control pills, while incarcerated. Participants were then released without any plan for continuation of the contraceptive method. One participant stated that she had been prescribed birth control pills on her release, but was given a limited supply with no follow up.

> The prison only gave me a three-month supply…Once you're released, you're released. That's it…I would've [preferred to stay on the birth control]. Definitely. −39-year-old, Mexican and German

Many participants had a positive view of the idea of integration of contraceptive care into an SEP. Participants discussed their long-standing trust in SEP providers, which would enhance their comfort with discussing contraception and disclosing details about substance use.

> I'm more comfortable with them also, I feel like. Because I have been around those people more. −26-year-old, White

Ease of access ("one stop shopping") was also identified as a reason for integrating these services, which is particularly important for a population with multiple competing priorities.

> Because it's hard for me to go out and get it done. So when people come out, like how you guys come out to us, it's way easier. −25-year-old, Hispanic

Discussion

This study provides novel insights into the unique intersections of injection drug use and contraception for women who utilize syringe exchange and harm reduction services, thus adding to the growing body of literature on this topic. Particularly, our findings demonstrate why, from the point of view of our participants, contraceptive services are desired at SEPs, and adds to the literature about integration of contraceptive care into SEPs.

The most common barriers to contraceptive care were issues with reliable transportation, homelessness and drug use itself, as well as the common misconception that women cannot become pregnant while using substances. Despite these barriers, women described their continued motivation to use contraception, including making major lifestyle changes and working toward sobriety prior to becoming pregnant. Women also discussed positive experiences with contraceptive methods that are less user-dependent, such as the IUD and implant, echoing prior evidence that women who utilize SEPs may actually be more likely to use the most effective forms of contraception than the general population. [11] These findings highlight the importance of reducing barriers to desired contraception for this population.

The criminal justice system was identified as an important point of contact for medical care. To our knowledge, this is the first study to directly demonstrate the link between substance use and the provision of contraceptive care in carceral spaces. In recent decades, the incarceration rate for women has risen dramatically and now is almost double the incarceration rate for men. [15] According to recent nationwide data, 82% of women in jail are incarcerated for low-level, nonviolent offenses (e.g. property or public order offenses), and 29% are incarcerated for drug offenses alone. [16] Thus, there is considerable overlap between women who use injection drugs and women who experience incarceration; indeed, 82% of women in jail have drug or alcohol dependence issues.[16] Further, there are substantial reproductive health needs among incarcerated women and prior research has identified the criminal justice system as an important potential venue for contraception provision.[17]

This raises some potential issues deserving of examination, including taking a closer look at the physicians tasked with contraceptive care in carceral facilities. One study showed that only 50% of a nationally representative sample of correctional health providers felt "good" or "very good" about their ability to counsel on oral contraceptive pills. [17] It seems prudent that healthcare providers in prisons and jails should not only be able to counsel

on the full spectrum of contraceptive options, but should also be trained in patient-centered contraceptive counseling. In addition, as discussed by a study participant, there is often a gap in healthcare upon release from incarceration, which means that women who have begun using contraception may not be able to continue it. Future research should focus on how women feel about receiving contraception while incarcerated.

Utilizing points of care that are already frequented by women who use injection drugs, aside from prisons and jails, is an important way to increase contraceptive access. Prior research supports the efficacy of screening women in opioid treatment programs for reproductive health concerns, including contraception. [8] Our findings confirm that SEPs could be another acceptable point of access for contraceptive care, and could even serve to bridge the gap between carceral spaces and the healthcare system.

While contraception may not currently be widely available at SEPs, SEPs as a space for medical intervention is not new. SEP clients have been shown to have unmet needs for health services, including sexual risk reduction services, and SEPs are often the sole source of such services for this population. [10] Indeed, SEP clients who do receive these health services often do so at their SEP. Convenience, regularity of visits, continuity of care and the close relationships with care providers have been documented as reasons this population prefers to receive medical care through their local SEP [10]; many of these same reasons were mentioned by participants in the present study. For SEPs to be effective points of contact for medical care, they should be widely accessible, which entails expanding hours and locations. [10]

Program implementation at SEPs has had mixed success. One recent needs assessment and pilot program done at an SEP in Hawaii demonstrated very little participant uptake of contraceptive services, which authors hypothesized may have been due to insufficient integration into the SEP itself, and that the SEP did not offer an appropriate environment in which to discuss family planning.[18] A more successful program was implemented and studied in Baltimore in 2012, in which reproductive health services, including contraception, were integrated into needle exchange mobile vans in the “red light district.” Outcomes of this pilot suggested that similar programs have the potential to be impactful.[19]

Finally, in discussing expanded access to contraception for women who use injection drugs, it is important to acknowledge that this population has been a target of coercion in reproductive decision-making. Project Prevention, for example, in which people with substance use disorders were offered $300 to use LARC or undergo surgical sterilization, was ostensibly started to reduce the number of infants born with neonatal abstinence syndrome. [20] Recent research also demonstrated that for healthcare workers providing contraceptive counseling for women with substance use disorders, the tension between wanting to be patient-centered while also encouraging the use of the most effective contraceptive methods may be particularly strong.[21] As we show in this study, at least one participant felt pressured by her provider to choose a specific contraceptive method. As we also demonstrate, however, women who use injection drugs are already highly motivated to utilize contraception.

Our study identified unique considerations (eg. Homelessness, transportation issues, misperceptions around fertility) among women who use injection drugs that can be integrated into counseling and service delivery. Providers of contraception should strive to create a non-judgmental environment that will encourage disclosure of substance use so that a discussion about the factors that affect contraceptive use for this population can be incorporated into contraceptive counseling (see Figure 1). Any intervention to enhance access to contraception implemented in this population must be patient-centered and non-coercive.

Limitations/ Confounding Factors

There are several limitations to consider in analyzing the findings of this study. The first is the small sample size. At the time that participant enrollment began for this study, the syringe exchange operations of the SEP had been halted by the county, and volunteers were solely able to provide backpack outreach and naloxone distribution. This reduced the number of clients that could be reached. Reliance on street outreach also meant that many of the participants who enrolled in the study were experiencing homelessness. This is a potentially confounding factor, as it can contribute to lack of resources, making medical care more difficult to obtain. In addition, interviews were conducted outdoors, and while care was taken to conduct interviews in locations with adequate privacy, it is possible that participants modified their answers if they were concerned about being overheard.

Conclusion

This study reinforces that there is an unmet contraceptive need, as well as unique barriers to contraceptive use, for women who use injection drugs. Syringe exchange programs could serve as an acceptable point of access for contraception for this population.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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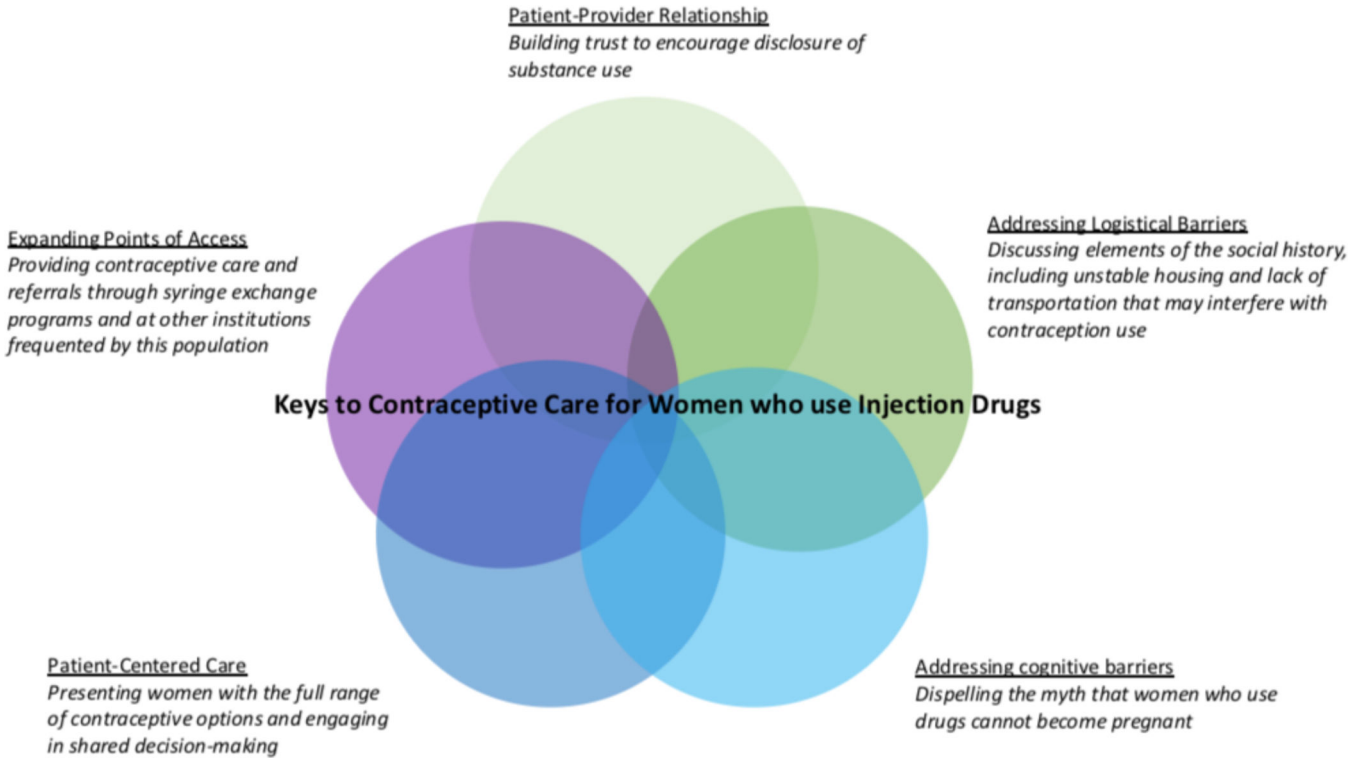

Figure 1.

Keys to contraceptive care for women who use injection drugs. Each of these elements is an essential component of effective contraceptive care for this population.

TABLE 1.

Participant Characteristics, N=14

	Frequency	%
Race/Ethnicity		
Hispanic/Latina	3	21.4
White	3	21.4
Two or more races	8	57.1
Educational Attainment		
Less than high school	4	28.6
High school diploma or GED	6	42.9
Some college	2	14.3
Vocational or trade school	2	14.3
Age		
21–25	2	14.3
26–30	6	42.9
31–35	3	21.4
36–40	3	21.4
Drugs Type Used *		
Cocaine	1	7.1
Heroin	8	57.1
Marijuana	2	14.3
Methamphetamine	8	57.1
Mushrooms	1	7.1
Did not specify	4	28.6
Past Pregnancies		
0	1	7.1
1	3	21.4
2–3	5	35.7
4–5	3	21.4
>5	2	14.3
Live Births		
0	3	21.4
1	4	28.6
2–3	4	28.6
4–5	3	21.4
Insured at Time of Interview		
Yes	7	50
No	7	50

* Participants could select more than one drug type; percentages do not total 100%. Number indicates drug(s) being used at the time of interview and does not include other drugs used in the past. At least one of these drugs was injected in order for the participant to qualify for the study. Category does not include alcohol.