INCONSISTENT CONTRACEPTION AMONG WOMEN 20-29: INSIGHTS FROM QUALITATIVE INTERVIEWS

Paula England (Stanford and NYU), Joanna Reed (U. California-Berkeley), Krystale Littlejohn (Stanford) and Brooke Conroy (Stanford)

When surveys ask unmarried American women whether their recent pregnancies were intended, only about a quarter say that they were. Unintended pregnancies are especially common among those with low income and education, and among disadvantaged racial/ethnic minorities. Past research makes it clear that most women having early, unintended, and/or nonmarital pregnancies know about contraception, and have contracepted, but are inconsistent. The main proximate cause of such pregnancies is having intercourse but not correctly using contraception consistently. But *why* do sexually active men and women who aren't consciously trying to get pregnant so often fail to contracept consistently? To answer this question, we use rich qualitative data from interviews with 51 women, age 20-29, including complete sexual histories with detailed narratives on each partner, including contraceptive use, nonuse, and discontinuation.

Data and Methods

We draw upon the College and Personal Life Study, a study we conducted using in-depth qualitative interviews lasting about 1-2 hours with 51 women in 2009 and 2010. The women were recruited at two community colleges in the San Francisco Bay Area. We chose Community Colleges as a way to recruit a relatively low SES population of women at the age where unintended, nonmarital pregnancies are common. Respondents could be part-time or full-time students from 20 to 29 in age. We recruited with flyers posted on the campuses promising $50 for the interview. Flyers stated that, to qualify, women must be full- or part-time students at the college, age 20-29, and never married. Using theoretical sampling to make it likely that a number of our respondents would have had unintended, nonmarital conceptions, half our sample at each school was recruited from a flyer stating that respondents must have been pregnant at least once--"whether or not you had the baby." The other half did not require a prior pregnancy, but only that they have had sex with a man.

Most interviews were done by the three authors, two of whom are close to the respondents' ages. The interviews, while covering fixed material, were informal and conversational, and most all the women seemed comfortable talking to us about these topics. The interview guide asked about a woman's living situation, what a typical school day is like, how she supports herself and gets money for school, aspirations for future marriage and/or childbearing, beliefs about proper timing of childbearing, how she would react if she got pregnant now, views on abortion, and her schooling and job goals. Women were also asked about conversations with their own mother as a teen about sex and birth control. They were asked where they have gone to get birth control, and about problems with its cost or how they were treated by medical staff. The interview includes a life history of all male sexual partners. For each partner we evoked narratives about the nature of the relationship (casual sexual hookup, boyfriend, how serious), what contraception if any was used the first time having sex with him, whether she quit contracepting at some point and why, any discussions or disagreements about contraceptive use (or abortion), whether she ever wanted to have a baby with him, whether she ever got pregnant with him (and if so whether it was intended, how she felt about the pregnancy, and her decision about abortion), how the

relationship ended (if not intact), whether any other sexual partner overlapped with him, and whether she stayed on hormonal contraception between partners. Interviews were transcribed verbatim and have been coded in NVIVO software for qualitative analysis.

Our qualitative analysis focuses on comparing "cases" of contraceptive consistency with inconsistency or nonuse. We utilize both between-respondent variation, and within-respondent (between-partner and over time) variation. For between-respondent variation, we compare women who almost always contracepted to those that were quite inconsistent, looking for differences in their life plans, world views, and situations. We also examine within-respondent variation because of our complete partner history; we found that a number of women were consistent contraceptors at some points and inconsistent at others. We compare the partnerships and situations in which a given woman was and was not using contraception, isolating the point at which she discontinued or started contraception.

Our quantitative analysis will use a quantitative dataset that we are in the process of coding from the coded text fields in NVIVO. Coding is in progress. This dataset will have respondent-partner dyads as the units of analysis. Each respondent contributes as many observations as her number of partners, giving us an N (# respondents times average # of partners) of about 250. We will examine predictors of nonuse, inconsistent use, or consistent use variables that are characteristics of respondents, partners, relationships, and situations.

Preliminary Qualitative Findings and Themes

Motivation to Avoid Pregnancy: Opportunity Costs and Social Norms about Life Cycle Stages. Although few of these women had ever explicitly wanted to get pregnant, how badly they wanted to avoid getting pregnant varied. We have narratives about this for the time at the interview ("how would you react if you got pregnant now?") and with each partner. Women had ideas about whether a baby was appropriate in their life cycle situation. They talked about this in terms of social role and age. One said, "it is out of the question for me to have a child right now… I always wanted to have my first child like at least two years after I was married. Like I want some time alone with my husband, have set up a base, find a house, then we can have a baby." Some of our poor single mothers don't want to be single when they have their next child. Others, in a relationship, talk about being "too young," often saying they want a child several years from now. Another theme is that being a "student" or "in my 20s" should be focused on social life and fun. Others are concerned that a pregnancy would interrupt prospects for a 4 year degree. One woman plans to transfer to university next year and is "totally focused on my education." She has a serious boyfriend, whom she plans to marry and have children with, but is on the pill because "a child right now would mess everything up." Others would "deal" with an unplanned pregnancy by having the baby, seeing it as a setback, but not catastrophic. But some saw being a high school, but not a Community College student as incompatible with motherhood. One woman said: "[if she had gone through with the high school pregnancy that she aborted] I probably wouldn't be able to do the things that—you know go ahead and go to school and try to better myself…I probably wouldn't have finished high school." She goes on to say that "[pregnancy now] is my biggest fear, just being stuck [as a single parent]. It's not a bad thing but it's just not something that I want for my kids," but that she would "go through with it" if she got pregnant now. Another respondent had a clear notion of how she would react if

pregnancy occurred. She says, "I would definitely not be going to school….Definitely dental hygiene school would have to be put on hold…And my boyfriend would definitely be supportive, like we wouldn't, like an abortion would be out of the question."

Our ongoing analysis of this theme has two parts. First, it is clear that how incompatible with motherhood a woman sees her current life cycle stage affects how badly she wants to avoid pregnancy, but we have not yet linked this up with our data on their contraceptive behavior. Second, links between life cycle stage, motivation, and contraception are predicted by two distinct theories, and we will use detailed narratives to evaluate each. One notion is opportunity costs—those who are on a trajectory to high earnings have a greater incentive to contracept. The other is that social notions of what one is "supposed" to do in various life cycle stages can affect support for contraception or abortion. In this view, roles such as "full-time student" create identities and social support consistent with birth control, quite apart from pecuniary motivation.

Self-regulation, self-esteem, and contraceptive efficacy. The fact that so many women get pregnant while not contracepting yet say that they did not intend to get pregnant suggests a lack of efficacy. Perhaps this sometimes stems from lack of belief in one's own ability to affect events, or actual lack of well-developed skills of self-regulation needed to follow through on all the mundane steps of getting and using contraception. While we have much more work to do to examine how much evidence there is of a link between efficacy and contraceptive consistency, preliminary analysis suggests that some women showed increased agency with age. One woman tells the story of her first sexual experience as if she were a passive onlooker. She hoped her partner would use a condom, but when he did not she did not bring it up, much less insist, although she says she was very worried about pregnancy. Another respondent describes having sex with her high school prom date when she did not want to. She says, "I didn't like him like that, but…I should have said no but I just didn't". Another got pregnant when she and her boyfriend were using "pullout" (coitus interruptus). She had her doubts about its effectiveness, but she kept them to herself instead of insisting on another method. She says "I was shocked and disappointed in myself [to learn about the pregnancy] like how could I let, you know, why would I do this?"

Male Partners Hindering or Helping. Another theme emerging from our analysis is how much male partners hinder or help consistent contraception. While past studies find that the more serious a nonmarital relationship, the more couples let contraception lapse, we find little of this pattern (although condom use is reduced). Sometimes men impede contraception. Women talk of partners that refuse to wear condoms, or that wear them down by pleading every time. Some men suggest "pullout" instead, and while women doubt its effectiveness, it is common. Indeed, probes often reveal that when women say they used "nothing" during an encounter, the men pulled out. Male resistance is mostly limited to condoms and is about concern for pleasure or convenience.

We also found that men who are highly motivated to avoid fatherhood help consistent use, even providing a check on the woman's behavior. Some partners in casual encounters carried and used condoms without being asked. Some regular partners initiated conversations about contraception, encouraged women to get and stay on the pill, and reminded them to take pills. One man whose partner complained of side effects researched other methods. Another drove his girlfriend to the clinic and pharmacy. Women often saw this as evidence that their partner cared about them. This

woman's experience with different partners illustrates both the positive and negative influences of partners on consistent contraception. She had never had sex without contraception until she was with her current partner, who prefers withdrawal. Her consistency with prior partners, she says, was due to their behavior. "He [current partner] says he doesn't like them [condoms]…like with the other guys they always had it [the condom with them] and I really wanted to have sex with [current partner]." Another respondent, who was on the pill, suggested her partner stop using condoms, which she viewed as redundant. She says, "At one point I said something like you should take the condom off, something stupid like that. And he was like well, I don't want any babies." Some partners altered women's view about whether it was the right time to have a baby. One woman describes a series of casual sexual encounters and some inconsistent use of contraception before meeting her current serious partner. She credits his love and respect for her with making her get serious about school and plan for a career in dance. She says she had to "step it up to be with him." Now she doesn't want kids for several years and is very consistent with taking the pill.

Access, Institutions, and Adult Attitudes about Sex. Past studies suggest that the cost of contraception does not seriously impede use, given Planned Parenthood's sliding scale, although the cost of abortion does deter use. Our preliminary findings are that access to contraception was seldom a serious problem *except* in women's *retrospective* reports of their teen years. (Rs were in their 20s at interview.) Interacting with institutional features were the negative attitudes toward teen sex among parents, doctors, or the culture at large. Teens often didn't want their parents or adult kin to know they were having sex, and, oddly enough, this extended to youth whose parents had invited them to ask if they needed birth control. It was hard to figure out where to go without talking to Mom. One woman talked to her mom, but didn't want her to know she was having sex, so convinced her mother that she needed to take the pill for her terrible menstrual cramps. Getting condoms was relatively easy—some got them at their urban high schools while others went to the drug store. Others felt too embarrassed to buy condoms themselves, especially if it meant asking a store employee to unlock the case they were stored in. Going to Planned Parenthood or a Public Medicaid Clinic took some teens two or three hours on public transit. Although it was more anonymous than going to a private doctor, some respondents had a hard time explaining to their parent where they were for the afternoon. Others could only get appointments during school hours, and had to cut school to go, and then explain a school absence. For some with private insurance, the prospect of asking one's pediatrician proved daunting. One teen asked her doctor about going on the pill and got a lecture about being "ready" for sex. Some worried that a parent would find out the reason for their visit because it would appear on an insurance statement. Others reported the doctor only prescribing one month of pills at a time, which in practice meant their usage lapsed. As respondents got older, they became savvy about dealing with institutions and cared little about hiding sexual activity from others, the access problem diminished dramatically. By then some had a child, however.

Other Themes. Other preliminary themes include the discontinuation of hormonal methods because of perceived side effects, and alcohol or drug use causing "just not thinking" about contraception, and negative attitudes about abortion, including among those who had had an abortion.