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"It's Worked Well for Me": Young Women's Reasons for Choosing Lower-Efficacy Contraceptive Methods

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Abstract

STUDY OBJECTIVE: To understand the diverse reasons why some young women choose contraceptive methods that are less effective at preventing pregnancy, including condoms, withdrawal and emergency contraception (EC) pills, even when more effective contraceptive methods are made available to them.

DESIGN: In-depth interviews with young women at family planning clinics in July-November 2016. Interview data were thematically coded and analyzed using an iterative approach.

SETTING: Two youth-serving family planning clinics serving predominantly Latinx and African American communities in the San Francisco Bay Area, CA

PARTICIPANTS: 22 young women ages 15–25 who recently accessed EC to prevent pregnancy

INTERVENTIONS: N/A

MAIN OUTCOME MEASURES: Young women's experiences using different methods of contraception, with specific attention to methods that are less effective at preventing pregnancy.

RESULTS: Young women reported having previously used a range of higher- and lower-efficacy contraceptive methods. In interviews, they described affirmative values that drive their decision to use lower-efficacy methods, including: a preference for flexibility and spontaneity over continual contraceptive use, an emphasis on protecting one's body, and satisfaction with the method's effectiveness at preventing pregnancy. Some young women described using a combination of lower-efficacy methods to reduce their pregnancy risk.

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Presentation of Findings

Findings from this study were accepted for poster presentation at the Society for Adolescent Health and Medicine annual conference, March 2020 (canceled due to the COVID-19 pandemic). Select findings were shared at the American Public Health Association annual meeting (November 2019).

Conflicts of Interest

The authors have no conflicts of interest to disclose.

CONCLUSION: Young women make contraceptive decisions based on preferences and values that include, but are not limited to, effectiveness at preventing pregnancy. These reasons are salient in their lives and need to be recognized as valid by sexual health care providers to ensure that young women receive ongoing high-quality care.

Keywords

Adolescent; contraception; condoms; withdrawal; emergency contraception; patient-centered care

INTRODUCTION

Over the past decades, there has been considerable investment and interest in increasing use of short- and long-acting reversible contraceptive methods. These methods are highly effective at preventing pregnancy, with intrauterine devices (IUDs) and the contraceptive implant having a <1% chance of pregnancy and oral contraceptive pills (OCPs), patch and ring having a 4%–7% chance of pregnancy after one year of typical use.[1] However, compared to these "higher-efficacy" methods, the comparably "lower-efficacy" methods are the most accessible, affordable and commonly used by young people. These include condoms and withdrawal, which have an annual pregnancy risk of 13% and 20% with typical use, respectively.[1] Among sexually active adolescent females, nearly all (97%) have reporting using condoms and 65% have used withdrawal.[2] While most young people (53%) have used OCPs, far fewer have used implants or IUDs (20%).[2] While there are important variations in use of specific contraceptive methods by age, race/ethnicity, relationship context, and sociocultural factors, condoms and withdrawal remain a common choice.[2]

Use of these lower-efficacy methods is often dismissed by clinicians and public health professionals as risky, especially for young people. Some may disregard young women's concerns about higher-efficacy methods by framing them as myths or misperceptions, emphasizing consistency of use and effectiveness over individual preferences.[3,4] Some may infringe on young women's reproductive autonomy through implicit pressure, an experience reported by young Latina and African American women in particular.[5] Lower-efficacy methods are often presented as equivalent to using no contraceptive method, even though they are far more effective than using no method, which results in an 85% chance of pregnancy within one year. Relative to the higher-efficacy methods that can require navigating numerous barriers to care,[6] lower-efficacy methods can be easy to get and use, enable male partners to have a role in contracepting and, when used consistently and correctly, chances of pregnancy for condoms (3%) and withdrawal (4%) are comparable to higher-efficacy methods. Moreover, EC pills are available post-coitally if needed.

An essential ingredient of patient-centered contraceptive counseling is to center the counseling on an individual's preferences.[7] Research has shown that effectiveness is rarely the only factor motivating method choice.[8–10] When surveyed about their preferences for contraceptive features, young women at risk of unintended pregnancy ranked effectiveness (80%) and lack of side effects (79%) as extremely important to them. Other features ranked nearly as important, including ease of access (77%), ease of use (66%), and affordability (63%).[9] Subsequent analyses found notable differences in contraceptive preferences by race/

ethnicity, with Latina and African American women more likely to rank as extremely important features that allowed them to have control over initiating and discontinuing the method, did not affect their menstrual cycle, and allowed them to become pregnant immediately after stopping use.[8] As other research has noted, the physical and emotional side effects of higher-efficacy methods make them "not inconsequential to use,"[11] and dissatisfaction among many women is common.[12,13] Thus, a narrow focus on increasing access to higher-efficacy methods ignores the fact that lower-efficacy methods may be the preferred option for some people, particularly women of color.

In this study, we aimed to explore young women's decisions to use lower-efficacy contraceptive methods, even when methods that are more effective at preventing pregnancy are available to them. Women accessing EC at a family planning clinic are a population particularly suitable for understanding the complexities of decisions about contraception. They are seeking to prevent pregnancy, motivated and able to get to a clinic, and often aware that free or low-cost contraception is available. While not representative of all young women, focusing on this population provides an opportunity to understand why young women may not choose the contraceptive methods that are most effective at preventing pregnancy. This design allows us to separate the well-known structural barriers to care from the individual characteristics, attitudes and experiences that influence contraceptive decisions. In this study, we conducted in-depth interviews with a sample of predominantly Latina and African American young women seeking EC at youth-serving family planning clinics, seeking to better understand their method choices.

MATERIALS AND METHODS

Study Design

Between July-November 2016, we conducted in-depth interviews with young women accessing EC at two youth-serving family planning clinics in the San Francisco Bay Area. Both clinics serve primarily low-income Latinx and African American communities and offer a full range of contraceptive methods at no charge through California's Medicaid and state family planning (Family PACT) programs. The initial study concept emerged from conversations with the director of one of the clinics, who had noted that among patients receiving EC, about half were choosing to leave without a hormonal or long-term reversible contraceptive method. At outset, we aimed to recruit at least 20 young women, which we deemed feasible given the clinics' volume of EC patients (about 40 per month) and appropriate given the exploratory nature of the study. Qualitative practice uses the concept of "saturation" to establish appropriate sample size, with some research noting that salient themes are often generated in fewer than 20 interviews.[14]

An onsite research coordinator approached patients seeking EC about participating in the study, provided informational materials, and screened patients for eligibility. English- and Spanish-speaking women, ages 30 and younger, who had sought EC at the clinic were eligible to participate. Because minors can consent to contraceptive services in California, parental consent was not required for study participation. After giving verbal consent, respondents entered their contact information in a secure iPad. Two trained female interviewers, fluent in English and Spanish, contacted and interviewed respondents by phone

within four weeks of their clinic visit. Respondents received a $25 gift card for participation. The institutional review board of the University of California, San Francisco approved the study protocol.

Procedures

We developed an open-ended interview guide that asked respondents to reflect on their experiences using contraception. The guide was developed based on the research literature on young women's contraceptive use and was reviewed by the study team, who included public health researchers, a social psychologist researcher, a medical sociologist, and a physician-researcher who provides clinical services to young people in similar settings. The guide was organized by key domains, including: reasons for choosing or declining a particular contraceptive method, past experiences using contraception, and perceived risks and benefits of contraception versus pregnancy. Interviews were semi-structured, allowing respondents to respond to questions and introduce new ideas. At the end of the interview, respondents were asked a series of brief questions about their background, including their age, race/ethnicity, education, health insurance status, pregnancy history, and when (if ever) they would like to have a/another child. Respondents were not asked about their sexual orientation or gender identity. On average, interviews lasted 35 minutes. Interviews were audio-recorded and transcribed verbatim. One respondent chose to be interviewed in Spanish; a certified translator transcribed and translated the interview into English. Following each interview, interviewers summarized reflections and salient points in a brief memo.

Analysis

We used a thematic approach to the analysis.[15,16] The first and senior authors reviewed five transcripts and generated a preliminary list of thematic codes regarding respondents' experiences using different contraceptive methods. Preliminary codes were discussed by the team, refined, and then applied to an additional five transcripts. Throughout this process, the authors compared application of codes and resolved differences through consensus, until a final codebook was generated. Rater agreement was not assessed quantitatively. The first author applied the final codes to all interviews using Dedoose qualitative data management software[17] and analyzed the data for thematic patterns, including recurrence of themes and differences across interviews, which were then deliberated by the team. We use pseudonyms in our results to protect respondent confidentiality.

RESULTS

Respondent Characteristics

We concluded that we reached saturation of themes regarding reasons for choosing and declining a contraceptive method after 22 interviews. Respondent characteristics are presented in Table 1. On average, respondents were 21 years old, ranging from age 15 to 25. Consistent with the populations served by the recruitment sites, most women reported their race/ethnicity as Latina (50%) or African American (23%). Ten reported they were currently in a serious relationship. Eight had previously been pregnant. All reported that they would

like to have a child in the future; half reported they would like to have a child in the next five years.

Most respondents had previously used contraception. Sixteen (73%) reported having used at least one higher-efficacy method, most commonly OCPs, and six reported trying more than one higher-efficacy method. Among lower-efficacy methods, eight reported having used condoms, eight had used withdrawal, and 18 had previously used EC pills.

All respondents left their clinic visit with EC, either pills or the copper IUD. Just over half of respondents (13 of 22) also chose a higher-efficacy contraceptive method: 6 IUD (4 hormonal, 2 copper), 4 implant, 2 injectable, 1 OCPs. Nine chose EC pills only and did not adopt another method at the clinic visit.

Thematic Analysis

Key themes emerged indicating respondents' reasons for using lower-efficacy methods. Young women described values that motivated their decisions to choose these methods, in the past and/or currently. These were: 1) a preference for flexibility and spontaneity over continual contraceptive use, 2) an emphasis on protecting their bodies, and 3) satisfaction with method effectiveness. Responses were often based on past experiences using different types of contraceptive methods. We did not find differences in themes based on prior method use or in their decision to adopt another method (in addition to EC) at the clinic visit.

Flexibility and Spontaneity—In interviews, some young women described using lower-efficacy methods because they preferred to use contraception only when they needed or wanted it rather than on an ongoing basis. They valued the flexibility and spontaneity of coitally-dependent methods over other methods that are "in use" regardless of their risk of pregnancy, or they valued switching method types based on how frequently they were having sex and on the level of commitment with their partner(s). These women described an explicit preference for not contracepting when they are not having sex and not committing long-term to a particular method. For example, Amber spoke of her preference for not wanting to think about or use contraception when she was not sexually active. Her primary preferred method was condoms; when she had unprotected sex, she used EC pills (Plan B):

> "There's no challenges [using Plan B]. That's why I like it. It's not a consistent thing. It's based on my sex life. So if I don't have a sex life, then I don't have Plan B. If I do have unprotected [sex], then there will be Plan B."

Other similarly praised lower-efficacy methods for their ease of access and use when needed. Christina noted that condoms are "*easy, very easy*" to get, including at clinics or schools for free. Olivia described no challenges using withdrawal with her partner because they "*were definitely very communicative about it."* Crystal, a frequent condom user, noted, "*I just ask [partners] if they have condoms or not. I usually have some just in case they don't*."

As described in these examples, women's decisions about contraception were often related to their current relationship - how frequently they were having sex and whether it was with casual or steady partner. They described experiences starting or discontinuing higher-

efficacy methods with the changes in their sex lives. Alexa had her IUD removed in the past because "*I wasn't having sex with anyone*," and Olivia previously "*decided to take birth control pills because at that time I was sexually active*." Jordan described her current decision to switch from using withdrawal and EC pills to an IUD as spurred by a new relationship where sex was more important and more frequent:

> "I didn't know I was going to get into such a strong relationship where sex was such a big deal… In my past relationship it wasn't always the number one priority, I should say. But now it's such a big deal with this, I really want my birth control back."

Most respondents did not express an aversion to using hormonal or LARC methods. Rather, they saw contraception as a choice that could be made, and then unmade, as their needs changed. Jordan noted, "*I'm still Team Birth Control [even when] I'm not on it at the moment. It's something that I think about all the time."* This was true for young women who chose to leave their current clinic visit with a higher-efficacy method after having been using lower-efficacy methods, as well as those who left without an ongoing method after receiving EC pills. As Sofia said about her decision to start the IUD: *"I honestly don't plan on having this forever. This is just something right now."*

Protecting the Body—Nearly all respondents expressed concerns about the impact of higher-efficacy methods on their bodies, both in terms of immediate side effects (weight gain/loss, acne, depression) as well as future consequences (fertility). They described hormonal and LARC methods as powerful in their ability to prevent pregnancy and questioned how else they might be affecting their bodies. Overall, these young women expressed an affirmative desire to protect and care for their health.

Christina shared a common concern about how higher-efficacy methods can physically affect the body beyond preventing pregnancy after learning at her clinic visit that OCPs have been linked to depression and mood changes: "*Just the fact of whether or not it's going to change my body in any sort of way, if it's going to change my behavior… [The clinic materials] said that it may cause depression. I'm just concerned about that."* Olivia decided to go back on OCPs after an absence and described her concerns about higher-efficacy contraceptive methods:

> "I feel like obviously it's going to alter your body in some way, shape or form….You have to literally put it into your body, put it into your skin or take it orally and have it chemically work your body in a different way than [your body is] supposed to work."

In particular, these young women wanted to protect their future fertility. All of the respondents voiced the desire to have children in the future, and saw their decisions about preventing pregnancy now as connected to their opportunity to become pregnant later. Daniela expressed fears about the IUD she chose at her clinic visit: "*That's probably the only thing I'm scared of. Maybe in the future, maybe in ten years, I would like another child. I'm not sure, but I wouldn't want that possibility to be taken away*."

Often, women expressed their concerns about higher-efficacy methods - and their consequent choice to use lower-efficacy methods - in terms of wanting to take care of their body. They described wanting to take a break from hormones in order to "*just be natural"* and *"let your body be."* Christina, who chose the implant, explained:

> "I do care about my well-being. I mean I do care about my body and what I put inside my body… That is just my main concern of whether it's going to change my body and affect my body in a negative way long-term."

Similarly, Jordan described relief that comes with not using higher-efficacy contraceptive methods: *"It gives me a sense of clarity that I'm clean from everything that's been in my system*." These women described stepping away from higher-efficacy methods for a period of time as beneficial and healthy.

Satisfaction with Effectiveness—Most respondents expressed confidence in the effectiveness of condoms, withdrawal and, in particular, EC pills at preventing pregnancy. Even though they knew that these methods are less effective at preventing pregnancy than the higher-efficacy methods, they expressed satisfaction with the level of effectiveness, especially at particular times in their sexual lives.

Some respondents described how these methods work in explaining their perceived effectiveness at preventing pregnancy. Having an understanding of how the methods work - such as, condoms are "*obviously like a physical barrier"* and withdrawal keeps the semen "*not inside you, basically [there's] less chance for pregnancy"* - promoted confidence in using the methods. The effectiveness of lower-efficacy methods was also expressed in comments about their widespread availability and use. Olivia, for example, described her satisfaction with using EC pills by noting: "*I like how a lot of women have used Plan B after having unprotected sex and it works. It's effective. So that's definitely a reason as to why I like it*."

Often, women relied on their personal experiences to reinforce their sense of a lower-efficacy method's effectiveness. Some pointed to how long they have been sexually active or how often they have relied on these methods without becoming pregnant. For example, Andrea described why condoms are a good method for her: "*I've personally never been pregnant with condoms, even now. So I mean it's worked well for me. I've always tried to be as safe and careful as I can with whatever partner I was with*." She also pointed to the drawbacks of condoms - namely that they require regular planning and communication - but felt confident that they have been an effective method for her. She continued, "*I guess it really depends on how responsible you are as a person. I think they do what they're supposed to do. And if you do what you're supposed to, they'll work good for you*."

Some respondents relied on multiple lower-efficacy methods, using each as a backup when needed. For example, Jordan spoke of the reassurance of taking EC pills when her partner didn't use withdrawal this time: "*It made me feel better*." Alexa described a backup system that included condoms, withdrawal and EC pills. She and her partner use condoms most of the time, but sometimes "*it's just a hassle having to run up and get them and remembering where they are at the moment*." Typically, they would then rely on withdrawal: "*Most of the*

time, if we don't have one, that's what we do." And for the times that withdrawal does not happen, "*that's when I'll have to get the Plan B*."

Sofia described her use of condoms, withdrawal and EC pills as centered on her goal of "*safety*," that is, preventing pregnancy and STIs. She used withdrawal regularly, and in particular when a condom was not available. Although she described condoms as taking away from pleasure for her and her partners, "*I still use them anyway*" because "*it keeps you safe from any transmitted diseases*." She has visited the clinic for EC pills in the past, and returned this time to the clinic following use of withdrawal during sex with a new partner. She explained: "*I just want to be safe. I wasn't really sure if, when the intercourse was happening [if] his bodily fluids went in me, so I just wanted to be safe*." Sofia aimed to prevent unintended pregnancy and relied on a sequence of lower-efficacy contraceptive methods to that end.

DISCUSSION

Despite their common reliance on lower-efficacy contraceptive methods, there has been little research to understand young women's motivations for their use. This study highlights young women's varied reasons for choosing to use lower-efficacy methods even when methods that are more effective at preventing pregnancy are made available with reduced barriers to care. Importantly, participants named considerations beyond the common critiques of hormonal and LARC methods (e.g., side effects) and described affirmative reasons for their choice that have not often been raised in health care practice or public health policy. Notably, we did not find differences in young women's opinions about lower-efficacy methods based on their past contraceptive experiences or current method choice. Rather, they described lower-efficacy methods as successfully meeting their needs at particular moments in their sexual lives. This is consistent with existing research that views contraceptive use as a "journey" that changes over the course of women's lives as their relationships and pregnancy intentions change.[18]

These findings add an important perspective to the existing body of research on women's contraceptive preferences. While nearly all adult women have used a contraceptive method at some point in their lifetimes,[19] it is clear that currently available methods are not meeting the needs of many people who wish to prevent pregnancy. The gap between perfect use and typical use failure rates can be high,[1] and method dissatisfaction is common.[11–13] For more than 90% of women, no contraceptive method has all of the features they rate as extremely important,[9] and the features of higher-efficacy methods are a poor match with the preferences of Latina and African American women in particular.[8] In making decisions about contraception, women are obliged to balance advantages and disadvantages that can be substantial.[11] While effectiveness at preventing pregnancy is one important desired feature, it does not necessarily follow that the most effective method is always the preferred choice.[8–10] In our interviews, young women describe satisfaction with the level of effectiveness of condoms, withdrawal and EC pills - whether used individually or as part of a backup plan - at reducing their pregnancy risk. Moreover, they voiced a preference for having flexibility in their contraceptive method to fit with the changes in their sexual relationships that occur over time. The higher-efficacy methods available to them, despite being available without

access and funding barriers, are not necessarily a good match with their current contraceptive goals or preferences. These findings are consistent with existing research on the contraceptive features preferred by women of color, who are more likely than white women to value features that keep contraception under their control, including methods that can be stopped at any time, are used only during intercourse, do not affect the menstrual cycle, and allow a person to become pregnant immediately upon stopping use.[8] A qualitative study with African American and Latina adolescents raised similar themes, with respondents seeing menstruation as natural, cleansing, and necessary and voicing concerns about the effect of hormonal contraception on their future fertility and physical health.[20] These preferences and concerns may stem from the long history of reproductive abuse and coercion experienced by Latina and African American women, as well as implicit pressures that young women have individually felt in discussions around contraception with their health care providers.[5]

The challenge for young women of choosing the “right” contraceptive method becomes a greater problem when healthcare providers and public health policies value one feature - effectiveness at preventing pregnancy - over others. In some governmental materials,[21] provider guidance,[22,23] and patient education materials,[24] the highest efficacy contraceptive methods have been privileged based on assumptions that all women should be moving along a continuum from lower- to higher-efficacy methods. Concerns about unintended pregnancy, especially for adolescents, feed into those assumptions and can result in policies and practices that devalue reproductive autonomy.[25–27] The common paradigm that dichotomizes pregnancies into either planned or unplanned does not resonate with some young people; they describe distinct, in-between spaces. Such variations in their desire for and acceptability of pregnancy will affect their contraceptive preferences and choices.[28,29]

This privileging of higher-efficacy methods conflicts with core principles of patient-centered care. Patient-centered approaches to contraceptive counseling are critical to ensuring that the individual needs and preferences of all women are met and reproductive goals are attained. This study’s findings make clear that patient-centered contraceptive counseling requires understanding and respecting the fact that lower-efficacy methods may be the preferred option of some young women. A truly patient-centered approach supports women in their decisions to use withdrawal, condoms and/or EC pills. It requires support for women’s decisions regardless of effectiveness of the method chosen.

We note this study’s limitations. The results are likely affected by our recruitment at youth-serving clinics in the San Francisco Bay Area, where counseling and services are available at no cost through state programs. All study respondents were aware that they had access to contraception, including EC. Knowing that EC is readily available in a supportive environment may have informed their perspectives on and decisions to use lower-efficacy methods as their primary contraceptive method. Women in other clinic settings and other geographic areas may have different experiences to share. Additionally, our respondents were primarily Latina and African American young women from low-income communities. Their perspectives may not be the same as those from other racial/ethnic or socioeconomic backgrounds. In addition, we note that this analysis was not scoped to explore other important psychosocial and interpersonal factors that may affect young women’s

contraceptive decisions. We did not ask respondents about their sexual orientation or gender identity, which unquestionably affect preferences for and decisions about contraception. All of these factors are critical to young people's experiences with reproductive health care and important avenues for additional research.

Conclusions

Young women's decisions about contraceptive use are informed not only by their desire to prevent pregnancy, but also other affirmative values. In conversations with young women, providers must acknowledge young women's diverse needs and respect their reproductive autonomy, including supporting their use of lower-efficacy contraceptive methods. Such patient-centered approaches are critical to ensuring that healthcare is both tailored and effective.

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Table 1.

Description of Sample (N=22)

	N	%
Age in years (mean ± SD)	20.8 ± 2.8	
Age group		
Age 15–17	2	9
Age 18–19	4	18
Age 20–25	13	60
Missing *	3	14
Race/ethnicity		
Latina	11	50
African American	5	23
More than one race/ethnicity	3	14
Asian	1	5
Missing *	2	9
Highest level of education		
Some high school	5	23
High school diploma/GED	3	14
Some community college or technical school	5	23
Some college	5	23
College degree	2	9
Missing *	2	9
Pregnancy history		
Ever been pregnant	8	36
Ever had abortion	4	18
Ever given birth	3	14
Preferred timing of having a/another child		
1 to 2 years	4	18
3 to 5 years	7	32
5 to 10 years	6	27
More than 10 years	3	14
Missing *	2	9
Current serious relationship		
Yes	10	45
No	9	41
Missing *	3	14
Payment for clinic visit		
Public (Medi-Cal, Family PACT)	12	55
Private	5	23
Other	2	9
Out-of-pocket	0	0

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	N	%
Missing *	3	14

* Two interviews were cut short due to respondent time constraints, resulting in incomplete demographic data.