Conceiving of Contraception: St. Louis Women's Perspectives on Family Planning & Contraception

Priya Suri

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Conceiving of Contraception:
St. Louis Women’s Perspectives on Family Planning & Contraception

Community Based Research Thesis
Presented to the Faculty of the Department of Anthropology
Washington University in St. Louis

By: Priya Suri
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I. Introduction

Chapter 1: Background

Vignette

“I have a whole lot of things in life that I need to complete. I don’t want a setback or an unplanned pregnancy or to be responsible of someone especially. If I were to conceive or have a child, I would be in the option of giving it to a family that was in need because I wouldn’t be able to do an abortion. That would still put my back. I’m very focused on school. And I’d rather it stayed that way.” ~ Participant 3

Women choose contraception after a variety of life experiences. Some women want to continue schooling; others are not financially stable enough to have a child yet. Dr. Leonard A. Wall shared the insight, “The most important thing in life is to be born wanted and loved” (Wall 2015). Effective contraceptive use plays a crucial role in preventing unwanted pregnancies. To use birth control successfully, it must match women’s needs and lifestyles. For this, understanding how women currently negotiate which method to choose is vital.

Context and Importance

In the UN’s Millennium Development Goals, two of the eight are targeted primarily towards women, promote gender equality and empower women as well as improve maternal health ("Unintended Pregnancy in the United States” 2015). With women’s empowerment and better health as a focus, family planning and contraception are at the forefront for women’s health. Family planning and contraception play a crucial role not only in limiting unintended pregnancies, but also in preventing risks of unsafe abortions. Effective use also increases chances of higher socioeconomic status, higher educational status, and empowerment (Ali et al.
In particular, the United States, which has been able to control fertility rates to realize desired family sizes, has a rich history concerning family planning and contraception (“Achievements in Public Health, 1900-1999: Family Planning” 1999).

The modern-birth control movement originated in 1912 with Margaret Sanger spearheading physicians’ role in advocating for contraception (“Achievements in Public Health, 1900-1999: Family Planning” 1999). It is estimated that approximately 1.3 million unintended pregnancies per year are prevented using contraception (“Achievements in Public Health, 1900-1999: Family Planning” 1999). Historically, over the course of the 20th century, family size went from 7 to 3.5 children. Following Sanger’s movement, 78% of a 1049 white, married women sample surveyed in 1978 claimed to use some kind of family planning strategy (“Achievements in Public Health, 1900-1999: Family Planning” 1999). During the 1960s, both the birth control pill and IUDs became more common. Through the 1970s and 80s, sterilization became more widespread and is now alongside the pill, surprisingly, the most prevalent contraceptive strategy in the US (“Contraceptive Use in the United States” 2015). America’s sterilization policies often targeted those of lower socio-economic standing, and these policies were later met with severe resistance.

A significant challenge regarding family planning is that reproductive health services are stratified by socioeconomic status (Potter, Trussell, and Moreau 2009). According to the Guttmacher Institute as of February 2015, “The rate of unintended pregnancy among poor women (those with incomes at or below the federal poverty level) in 2008 was 137 per 1,000 women aged 15–44, more than five times the rate
among women at the highest income level (26 per 1,000)” (“Unintended Pregnancy in the United States” 2015). Unintended pregnancy rates also differ by race and educational level. Black women had the highest rates of unintended pregnancy. Education was another correlate, with women who had not completed a high school degree having higher rates of unintended pregnancy (“Unintended Pregnancy in the United States” 2015).

Recognizing the United States’ history, with women at the center of family planning initiatives, the reasons why women are motivated to use contraception could be reflective of many social factors. Ranjan Kumar Prusty argues that contraception fulfills two needs: the unmet need of spacing births (primarily younger women) and the unmet need of limiting births (primarily older women) (Mahanta and Goswami 2014). He further correlates effective contraceptive use with both educational literacy and spousal communication (Ranjan Kumar Prusty 2014).

Nationally, about 70% (43 million women) are at risk for unintended pregnancy (“Contraceptive Use in the United States” 2015). However, of those women, only 8% are not using contraception (Mahanta and Goswami 2014). In the United States, 51% of pregnancies are unintended (“Unintended Pregnancy in the United States” 2015) and women using contraception consistently and effectively contribute only 5% to the unintended pregnancy rate (State Data Center 2015). Missouri’s overall unintended pregnancy rate is a little below the national average with a 41-47% unintended pregnancy rate (“Unintended Pregnancy in the United States” 2015). Unintended pregnancies in the United States are much higher
compared to other developed countries ("Unintended Pregnancy in the United States" 2015).

Research Objectives

This look into family planning and contraception in St. Louis showcases women’s pivotal role in curbing unintended pregnancy. I am interested in the reasoning behind the contraceptive choices made. How do women come to their contraceptive choices? What factors do they feel are most important? How does spousal support affect their decision? How much choice do these women feel they have regarding their reproduction? Other than limiting children, do they feel contraception has any other effects (benefits/harms)? I am interested in how women navigate their reproductive choices, what support they get/obstacles they face, and how they promote their agency to make the decisions that they ultimately make.

Literature Review

Contraceptive Choice Project

The Contraceptive CHOICE project at Washington University in St. Louis was an influential study that gathered data on long acting reversible contraception (LARC). The new focus on LARC (IUDs and sub-dermal implants) stems from its ability to reduce unintended pregnancies and mitigate health disparities (Winner et al. 2012). Additionally, the CHOICE project has allowed researchers to overcome some of the consistent obstacles to contraception including financial barriers including education and access (Birgisson et al. 2015). This project provides a
baseline for researchers to understand contraceptive choice through the lenses of “continuation and satisfaction” with their contraceptive product (Schmidt et al. 2015). Overall, in CHOICE, women were more likely to choose LARC methods when given “comprehensive, accurate, unbiased counseling” and were more likely to continue this usage compared to shorter-acting methods (Birgisson et al. 2015). The Contraceptive CHOICE project is crucial in future family planning and contraceptive studies because it lays a medical foundation for understanding how women choose contraception and their satisfaction.

In the *Long-term utilization and continuation of intrauterine devices* (LUCID) study by Dr. Justin Diedrich et al., researchers studied the continuation of copper and levenorgestrel IUDs after 48 and 60 months to measure long term usage of IUDs (Diedrich et al. 2015). The purpose of this research was to understand when women maintain the contraceptive choice they started with in regards to the IUD. They hypothesized that due to the increased bleeding and cramping of the copper IUD that its continuation would be lower. However, surprisingly, they found no discrepancy between the continuation rates of the levenorgestral and copper IUDs. Their major finding indicated that women above 29 were more likely to continue and those below 24 were most likely to discontinue (Diedrich et al. 2015).

*Adolescent Experiences with Intrauterine Devices: A Qualitative Study* by Dr. Elizabeth Schmidt et al. focuses on how adolescent women originally chose and how they chose to continue or discontinue with the IUD. This study drew participants from the CHOICE project. Conducting focus groups, researchers found that “Effectiveness, duration of use, convenience, and potential changes in bleeding
patterns drove adolescents’ choice and continuation of an IUD” (Schmidt et al. 2015). These themes of efficacy, comfort, and convenience were key in understanding women’s perspectives on LARC and can be extrapolated to women’s interactions with contraception on a broader scale, which is a significant parallel to my research. While qualitative, Dr. Schmidt’s research utilized a public health perspective to garner information resulting in narratives with a medical focus. Women talked frequently about experiencing hormonal changes and differences in bleeding. My research hopes to situate women like these in their broader social contexts by asking questions about social support, religious background, etc.

Dr. Tessa Madden’s et al. research *The role of contraceptive attributes in women’s contraceptive decision making* looks at how women rate the importance of different factors in their contraceptive decision (Madden et al. 2015). This research found that,

“Effectiveness and safety had the highest mean scores. Cost of the method, whether the method is long lasting, whether the method is forgettable, health care providers’ recommendation, avoiding irregular bleeding, whether the method protects against STI, and side effects all had mean scores >2 (on a 3-point scale). Women did not rate the influence of partner, family, friends, and religious community highly in their contraceptive decision making with mean scores of <1.6” (Madden et al. 2015).

Furthermore, side effects seemed to play a large role in discontinuation of a particular contraceptive choice. Although effectiveness and safety had the highest scores overall, all factors were ranked in the top three for at least a few women
leading the authors to conclude, "Multiple contraceptive attributes influence decision making and no single attribute drives most women’s decisions" (Madden et al. 2015). This survey style research had 2509 participants and therefore is statistically robust. The authors recommend that individually tailored counseling will provide the maximum satisfaction for women, seeing as there seems to be no one particular overriding factor in decision making. My qualitative, ethnographic data complements this statistical data to provide a richness in narrative through sharing their stories.

**Anthropological Studies**

Anthropology studies the socio-cultural context of interventions. It seeks to not only illuminate the choices people make but also the reasoning behind their actions. As Celia Roberts notes in her review of *Contraception Across Cultures: Technologies, Choices, Constraints*, anthropology is critical in understanding contraceptive adherence, the meanings ascribed to contraception, and how these connotations reflect people’s “hopes, desires, and fears around these technologies” (Roberts et al., 2003). Roberts analyzes several repeated themes that emerge even across cultures. For instance, “the association of condoms with promiscuity, the idea that contraception is women’s responsibility, the fact that women may be subject to male violence when using contraception, and the importance of concerns about side effects” were often cross-cultural ideas that emerged in studying contraception’s impact (Roberts et al., 2003). The globalization of contraception allows for the use of anthropological perspectives to understand this technology.
Currently, ambivalence about pregnancy is a topic few anthropologists are researching. Pregnancy ambivalence can be thought as having two definitions: one that is neutral, not feeling strongly whether a pregnancy occurs or not, and one that is mixed, having both positive and negative emotions regarding pregnancy (Yoo et al., 2014). Yoo analyzed an important theoretical paper by Trussell, Vaughan, and Stanford (1999) emphasizing the multi-faceted nature of ambivalence towards pregnancy. They found that approximately thirty one percent of births from failed contraception were considered intended, and twenty five percent of women with unintended births stemming from failed contraception categorized themselves as “happy” or “very happy” regarding their pregnancy (Yoo et al., 2014). This discrepancy alerted Yoo and her team that feelings towards pregnancy could not be thought of as a homogenous entity. Ambivalence has multiple components. Lack of understanding of ambivalence could contribute to “high levels of inconsistency among reported pregnancy intentions, contraceptive behaviors before the pregnancy, and feelings about a pregnancy” (Yoo et al., 2014). Yoo used two main ideas to measure ambivalence, which she called cognitive and affective. Cognitive dimensions include what participants think they “should” do; for instance, “I should wait until I am financially secure to become pregnant.” Affective perspectives focus on the feelings; for example, “I would be happy to have a child now.” With these two dimensions, Yoo conducted a prospective study and categorized women participants into four groups: anti-natal consistency, negative ambivalence, positive ambivalence, and prenatal consistency as show in Table 1.1 below.
Table 1.1: Attitudes regarding Pregnancy (Yoo et al., 2014)

<table>
<thead>
<tr>
<th>Classification of attitudes toward pregnancy</th>
<th>&quot;How would you feel if became pregnant/got someone pregnant now&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important</td>
<td>Upset</td>
</tr>
<tr>
<td>Anti-Natal consistency: More likely to be protected</td>
<td></td>
</tr>
<tr>
<td>Positive ambivalence: more likely to be protected</td>
<td></td>
</tr>
<tr>
<td>Not Important</td>
<td>Pleased</td>
</tr>
<tr>
<td>Negative ambivalence: Less likely to be protected</td>
<td></td>
</tr>
<tr>
<td>Pro-natal consistency: least likely to be protected</td>
<td></td>
</tr>
</tbody>
</table>

Yoo hypothesized that those who thought it was important to avoid pregnancy (thereby valuing the cognitive aspect) would take a more proactive role in preventing pregnancy. This is because taking contraception, even if a pregnancy is desired, is a planned action and therefore the cognitive dimension more likely plays a greater role than the affective one. Yoo's hypothesis was supported by measuring contraceptive use. “Women with positive ambivalence were not found to differ from those with anti-natal consistency in contraceptive use. Negative ambivalence consistently shows a strongly negative association with women’s contraceptive protection status” (Yoo et al., 2014). Understanding how a nuanced perspective of ambivalence impacts contraceptive adherence is an anthropological asset.

Gendered narratives often come to light in studying contraceptive use. Dr. William R. Grady et al’s *The Role of Relationship Power in Couple Decisions about*
Contraception in the US examined heterosexual couples’ contraceptive choices. The research was conducted in an interview style where a total of 413 married, cohabitating, and non-cohabitating dating couples were interviewed in their joint decision process. Women and men were interviewed simultaneously and separately. A key, albeit unsurprising, finding was that in heterosexual couples, men’s method preferences matter. Similarly, perceived preferences had equal effects between sexes regarding switching and discontinuation. The researchers established, “These analyses provide evidence that the majority of men in the US believe that family planning is a joint responsibility” (Grady et al. 2010). Through an anthropological lens, the scientists examined how structural and individual power differences may play into contraceptive decision-making. Their results suggest that, “when the husband is dominant (as reported by the couple)...the couple tends to choose a vasectomy, and when the wife is dominant (as reported by the couple) in these decisions they tend to select a tubal ligation” (Grady et al. 2010). The data was consistent with the “Equity rule” which states, “the partner whose fertility goals are met by using contraception assumes more of the costs of contraception” (Grady et al. 2010). A surprising result was found regarding differences in income. There was a negative correlation between difference in women’s income compared to men’s and contraceptive influence; therefore, if a woman’s salary was much higher than her partner’s, it was predicted that she would contribute less to decision-making (Grady et al. 2010). This unexpected result is explained as “doing gender,” where women essentially perform their expected gender role and grant more power to their partner as compensation for their “non-normal” power (Grady et al. 2010).
Further, relationship status played a role in navigating choice; with married women, overall, having greater influence than dating women. In married couples, structural sources of power such as education and income had a greater level of influence compared to dating couples whose power differentials yielded inconsistent influence (Grady et al. 2010).

*Raging hormones, domestic incompetence, and contraceptive indifference:* narratives contributing to the perception that women do not trust men to use contraception explores gendered discourse regarding contraception. Starting with the premise that new methods for men’s contraception may soon be available (such as a male pill), Campo-Engelstein analyzes the lack of trust by women regarding male contraception. Campo-Engelstein examines masculinity and three common discourses that “inhibit men’s contraceptive trustworthiness as a group” even though women retain their trust in male partners (Campo-Engelstein 2013). The three dominant ideologies include men have an insatiable sex drive, men are unskilled at domestic tasks under which contraception falls, and men are less dedicated to pregnancy prevention compared to women. This paper presents a theoretical argument negating the previously stated stereotypes. Beginning with the first ideology, the author holds that this line of reasoning follows “biological determinism: the belief that our biology determines our desires, characteristics, and action” (Campo-Engelstein 2013). This reasoning is not logical because it postulates, “biologically-based desires are uncontrollable” (Campo-Engelstein 2013). The author goes on to establish,

“Even if a woman believes her partner has a strong libido and that once he is
sexually aroused he is unable to focus on anything but sex, she may still be able to trust him to use types of contraception that are not related to the timing of sexual activity, such as an implant or a daily pill. Given that most women seem to trust their partner with contraception, it is logical to conclude that they do not think their partner’s libido prevents him from successfully contracepting” (Campo-Engelstein 2013).

She goes on further to negate the second trope of masculinity as being “incompetent in domestic tasks.” Drawing from many movies including Cheaper by the Dozen and Mr. Mom, Campo-Engelstein highlights how men seen in a “traditional women’s role” are considered comedic because of the men’s incompetence. She argues that this stereotype perpetuates the gendered division of work into public realms for men, and private realms for women. By normalizing men’s incompetence in domestic tasks, it seems natural to distrust men as a group in contraception. However, this is rarely true in individual, interpersonal relationships. As the writer states, “women generally look beyond the cultural trope that men are incompetent with domestic chores and base trust on individual traits. This opens up for the possibility for women to trust their partners with specific domestic tasks, including contraception” (Campo-Engelstein 2013). The third theory Campo-Engelstein refutes is that men do not want to prevent pregnancy. There is the idea that men’s masculinity is based off of reproductive prowess and men do not want to diminish that. Also, others see that men don’t bear the physiological brunt of pregnancy and therefore are not as committed to pregnancy prevention (Campo-Engelstein 2013). However, when surveying men, “9000 men in nine countries in 2005 revealed that 55% of men were
willing to use male hormonal contraceptives, while only 21% were unwilling to do so” (Campo-Engelstein 2013). Overall, Campo-Engelstein argues that women distinguish the nuances between group and individual levels. Therefore, while women may not trust men as a group in turning over their contraceptive responsibility to them, they may (in individual cases) trust them with that responsibility. Further, Campo-Engelstein also hypothesizes that women “may not want to relinquish contraceptive responsibility to men” as it gives women agency in control (Campo-Engelstein 2013). Analyzing the power relationships exposed by contraception puts it in a wider context and allows for deeper understandings of the impact of contraceptive usage.

Further, men and women were surveyed to understand how both sexes prioritized and conceptualized contraception. “Despite many similarities between women and men in their perceptions about the characteristics of each method type, numerous differences between them may have an important influence on how couples make their method choices” (Grady et al., 1999). Participants evaluated contraception off the following characteristics: “perceived convenience, effectiveness, health effects, interference with sex, etc.” (Grady et al., 1999). Stark differences emerged: women as a group rank pregnancy prevention highest followed by STD prevention, while men as a group rank them equally or STD prevention as the prevailing contraceptive concern. Overall, women saw the pill as more effective than did men and saw condom use as less effective than how men perceived it. Additionally women emphasize “ease of use,” “no need to plan ahead” as compared to “interference with sexual pleasure;” however men assigned low
ratings to all three of these categories (Grady et al., 1999). The authors hypothesized that factors such as exposure to interventions (women targeted in family planning clinics, men targeted in condom campaigns) and actions needed for contraception to work in each sex could contribute to the varying perceptions (Grady et al., 1999). Grady also postulated that women are more affected by unintended pregnancy. This notion aligns with the prevailing stereotype that women may not trust men with male-based contraception because pregnancy impacts women more. As mentioned previously, Campo-Engelstein questions if men are less concerned about unintended pregnancy, and emphasizes that this kind of logic reinforces patriarchal systems in play.

Overall, anthropology searches for the “why” behind people’s actions. From identifying the role of the patriarchy, gender norms, and understanding the nuances of “wanting” a pregnancy, anthropology delves deeper into analyzing thoughts and actions. This study examines the thoughts and actions of women specifically in regards to contraception.
Chapter 2: Setting & Methods

Setting

The data were collected in the South Grand St. Louis Planned Parenthood location. This Planned Parenthood clinic traditionally serves women and men of varying socio-economic strata, with a focus on lower-income women and men. The physical research space was behind the front desk. This space was limited to Planned Parenthood staff and an individual participant.

Methods

Fifty-one women were interviewed using a semi-structured interview technique using thirty-eight questions in this clinic. Before each interview, informed consent was obtained, stating that participation was voluntary and asking for written consent. When given permission by the participants, audio recordings were made and the interview was later transcribed. The front desk staff recruited women. When women were checking out for their appointments, they were asked if they would be interested in participating. An IRB approved recruitment poster was also posted around the clinic (Appendix A). Compensation included a $15 American Express Gift Card. Because a semi-structured interview is flexible, supplementary questions were added for each specific interview. This semi-structured interview format provides open-ended questions through which to explore multiple perspectives regarding contraception while ensuring that standard topics are covered to allow for comparisons. The structural questions, which every participant was asked (excluding the pilot interview), can be found below.
**Interview Questions**

Demographics
1. Before I begin is there anything you would like to ask me?
2. How old are you now?/What year were you born?
3. What is your race or ethnicity?
4. What is your highest level of completed education?
5. What is your marital status?
6. Do you identify with any religion or cultural heritage? If so, what?

Family Planning/Contraception Questions
1. What is your ideal family size/composition?
2. What is your current family size/composition?
3. What does family planning mean to you?
4. Do you use family planning?
5. How would you define contraception?
6. If you practice contraception, how so?
7. When did you first start family planning/contraception?
8. What caused you to start?
9. Have your reasons changed since then?
10. Do you use “home remedies” for contraception?
11. What does your partner think of contraception?
12. Why do you use contraception?
13. How did you come to choose this mode of contraception?
14. How has the climate changed from when you first began using contraception?
15. Have your reasons for using contraception changed?
16. How did you come to choose this mode of contraception?
17. Were there other modes of contraception you were considering? If yes, what were they?
18. Why did you choose not to use other modes of contraception?
19. What, if anything, would you want to change about how you get/choose your contraception?
20. Were there other modes of contraception you were considering? If yes, what were they?
21. Why did you choose not to use other modes of contraception?
22. What contraceptive choice do you believe to be the most effective?
23. Why do you think it is the most effective?
24. Do you feel that your external environment influences your contraceptive choice? If yes, how so?
25. How, if anything, could you obtain more support in your contraceptive decisions?
26. How does using contraception make you feel?
27. What would you say are the main factors in your contraceptive choice?
28. How, if anything, have the perspectives on family planning and contraception of others influenced your contraceptive choice?
29. Do you believe some women face social pressures/barriers regarding contraception? If yes, describe them.
30. Have you ever felt your financial status/insurance has influenced your contraceptive decision? If yes, how so?
31. Have you ever felt your religion or cultural background has influenced your contraceptive decision? If yes, how so?
32. Would you make a different contraceptive choice if your environment was different?
33. What does your partner/family think of your choice of contraception?
34. Are you happy with your choice of family planning?
35. Is there anything that could be improved?
36. How do you feel using contraception has impacted you?
37. Do you have any questions for me?
38. Is there anything that I haven’t asked that you would like to tell me about?

The analysis was conducted using both quantitative and qualitative methods.

Interview responses were grouped together by common responses and themes, as abstracted from the data by the researcher.
Chapter 3: Basic Results & Data

Population Description

The South Grand Planned Parenthood serves a variety of men and women.

The following data encompass the 2015 calendar year regarding sex, age, race, and poverty level.

Table 3.1: South Grand Planned Parenthood Sex Ratios

<table>
<thead>
<tr>
<th>Sex</th>
<th>Count</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>4,034</td>
<td>86.7%</td>
</tr>
<tr>
<td>Male</td>
<td>619</td>
<td>13.3%</td>
</tr>
<tr>
<td>Total</td>
<td>4,653</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Ruhr 2015)

Table 3.2: South Grand Planned Parenthood Age Percentage

<table>
<thead>
<tr>
<th>Age</th>
<th>Count</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 &amp; under</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>13-14</td>
<td>19</td>
<td>0.4%</td>
</tr>
<tr>
<td>15-17</td>
<td>269</td>
<td>5.8%</td>
</tr>
<tr>
<td>18-19</td>
<td>409</td>
<td>8.8%</td>
</tr>
<tr>
<td>20-24</td>
<td>1,189</td>
<td>25.6%</td>
</tr>
<tr>
<td>25-29</td>
<td>1,237</td>
<td>26.6%</td>
</tr>
<tr>
<td>30-34</td>
<td>761</td>
<td>16.4%</td>
</tr>
<tr>
<td>35-39</td>
<td>406</td>
<td>8.7%</td>
</tr>
<tr>
<td>40-44</td>
<td>200</td>
<td>4.3%</td>
</tr>
<tr>
<td>45-49</td>
<td>94</td>
<td>2.0%</td>
</tr>
<tr>
<td>50-54</td>
<td>42</td>
<td>0.9%</td>
</tr>
<tr>
<td>55 &amp; over</td>
<td>26</td>
<td>0.6%</td>
</tr>
<tr>
<td>Total</td>
<td>4,653</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Ruhr 2015)

Table 3.3: South Grand Planned Parenthood Race Percentage

<table>
<thead>
<tr>
<th>Race</th>
<th>Count</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>2,212</td>
<td>47.5%</td>
</tr>
<tr>
<td>Asian</td>
<td>116</td>
<td>2.5%</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>247</td>
<td>5.3%</td>
</tr>
<tr>
<td>Native American</td>
<td>9</td>
<td>0.2%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>8</td>
<td>0.2%</td>
</tr>
<tr>
<td>Unknown</td>
<td>37</td>
<td>0.8%</td>
</tr>
<tr>
<td>White</td>
<td>2,024</td>
<td>43.5%</td>
</tr>
<tr>
<td>Total</td>
<td>4,653</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Ruhr 2015)
Table 3.4: South Grand Planned Parenthood Federal Poverty Level

<table>
<thead>
<tr>
<th>Federal Poverty Level</th>
<th>Count</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100% FPL</td>
<td>2,738</td>
<td>58.8%</td>
</tr>
<tr>
<td>101-150% FPL</td>
<td>611</td>
<td>13.1%</td>
</tr>
<tr>
<td>151-200% FPL</td>
<td>400</td>
<td>8.6%</td>
</tr>
<tr>
<td>201-250% FPL</td>
<td>234</td>
<td>5.0%</td>
</tr>
<tr>
<td>251% and higher FPL</td>
<td>525</td>
<td>11.3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>145</td>
<td>3.1%</td>
</tr>
<tr>
<td>Total</td>
<td>4,653</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Ruhr 2015)

Patients came in to access many services; the following chart breaks down women’s reasons for visiting.

Table 3.5: Reasons for Visiting Planned Parenthood 2015 Breakdown

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Count</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC/WWE</td>
<td>4,103</td>
<td>48.2%</td>
</tr>
<tr>
<td>Supply</td>
<td>1,255</td>
<td>14.8%</td>
</tr>
<tr>
<td>EC Walk-in</td>
<td>108</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other</td>
<td>3,040</td>
<td>35.7%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>8,506</td>
<td>64.3%</td>
</tr>
</tbody>
</table>

Definitions:
BC/WWE: Includes all encounters with a reason for visit for birth control or well woman exam, even if the patient was also seen for a problem as well
Supply: Over-the-counter pill sales only (for patients with existing prescriptions)
EC Walk-in: Over-the-counter EC sales to anonymous patients
Other: All other encounters not related to birth control or well woman exams

(Ruhr 2015)

Therefore, women primarily visited the South Grand Planned Parenthood location for birth control and well-women exams with a little under half of the women under the federal poverty line. In addition, the most represented age group is between the ages of 20-29 and African-American is the primary racial demographic served.
Demographic Charts

The following charts show the age, race, and levels of education for the women I interviewed.

Figure 3.1: Age, Race, & Education Breakdown of Interviewee Sample

[Charts showing age distribution, race distribution, and education level distribution]
**Birth Control Methods**

In order to understand the data, it is important to be familiar with common contraceptive methods. The following section includes a quick description of the prevailing forms of contraception.

**Figure 3.2: Birth Control Methods**

(“Birth Control Methods” 2016)

**Descriptions:**

1. **The Shot (Depo-Provera):** Women must return every three months to get an injection which helps prevent pregnancy. It is a hormonal method.

2. **Implant (Nexplanon/Implanon):** Inserted under the skin of an arm. The implant lasts for up to three years. It is a hormonal method.

3. **IUD (Mirena/Liletta/Paraguard):** A device is inserted into the uterus where it remains and depending on its brand can last anywhere from 3-6 years. There are two types: a hormonal IUD and a copper-based IUD.
4. The Patch: To use, women apply it to a body part (usually upper arm or back) and replace it every week. As a part of its schedule, every fourth week, women go without a patch. It is a hormonal method.

5. Diaphragm: Inserted in vagina covering the cervix. Must be used with spermicide for best efficacy.

6. Female Condom: Inserted into the vagina to prevent sperm from entering the cervix. This method also can lower the risk of STI transmission.

7. Sterilization: A permanent form of contraception that interrupts the continuity of the fallopian tubes.

8. Male condom: The penis is sheathed with a condom in order to contain sperm within the condom. Also, male condoms lower risk of STI transmission.


10. The Ring (NuvaRing): Bendable ring inserted in the vagina where it remains for up to three weeks. It is a hormonal method.

11. The Pill: Oral contraception that women have to take at the same time every day for maximum efficacy. It is a hormonal method.

12. Sponge: A small piece of foam that continuously releases spermicide that is inserted into the vagina before sex.

13. Fertility Awareness (Rhythm Method): This method is where women chart their menstrual cycles to determine when to abstain from sex due to ovulation.

14. Spermicide: Inserted deep into the vagina before intercourse to kill sperm.
15. Withdrawal (Pulling out): This method is a colloquially common practice where the male partner pulls out of the vagina before ejaculating. This is an extremely unreliable method.

16. Cervical Cap (FemCap): A silicone cup inserted over the cervix to prevent sperm from entering uterus. This method should be used with spermicide around the cap.

17. Emergency Contraception (EC/Plan B/Ella/Paraguard IUD): These methods work prevent pregnancy after intercourse has taken place. Everything but the copper IUD is a hormonal pill that are usually 1 or 2 pills.

(“Birth Control Methods” 2016)

The next chart compares methods based on a variety of factors and rates them on the efficacy of each.

**Figure 3.3: Birth Control Methods Comparison**

<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness</th>
<th>Side Effects</th>
<th>Do Me Now</th>
<th>STI Prevention</th>
<th>Hormone-Free</th>
<th>Easy to Hide</th>
<th>Easy to Get</th>
<th>Mistake-Proof</th>
<th>Cost</th>
<th>Effort</th>
<th>Health Benefits</th>
<th>Reduces Periods</th>
<th>Party-Ready</th>
<th>Safe for New Moms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemicals</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
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<tr>
<td>Spermicides</td>
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<td>⬤</td>
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<td>⬤</td>
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<td>⬤</td>
<td>⬤</td>
</tr>
<tr>
<td>Oral Contraceptives</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
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<td>⬤</td>
</tr>
<tr>
<td>Intra-Uterine Devices</td>
<td>⬤</td>
<td>⬤</td>
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<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
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<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
</tr>
<tr>
<td>Emergency Contraception</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
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<td>⬤</td>
<td>⬤</td>
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</tbody>
</table>

(“Compare Birth Control Methods” 2016)
Results

In order to analyze the data, it is essential to know the distribution of contraceptives among the interviewees. The following is a breakdown of what women used at the time of their visit and interview. This chart does not capture the contraception women utilized previously or hope to use in the future but is rather a snapshot at the moment of the interview.

**Figure 3.4: Birth Control Methods used in Sample**

In addition, 30% of the sample women mentioned condoms as a contraceptive tool out of which 60% mentioned it in addition to another birth control method. I further segmented the data based on age, race, and educational level. I am including the average age based on the contraceptive method. As I had predicted, younger women made up the majority of long acting reversible contraceptive uses.
Table 3.6: Contraceptive Methods & Average Age

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Rounded Age Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal</td>
<td>22</td>
</tr>
<tr>
<td>Implant</td>
<td>24</td>
</tr>
<tr>
<td>IUD</td>
<td>27</td>
</tr>
<tr>
<td>Shot</td>
<td>27</td>
</tr>
<tr>
<td>Condom Exclusively</td>
<td>28</td>
</tr>
<tr>
<td>Pill</td>
<td>29</td>
</tr>
<tr>
<td>No Birth Control</td>
<td>30</td>
</tr>
<tr>
<td>Rhythm</td>
<td>30</td>
</tr>
</tbody>
</table>

However, I did not find any noteworthy trends based on race or completed education. I have included a table organized by contraceptive method that showcases these variables (Appendix B).

Most of the analysis focused on qualitative explorations of women’s perspectives. In the following ethnographic chapters, I will be focusing on religious influence, the concept of choice, contraceptive narratives, and general barriers.
II. Ethnography

Chapter 4: Definitions of Family Planning & Contraception

Before beginning the analysis of the different facets of contraception, it is important to lay the foundation of what family planning and contraception meant to the women I interviewed. When asked to define family planning, most often women responded with answers that followed this template: “I need to be financially secure to support a family and communicate with my partner in order to make sure we have the same family goals. It means being prepared.” Participant 10 summarized, “Planning means preparing. Making sure you are prepared before you bring offspring into the world. Making sure that you are prepared financially, emotionally, basically that you are stable before you bring someone into the world. You just want to make sure everything is stable before going any further basically.” Another definition that family planning elicited was that family planning is “practicing safe sex.” Likewise, most often participants defined contraception as a tool to preventing pregnancy. There were a few women who did not know what contraception meant but quickly understood the encompassing phrase birth control. Therefore, I used the words contraception and birth control interchangeably throughout my data collection. When asking women if they used family planning, the answers were not black and white. Some women reported that they did not use family planning earlier but are now on track by practicing safe sex and getting ready for future pregnancies. Other women talked about how they were still too young to be actively planning for a family but hope to be consciously thinking about it when they are ready to have a
family. However, there were some unconventional answers as well. Participant 4 believed,

“I don’t really think that you can plan it. You can try to plan it and things go wrong and you don’t get what you planned out for. You can like plan on not having a family and then boom you have 7 kids. It’s like, me personally, God is the higher power. He has control over everything. If he wants you to have babies, you’re going to have babies. If he doesn’t want you to have babies, you are not going to have no babies. You can be healthy and all kind of upside down fertilizations but that’s just my view. I thought I wasn’t going to be able to have kids you know because I was going through some things personally. And I’ve got 4. 2 girls and a boy. I did get my tubes tied though so that I wouldn’t have any more as a single parent. You know because in this day and age you’re not really husband and wife-ing it up...The only think that I think works is condoms. I don’t think the pills or any of this works either. It makes you too fertile. I believe. It makes everything else go wrong and then they recall it and you have a lawsuit on your hands.”

This answer is particularly interesting as she does not believe in medical contraception except for condoms, yet she continued to get her tubes tied. Because she does not believe family planning is actually possible, in some ways, she chooses not to plan her family. It is important for healthcare workers to understand patients’ unique perspectives such as Participant 4. From the first part of her answer, her fatalistic viewpoint—in her mind—absolves her from any contraceptive responsibility. However, delving deeper, it is possible to see that she is open to
certain contraceptive methods such as sterilization in order to prevent a growing family size. Recognizing that all women do not easily believe in the efficacy of all contraceptive methods, healthcare practitioners can give medical advice tailored to the specific patient such that she is comfortable with and will adhere to her birth control method.

Understanding women’s basis for what family planning and birth control meant to them allowed me to delve into the different pieces after obtaining a holistic picture. It ensured that I understood their definitions before asking them subset questions.
Chapter 5: Religion & Contraception

Religion’s Influence

In order to understand religious influence, it is imperative to have a foundation of what religion is. Religion itself has many definitions. The famous anthropologist Clifford Geertz defined it as, “(1) a system of symbols which acts to (2) establish powerful, pervasive, and long-lasting moods and motivations in men by (3) formulating conceptions of a general order of existence and (4) clothing these conceptions with such an aura of factuality that (5) they moods and motivations seem uniquely realistic” (Banton et al., 1966). Another anthropologist Melford E. Spiro provides an alternate definition. He outlines religion as, “an institution consisting of culturally patterned interaction with culturally postulated superhuman beings” (Banton et al., 1966). He translates this definition more simply as: religion is used as a social tool to convey value systems, which interact with a belief system that may consist of beings with power greater than humans. In seeking to understand the connections between religion and contraception, I wanted to know whether or not a woman’s religious beliefs did or did not lead her to a particular contraceptive method. The following significant anecdotes demonstrate a range of religious influence.

Women attributed varying levels of religious influence on their choice of contraception. I categorized women’s responses in five ways:

1) Religion/cultural background and contraception are completely unrelated.

2) Religion/cultural background influences others but not me.
3) Religion/cultural background influenced my contraceptive decisions in the past.

4) Religion/cultural background helps me decide which contraception to use but is not a huge factor.

5) Religion/cultural background plays an integral role in my choice.

Many women fell into the first category. When asked about religion’s influence, they immediately claimed that religion and contraception were in completely different spheres of their lives. Out of 47 women who were asked this question, 34 women felt that religion had no role in their decision. While for some women this may be true, there was also an interesting subtext from the tone of the response. Compared to other questions, this inquiry often received a cynical brush off in order to disassociate themselves from the stereotypical religious conservative, whose life is and choices (such as contraception) is dictated by religion. Many women in the separation of religion and contraceptive choice scoffed at the idea of religion being pertinent to their decision. Others stressed that while religion was an important part of their lives, it did not play a role in how they thought about contraception. In fact, it seemed as if women did not want to be associated with those who made contraceptive choices based off religious edicts. Although not explicitly stated, those who did not claim religious influence may have desired to seem more progressive and scientific than their religiously informed counterparts.

Another common theme was the recognition of religion’s influence on others but not on the participants themselves. In response to the question, “Have you ever felt your religion or cultural background has influenced your contraceptive
decision? If yes, how so?,” Participant 25 boldly stated, “Not really no. Do you know of anyone’s whose it has? Yes. A lot of people. They don’t have kids and don’t have sexual intercourse until they're married and things like that. Yeah.”

Others voiced an active separation from their past with regards to sex and contraception. Participant 22 recounted her experiences growing up in a small town that was predominantly Catholic. Her personal experience has been to now distance herself from the religion she grew up with.

“How was that growing up in a small town and a Catholic town? Oh you weren’t supposed to want sex or think about it. You were supposed to feel ashamed and oh my god to get pregnant. That was the end of world. The worst. So shameful. To look back on that now. I did have a couple friends. Too many who got pregnant and because they weren’t able to get birth control. And the thought of that is just sad to me actually. I think there are a lot of people who don’t get enough support. You mentioned that your mom was relatively supportive. Were there a lot of parents like that or? Very hush-hush. But the circles my mother ran in. She taught gender equality. She was a professor at a university. Feminist all this kind of stuff. So she was very concerned about that. And the circles she ran in were very open about that, but that was a small group in our small town. And I think you weren’t supposed to talk about it. You weren’t supposed to talk about your daughter needing birth control and that’s why she took me somewhere else instead of our normal doctor. Because she didn’t want people to know. And that’s a pressure she had which is a shame. Twenty-five years ago so I hope it has
changed. *Was religion an influence?* Yeah you grow up Catholic and you're taught a lot of shame about your natural, your completely natural desires. And I still struggle with that. That's what you grow up with. That's why I'm not practicing at all because I don't believe in that. But absolutely. *Could you describe some of the struggles?* Well stuff like. Even having a boyfriend in high school. I had boyfriends when I was 13 and didn't become sexually active till I was 16 just being closely monitored about what I was doing where I was going. It is important but just being judged about it [was hard]. I know once I did have sex and when I talked to my mom about that she kind of knew but didn't really approve. She had to have a really long talk with my father who wanted me to have nothing to do with boys. So. Yeah it was tough. And you didn't want to expose too much of what you had done to too many people because then you'd get a reputation.”

Participant 22 grappled with how she understood her background’s influence. While not a direct factor in her current preference in birth control, the residues of her past still linger in her decisions and emotions regarding sexual health. Other women also experienced a disconnect from their childhood backgrounds. Participant 3, a Bosnian-American woman, described the generational gap she felt between her and her parents,

“*My parents were all about the man being the breadwinner of the house and things like that. Swallowing your pride for men. And sex is taboo because obviously you shouldn’t do it unless you are married. My parents are in that state of mind. I feel like I’m in a completely different century. I can’t blame*
them for their opinions and thoughts. But I don’t have to choose my lifestyle based on that. So moving out had given me access to make decisions where I could pick my own life path and I wouldn’t have to do all these traditional based things that were more degrading to me as a woman. I didn’t think it was the type of life I could have lived.”

Her physical separation from her family distanced her cultural background’s prominent influence. These women’s stories showcase the prevalence religion and cultural backgrounds can play in a personal choice such as contraceptive choice. Although the women now do not use this context for the decisions; it was their active distancing that contributed to their current family planning choices.

Women also expressed that religious influence was present but minimal. For instance, Participant 36 noted that she is Christian. She also mentioned that she is active in her church. She described a somewhat complicated relationship between contraception and her religion.

“Yes. In Christianity, certain contraceptives are considered sinful. I guess certain methods that you can choose they consider it being the same thing as abortion. I believe certain types of birth control pills. Even the depo shot, there was another birth control they were saying that even if an egg was fertilized it would kind of kill it. I can’t remember what it was. But certain methods were considered. Would you not want to/consider them? I wouldn’t consider them. Because if it can do something like that, I wouldn’t want it in my body. You know? (For the chemical reasons). If it has the power to realize when something is being fertilized in your body and kill it, I wouldn't want to
take anything like that. *How did you choose to have the depo shot when you were younger?* I wasn't thinking about that. *Was religion a part of your consideration when you began the rhythm method?* No. I was already doing the rhythm when I learned what that was. I don't have religion. I have relationship. The relationship that I have with God is between me and God. I believe that He can lead and guide me if I allow him to. If God leads me away from something or towards something, I have respect for spiritual leaders. But they don’t have the authority over God to tell me these things.”

Participant 26's story shows us how nuances of religious expression affect contraception. While her exposure to certain birth controls as being inappropriate come from her church, her primary reasons for not choosing those birth controls comes from a “chemical understanding” of her body. Religion plays a role as an information source, but she does not regard it as a decisive tool. Although religion and science need not be contradictory, in this case, her understandings of the depo shot do not stand under scientific scrutiny. Participant 22, however, shared that her background as an acupuncturist made her lean towards birth controls that were less hormonally controlled. While this background didn't play a major role in the foreground, she generally preferred local hormonal control to stay with that sense of balance in her body. She explains,

“Well when I was 16 started on birth control pills. Never had an issue with it. I was fine. All through college I guess. I was probably 25 then I went to school and learned how bad [they were]. I went to school for acupuncture and oriental medicine and learned their theory of energetics of hormones where I
just got really turned off by it, so I stopped taking it. Plus I was with my husband so I didn’t think much of it. Went off any form of birth control for about 10 years. I used the Nuva Ring [intermittently]. And then we got divorced which is about a year ago. And then waited for a while. And now that I have potential new partners I use the IUD. *How has the IUD been with your acupuncture background?* I’ve kind of gotten away from that a little bit. What I like more about the IUD is that it’s not circulating through your bloodstream as much. Which I appreciate. And I personally have never had problems with it. Chinese medicine they’ve made links to pretty bad migraines and stuff like that that they’ve noticed. For me it has worked really well. *So how would you differentiate between the hormonal birth control and the Mirena? Is there a difference with the acupuncture background?* It’s been a while since I’ve studied. I graduated 05. It’s pretty much all the same. But of course the dosage is relevant.”

As this exploration shows, Participant 22, and many other women, could not easily be placed into specific categories. While her Catholic background did not currently influence her current contraceptive decision, her acupuncture background did.

For other women, religion and cultural background played an integral role in their contraception. For Participant 18, discretion was vital. Her cultural background and family members do not approve of pre-marital sex. Therefore, it was imperative that her birth control method be concealable in some way. She decided to choose the pills because whenever she visited her family in another country, she chose to abstain from sex and not take her birth control. She explained,
“Whenever I travel to Muslim country I don’t take my contraceptives because I’m not married. And if they found them, it might raise questions that I don’t want to deal with.” However, she chose not to pursue an IUD or other types of concealable contraception because of the constant hormones present in those types of birth control. Further, her friends had negative experiences that steered her away from long-acting reversible methods. Additionally, to Participant 45, it was important to have periods. She believed that “God wanted us to have periods. I have to let it happen. Even though it hurts and gets on my nerves, you just got to let it go.” Therefore, she would not want to choose a birth control where not having a period was a side effect. After further questioning, she said she would consider methods such as the IUD if her period was retained which she did not think occurred.

The majority of women did not find religion’s impact to be substantial. However, for those affected, their stories illuminated the relationship religion/cultural background had with their choice on two levels. Religion/cultural background shaped their access to birth control and their information about it. It also worked on a sub-level of choice by modifying which method they decided on. Certain methods were more amenable to particular religious beliefs than others.

**Spirituality & Understandings of the Body**

An unexpected finding was the differentiation women made between religion and spirituality. Ten percent of women specifically mentioned spirituality in contrast to religion. Within women who identified as spiritual, some believed in God while others didn’t. Those that believed thought of their unique relationship to God to be a part of spirituality rather than religion. Other women used spirituality to
describe their life approach; for instance Participant 26 understood it as, “Spirituality to me in my eye means is master of self. Do what makes you happy.” This distinction between religion and spirituality led to further self-reflective exploration.

Interestingly, participants utilized both spirituality and science as tools in understanding their bodies. Participant 14 felt that she was in tune enough with her body to be able to use the pull out method. She describes, “I know my body a little differently. Some people can’t always read their body, and I can’t always read my body. But I feel for the most part when I’m using the pull out method I feel safer doing that. And I have a trust with my partner.” Participant 14’s spiritual ideas allowed her to feel connected to her body such that she did not feel she needed medical birth control methods. Ironically, she mentioned that she understands her body more than other people. However, the onus of responsibility in withdrawal is on the male’s body. Scientifically, this understanding does not hold up. Surprisingly, another woman, Participant 36, began to use the rhythm method after completing more science courses in college. Through biology and psychology she reached a deeper understanding to how women’s bodies worked. She explained, “I think I learned when you are ovulating how you can understand your body when your ovulation comes so I decided that that was another option. I don’t think I even knew it was called the rhythm method until I told my friend what I was doing and they told me it was called the rhythm method.” Both these women sought out methods to understand how their bodies responded. With their knowledge—one from
spirituality and the other from science—they used these models to make decisions about what was best for their body.

**Sex and Shame**

Another motif that often found its way into this response was the idea of shame. In her book, *Sex and the Soul*, Donna Freitas describes religion’s role in college students’ sexual experiences. She elaborates,

“One young man who has been dating someone for more than a year tells me that sex is a ‘big block’ spiritually. If you aren’t married and you are engaging in anything sexual, then ‘you’re not with God, and you’re disconnected, and you’re letting God down.’ Though he and girlfriend have never done anything other than kiss, he feels lots of guilt and shame about doing even that, since kissing gives rise to sexual feelings. ‘I’m supposed to be a great Christian guy and I have sexual feelings, and with God I feel guilty, and I ask God to forgive me, and I feel that I’m going to run out of grace. And I feel that I’m messing up sometimes and living a lie’” (Freitas 2015).

The religious shame regarding sex seems quite common as many of Freitas’ interviewees expressed similar sentiments. Another participant dramatically recalled, “I think [sex] is damaging’ just because you feel so much shame. In every sexual act, shame is in company with it, so God becomes less of a loving God and more of a God that hates you because you made a mistake” (Freitas 2015). In regards to ‘shame’s’ connection to religion, I also found literature that suggested, “Parental public religiosity curbs the frequency of conversations about sex and birth control, and after accounting for conversations about sexual morality, so does
parental religious salience” (Regnerus 2005). Further, girls were more likely to have these conversations with their parents as compared to their boy counterparts (Regnerus 2005). Religious parents were more likely to communicate sexual values in place of birth control and safe practices. Within the stories I collected, shame wove in and out of certain narratives. Participant 30 concisely explained,

“I think when I was younger it did. [Religion influenced her when she was younger]. I used to be much more religious than I am now. I’m more spiritual and less religious if that makes sense. There were times in my life where there was more of an element of shame surrounding just the fact that I was having premarital sex. Did it influence what birth control you chose? Didn’t change what I chose but changed how I felt when I was doing it.”

As women connected their religion and their contraceptive choice, the sexual moral values they were taught came to light. Further, Participant 18 attributed guilt from the social stigma of being “slut-shamed” by her sister and temporarily cut off from her family. She recounted,

“My dad’s really religious so that’s [premarital sex is] not ok. When they found it was really, really bad. Like really bad. So yeah. So it went from being like a secret to being really, really bad then to just being like I’m an adult and I make my own decisions...I was living with him at the time and I moved out. That was when I was 18...And I didn't talk to my dad for like 6 months. It was pretty bad. So he came around? No, it's like one of those things that you see, it but you don’t address it. You don’t talk about it [being sexually active]. It never happened.”
The religious shame pertaining to sex shapes how some of my participants regulated when and how they administered birth control, but more importantly the feelings and associations they had with the process. These choices can be difficult and without support systems, it only complicates the decision. Women racked with guilt suffer unnecessary emotional strife.

Ultimately, religion and cultural backgrounds had varying influence in the particular type of birth control women chose. The majority of women expressed little or no influence and took an active role in distancing themselves from the “type” of women they believed would use religion as means to choosing contraception. Unfortunately, religious explanations sometimes contradicted scientific descriptions and could contribute in feelings of shame. Within religious choice, there were those who saw religion as a force that inhibited their birth control methods, while others saw it as a tool for exploring and understanding the elements that they were introducing into their bodies.
Chapter 6: External Environment & Individual Choice

What is agency and choice?

The American ideal of individual choice frequently plays out across the political stage. From the regulation of the food industry to birth control, there is a tension in America regarding the sacrifice of autonomy for a social good. When New York Mayor Bloomberg proposed a ban on high sugar sodas in order to help curb obesity, the soft drink industry furiously lobbied against this by invoking the American narrative of freedom of choice for consumers. Historically, the United States emphasizes free will and the consumer choice as the crux of decision making (Boholm, Henning, and Krzyworzeka 2013). The Paradox of Choice complicates this narrative by stating that although choice is integral to freedom and autonomy, too much choice is physiologically detrimental because consumers experience anxiety in determining that their choice is the “best” among a plethora of options (Schwartz 2007). With this backdrop, it is expected that these American women generally want to portray themselves as free agents able to make their own choices.

Broadly speaking, agency may be understood through both flexibility and accountability as well as knowledge and power (Kockelman 2007). Kockelman further analyzes,

“Agency might initially be understood as the relatively flexible wielding of means toward ends. For example, one can use a range of tools to achieve a specific goal, or one can use a specific tool to achieve a range of goals. In this way, flexibility may involve having lots of options open or having a strong say in which particular option will be acted on. And to say that one entity has
more agency than another entity is to say that it has more flexibility—relatively more means and ends to choose from (in some given environment, or under some given conditions”

Accountability follows flexibility; with more agency over a process, an actor holds more responsibility for the outcome based on his/her actions, which can lead to “praise or blame, reward or punishment, pride or shame” (Kockelman 2007).

Alternatively, in the tradition of Francis Bacon, agency can be understood in terms of power and knowledge. Bacon defines two types of agency: one as the ability to have power over social, symbolic, and material processes and the other as having knowledge over social, symbolic, and material processes (Kockelman 2007). There are even more anthropological perspectives on agency and choice, including “control, composition, commitment, thematization, characterization, and reason” (Kockelman 2007). Different aspects of agency provide frameworks for analyzing how participants chose their birth control method, especially when there are discrepancies between feelings of control and external influence. I thought it was important to take “into account how the world is perceived, understood, and related to by means of lived experience” not only by asking directly about choice but also by exploring the social, cultural, and economic contexts of choice (Boholm, Henning, and Krzyworzeka 2013).

Contraceptive narratives are often framed by choice and control. Regarding the pill specifically, Dr. Kara Granzow explores the pill’s prominence and women’s choice through its historical context. She argues, “women’s articulations of ‘choice’ challenge the notion of genuinely available and viable alternatives for women, and
demonstrate how the use of a technology can silence understandings of contraception as something other than an individual responsibility” (Granzow 2007). She first writes that women’s reproductive cycles (menstruation, ovulation, pregnancy, menopause) were traditionally labeled as natural and therefore animalistic; thus, incapable of rational control. Early feminists focused much of their efforts for equality on the control and regulation of reproduction as a means to women’s freedom. Margaret Sanger proclaimed, “No woman can call herself free until she can choose consciously whether she will or will not be a mother” (Granzow 2007). This idea was prevalent as it was “reproduction that inhibited women from entering the public sphere” dominated by men (Granzow 2007). However, Granzow argues that suppressing women’s reproduction in order to enter the public sphere also follows patriarchal structure. She asserts that this idea assumes the public sphere is to be inhabited by men (non-childbearers) and for women to enter they must conform to non-childbearing status. Granzow declares,

“Yet the idea that agency is a free floating ideal, value-vacant, something to which people can aspire, and of which people do achieve, is largely accepted. The common understanding of agency is overly crude and inherently sexist: such forms of free agency cannot truly exist for any social actor, and to be clearer, they can only appear to exist for some”.

She questions if women who choose the pill are actually in favor of this method or because of the pill’s vast historical promotion, see it as their one viable option. She believes women are only presented with a few options and are then asked to make a choice among these options. Because the original field of options is already
restricted, agency is also limited. Thus when women describe their reasoning, not only are the historical contexts important, but also the social, financial, and cultural aspects that play into an ultimate decision.

**Assumptions**

How did women perceive the influence of their external environment on their birth control decisions? In my research, I asked two questions that related directly to women’s perception of control with regard to their contraceptive choice:

1. Do you feel that your external environment influences your contraceptive choice? If yes, how so?
2. Would you make a different contraceptive choice if your environment were different?

I expected women to be consistent in their responses to these questions; however, a sizeable minority of women answered the two questions differently.

**Agency and choice in the data**

There were women who unequivocally did not think that their environment affected them in anyway. There were also those who thought it was a major part of their decision. For instance, Participant 4 described,

“The environment around you is worse. Just being. It is more open to it now. It’s always been here. More of the violence. No safe place for real. No where to get a peace of mind. Everywhere you go you kind of like paranoid and nervous. You still got to live and take care of whatever you got to take care of. I think my stress levels are more higher than they were then. Because I am an
adult and I am responsible for my own self. And not only me, I have kids now. I can’t just walk around with a teenager mind. I have bills and kids. Do you think that has affected your contraceptive choice in any way? It’s probably affected every choice that I make in every way. Majorly. Probably that especially. It made me think about being a single parent more. That’s probably why my tubes are tied.”

For her, the increasing violence in her community made her feel unsafe, and she did not want to bring more children into that environment. Therefore, because she was so sure, she decided to obtain a permanent sterilization.

Women who did not answer both of my external environment questions similarly were interesting because of the presence of the idea of control. Although it was a relatively small proportion of my data, I wanted to explore the tension in these contradictory results. 8.3% of the women answered “no” to the first question and “yes” to the second; 18.8% answered “yes” to the first and “no” to the second. A possible explanation is that the phrasing of the question was unclear and women only understood one question; however, a closer examination of the data show that women expressed their answers using motifs of control. Women who answered “no” to the first question while responding “yes” to the second, often framed their answer this way: “The environment doesn’t influence me. I make my own choices, and if the environment was to change, I would still have the onus of making new, different decisions.” For instance, Participant 34 quickly and confidently answered “No.” to the first question. However, her response to the second question was, “Maybe. I could just see if you had a better economic status and made more money you could
probably afford better things or people to help you remember you know what I’m saying. I’m sure it could affect [me] in certain ways.” Her answer acknowledged that her financial situation might play a role in limiting her options; however, she simultaneously retained her decision making power by making it clear that she would choose what she could pay for. Alternatively, women who answered “yes” to the first and “no” to the second communicated this general core concept: “My external environment is a factor, but I make my own decisions and am confident in my choice.” In her response, Participant 17 addressed the stigma many women face in their birth control choices:

“Oh most definitely. If a female is seen taking a pill, even [though] most people use pills to regulate periods, they see a female taking a pill and oh you’re sexually active. No, my period is just on for three days, off for four, and so I need to regulate my period. It’s like a stigma depending on if you have the Depo-Provera, ‘It’s going to make me fat.’ or I won’t get my period. ... If people in society see a woman carrying a condom they are going to think bad of her—not necessarily of her being a responsible adult. We always put together responsibility. I think we are hypocrites when it comes down to it. We say be responsible but when people are being responsible we tear them down. We are being sort of hypocritical.”

Although she recognizes how the external environment influences her, in response to the second question, she immediately answered, “No. I would still continue with condoms, diaphragms, and sponges.” This follows the common theme of control. Women in this group recognized external influences but were so confident in their
choices that they believed their decision transcended the external influences they knew were present.

**The influence of others**

Another reoccurring theme was the idea of choosing to use contraception after looking at others’ lifestyles. While I had initially expected this question to acquire responses whereby participants’ options were constrained by their external environments, women often interpreted and answered the question to imply that they were motivated by their environments to seek contraceptive care. Women getting birth control did not want to seem like “them,” women they characterized as having too many babies with too little support. Seeing other community members’ choices, they fashioned their own in response. Without any hesitation, Participant 27 stated, “Oh yeah. People in my school are getting pregnant all the time and I don’t want to be one of those people.” She adamantly wanted to distance herself from her surroundings in which she felt people made poor choices. Similarly, Participant 13 saw her external environment within the larger context of her neighborhood. She described,

“Yes. Yes. Yes. The neighborhood I grew up in. What I see is mind blowing. Just a lot of children that are not being taken care of. They’re not being provided for because of financial reasons. You can’t afford to have them. This is not what I am assuming. This is what I see on a daily basis going home. Going into my home. Yeah it has [affected my decision.] If you can’t afford it, I just don’t feel like you should be on some sort of method to help you prevent that.”
Participant 13’s understanding of her neighborhood and seeing the negative experiences of others influenced her own decision to prevent unwanted pregnancy. She recognized her financial situation was not sufficient to raise children to the standard that she wanted and therefore she sought out birth control.

The concepts of choice and control run through the data. Women wanted to be the agents of change in their lives and did not perceive limitations in their options. This follows closely with Western ideas of free will and choice. However, with further questioning some women recognized that outside factors could influence their actions. Ultimately, women’s control of their contraception and external influences interact with one another in complex ways.
Chapter 7: Contraceptive Narratives

Support

There are numerous studies which show that lack of social support contributes to decreased levels of psychological health and to increased prevalence of physiological disease (W. R. Gove 1972). Similarly, previous research has shown that limited “instrumental support (such as help when sick and financial sickness) is associated with perceived poor health in middle-aged women” (Moon, Park, and Cho 2010). Within social support, I found four main sources: family (especially mothers), partners, friends, and health care practitioners. I asked the interviewees how they began their contraceptive journeys. Their answers usually included hormonal reasons, sexual activity, and/or surprisingly mom’s insistence.

Mother Knows Best?

The idea of “my mom wanted me to get on it” was especially prevalent from the participants. Participant 10 discussed,

“Well my mom for one [was a source of support]... How did your mom influence you? She didn't want me to have any children, so I was able to take care of myself. She really just told me [about the importance of] being able to provide for everybody. Not going over board in having kids and everything.

Did she tell you about your contraceptive options at that time? Yeah, she works at where I work at now. She was on top of informing me about anything.”

Moms had a strong influence as key drivers in obtaining contraception. Many women echoed sentiments of not initially seeing the necessity of contraception at that age, but their moms found it to be essential. Indeed, women also were grateful
to be able to talk to their mothers about what particular method they were going to choose. In one particular case, a mother steered her daughter away from the implant because of her own personal negative experience. Participant 28 described, “Yeah. At first, I was considering the implanon. When she was younger. It had bad side effects with her. She had really bad periods. It made her moody and everything. But I wanted to try it because I’m very athletic. I play soccer. And I thought that maybe the 3-5 year one might be cool. But my mom was really worried about it and she’s like I don’t want you to go through all that because once you get it taken out you still have a period for 3 months after that. So it’s a huge ordeal so I just went through with the pills and stayed with it. Have you ever considered switching? I thought maybe after school. Since it is 3-5 years because I’m 21 now. And at around 25 I’d be ready to start thinking about having kids...Me and my mom are very similar. Like all the way down to the tee. With my luck, I’ll probably have the same problem and I don’t even want to go there.”

This particular mother was especially concerned with the potential side effects. In fact, another mother was not ready to accept that her daughter was sexually active. However, her birth control decisions allowed her to have a more open relationship with her mother. Initially, her mother was hesitant about obtaining contraceptives. As they discussed how this was the daughter’s informed decision, they began to develop a mutual understanding and a closer relationship. However, these experiences were rarer than mothers promoting contraception. Most women’s stories focused on mothers encouraging them to get on almost any kind of birth
control. Women often mentioned that their mothers were worried about sexual activity and/or rape. Participants felt their mothers thought of contraception as a safety measure. Once girls reached a certain age their mothers believed “it was time to get on something.” Mothers were also informed by the experiences of their other children. One participant recounted that as soon as her brother got his girlfriend pregnant, her mother made sure that she started birth control. Mothers wanted to ensure that their daughters received an education and in some cases, did not follow in their footsteps. Therefore, as a preemptive strategy, they promoted birth control for their daughters.

**Partner Pressure**

Another source of support and pressure were partners. Participants had a variety of ways describing partner influence. Answers ranged from “He does not know or care what I’m on as long as it is something” to “We never really talk about it” to “He does not like certain methods because he can feel them.” Partner support was a nuanced conversation because women simultaneously wanted to maintain their own control while also respecting the needs of their partner. Participant 10 summarized it quite nicely.

“I had a lot of support with my husband. Like I said he is pretty neutral on the situation but I think that is a big thing. If you do have a partner that you consult with them and make sure it is something that you are both comfortable with. With that all said and done, it is your decision because it is your body. But at the same time, you want to be a little considerate of the other person if this is going to your family, you are trying to plan for a family,
that’s the best way to do it. I think on my end, I have no regrets on how things were handled. I have a good support system.”

While most participants were similar to Participant 10 in that they felt little to no pressure, when probed, women mentioned their partners’ dislike for condoms.

Participant 22 describes how her partners abhorred condoms, which led her to seek birth control. She explains,

“Well honestly they didn’t have to think much about it. The onus was on me. Which was fine because I prefer that personally. Not that it is an issue of trust but I like to be more in control of my body. They always hated condoms I know that. But I’ve always been in pretty monogamous relationships and there has always been a lot of talking about it. So I was never worried. It was always me in control. Has there ever been a preference? From them? Anything that didn’t involve condoms pretty much.”

Many women had similar stories, As Participant 13 corroborated,

“They did not like to use it. Were their particular methods they didn’t like? They did not like condoms. A lot of guys they do not like to use condoms. Did they want you to be on a contraceptive choice? We never had that conversation. It was totally my responsibility to take care of me. Never had a conversation about ‘Are you on birth control? Would you like to use condoms?’ Everything was left up to me. During that time did you have a preference for condoms s. no condoms? It wasn’t the best feeling in the world but absolutely. So most of the time they were used? Yes most of the time they were. Even though they didn’t prefer them? Yes.”
Unlike Participant 20, Participant 13 insisted on condoms even though both her and her partner(s) did not enjoy the feeling. The reluctance of men to use condoms puts the contraceptive responsibility on women. Additionally, the concept of trust was very much related to condom usage. Women revealed that while condoms were disliked by both partners, they were employed during the initial stages of a relationship. However, as partners began to trust each other more, condoms had a way of slipping under the radar. This arises because women often see the condom as primarily a sexually transmitted infection inhibitor and only secondarily as a tool for pregnancy prevention. Because women trust their partners more regarding sex, they view their risk of catching an STI to be much lower and therefore, decrease their condom use.

Interestingly, few partners had more influence in choosing women’s contraception. Participant 9 shared,

“What did your past partners think of contraception? Nothing. I’ve been with the same person. My son’s daddy. I’ve been dealing with him. My son’s going to be six, but we have been dealing with each other for nine years. He doesn’t have anything to say. Does he have a particular preference for a certain kind of contraception? No. When I had the IUD, he didn't like it. It used to make him sore. So the depo shot was basically the best. I didn't have to worry about missing the pill. I didn't have to worry about the IUD moving or him being sore or me being sore or any of that. So with the depo shot I never had a bad experience with it, and it has almost been 10 years.”
Essentially, Participant 9 moved off the IUD because of her partner’s discomfort with it. While her partner informed her contraceptives decisions, other evidence shows that it is unlikely for male partners to feel the IUD or have effects from it—although there have been claims of men being able to touch the strings of the IUD or feel the IUD if it is being expelled (Rodriguez 2015). Overall, it seems that partners had more effect than they were given credit for. Women often consciously distanced themselves from stereotyping their partners as the controlling, demanding masculine trope. However, in doing so, they gave their partners less power than what they realistically wielded.

**Friendly Advice**

Women’s social networks included their friends; they relied on them for learning about new methods and gave their friends’ opinions high importance. In regards to how she chose her birth control Participant 21 stated,

“Listening to other people. Other people’s choices, and other people’s side effects and stuff everything is different for other people but just knowing what it might be for that person it might be for you. So that helps a lot. Just knowing what did and did not work for others in the past. What has happened to your friends? I heard like I said that on the shot you get an appetite. You want to eat more. You be bloated. My mom she can’t have any kids. Her tubes are tied, cut, everything. She’s still on the depo to regulate her cycle. It’s just all-different. The nurse told me I might not have a period with the depo. With my implanon, I had a regular period every month around the same time. It would switch up but it was kind of normal for me then.”
Although friends give rise with good intentions, unfortunately scary stories and myths permeate through these retellings—causing women to shy away from effective birth controls. For instance Participant 44 remembered, “I was thinking about the Mirena IUD. But my god-sister she got pregnant on that. I think her boyfriend knocked it out of place and she found out she was pregnant a couple weeks after. In my mind, I was just like I’ll just stick with my depo shots.” These stories pervade popular culture and dissuade women. Participant 45 fearfully responded,

“Is your main concern in not using birth control stopping your period? Yes. That and the different effects it has on your body. You can gain weight, your face can break out tremendously. It’s just a lot of different things that can happen that I’ve read about. I kind of don’t want that to happen. Have you had experiences with your friends that have had those effects? Yeah my best friend her friend had birth control. She had the little thing that you stick inside of you or whatever. And when she took it out but she ended up getting chlamydia from it. And I was like yeah kind of glad I steered clear of that. It was just my cousin did it and she bloated up really bad. Started breaking out. Hormones are off the chart. Lots of different examples of why I don’t want to do it...The main factor for not getting on birth control was the dead eggs still in my body. That’s what the main concern. How it could affect my uterus and all the other stuff down there. Just if I wanted to have children later in life that could affect those dead eggs then instead of getting out like they’re supposed to. That was my main concern. Not being able to have children later
down the road or possibly contracting an STD or yeast infection or something terrible just from draining those dead eggs from my body.”

When women mentioned friends, they often mentioned the horror stories that came as well. Few women mentioned positive experiences with friends’ birth control. This is partly just because negative experiences tend to stick in people’s memory for longer times (Jeff T. Larsen et al., 2003). However, this provides additional work for health care practitioners who must battle these stories so that patients receive accurate data. In fact, the IUD especially has a checkered history, which provides ample material for current misconceptions. In the 1970s, the Dalkon Shield, an IUD with design flaws, was correlated with increased maternal death for those who became pregnant on it, an increased risk for PID, and research that suggested links to infertility (David Hubacher 2002). Because of the public scandal of the Dalkon Shield, women still incorrectly associate the IUD with infertility and potentially STIs. Current IUDs, however, have research supporting their safety and efficacy.

It is important to understand these colloquial narratives so that nurses and physicians understand that these are real fears and not to be dismissed as myths that people do not seriously believe. Recognizing these rumors is the first step to dispensing the stories and providing accurate information.

**Healthcare Practitioners’ Recommendations**

Women had a range of experiences with their healthcare providers and birth control. Participants 16 and 25 had similar stories where they initially researched online. Then, they talked to the nurse practitioner who recommended what was best
for the patient. Similarly, Participant 28 discussed her options with other people namely her mom and the nurse practitioner. She recalled,

“And then the nurse I had at the time was like you are a little bit smaller. You're active. I think that [the implant] will be better for you. Because the first pill that I tried, was strong. And it hurt my stomach all the time and I used to have headaches. It wasn't for me. The nurse practitioner was really important on that because she was like I think you should try this. I think you should try this because she knows it better than I do. I was just taking it. I didn't know what was happening.”

While professionals were sought for contraception-lifestyle compatibility advice, they were often most influential when other medical conditions were also present. Because of Participant 21’s weight loss, her medical advice was to switch from the implant to the Depo-Provera shot. Likewise, doctors took into account Participant 50’s gestational diabetes when recommending the Nexplanon for her.

The relationship between the physician and the patient was extremely important. The ease and rapport Participant 50 had built with her doctor comforted her. She claimed, “I was only diabetic for 2 years. That was kind of stressful. Surprisingly, the baby came out healthy. He’s been my doctor since the day I was born and I still go to him and everything so he was a big help. It’s a good relationship with the doctor so that helps out a lot.” However, others had more difficult experiences. Participant 17 was in the military and had physicians who were stern. When asking her to describe her support, she responded,
“Well the doctors there weren't very nice. Very rough. So it was kind of like. You didn’t really want to go. I think they did that on purpose. ‘Are you having any symptoms?’ No. ‘Ok.’ So they’d put you on a table and do the thing, but they’d do it extremely painfully. They would be like, ‘Ok, you are going to take this med. Take this. Take that.’ Well would it make me? ‘I don’t care take it.’ It's really not very supportive when it comes to contraceptives or comes to people's bodies just in general.”

Another woman described having an almost robotic interaction with her physician that left a sour taste in her mouth. Participant 7 wanted an interaction that was more personable where she could explore her options. She felt,

“...It should be more personal thing not as clinical. You should be able to go to a place like this [Planned Parenthood] and talk to someone and just go through all your options. Not necessarily a doctor but a consultant. Some of it isn’t really medical; it is more personal. For example, well I wish I had known more about different options to have or different pills. I just went to my primary care physician, who I had literally seen since I was a baby and he was like, ‘Here’s a pill. Take it.’ And I was like ok. It would have been nicer. This was 15 or so years ago and that was just what it was. I mean it would be nice to talk to someone and make it more like a social worker of sorts. Maybe not like a doctor. Yeah, these are your options do whatever. I was 17 when I really started and you don't really have many options when you are 17 especially in Missouri.”
In a time where she did not know her options, having someone to work with her could have been empowering. The lack of knowledge inhibited her from exploring for other methods. However, while this may still be true for some patients, now people have much more access to information via the Internet. Health care practitioners must be sure to account and dispel myths all the while addressing very real fears and misconceptions.

**Reasons for starting**

Women had three major reasons for beginning contraception:

- Hormonal/menstrual regulation
- Sexual activity
- A mother’s insistence

**Figure 7.1: Reasons women began using contraception**

![Graph showing reasons for starting contraception by race/ethnicity](image)
Women were pretty evenly spaced throughout these categories, with each reason almost equally representing my overall demographic sample. Within menstrual regulation women had a variety of reasons. There was a participant who was soon to be a college varsity athlete and did not want to worry about the hassle of periods interfering with her track and field ability. Other participants had heavy periods and debilitating cramps that they wanted to manage. Participant 42 had a more medically induced birth control experience that she described, “I was dealing with endometriosis. My surgery recommended that I get on birth control to stop the growth of my cysts. That's what made me get on it. I got on it for regulation and pain.” Whereas, those who indicated sexual activity as a primary cause thought of using contraception more along the lines of pregnancy prevention. Nevertheless, women had a variety of motivations that inspired them to start.

**Reasons for changing**

Women more than anything changed contraception due to negative side effects. If women were not experiencing negative consequences, they were more likely stay on the current method that they were on. Participant 20’s journey included trying many forms.

“Depo to Implanon to pills. Well with the depo, I didn't have any problems with irregular periods or anything like that. I started gaining weight. And then with the implanon I was pretty much on my period for about 14 weeks. For the implanon, until the time they put it in to the time they took it out. After that, I went back on the pill and it got me regular again. So it was mainly gaining weight and then being on my period for a really long time. It [the
implanon] started giving me really bad pain in my cervix because of me bleeding for so long. I was starting to have a lot of pain. And then they were like we'll just take it out. Just from me bleeding for so long.”

Both Participant 6 and Participant 9 removed the IUD due to consistent bleeding for multiple weeks. Because Participant 9 was anemic, this excessive bleeding was not only uncomfortable but also medically unfavorable according to her physician.

Conversely, the major complaint with the Depo-Provera was the aesthetic changes. Women often reported excessive weight gain and did not like the cosmetic effects. Overall, only woman out of fifty expressed dissatisfaction with her family planning and birth control; therefore, the overwhelming majority of women were happy despite the side effects they endured.
Chapter 8: General Barriers & Factors of Contraception

Convenience and Comfort

Both convenience and comfort were the primary factors women considered when making their contraceptive choice. Participant 14 clearly stated,

“It depends on how easy it is to use. Like the implanon. I wouldn’t have to worry about it. It’s not a daily thing. Its something I can put at the back of my mind and not make an issue. Depo same way; 3 months I can go out with out it. At this point of the year you have to do something. Timeline is easier than the pill. Some people are good at that and making it a habit. Not me.”

A contraceptive’s ease of use made it a more promising option. However women varied in what they believed to be easy. For many, the pill was much too inconvenient. Those on the pill however found the consistency of taking it everyday to be convenient and found the feeling of control empowering. Women were equally concerned with side effects’ potency in regards to comfort. Understandably, they did not want excessive bleeding or atypical weight loss or gain. Women expressed that the contraceptive they used ought to make them feel positive. Further, most women did in fact feel positive as they used the words “safe,” “in control,” and ”protected” when describing how contraception made them feel.

Efficacy

Efficacy was also important to women when they chose their birth control. I incorrectly assumed women would consistently choose the birth control they thought was most effective. Interestingly, women’s perceptions of which methods
were the most effective did not always correlate to what they themselves used.

**Figure 8.1: Participants Contraceptive Efficacy Perceptions**

![Bar chart showing women's perceptions of contraceptive efficacy](chart.png)

Although only 14% of my sample was on Long-Acting Reversible Contraceptives (Implant or IUD), about 25% reported that they believed LARC methods were the most effective. More surprisingly, although 98% of my sample was sexually active, 14.3% thought that abstinence was the best contraceptive method in terms of efficacy. Additionally, women had a nuanced philosophy on efficacy. They thought different women had different needs and bodies, and hence, there is no one universal birth control that is the most effective. Participants reckoned that it depends on the woman, her situation, etc.
Financial Status

Participants believed that affordability of different contraception was important in influencing their ultimate choice. Many participants acknowledged the influential role of Planned Parenthood and Obamacare in providing subsidized birth control that they otherwise would not be able to afford. Participant 3 gratefully announced,

“I would have gotten on birth control way earlier if I had insurance but it isn't an option for everybody and I can't afford it. So I decided to give them a call and best part of coming here they will definitely help you out and give you resources. Even if you can afford them, there are not many places that would help you like that. It sucks that there isn’t insurance but thank god I have Planned Parenthood.”

However, for others, finances still inhibited their options. For instance, Participant 16 would have rather received a tubal ligation if not for the expense. Similarly, Participant 10 would have preferred trying the patch instead of the pill if not barred by finances. One woman took an entirely different spin on the question of whether finances affect her contraceptive choice. Her answer integrated African American history and big pharma experimentation.

“Oh yeah. Most definitely. I think that this is just me because I’m not a big fan of the pharmaceutical companies. I think they give the people that you could say are low income the more experimental drugs that they’re really not sure of. If you are at a higher income, you can afford that insurance number one. They are going to give you the best of the best. They are going to give you
everything. The best of everything. They’ve already tested on these guinea pigs. Did you personally feel that you were experimented on? Oh most definitely. Example? Actually any birth control. When I was 16 and my mom put me on orthotricyclin I think I was being used. But I think that technically any medication you are being used because nobody’s going to react the same even when it comes to Tylenol, ibuprofen or Aleve. I think every single thing that we put into our body we are a guinea pig. You know even from Cheetos. You’re a guinea pig. If you are putting lotion on your skin, you’re a guinea pig. Just to see how it reacts to you. I think we are all being tested to see how our bodies react. I guess you could say a larger scale of the Tuskegee experiments. They are testing to see how fast we die or how slow we die.

That’s just my thing with pharmaceutical companies. I’m just a little cynical. That informs what you choose and what you feel in the end? Exactly. Holistic approach on what I take because our body is organic. Is that how you come to more condoms vs. other methods? Yes. 100 percent. Do you think your financial or insurance status was different would you have tried to choose something else? 100% would have. What would you have chosen? If my financial status was better back then I probably wouldn’t have even gone to the military. I probably would have just traveled which is what I wanted to do in the first place. I didn’t get to travel a lot within it. Let’s see. I don’t know. I don’t even know if I hadn’t gone into the military if I would have actually gotten married because my husband, my soon to be ex-husband, proposed to me when I was in basic training. So I’m like if I wouldn't have gone would I have actually
married him? And if I would not have married him, would I have been sexually active? I’m not sure.”

Her cynicism for the pharmaceutical industry coupled with the United States’ abhorrent history of experimentation made her wary of trying birth control methods. Furthermore, she saw her financial status not only as a monetary measure but where she was in life. Because of her initial position in life in terms of money, she was driven to make certain choices (such as joining the military) which then limited what options she had in regards to birth control.

Indeed, convenience, comfort, efficacy, and finances all contributed to the methods of birth control women decided upon. These factors have a nuanced intersection when choosing contraception. Women’s stories demonstrated how each of these factors was a piece in their decision-making. Depending on each woman’s life experience, these elements had varying weights.
III. Conclusion

Chapter 9: Research Summary

“It’s like everyone tells a story about themselves inside their own head. Always. All the time. That story makes you what you are. We build ourselves out of that story.”
~Patric Rothfuss, Author of The Name of the Wind

This work highlights the stories women weave as they make their contraceptive decisions. Contraception itself was primarily thought of as a scientific technology; however, in the context of family planning, it took on social meanings that reflected preparedness in life, financial security, religious viewpoints and the ability to choose. Most women thought favorably of both family planning and contraception. However, there were a few who did not. These women should be taken into special consideration, and medical experts should tailor advice that these women will accept while also receiving the best contraceptive care possible.

The religious/cultural background influence varied among the participants. There were those who believed they experienced zero influence and some who thought religious authority was a burden on others but not themselves. Others acknowledged past impact and some women recognized moderate religious/cultural background weight on their decisions. Then there were those who recognized religion/cultural background’s high influence. Women’s past experiences also affected their understandings of the body and how they correlated sex and shame. It is hard to tease out something complicated like religious influence; however, both women’s conscious association and subconscious distancing led me to value the heavy impact religion and cultural background can have. If religious and
cultural leaders are open to contraception, they would be valuable assets in battling misinformation. However, realistically, this is not always the case. Therefore, understanding how each woman understands her own relationship with religion, God, and/or her cultural background will allow for a nuanced discussion of contraception.

The idea of choice was crucial to many women. Participants eagerly expressed themselves in terms of being in control of their decisions regardless of or in spite of external influences. Women did not want to be inhibited and were both happy and confident with the methods they chose. Although they entertained other ideas, women expressed that it would take a lot of negative effects for them to change what they were currently using. Thus, it is important that women obtain methods that suit their lifestyle early on. Although some trial and error is inevitable, recognizing that women will be more unlikely to change as time passes because they want to have made the “best” and “right” choice, reemphasizes the importance of paying attention to their narratives. If they are offered the contraception that best suits their needs, they have the highest chances of staying happy and in control of their reproductive choices.

Various sources of support and information led women towards different contraceptive methods. Mothers were key in the initial stages of birth control. Often women reported their mothers encouraged them to obtain contraception or women sought their mothers’ advice. While others had disagreements with their moms regarding birth control, it later provided a space to forge a bond. Spousal/partner interaction manifested through both nonchalance as long as the woman was on
some type of birth control all the way to having specific preferences. Women often
directly attributed less partner influence than what their stories give evidence for.
Friends could be both a motivating and inhibiting factor regarding contraception.
They were usually the conduit for many myths, misconceptions, and/or personal
negative experiences. Healthcare professionals were essential in steering women
towards birth control methods. Many women, especially older women, expressed
that during their initial birth control visits they were only offered the pill.
Participants generally respected medical advice and took it into serious
consideration.

Convenience, comfort, efficacy, and finances all contributed to contraceptive
decisions. Women were motivated to find contraception that was easy to use, with
minimal side effects, worked consistently, and inexpensive. These factors both
individually contribute to a woman's decision but also work together to inform her.

Ultimately, healthcare professionals should listen to and acknowledge
women's stories. This will allow them to adapt the best contraception for the
individual and will also aid in counteracting prevailing myths surrounding birth
control. Although it may be difficult for healthcare workers to manage a high volume
of patients, gaining this holistic perspective will ensure better healthcare. Nurse
practitioners and doctors will be able to more accurately predict which methods
patients are more likely to stay compliant on and be comfortable with considering
the patient's unique background.
Chapter 10: Limitations & Acknowledgements

Limitations

A major limitation in my study was the lack of LGBTQIA* inclusivity. I assumed heterosexual relationships. Only one woman explicitly mentioned that she was bisexual and that her contraceptive choices varied partner to partner. Because I did not have inclusivity in this regard, I may have missed data or misattributed risk when in reality varying levels of risk may be present.

Additionally, the lack of sexually transmitted infection questions may have also affected my data. As my research progressed, I noticed many women made the distinction between condoms as a pregnancy versus STI prevention tool. Women connected condoms and STIs more frequently and therefore may have not mentioned them as a part of their contraceptive narratives even if they utilized them. Also, there are times birth control initiatives and STI initiatives can be in conflict. Because women use long-term methods or other forms of birth control, they often decide not to use condoms. Recognizing this tension within the public health community, it would have been beneficial to merge some of my data to get an intersectional and integrated perspective on women’s safe sex practice.

Further, no men were interviewed; thus, my sample was limited. Because men also actively engage with contraception (often through condom preference and even sterilization sometimes), this viewpoint is also valuable.

Another factor influencing my data could be the lack of full privacy. The South Grand Planned Parenthood was a relatively small space. Although only nurse practitioner could hear the responses, participants may have still felt inhibited to
share all of their contraceptive preferences knowing that a medical professional is nearby.

**Future Research Projects**

This research project focused on how women make choices regarding contraception. Further research could link if the decision-making technique or if the contraceptive method itself is correlated to unintended pregnancy. Additionally, because my research was mainly qualitative explorations, it could be beneficial to combine the qualitative narratives with quantitative analysis that predicts how much weight each factor has in determining a contraceptive decision. While there have been few studies documenting mother-daughter relationships regarding sex education, there could be a more in depth look at contraceptive use and these relationships.

**Acknowledgements**

I would like to thank Dr. Wall for providing me mentorship and valuable insight for this study. Not only did Dr. Wall give me critical improvements, he also was a key figure in championing my first scholarly endeavor. Dr. Song and Dr. Parikh offered their time and knowledge to hone this project. I am also extremely thankful to Dr. Eisenberg and Lindsay Ruhr from Planned Parenthood. They were essential in my smooth transition into their workspace. Lindsay Ruhr was instrumental in encouraging my research process and for providing me with general population data for the South Grand Planned Parenthood. Further, the entire South Grand Planned Parenthood team including all the nurse practitioners and medical
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doi:http://dx.doi.org/10.1017/S0021932009990563.


Appendix A

Research Study: Looking for Participants!

Perspectives on Family Planning & Contraception from Women in St. Louis Study

**Purpose:** Understand why women make the choices they make regarding family planning and contraception

**Eligibility:** Women over

**Contact Information:**
Priya Suri
(262)-853-4671
priya.suri@wustl.edu

**Location:** South Grand Planned Parenthood

**Time Commitment:** 30-60 minutes for an interview

**Compensation:** $15 American Express Gift Card

Family Planning & Contraception Perspective
## Appendix B

**Age, Race/Ethnicity, & Education Organized by Contraceptive Choice**

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<th>Participant</th>
<th>Contraception</th>
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