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THE PROCESS OF CONTRACEPTIVE DECISION-MAKING IN WOMEN:
USING A FEMINIST GROUNDED THEORY APPROACH

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Abstract

Half of pregnancies in the United States that occur annually are unintended. Half of these pregnancies occur among women using contraceptives; half are electively terminated. Reducing contraceptive discontinuation and failure could have a significant impact on abortion rates and the toll that unintended pregnancies have on women. The purpose of this study is to develop a theory of contraceptive decision-making in women to contribute to knowledge development, which may make a difference in women's lives as they negotiate contraceptive use. A feminist, grounded theory design was chosen using the data collection method of open-ended interviews. Sixteen women were interviewed from August, 2002, through January, 2003 on the island of Kauai using a semi-structured interview guide. The data, which included interviews, field notes and memos, were coded using open, axial, and selective coding methods and analyzed using constant comparative analysis until saturation occurred. The core category that describes the process of contraceptive decision-making in women is "finding the best fit". Women choose a method or methods to prevent pregnancy based on their knowledge, experience, and evaluation of what would be the best fit within the context of their current life situation. Categories of "finding the best fit" are "becoming aware", "weighing what's best for me", and "navigating a course". Women become aware of options and/or resources for preventing pregnancy. In "weighing what's best for me", a woman evaluates one or more methods for preventing pregnancy in order to choose one that is most suitable within the context of her current life

circumstances. In “navigating a course”, women contend with access to and use of one or more birth control methods.

It is recommended that providers should conduct a thorough contraceptive history, identify a woman’s perceptions of methods, and identify personal and clinical practice biases. Providers should offer a variety of educational materials and explore ways to link with community, educational, and political agencies to offer programs for and increase access to birth control. Further knowledge development about becoming aware, having support, women’s perceptions of methods is recommended as well as to repeat this study in different populations.

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Chapter 1. Introduction

This chapter presents the background for this study, impetus for the study, definition of terms, philosophical orientation, assumptions, problem statement, statement of purpose and significance, and research question.

Background

Contraceptive use has a significant influence on pregnancy and birth rates (Piccinino & Mosher, 1998). Half (2.7 million) of the 5.4 million pregnancies in the United States that occur each year are unintended and half of these unintended pregnancies occur in women who used contraception during the month they conceived (Henshaw, 1998; Piccinino & Mosher, 1998). Half of these unintended pregnancies are carried to term while the other half are electively terminated (Henshaw, 1998). In fact, 43% of all U.S. women can expect to have an induced abortion by age 45 (Henshaw, 1998). Thus, reducing contraceptive discontinuation (premature termination of a method by someone desiring contraception) and failure (pregnancy while using contraception correctly or incorrectly) could have a significant impact on abortion rates as well as the financial and emotional toll that unintended pregnancies have on women in today's society.

Contraceptive discontinuation and failure are major public health concerns facing health care providers delivering family planning services. Contraceptive failure and discontinuation vary according to methods and characteristics of the user (Bracher & Santow, 1992). According to the 1995 National Survey of Family Growth, first-year failure rates for contraceptives ranged from 2 to 4% for

implants and injectables to 28% for spermicides. Lack of access to and lack of knowledge about contraceptives contribute to unintended pregnancies. Poor, unmarried adolescents and women in their twenties have the highest rates of contraceptive failure (Fu, Darroch, Haas & Ranjit, 1999). According to the same survey, 16% of oral contraceptive users are inconsistent in their pill-taking (Peterson, Oakley, Potter, & Darroch, 1998).

Economic costs to society, family and individuals of not only contraception but contraceptive failure as well are significant. First-year costs of contraception can range from a low of \$422 for oral contraceptives to a high of \$2,554 for tubal ligation based on a 1993 cost analysis, which includes the cost of method, treatment of adverse effects, and cost of unintended pregnancies (Haws, Butta, & Girvin, 1997). The annual cost of supplies alone per woman can range from \$180 for Depo-Provera to \$360 for oral contraceptives. Only about half of insurance programs cover reversible methods of contraception while about 15% cover all methods. While 97% of health care insurance companies provide prescription services, only one-third cover oral contraceptives (Alan Guttmacher Institute, 2000). It is not surprising, then, that women of reproductive age pay 68% more than men of similar age do for out-of-pocket health care costs (Alan Guttmacher Institute, 2000).

Lack of satisfaction with a chosen method is a very real problem, particularly for those choosing a permanent method. Twenty per cent of women who selected sterilization at age 30 or younger expressed regret for their decision (Wysocki, 2002). Other risk factors for regret related to female

sterilization are marital instability, a sterilization decision related to an obstetrical event such as pregnancy, and sterilizations paid for with public funds (Haws, Butta, & Girvin, 1997). Most contraceptive discontinuances of reversible methods are related to dissatisfaction of the method caused by side effects.

It has been difficult to illuminate patterns of women's contraceptive decision-making. In a retrospective record review of 800 women from varying ethnicities who were seeking contraception, Matteson and Hawkins (1997) could not detect or predict any pattern to contraceptive choice based on efficacy or past contraceptive use. They concluded that contraceptive choice was an individualized, multifactorial, complex process.

Although there has been much research in the area, a comprehensive theoretical framework of contraceptive decision-making in women has not been developed. In a survey spanning 50 countries, over 90% of women intending to use family planning services already know what method they want before coming to the clinic (Upadhyay, 2001). How do women decide upon a method of birth control? Exploration of factors that influence contraceptive decision-making in women may lead to further understanding of the phenomenon. A more complete exploration of contraceptive decision-making in women may lead to generation of hypotheses upon which interventions may be built to prevent contraceptive discontinuance or failure. This may have a significant impact on unintended pregnancies and abortion rates, which will make a difference in the lives of women. Such impact will lessen the financial and emotional toll that unintended

pregnancies and the abortions that may ensue have on women and their families and by doing so will contribute to improving the health of the population.

Impetus

The impetus for this study can be found in the researcher's education as a nurse practitioner and clinical experience as a family nurse practitioner in a college clinic with a focus on family planning. For example, during a class on contraception, it was said that diaphragms were rarely used in Hawaii because women were uncomfortable touching their vaginas and similarly did not use tampons. Although this information was anecdotal, this caused the researcher to begin to think about how women decide on a method of contraception. It was evident that women who came to the clinic had different experiences and desires about contraceptive methods, further stimulating questions such as (a) how can health care providers best help women make contraceptive decisions? and (b) how can providers help women make contraceptive decisions if there is not an adequate knowledge base about how women make these decisions. In reviewing the literature on contraception, themes surrounding contraceptive decision-making seem to center around the categories of method properties, external influences, relationship dynamics, and personal characteristics (See Chapter 2). However, studies looked at specific influences or correlates; there was not a comprehensive framework for understanding contraceptive decision-making in women. Exploring how and why women make decisions about birth control will contribute to knowledge development and may make a difference in women's lives as they successfully negotiate contraceptive use. More successful

contraceptive use will reduce the financial and emotional toll that unintended pregnancies and abortions have on the lives of women.

Definition of Terms

For the purpose of this study, contraception is defined as any method or practice used to prevent pregnancy. It includes periodic abstinence, withdrawal, barrier methods, hormonal methods, intrauterine devices and sterilization. In this study, elective abortion is not considered a contraceptive method.

Decision-making is defined as the intentional selection of a salient alternative or an acceptable solution to a problem that commits a person to a path of action in order to accomplish a specific goal or goals. Decision-making occurs within a complex, multidimensional, situation-specific context.

Philosophical Orientation

Decision-making is an essential process of human nature (Kim, 1987) and, as such, is an important area for nursing study. Decision-making in health care can be categorized according to the client domain and the nursing practice domain, also known as clinical decision-making (Schartz-Barcott & Kim, 2000). Although certain characteristics of decision-making apply to both domains, the focus in this discussion is on client decision-making related to health care concerns. Nurses, as well as other health care providers, daily assist clients with making health care decisions, which may range in intensity from minor to potentially life-threatening. Decisional conflict has been accepted as a nursing diagnosis since 1992 (Carroll-Johnson & Paquette, 1994).

The nurse-client interaction is one of the major tools used for effective contraceptive counseling (Meleis, 1997). This may be because many contraceptives are tied to prescriptions. This may also be because health care providers are the repositories of health and reproductive knowledge. Nurse-client interactions have the potential to influence behavior and decision-making. In order for the nurse-client interaction to be effective, it is important to understand how women make these decisions as the basis for effective counseling.

Hanna (1993) conducted a quasi-experimental study with 51 adolescent females who were first starting oral contraceptives. Both experimental and control groups received contraceptive teaching. The experimental group also received a nurse-client interaction, the goal of which was to facilitate the client's consideration of perceived benefits and barriers of oral contraceptives, which included mutual goal setting to prevent pregnancy and developing a plan for adherence. At a three-month follow-up visit, the experimental group had significantly greater contraceptive adherence.

A literature review suggests that the environment plays a strong role in how women make contraceptive decisions. The environment here includes the impact of the culture, sexual partner, the health care system, social or family prohibitions on use, and the media. It will be helpful to explicate this influence further.

If health is viewed as the ability to perform one's roles and looked at in terms of personal awareness and empowerment as well as being in harmony

with one's body, then assisting women with contraceptive decisions falls within the realm of health promotion. By assisting women to make wise contraceptive decisions and negotiate contraception successfully, women are able to negotiate their reproductive lives that empower them to perform their roles and functions in society as they see fit.

There has also been a call in nursing to develop gender-sensitive theories in women's health (Im & Meleis, 2001) that contribute to knowledge development in nursing. Such gender-sensitive theories attend to contextual factors, reflect and respect women's own voices and experiences, and recognize the complexity and diversity of these experiences.

Assumptions

One assumption of this study is that birth control is a beneficial tool for women and that the use of a birth control method by women will increase their efficacy to avoid an unplanned pregnancy. Another assumption is that the use of any birth control method has benefits and inconveniences that women need to negotiate. A final assumption is that there is no one optimal method – the best method will be different for each individual woman and will change for that woman throughout her lifetime.

Statement of the Problem

Contraceptive discontinuance and failure have a significant influence on pregnancy and birth rates. Half of all pregnancies in the United States are unintended and half of these unintended pregnancies occur in women who used contraception during the month they conceived. The average first year failure

rate for contraceptives is 13% overall, ranging from a low of 2 to 4% for implants and injections to as high as 23 to 28% for periodic abstinence, withdrawal and spermicides, respectively (Fu, Darroch, Haas & Ranjit, 1999). Although second year failure rates fall to an average of 8%, ...“during a lifetime of use of reversible methods, the typical woman will experience 1.8 contraceptive failures” (Trussell & Vaughn, 1999, p. 64). Exploring how and why women make decisions about birth control will contribute to knowledge development and may make a difference in women’s lives as they successfully negotiate contraceptive use. More successful contraceptive use will reduce the financial and emotional toll that unintended pregnancies and abortions have on the lives of women.

Purpose and Significance of the Study

The purpose of this study is to begin to generate a theory of contraceptive decision-making in women in order to further explore the phenomenon and to contribute to knowledge development on which interventions may be built to minimize contraceptive discontinuance or failure. Use of a grounded theory approach to further explicate the process of contraceptive decision-making in women is intended to lead to a more comprehensive framework or basis for developing nursing knowledge about this area of study. Both registered and advanced practice nurses (APNS) are uniquely situated to assist women with birth control decisions as they counsel, provide education and, for APNs, prescribe methods. Explication of factors that influence women’s decision-making about birth control will assist in developing nursing knowledge on which evidence-based practice can be based.

Research Question

The research question for this study is “what is the process of contraceptive decision-making in women?” In other words, how do women make decisions about birth control?

Chapter 2. Literature Review and Conceptual Orientation

The purpose of this chapter is to review the pertinent literature on contraceptive decision-making in particular and decision-making in general. A conceptual orientation for this study is provided.

Contraceptive Decision-Making

In reviewing the literature, themes surrounding contraceptive decision-making seem to center around the categories of method properties, external influences, relationship dynamics, and personal characteristics. There appears to be interaction among all these variables, which leads to the decision of contraceptive choice.

Contraceptive Method Properties

Contraceptive method properties play an enormous role in contraceptive decision-making and have multiple components. The themes identified relating to method properties are effectiveness, safety, side effects, ease of use, ease of access, lack of interference with lifestyle, noncontraceptive benefits, and duration of method. Effectiveness is one of the most influential method properties that impact the type of contraceptive used (Fuchs, Prinz, & Koch, 1996; Monsen, Jackson, & Livingston, 1996; Sadana & Snow, 1999) and influences the type of method chosen.

In a study of 2,000 women seeking contraceptive services, 73.4% of IUD users and 97.6% of women who were sterilized viewed effectiveness as an important factor in the method chosen (Konje, Oladini, Otolorin, & Lapido, 1998). Unfortunately, the effectiveness of a method must be balanced with its probability

of causing side effects and health problems (Erickson, 1996; Lethbridge, 1991). Side effects are also a significant correlate of contraceptive choice and a major reason for early discontinuation of a method (Bracher & Santow, 1992; Erickson, 1994; Fuchs et al., 1996; Stevens-Simon & Kelly, 1998). Side effects such as breakthrough bleeding and nausea are common reasons for discontinuing oral contraceptives while weight gain and unanticipated spotting are common reasons for discontinuing Depo-Provera®.

Another important property of a method is its safety in avoiding health risks and problems (Konje et al., 1998). Not only are current health issues a concern for women, often women are influenced by past health problems that have been associated with a method, such as the thrombogenic problems associated with the pill and uterine perforation associated with the intrauterine device in the 1970s. Concern over safety of contraceptive methods has invited political and legislative intervention. During the late 1960s and early 1970s, controversy ensued over birth control pills' links to side effects, such as blood clot formation and cancer. The long-term effects of oral contraceptives were not known. Congressional hearings on the safety of the pill were begun in 1969. During these hearings, it became clear that women were not being fully informed by physicians of the risks associated with the method. This resulted in the redesign of patient package inserts to fully inform patients about the drug's uses, benefits, risks, and side effects (Watkins, 1998).

Another method property that influences choice is the ease of use or convenience. A component of this theme is the aesthetics of a method; many

women referred to barrier methods as “sloppy” and “messy” and “uncomfortable” (Bernat, 1993; Choi, Roberts, Gomez, & Grinstead, 1999; Matteson, 1991). The diaphragm was viewed by some as difficult to insert (Kuss, 1997; Matteson, 1991). Women who viewed these methods this way were less likely to use them consistently (Choi, et al., 1999). Certain methods that are less efficacious, such as withdrawal (Erickson, 1996) and natural family planning (Kuss, 1997), may be viewed as easy to use.

Ease of access includes the cost of the method (Bernat, 1993; Matteson, 1991; Okun, 1997; Sadana & Snow, 1999) and the ability to access the method without a prescription (Bernat, 1993; Matteson, 1991). The cost of the method can be a real barrier to many women. Contraception can be expensive and access to low-cost contraception in the United States is fragmented at best. For many methods, particularly the more effective ones, the expense is borne upfront. Seventy-five percent of women of child-bearing age rely on private insurance to cover medical costs (Alan Guttmacher Institute, 2000) but private insurance may not cover the cost of certain contraceptive methods, particularly hormonal ones. Low-income women may not qualify for Medicaid or have access to federally subsidized clinics.

Lack of interference with lifestyle includes method interference with sexual spontaneity (Erickson, 1996; Kuss, 1997; Choi et al., 1999) or with sexual pleasure (Bernat, 1993; Erickson, 1996; Matteson, 1991); if the method interferes with one’s usual activities by necessitating follow-up visits (Erickson, 1994; Sadana & Snow, 1999); and the method’s visibility (Choi et al., 1999; Okun,

1997; Sadana & Snow, 1999). The female condom was viewed by the women as superior to the male condom in a study by Choi et al. (1999) because it could be inserted prior to sex and thus did not interrupt intercourse.

Noncontraceptive benefits are important factors for many women; especially those that decrease the risk of sexually transmitted diseases (Choi et al., 1999; Erickson, 1996; Fuchs et al., 1996) and methods that improve menstrual cycle control, dysmenorrhea, and acne (Fuchs et al., 1996). In a study of oral contraceptive use, Fuchs et al. (1996) found that women were more aware of common observable noncontraceptive benefits, such as acne improvement and menstrual-cycle control, but were less aware of the health benefits that could not be readily observed and experienced, such as a decreased risk of ovarian and endometrial cancer.

The final theme, duration of method or length of time a method is used, is important especially in relation to one's stage in the reproductive cycle (Cromer et al., 1994; Konje et al., 1998; Okun 1997). Long-term methods may be chosen if pregnancy is not desirable in the near future or if the woman is uncertain if she wants to get pregnant. Permanent methods may be selected when a woman decides she no longer wants to become pregnant.

External Influences

Themes related to external influences that emerged from this analysis are the health care provider; medicalization; political influence; influence of relatives, friends, and neighbors; social norms, including cultural and religious beliefs; the

media; and educational classes. The partner is an important external influence and is addressed separately in a later section on relationship dynamics.

Health care provider. One of the strongest external influences on the choice of contraception by women is the influence of the health care provider (Monsen et al., 1996; Oddens, 1997; Sadana & Snow, 1999; Thompson, 1998). Women look to health care providers for counseling and are swayed by their recommendations. In interviews with women about contraceptive use, Matteson (1991) found that all women interviewed followed their physician's recommendation, even if it was different from their initial choice. In a study of contraceptive choices among Dutch women (van Lunsen, Arnolds, & van Maris, 1994), women who chose the IUD or sterilization were more influenced by their health care providers in their decisions than were women who chose oral contraceptives or condoms. Health care providers have been noted to have a contraceptive preference or bias, which may conflict with the woman's first choice.

In a study evaluating contraceptive choice in women in India (Baveja et al., 2000), providers' first choice of method for women was Norplant® (35.6%), followed by the IUD (32.8%), whereas women's first choice of method was the IUD (58.6%) followed by female sterilization (14.9%). More than 90% of the women studied, however, received their first choice of method. In a study of Indonesian women and their contraceptive use (Pariani, Heer, & Van Arsdol, 1991), 86.3% of women received their first choice, which positively correlated with sustained use of the method. Of the women who received their first choice

of method, only 8.9% discontinued the method, while most women (72.2%) who did not receive their first choice discontinued the method. Negative views on a method, such as the IUD, held by health care providers may result in a decrease in its use (van Lunsen et al., 1994). Choices may be limited when providers do not offer the whole range of contraception (Lethbridge, 1991).

Medicalization. One cannot explore the factors that affect contraceptive choice without understanding the influence of medicalization on contraceptive decision-making. Contraception, along with other issues of concern to women, such as premenstrual syndrome, pregnancy, childbirth, and menopause, have been appropriated by medicine and medicalized (Cahill, 2001). Medicalization can be defined as a “process whereby more and more of everyday life has come under medical dominion, influence, and supervision” (Zola, 1983, p. 295). Riessman (1983) defined a framework of medicalization that encompasses not only defining behaviors and conditions in terms of health and disease, but allows medicine to have the control over these areas as belonging within their jurisdiction.

A major criticism of medicalization is that medical influence constrains the autonomy of people, particularly women.

A plethora of female conditions has come to be either reconceptualized as illnesses or, if they escape medical labeling, understood in ways that connote deviation from some ideal biological standard. Because they are seen as biological events, medical solutions are applied. (Riessman, 1983, pp. 9-10)

Thus the human body is viewed through a 'medical' or 'clinical' gaze (Lupton, 1997) and medicine becomes not only a scientific institution, but a social one as well. A power differential occurs when patients' voices are not heard and the medical experts' power becomes the voice heard and listened to (Malterud, 1993).

Conrad (1992) described three levels of medicalization: the conceptual, the institutional, and the interactional. At the conceptual level, medical terminology is used to define the problem although the intervention of health care providers is usually not required. The term "contraception" is one example, even for methods such as natural family planning, condoms and vaginal creams and suppositories, which do not require access to medical services. At the institutional level, medicine acts as gatekeepers for organizations, who adopt a medical approach to treat a problem, although nonmedical personnel may treat the problem. State departments of health and family planning clinics become the repositories for knowledge about birth control and reproduction. An example of this level of medicalization for birth control occurred in the late 1960s and early 1970s with the advent of the birth control pill. The 1938 Federal Food, Drug and Cosmetic Act required all prescription drugs to carry a physician insert that described the drug. During the Congressional hearings of 1969 and 1970 about the safety of the birth control pill, a proposal was made to create a patient insert, to inform the patient about risks and side effects. This insert was strongly opposed by the pharmaceutical industry and the medical profession, who declared interference between the physician and patient relationship (Watkins,

1998). At the third level, the interactional level, direct interaction between health care providers and patients becomes necessary. Prescriptive and surgical contraceptives fall into this category.

Most, if not all, contraceptive methods are tied to health care. Some methods, like implants or surgery, require the skill of a licensed health care provider. Others, like oral and injectable contraceptives, are tied to a prescription and an annual visit that is really screening for cancer and sexually transmitted diseases. Even barrier methods are linked to health care. Diaphragms must be fitted by a health care provider. Condoms and vaginal creams and suppositories are found in pharmacies or the health and beauty aisles of the supermarket.

Looking at the history of family planning in the United States provides a lens for understanding how contraception became medicalized. Historically, there has been both legal and religious opposition to the use of contraception. In 1863, the anti-obscenity Comstock Law was passed, making it illegal to mail information about contraception, which the law defined as obscene (Poirer, 1990). Margaret Sanger, a public health nurse, challenged the Comstock Law in New York City (Chesler, 1992) because of her experience with poor, immigrant women and their need for reliable birth control. Although she was arrested and indicted for violating the Comstock Law in 1916, the New York State Court of Appeals in 1918 reinterpreted this law and allowed physicians to prescribe contraceptives on medical grounds. However, it took until 1936 for the federal Comstock Act to be abolished and until 1971 for federal prohibitions against birth control in general were removed. Sanger was also strongly influenced by

feminist political activists of the time, such as Emma Goldman (Chesler, 1992). Although Sanger coined the term “birth control” to stress that women had control over their bodies, she realized that moving contraceptive services within the realm of medical care would be the way around the federal and state Comstock Laws until they could be overturned. Although the federal law was overturned in 1938, state laws took until the 1960s and 1970s to be repealed. By that time, contraceptive services were firmly entrenched within medicine, mostly because of the availability of the birth control pill and the adverse effects associated with its early formulations (Watkins, 1998).

Safety concerns about oral contraceptives have been addressed and there has been a recent call for demedicalizing oral contraceptives to allow them to be available without a prescription (Trussell, Stewart, Potts, Guest, & Ellertson, 1993). However, the question is will women support this, as contraceptives are often available to them at low or no cost through subsidized services or covered by drug health plans. In addition, the medicalization of contraception will remain as new high-technology methods emerge (Riessman, 1983). Riessman (1983) also suggested that “women collaborate in the medicalization process because of their own needs and motives” (p. 3), further reinforcing the process. For example, historically, middle- and upper-class women in the early 20th century joined with physicians to medicalize contraception. “Physicians used science as the rationale for professional dominance. ...women’s participation in the redefinition of (contraceptive) experience was the result of complex historical and class-specific motives, and they not only gained but lost with the medicalization

of (contraception)” (Riessman, 1998, p. 56). This collaboration with medicalization in the 21st century could be related to the need to access low or no cost subsidized contraception, reproductive knowledge or information on safety concerns that could be addressed by a health care provider. As a result of all these forces, this history of contraception in America reinforces Zola’s (2001) assertion that “medicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law” (p. 404).

Focusing on the history of birth control in the United States provides a lens for understanding the political influence on contraception. As Comstock Laws were overturned and birth control became available by prescription, it was largely available to middle- and upper-class women. Federal legislation was enacted in the 1960s and 1970s (Titles V, XIX, and XX of the Social Security Act, Title X of the Public Health Service Act) as well as various state laws to offer birth control services to low-income women. Funding and restrictions, such as parental notification, to these services have waxed and waned since then depending on the conservative nature of the political administration and federalist issues that resulted in block funding to states, which meant that money was distributed in blocks and not specifically earmarked for family planning services. Despite this, funding for birth control service has remained relatively stable (McFarlane & Meier, 2001).

Relatives. Additional external influences are people who may influence women’s contraceptive decision-making. These include relatives, particularly

mothers or sisters, and friends. Two studies of American adolescents demonstrated the strong maternal influence on the choice of contraceptive method. Cromer et al. (1994) examined adolescents' choice of Depo-Provera®, oral contraceptives, or Norplant® in comparison with the mother's choice. There was strong agreement, in general, between adolescent and maternal choice. However, when disagreement arose, the maternal option was overwhelmingly chosen. In a study of 121 female adolescents who chose Norplant® (Rickert, Hendon, Davis, & Koslowski, 1995), 40% stated that their mothers were the most important influences on their decisions. In contrast, some adolescents and young women may want to maintain secrecy from their parents about contraception (Bernat, 1993). In interviews with Vietnamese women living in the United States, women would not speak to their mothers about contraception, partly due to the fact that their mothers had little knowledge of contraception (Kuss, 1997). Not only do other people's contraceptive experiences influence women. Other women's experiences with unwanted pregnancies or abortions may motivate women to seek more effective methods (Bernat, 1993).

Friends. Beyond the family, close girlfriends may also influence women's contraceptive decision-making (Kuss, 1997). They may be particularly influential to those women who are making their first contraceptive decision (Sadana & Snow, 1999).

Social norms. In some Asian cultures, contraception may be a private matter that should be kept shielded from neighbors (Sadana & Snow, 1999) and parents (Kuss, 1997), which may be related to the social norms on sexuality.

Social norms may affect perceptions of a certain method. In focus groups with Cambodian women, Sadana and Snow (1999) found that condom use would not be considered as a method between married couples because the condom was associated with prostitution. In a study of Hmong women living in the United States (Jambunathan & Stewart, 1995), the researchers found that women would consider it disrespectful to ask a man to use a condom. The social norm of using the male condom was a barrier to female condom use for women of diverse ethnicity in the United States; that is, the familiarity and ubiquitousness of the male condom made it less likely that women would try the female condom (Choi et al., 1999). Oddens (1997) found differences in Germany and Great Britain regarding contraceptive choices, which may relate to a national social influence on contraceptive services, such as which contraceptives are federally subsidized.

Culture and religion are a part of societal norms exerting an influence on the acceptability of methods. In some cultures, beliefs about menstrual flow and the effects of the method on menstrual flow may influence their use. In some Asian cultures, a normal menstrual flow is considered healthy and what differentiates women from men. This view may influence the acceptability of certain methods such as the IUD and Norplant® or Depo-Provera® that alter the menstrual flow (Bhat & Halli, 1998; Kuss, 1997). Hormonal methods may be viewed as causing the woman to become undesirably hot (Kuss, 1997).

Religious beliefs may influence the woman to use methods such as withdrawal, natural family planning (Kuss, 1997), or barrier methods (Lethbridge, 1991).

Religion may influence decision-making, not only at the individual level, but also

at the societal level, through affecting social policies or institutions that can provide or limit access. For example, a large nationwide pharmaceutical chain with conservative religious links, Walmart does not dispense emergency contraception because of the belief that it is an abortifacient (Karen Mak, personal communication, January 26, 2002).

Media. Finally, media, such as television and magazines (van Lunsen et al., 1994) and educational classes (Bernat, 1993) influence women's choices, either positively or negatively. For example, advertisements, particularly for oral contraceptives, which appear both on television and in magazines, seem directed at young, married women. These advertisements may positively influence the decisions of the targeted audience.

Relationship Dynamics

Themes that fall under the category of relationship dynamics include birth control responsibility, partner influence, steady versus casual relationship, frequency of intercourse, change in relationship, and male health problems. The first theme, birth control responsibility, focuses on who bears the responsibility, as well as the burden, for contraception in a relationship. This affects the method used. In relationships where the man takes the responsibility for contraception, male-controlled methods such as condoms and withdrawal are more likely to be chosen (Bernat, 1993; Okun, 1997). Other components of relationship dynamics relating to method properties, include partner preferences and objections to particular methods. Often one or both partners object to barrier devices (Choi et al., 1999) and/or male sterilization (Matteson, 1991). In certain relationships, the

necessity of partner consent to the use of birth control may influence the method used. A woman may prefer to use a more secretive method, such as the IUD or Norplant®, if the partner objects to the use of contraception in general (Konje et al., 1998; Wolff, Blanc, & Ssekamatte-Ssebuliba, 2000).

A steady relationship (Fuchs et al., 1996) and frequency of sexual intercourse (Durant, Seymore, Pendergrast, & Beckman, 1990) may influence a woman to select a more reliable method. With casual relationships or a change in a steady relationship (Erickson, 1994), women may discontinue a method or choose less reliable methods.

A partner's health problems may influence the method chosen by a woman. Bernat (1993) found that a partner's health problem that interferes with the ability to achieve and maintain an erection may cause a woman to use a method that does not interrupt the spontaneity of intercourse, such as hormonal methods.

Personal Characteristics

The category of personal characteristics includes the themes of reproductive stage, fear of pregnancy, perceptions and beliefs, self-efficacy, modesty, educational level, past contraceptive experiences, and willingness to experiment.

Reproductive stage and fear of pregnancy. Women can be at risk for pregnancy for thirty to forty years of their lives. During this time, women may be at any point along a reproductive continuum. Some examples of this continuum are not wanting children, not wanting children yet, thinking about having a child,

ready to have a child, having a child, probably finished with child-bearing, and definitely done child-bearing. Where a woman is in her reproductive stage has a strong influence on her choice of contraceptive. Women nearing the end of their reproductive cycle may choose a more effective method (Wolff et al., 2000), a more permanent method (Baveja et al., 2000; Hamill, Tsui, & Thapa, 1990; Piccinino & Mosher, 1998), or one that is of longer duration (Oddens & Lehert, 1997). Women who plan to have more children in the next few years may choose a less effective method (Okun, 1997). Closely related to a woman's reproductive stage is her degree of fear of pregnancy. Women with a greater fear of pregnancy are more likely to choose a more effective method (Bernat, 1993; Lethbridge, 1991). A woman's perceptions of her pregnancy risk positively correlate with the reliability of the method she chooses (Durant et al., 1990; Oddens, 1997).

Method perceptions and beliefs. A woman's perceptions of a method may influence her choice. Perceptions may vary from general to specific. Women's individual perceptions can be characterized as vague generalities, such as dislike of a hormonal method because it is perceived as not natural (Fuchs et al., 1996) or fear of long-term effects (Matteson, 1991) or can be specific to actual effectiveness and risk. Other perceptions are associated with a lack of understanding or knowledge of the method (Bernat, 1993; Okun, 1997).

Beyond perceptions, certain beliefs relate to the idea that one should act responsibly to avoid pregnancy and beliefs related to abortion (Bernat, 1993). That is, the stronger a woman's views against abortion are, the more likely she is

to use a reliable method. In addition, if a woman has views on abortion that conflict with her partner's, she may be more likely to use an effective method to avoid that conflict (Bernat, 1993).

Self-efficacy and modesty. A woman's belief about her degree of self-efficacy, or ability to use the method correctly, may influence the method she chooses. This may relate to remembering to take a pill daily (Oddens & Lehert, 1997), to reliably use a barrier method consistently, or remembering to return for follow-up injections (Sadana & Snow, 1999).

A woman's degree of modesty influences her choice of method. The embarrassment of submitting to a pelvic examination for IUD insertion or for a hormonal prescription, especially if performed by male health care providers, may preclude the use of such methods (Libbus & Kridli, 1997; Matteson, 1991; Sadana & Snow, 1999). Barrier methods that require vaginal insertion, such as the diaphragm, cervical cap, or female condom, may not be used because of modesty (Choi et al., 1999; El-Bassel et al., 1998, Matteson, 1991).

Educational level. Some investigators delineated differences in contraceptive method selected to a woman's education level. Oddens and Lehert (1997), in their study of women in Great Britain and Germany, found a positive association between a higher educational level and the use of oral contraceptives and periodic abstinence and a negative association between a higher educational level and the use of IUDs, sterilization, and withdrawal. Okun (1997) found that Israeli Jewish women with a lower educational level were more likely to use withdrawal as a method than the pill, IUD, or other methods. Among

women in the United States, female sterilization was more likely to be chosen by less-educated women (Piccinino & Mosher, 1998). In a study of Turkish women (Ozalp, Yalcin, Hassa, Erbay, & Dalan, 1999), more-educated women tended to choose sterilization and oral contraceptives, while less-educated women more often chose condoms and IUDs. None of these investigators thoroughly explained the association between educational level and contraceptive choice and some study results were conflicting.

Past contraceptive experiences. A woman's past contraceptive experiences, or lack of them, affect the method she chooses. First-time users who choose a nonprescriptive method are more likely to change methods than those first-time users who opt for a prescription method (Matteson, 1991). First-time users of prescription methods are more likely to choose oral contraceptives than Depo-Provera® or Norplant® (Cromer et al., 1994) and are more likely to be influenced by friends and family in their choice of method (Sadana & Snow, 1999). The experience of side effects with a method and especially method failure are likely to cause women to discontinue that method (Bracher & Santow, 1992). African women who experienced an accidental pregnancy (Obwaka, Ruminjo, Ndavi, & Sekadde-Kigondu, 1997) were more likely to be using the method incorrectly and for a short period of time. These women were less likely to know about other methods and to have been adequately counseled about contraceptive methods.

Willingness to experiment. A woman's willingness to experiment with a new method to test the fitness of its properties with her needs may influence

method choice. Women in Choi et al.'s (1999) study were willing to try the female condom because it was different. In Matteson and Hawkin's (1997) study of patterns of contraceptive use, some women changed methods as new methods became available. This finding is currently pertinent, as two new hormonal methods, the vaginal ring and transdermal patch, have recently become available.

Discussion of Contraceptive Literature

In summary, the current literature points to four categories that influence contraceptive decision-making in women: contraceptive method properties, external influences, relationship dynamics, and women's personal characteristics. See Table 1 for the categories and associated themes that relate to contraceptive decision-making that emerged from the literature. Most of the research cited, however, only looks at discrete variables that influence contraceptive decision-making. Although the studies included a variety of methods and represented findings from a number of countries, these findings do not speak for all women who are making decisions about contraceptive methods. Investigators looked at specific influences or correlates; there was not a comprehensive framework for understanding contraceptive decision-making in women.

Table 1

Contraceptive Decision-Making Themes

Contraceptive Method Properties	External Influences	Relationship Dynamics	Personal Characteristics
Effectiveness	Health care provider	Birth control responsibility	Reproductive stage
Safety	Medicalization	Partner influence	Fear of pregnancy
Side effects	Political influence	Steady vs. casual relationship	Perceptions
Ease of use	Influence of relatives	Frequency of intercourse	Beliefs
Ease of access	Influence of friends	Change in relationship	Self-efficacy
Lack of interference with lifestyle	Social norms	Male health problems	Modesty
Noncontraceptive benefits	Cultural beliefs		Educational level
Duration	Religious beliefs		Past contraceptive experiences
	Media		Willingness to experiment
	Educational classes		

There were adequate data to support the following as reliable influences on contraceptive decision-making: the contraceptive method properties of effectiveness, side effects, ease of access, and certain noncontraceptive benefits, such as protection from sexually transmitted diseases. Since convenience seemed to mean different things to different women, it needs to be further explored in order to provide a more comprehensive understanding of this influence on method choice. In addition, there is a need to understand how lesser known noncontraceptive benefits, such as prevention of ovarian and endometrial cancer for oral contraceptive users, influence contraceptive choice.

A number of researchers identified health care providers as important external influences on contraceptive decision-making. Data on the influence of other people, especially family, friends, and neighbors, were inconsistent and varied according to women's age and culture. A more thorough understanding of such influences across cultures would be helpful to those providing contraceptive care. An ethnographic understanding of social norms and beliefs about different contraceptive methods, sexuality, and related issues, such as menstruation, would illuminate the effects of these influences on method choice. The influence of media, such as television, books, magazines, the internet, and educational classes, as sources of information for women to help them with contraceptive decision-making deserves exploration.

Dynamics of relationships and their influence on contraceptive decision-making have only been studied peripherally and the results from this literature review are limited. Understanding how these dynamics influence method

decision-making, particularly secrecy in cultures where partner consent for birth control is an issue, is critical.

The data on women's personal characteristics appear to be consistent and trustworthy. These data include a woman's past experiences with contraceptives and her stage along the reproductive continuum, which influence the choice of method. The influence of a woman's educational level on her contraceptive choice has not adequately been explained and results are inconsistent across cultures. A woman's perceptions of the risks of the method have been understudied, as well as a woman's willingness to experiment with different methods as a way of gaining information about these.

Decision-making

Although decision-making is an area for nursing knowledge development and practice, client decision-making is a poorly understood concept. A recent review of health literature using the keywords of "concept" and "decision-making" produced only one citation of a concept analysis of client decision-making (Matteson & Hawkins, 1990). Exploring the concept of client decision-making in relation to health care decisions may provide some insight into how women make decisions about contraception. Constructing the meaning of a concept assists in its empirical study and knowledge development (Chinn & Kramer, 1999). Kim (1987) organizes nursing knowledge into four domains: client, client-nurse, practice and environment. She recommends concept clarification as one type of knowledge generation for phenomena within the client domain of nursing knowledge.

The Concept of Decision-making

Decision is a noun defined as “the act or process of deciding; a conclusion or resolution reached especially as to future action, after consideration; the settlement of a question; a formal judgment; tendency to decide firmly; resoluteness” (Oxford American Dictionary and Language Guide, 1999, p. 245). Decision-making occurs within a complex, multidimensional, situation-specific context, which has both personal and environmental components.

For the purpose of this study, decision-making can be defined as the selection of a salient alternative or acceptable solution, which is not limited to only the best or most ideal solutions. Attributes of decision-making are an intentional choice between two or more discrete options that is based upon recognition of a stimulus for action and commits a person to a path of action which expects to accomplish a specific goal or goals (Noone, 2002). Decision-making requires recognition of a need to make a decision (the stimulus for action) in order to attain or accomplish a desired outcome. In health care, the stimulus for action may be a symptom such as chest pain or a need to choose among therapeutic options for illnesses that may be acute or chronic, minor or life-threatening. It also may be a choice regarding health behaviors, such as contraception, hormone replacement therapy, safe sex, and avoidance of substance abuse. An intentional choice among options is made that commits the person to a path of action to accomplish the goal.

Before decision-making takes place, a person recognizes the need to act and evaluates the stimulus for action in relation to appraisal of risk. The person

needs to be aware of the available options to make a choice, gathers information and evaluates the alternatives, their risks and benefits, based on personal and environmental contextual factors. These sets of actions vary according to the person and situation. For example, in some situations, minimal evaluation of the stimulus or of alternatives may occur, such as in the situation where a person immediately defers to the health provider's choice. Extensive appraisal may occur in others, with the person seeking out multiple sources of information before selection of an option. In addition, there is varying intensity of the influence of contextual factors for each individual decision.

Literature Review of Decision-Making

Classical Models. Theories of decision-making exist in other disciplines, within both scientific and social science paradigms. In statistics, decisional theory is a strategy of quantifying the decision-making process, or putting it into mathematical form, in order to make the most effective choice (Anastasi & Urbina, 1997). Early economic theories reflected the decision-making model of economic utility – that people choose the best alternative that provides the maximum positive utility (Edwards, 1954). These early theories, sometimes referred to as classical decision-making, were often prescriptive or normative in nature; that is; how decisions are made in ideal situations. There have been some attempts to adapt this type of decision-making model to nursing situations (McDevitt-Graham, 1987). However, decision-making strategies that incorporate mathematical models often fail to incorporate individual preferences (Pfettscher, 1997).

In psychology, the stress of the decision-making process has been a primary area of focus and study (Broadbent, 1971; Janis & Mann, 1977). Janis and Mann's Conflict Model of Decision-making (1977) views decision-making as a stressful process that includes an appraisal of risk and an assessment of success and time availability to make the decision. This model postulates that people make decisions through a decision balance sheet, where the person assesses the gains and losses of a decision on the basis of tangible gains or losses for the self or for significant others and approval or disapproval from the self or significant others. Five basic patterns of decision-making are delineated that influence one's style of decision-making: 1) unconflicted adherence, where the decision maker ignores the need to make a decision and continues one's present path of action; 2) unconflicted change, where one accepts a recommended course of action without serious deliberation of choices; 3) defensive avoidance, where one avoids making a decision through procrastination or shifting responsibility for decision-making; 4) hypervigilance, where one searches stressfully for a decision and may act hastily without full deliberation; and 5) vigilance, where the decision maker evaluates choices carefully before making a decision. In this model, vigilant decision-making is the pattern that is normative and may be associated with moderate stress while the hypervigilant and defensive avoidance patterns may be associated with high stress.

The conflict model of decision-making was supported in a study of patients who were asked to participate in a clinical trial (Verheggen, Nieman & Jonkers, 1998). One hundred ninety-eight patients were interviewed (172 who had agreed

to participate and 26 who had declined to participate in a clinical trial) to determine why patients choose or decline to participate in clinical trials. Analysis of the results showed that patients decide by making a personal balance account when deciding to participate in a clinical trial, which comprises the physical and emotional gains patients hope to get minus the risks and other negative aspects, such as the amount of time involved. Other influences include: the extent they feel physically threatened by their illness, their opinions about medical care and care-givers in general, and how they regard their illness.

Scott and Bruce (1995) developed a tool to measure decision-making style, which they defined as "the learned, habitual response pattern exhibited by an individual when confronted with a decision situation" (Scott & Bruce, 1995, p. 820). They developed and tested their instrument based on an analysis of the literature of four styles: rational (based on a thorough evaluation of choices), intuitive (reliance on feelings or hunches), dependent (reliance on others for assistance) and avoidant (ignores need for decision-making). During testing of their questionnaire, a fifth style emerged: spontaneity, which related to a need to make a decision immediately. This instrument was then tested in four populations - military officers, graduate and undergraduate college students, and employed professionals (engineers and technicians). Control orientation and innovativeness were also measured. Subjects with an internal locus of control were more likely to demonstrate a rational style of decision-making than those with an external locus of control; they were also less likely to use an avoidant

style. Innovativeness was associated more frequently with an intuitive style than with a rational or dependent style.

Naturalistic models. A criticism of classical decision-making models is that although they may be useful when attempting to identify the optimal decision, they may not always work in the real world of decision-making where the best option is not always the one that is chosen (Orasanu & Connolly, 1993). More recently, there has been a paradigm shift in attempting to understand how decisions are made in the real world, or naturalistic decision-making (Cannon-Bowers, Salas & Pruitt, 1996). Naturalistic decision-making theory posits that decisions are made in a dynamic, contextual environment and are influenced to varying degrees by different personal and situational factors. Most of the current research reviewed in a literature review on client decision-making begins to identify many of these contextual factors. Balneaves and Long (1999) delineate an embedded decisional model of stress and coping. This model states that decisional conflict occurs when a choice of options is available and that decisions are influenced by personal variables, such as values, beliefs, goals and commitments as well as environmental variables, which are situation-specific.

Paterson & Thorne (2000) interviewed 22 patients with long-standing diabetes who were viewed either by themselves or their health care provider as expert in self-care management to determine how patients make decisions about unanticipated blood glucose levels. Decision-making occurred in familiar and unfamiliar situations according to the patient's previous experiences. Five components of decision-making were identified in both familiar and unfamiliar

situations: assessment of risk; comparative analysis; diagnosis; choice of action; and evaluation. Familiar situations were compared to past experiences and choices were based on the perception of risk and personal preferences. Unfamiliar situations were attributed to the most plausible diagnosis and choices were based on experimentation or seeking help to resolve the problem.

Pierce (1993) interviewed 48 women diagnosed with early stage breast cancer to describe their decision-making process. Five empirical indicators of decision behavior were identified: (1) perceived salience or attractiveness of alternatives, (2) decision conflict in considering more than one option, (3) information seeking in order to evaluate choices, (4) risk awareness, and (5) deliberation or evaluating the alternatives. Three processes of decision-making were distinguished: deferring immediately to an attractive choice, usually to the option recommended by the physician; delaying or vacillating among choices based on superficial and random deliberation; and deliberating or purposely using a plan and information seeking. In contrasting these results with ones identified by the Paterson and Thorne study, both found the similarities of risk assessment and evaluation of choices. The attractiveness of alternatives found by Pierce could be related to the familiar situations delineated by Patterson and Thorne, where past experiences led to more salient options.

Decision-making styles were studied in a group of 120 patients with various types of cancer (Petersen, Heesacker, Schwartz & Marsh, 2000). The Elaboration Likelihood Model (ELM) was used to see if decision-making styles could be predicted. Within the ELM, important variables for decision-making are

the ability to process information and discriminate between options and the motivation to thoughtfully consider the information before deciding. Four types of decision-making styles were found: information-seeking (actively seeking out options), information-processing (choosing among predetermined options), advice-following (choosing a recommended course without consideration of options), and ruminating (vacillation and inability to choose among options). The ELM variables, when considered together, successfully predicted decision-making styles 60% of the time. These styles appear somewhat related to Janis and Mann's (1977) Conflict Model patterns: e.g., information seeking – vigilance, advice-following – unconflicted change, and ruminating – defensive avoidance.

In an interview of eight recently discharged patients, Biley (1992) studied patients' decision-making about nursing care. Although thematic saturation was not achieved, three tentative categories emerged reflecting patient choice and participation in decision-making about nursing care. The first category was if the person was well enough to participate, the second category was if they had enough information to make a decision and the third reflected organizational constraints, such as hospital routine, that impacted their ability to make decisions. Further exploration regarding hospitalized patients' decision-making processes is necessary to validate the knowledge generated in this study.

Keith (1997) interviewed 8 women who had a biological child aged 18 to 40 months in order to understand how women make an infant feeding decision. She concluded that decisions are contextualized and based on factors that are considered salient by the mother. Categories that impacted decision-making

included benefit to infant, feeding decision is mother's, procedural issues, body circumstances, relationship factors and need for expertise. In the categories of procedural issues and the need for expertise, the theme 'need to gather information' was identified. Body circumstances included personal preferences regarding embarrassment and discomfort and related to cultural norms about breastfeeding and women's breasts.

The context of risk as a factor in decision-making was apparent in several studies. In Paterson and Thorne's (2000) study of long-standing diabetics, risk appraisal preceded all decision-making situations regarding unanticipated blood glucose values. This perception of risk strongly influenced the choice of action in both familiar and unfamiliar situations. Whittaker and Albee (1996), in interviews with 20 dialysis patients regarding their selection of a treatment method, developed a two-stage model of decision-making. During the first stage the person identifies important values and evaluates perceived threats in assessment of each method. During the second stage, weighing alternatives, individuals compare the benefits and concerns of each dialysis modality and choose the modality that maximally supports identified values and minimizes the number of threats. This second stage seems to correlate with Janis and Mann's (1977) balance sheet discussed earlier. In a study of women's decision-making processes in seeking care for symptoms of acute myocardial infarction (Dempsey, Dracup, & Moser, 1995), once the symptoms were appraised as a perceived threat then women began to seek treatment.

Personal preferences were a consistent finding in studies on decision-making. The influence of personal suitability on the choice of action was a finding in Paterson and Thorne's (2000) study of the decision-making process in diabetics regarding unanticipated blood glucose values and in studies of renal patients' decision of treatment modalities (Breckenridge, 1997; Whittaker & Albee, 1996). Kelly-Powell (1997) interviewed patients with potentially life-threatening illness to describe their decision-making experiences regarding treatment options. The core variable identified was "personalizing choices". Participants' perceptions of the effect of treatment on their lives, for many, was a more important component of their decision-making process than the effectiveness of the treatment. Truant and Bottorff (1999) investigated the decision-making processes of women with breast cancer regarding use of complementary therapies through ethnographic interviews. They identified three phases of decision-making: 1) getting something in place: covering all the bases; 2) hand-picking complementary therapies that fit: getting a personalized regimen in place; and 3) living with the security of complementary therapies: fine tuning a regimen with which to live. During phase two, women selected therapies based upon their personal beliefs about cancer and alternative therapy.

A corollary of personal preferences also found in decision-making studies was one's past experience with illness and treatment as well as others' experiences with similar diseases. In a study of diabetics' decision-making processes in familiar and unfamiliar situations (Paterson & Thorne, 2000), comparing abnormal blood glucose values with similar previous situations aided

patients in hypothesizing a diagnosis. In Kelly-Powell's (1997) interviews with patients with potentially life-threatening illnesses, previous experience or familiarity with treatment options was a major influence in their decision-making process. They were also influenced by the past experiences of friends and family with illness and treatment. This theme was also apparent in interviews with 17 caregivers of an adult or child with a chronic illness in the home care setting (Sims, Boland, & O'Neill, 1992). The purpose of this study was to elicit descriptions of decision-making and problem framing from the perspective of the family caregiver. Initially, caregivers were passive in decision-making but became more active and in control as they became familiar with the situation.

One's desired role preference in decision-making has been an area of increased interest in understanding its impact on decision-making. Degner and Sloan (1992) interviewed 436 newly diagnosed cancer patients and 482 members of the general public to determine what roles people actually want to assume in selecting cancer treatments using a card sort for role preferences in decision-making. The card sort differentiates patients into three categories of decision-making role preference: an active role (having the final selection), collaborative (sharing decision-making with the physician) and passive (preferring that the physician make the decision). The impact of being diagnosed with a life-threatening illness may influence preferences to participate in decision-making. The majority (59%) of cancer patients wanted physicians to make treatment decisions on their behalf, while 64% of the public thought they would want to select their own treatment if they developed cancer. This methodology

was extended to other client settings. Davison, Degner, & Morgan (1995) used the card sort in patients with prostate cancer to determine if a relationship exists between patient decision-making preference and the type of information desired regarding cancer. The majority (57.9%) of men preferred a passive decision-making role, 23% a collaborative role between themselves and their physician and 19% an active role. Information preferences, however, were similar regardless of preferred decision-making role. Most recently diagnosed patients preferred to play a more passive decision-making role. There was also a trend, although not significant, for men who were less educated, married, had not received treatment and who had earlier stage disease to prefer a passive role in decision-making. Beaver, Luker, Owens, Leinster, Degner, & Sloan (1996) explored the hypothesis that women with breast cancer had specific preferences about the degree of control they wanted over treatment decision-making using the role preference card sort. Participants included 150 women newly diagnosed with breast cancer and 200 women with benign breast disease as the comparison group. The majority of the newly diagnosed women preferred to play a passive role in treatment decision-making, while the comparison group preferred a collaborative role in which joint decisions could be made between the patient and the physician. In the women with breast cancer, older women, those with lower levels of education and those from lower social classes preferred a more passive role in decision-making although the correlations were weak.

Breckenridge (1997) explored patient perceptions of how dialysis treatment was chosen through interviews with twenty-two participants who were

recruited from inpatient and outpatient renal dialysis units. Decision-making patterns were viewed from the context of if the decision was made by the self, the family, the provider, or jointly. Themes that emerged in this study were that some patients made their own decisions on choice of therapy, others were strongly influenced by their significant others and, in some situations, the method was chosen by the physician with little or no input from the patient.

In Truant and Bottorff's (1999) interviews with women receiving traditional treatment for breast cancer who used or were considering using complementary therapies, deciding to use complementary therapies was a way to maintain control over their disease. This helped to promote hope during an uncertain period.

Another aspect of decision-making is the use of heuristics, or subjective, individualized ways to simplify the complex task of decision-making (Redelmeier, Rozin, & Kahneman, 1993). Stressful situations may result in the oversimplifications of solutions or the use of short cuts. Schaeffer (1989) found no increase in the use of heuristics during stressful decision-making, but did observe an increase in their use in the post-stress period. Heuristics include preference for the status quo, irrational concerns, the tendency to see one's experience as typical, and framing of the event (Travis, Phillippi, & Tonn, 1989). Framing of the event is one's interpretation of it based on its presentation. Events may be framed by emotions, especially fear, as well as values and experiences (Sims, Boland, & O'Neill, 1992).

Most of the studies discussed address decision-making in clients with diseases, some of which are potentially life-threatening. Marmero, Brown, Batty, Cummings and Powell (1998) assessed post-menopausal women's patterns of decision-making regarding hormone replacement therapy in a series of focus groups. Four themes emerged that the authors labeled "spheres of influence": the woman's internal influences related to perceptions and feelings, interpersonal relationships, external or societal influences, and the consequences of the decision. The authors found that the weight or intensity of influence of each sphere differed according to the context of each individual decision.

Age-related, as well as developmental, aspects of decision-making need to be explored and understood in relation to how they influence the process. Some studies indicate that older clients prefer a more passive role in decision-making (Degner & Sloan, 1992). It is unclear if this is an age or generation related factor. Adolescent decision-making styles also need to be considered to see if they markedly differ from adults. Adolescents begin to make decisions regarding alcohol, drugs, tobacco and sexuality that affect their health. Langer & Warheit (1992) identify a Pre-Adult Health Decision-making Model that stresses, "adolescents' decision-making is strongly influenced by their significant referent group" (p. 922). Included in the model is decision-making orientation or directedness as an influence of adolescent decision-making. Directedness refers to whether decision-making is influenced by peers, parents, or is self-directed. This sense of directedness was studied in relation to AIDS-related knowledge, attitudes, beliefs, behaviors, and skills (KABBS) in a group of 2,515 tenth grade

Hispanic, black and white adolescents (Langer, Zimmerman, Waheit, & Duncan, 1993). Sense of directedness was found to be a significant predictor of AIDS-related KABBS; low-risk KABBS were more often found among self-directed adolescents and least among peer-directed adolescents. In fact, self-directed students were less likely to have engaged in sex. Girls were more likely to be self-directed while boys were more likely to be peer directed. There were also differences among racial-ethnic groups. White students were more often peer-directed while black and Hispanic adolescents were more often self-directed. Grimes & Swisher (1989) looked at factors influencing adolescent drug and alcohol use in a sample of over 5000 high school students. Self-confidence was one factor that was negatively associated with the use of drugs and alcohol.

Other variables that may affect decision-making include the cost of treatment and availability of resources (Breckenridge, 1997), one's culture through the influence of social norms and values (Sims, Boland, & O'Neill, 1992; Whittaker and Albee, 1996; Keith, 1997), and locus of control (Verheggen, Nieman & Jonkers, 1998). Personality characteristics, such as anxiety, tolerance for stress, usual coping or decision-making style and ability to process information may also influence decision-making (Mann, Burnett, Radford & Ford, 1997).

In summary, the literature points to a variety of environmental and personal influences that form the contextual background for decision-making. These are summarized in Table 2.

Table 2

Contextual Factors

Environmental	Personal
Temporal nature of situation	Past experience with illness, treatment
Stress of decision	Use of heuristics
Resources – social support and economic	Personal preferences
Culture	Education
Social norms	Physical abilities
Family history	Values
Experiences and influences of others	Locus of control
	Self-esteem
	Role preference
	Framing of event
	Personality traits
	Usual pattern of decision-making
	Age/Developmental stage

Discussion of Decision-Making Literature

Although the study of client decision-making has received increased attention in nursing research, there has been less focus on the theoretical understanding of the decision-making process. There is a need to further explore the concept of decision-making, particularly the consequences or outcomes of the process. Much of the research has centered on potentially life-

threatening illnesses, such as cancer and renal disease. There is a need to understand health care decision-making processes in a variety of contexts and in various stages of health and illness. How decision-making differs in different groups, such as across cultures and within different age groups, also needs to be further delineated. There is also a need to further develop reliable and valid tools to measure and assess decision-making. Qualitative studies may illuminate the perspective on individual experiences of decision-making, which could lay the groundwork for tool development.

Gender-Based Decision-making

Developmental psychologists who have studied women and their ways of understanding and knowing support Keith's (1997) and Marmero et al.'s (1998) findings that women are influenced by the context of the situation when they make decisions. Chodorow (1974) in her understanding of identity formation in girls stresses that it occurs within the context of relationship. Gilligan (1982) describes women's lives as being embedded in social interaction and personal relationships. Within this framework, women make contraceptive decisions within the context of their lives and are embedded in the labor of and responsibilities for contraception. For example, in a content analysis of interviews with 25 married Jordanian Muslim women (Libbus & Kridli, 1997), contraceptive behavior was influenced by the individual's concern for family and individual well-being, as well as husbands' and families' opinions. This is an example of contraceptive decision-making occurring within a multi-dimensional, situation-specific context. Contraceptive decision-making is an intentional

choice of a method of birth control. One needs to be aware of the need for a contraceptive. This is especially true for young women, breastfeeding women and perimenopausal women who may not perceive themselves at risk for pregnancy. The method may be chosen to accomplish not only the goal of preventing pregnancy, but for other purposes, such as protection against sexually transmitted diseases, regulation of the menstrual cycle and treatment of acne, for example. It may be a minor or major decision for the woman, depending on her fear of a current pregnancy or her stage on the reproductive continuum. She may want a temporary or permanent method. For a temporary method, she may desire one that has a long-term effect or one that has a short-term effect. She may be restricted in choice by secrecy, finances, health, previous experiences, health care insurance, availability of services, cultural norms or preferences, and her own personal preferences. The method she uses may change as she moves along her reproductive continuum and may be dependent on her partner's preferences. The individual woman's decision-making style, role preference for making decisions, and others who influence her decision (provider, peer group, partner) may affect her choice of method.

It is also possible that women's ways of knowing may influence how they make decisions. Belenky, Clinchy, Goldberger, & Tarule (1986) describe different patterns of women's knowledge of the world. Silent women, as described by the authors, depend on external authority for direction. Women who use received knowledge as a way of knowing learn by listening to others, such as friends and authorities. Are women who use these two types of knowing

more influenced by others in contraceptive decision-making? Do women who are subjective knowers, who are more intuitive and listen to inner voices and subjective experiences, make decisions about contraception by themselves? Women who are connected knowers, who integrate others' knowledge with their own, may make their decisions about contraception based upon both personal and external influences.

Grounded Theory and Symbolic Interaction Theory

Grounded theory is primarily an inductive qualitative method useful in generating substantive theory when seeking the perspective of the individual(s) experiencing the phenomenon (Glaser & Strauss, 1967; Strauss & Corbin, 1998) or to "gain a fresh perspective in a familiar situation" (Stern, 1980, p. 20). Grounded theory also has a deductive approach when the researcher attempts to verify the hypotheses generated through further data collection (Milliken & Schreiber, 2001). It is an interpretative approach to inquiry based upon the symbolic interaction theory of human behavior, which explores how people define reality or events in every-day settings and how they act as a result (Chenitz & Swanson, 1986). Symbolic interaction theory was developed and refined by social psychologists George Herbert Mead (1934) and Herbert Blumer (1969) and is rooted in the philosophy of pragmatism. The pragmatic perspective, based on the work of John Dewey and William James, is anti-dualistic and proposes that people interpret the world and act on it based upon the utility it has for them (Pursley-Crotteau, Bunting, & Draucker, 2001). According to symbolic interaction theory, how people act is based on their interpretation of the

meanings they ascribe to events, people, situations, etc. Blumer (1969) states that symbolic interaction is based on three premises. “The first premise is that human beings act towards things on the basis of meanings that the things have for them... The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows. The third premise is that meanings are handled in, and modified through, an interpretative process and by the person dealing with the thing he (sic) encounters” (Blumer, 1969, p.2).

Social interaction, which occurs through symbols such as language, text, perceived time and space, determines the meanings and interpretations that result (Annells, 1996; Benoliel, 1996) and redefines these meanings as the individual encounters new situations over time (Swanson & Chenitz, 1993). “These symbols, instead of being a mere conditioning of reflexes, are ways of picking out the stimuli so that various responses can organize themselves into a form of action” (Mead, 1934, p. 123).

In symbolic interaction, there is a consideration of intentionality, experiences, as well as conscious interpretation and choice (Benoliel, 1996). “To provide meaningful evidence-based care to women as researchers, we need to attend to women’s experiences, their own understanding of health-related issues, and the social interactions within which they gain meaning and insight about their situation” (Crooks, 2001, p.12). Crooks (2001) further goes on to say, “little is known about women’s health experiences from their own perspective” (p. 13).

Use of grounded theory to explore contraceptive decision-making is an attempt by the researcher to explore this phenomenon from the perspective of women rather than through the lens of the health care provider. Use of an inductive methodology, that is not stating one's theory or expectations up front, helps to place the subjects and their experiences at the center of the study, rather than the researcher (Spalter-Roth & Hartmann, 1999). "Potential entrances for female voices into medical discourse need to be found so that reconstruction of medical knowledge can occur" (Malterud, 1993, p. 366), that actually reflects women's experience and reality.

A Feminist Perspective

"Feminism supplies the perspective and the disciplines supply the method" (Reinhartz, 1992, p. 243) so that the demands of both approaches are met. The goal of this study is to apply a feminist perspective to grounded theory methodology. Feminism and grounded theory have some common elements; feminism will also add other perspectives to consider that grounded theory may not alone consider. Common elements of grounded theory and feminism are (Wuerst, 1995):

1. to place the participants interviewed in the center of the study – both grounded theory and feminist theory respect participants' experience as a source of knowledge. Feminist theory is characterized by valuing women's experiences as a major source of knowledge (Campbell & Bunting, 1991). Use of grounded theory to explore contraceptive decision-making is an attempt to explore this phenomenon from the

perspective of women rather than through the lens of the health care provider.

2. to consider the role of the researcher in the study. Although the goal is, through grounded research, to listen to the women who tell their story, the researcher is the one who decides what questions to ask and interprets the story. "This story reflects the viewer as well as the viewed" (Charmaz, 2000, p.522). As the researcher who is studying the phenomenon, I am both an insider and outsider as I am also a woman who has personal experiences with contraception and a health care provider who counsels women about birth control. My story is part of the process and there are multiple voices to hear. As an insider, I have some understanding of other women's contraceptive experiences. As an outsider, I compare their stories and see the theory that emerges. It will be helpful to recognize me as the researcher, woman, contraceptive user, nurse as I go through this research project. I am not an invisible, objective observer or the anonymous voice of authority. I have my own experiences with and assumptions about gender, class, health care, and contraception.
3. that there are multiple explanations of reality – both approaches recognize diversity and change. Feminism particularly rejects dichotomies and absolutes (Campbell & Bunting, 1991).
4. that experiences are contextual and knowledge is relational. In grounded theory, this characteristic is based in symbolic interaction

theory. In feminist theory, this element is borne out in how women view the world.

What a feminist perspective can add to grounded theory methodology is to also consider the power differentials within society that influence contraceptive decision-making. Issues of gender, race and class should be emphasized to look at what has been left out. As feminist Marjorie DeVault (1999) states “every study ought to be conducted and written with an acute consciousness of what’s being left out and the implications of omissions for the claims that can be made.” (pp. 212-213). A feminist perspective is also helpful to avoid trying to fit the findings into a simple theory. One can look at geneticist Barbara McClintock’s work and learn the lesson from her experiences that she avoided the simplest conclusion – that this may only be the beginning to understanding the results (Keller, 1983). McClintock was a geneticist long before women were accepted as researchers and she worked in isolation in studying corn genetics for over forty years before her contributions to her field of science were recognized. She didn’t look at what was different as an aberration. She looked to the aberration as a clue as to what to research next. “Her passion is for the individual, for difference. ‘The most important thing is to develop the capacity to see one kernel that is different, and make that understandable’, she has said. ‘If [something] doesn’t fit, there’s a reason, and you find out what it is’” (Keller, 1983, p. xxi). After reading McClintock, it may do a disservice to the women and the research to come up with the simplest conclusion. The differences that may not fit with the theory shouldn’t just be explained away as aberrations – they should lead to

exploring other possibilities. However, becoming submersed in the data should provide a “feeling for the organism” and allow the minute details to be seen that provide an understanding of the whole.

Summary

In this chapter the literature on contraception and decision-making has been discussed. The lack of a clear understanding of how women make contraceptive decisions provides the basis for selection of grounded theory as the framework for this study. Providing a feminist perspective to the grounded theory approach enhances the framework through providing a critical reflection on the research process.

Chapter 3. Methods

This chapter presents the methodology for conducting this study describing the process of contraceptive decision-making in women in order to gain an understanding of how women make decisions about contraception. The research design, process of data collection, setting and sample, protection of human subjects, instrument, data analysis and methods of establishing trustworthiness are discussed. The chapter ends with a summary of the data collection and analysis process.

Research Design

Due to the selection of symbolic interaction theory and feminism as the conceptual orientations for this study, an inductive, grounded theory design was selected as the most appropriate design using the data collection method of open-ended interviews. A grounded theory design is most appropriate for this study because no conceptual model exists for contraceptive decision-making in women. In addition, it is desired in this study to gain an understanding of contraceptive decision-making from the woman's perspective. There are power differentials within society, for example medicalization, that affect how women make decisions about birth control. Supplying a feminist perspective will attend to these power differentials so a multi-dimensional viewpoint is provided.

Data Collection

In order to obtain the most current information, women of child-bearing age were interviewed who were eighteen or older, spoke English, and had used at least two methods of contraception. Women were excluded if they had

reached menopause, had not used a contraceptive method in a year or more, or had used the method of male or female sterilization for one year or longer. At the time of first contact via cell phone or email, women were screened for inclusion criteria. Exclusions and the reason(s) for exclusion were documented throughout the study (See Appendix A for Research Contact Form). If eligible, women were informed of the purpose of the interview as well as risks and benefits to the woman. The time and place of the interview was agreed upon mutually. Concerns regarding confidentiality and the ability to withdraw from the study at any time were addressed at this time and throughout the study, as necessary. Written permission was obtained for the interview and its audiotaping before beginning the interview. Participants received a stipend of \$25.00 to demonstrate respect for the time they spent in the interview. Interviews were audio-taped and transcribed verbatim for data analysis.

Setting and Sample

Women were recruited from health clinics, educational and community settings. Fliers, newspaper and television advertisements, and email announcements were used for recruitment. With permission, fliers were posted on the local college campus, family practice and women's health clinics, in neighborhood community settings and at the local YWCA. An advertisement was placed in the community newspaper and ran weekly until recruitment was complete. An email announcement was sent to all faculty, students, and staff at the local college. A television advertisement ran on the local information channel. See Appendix B for recruitment information. Women contacted the

researcher via private cell phone or email response. Interviews were scheduled at a time and place convenient to the woman, in a mutually agreed-upon private setting. A contact number for the woman was obtained in case rescheduling became necessary and to arrange the follow-up interview. Interviews continued until categories were saturated. It was anticipated that approximately twenty interviews would be necessary to reach saturation. Theoretical sampling was used to further explore categories. Theoretical sampling is purposeful, rather than random, selection of a sample based upon analysis of the data already collected and the need to further explore a category (Chenitz & Swanson, 1986).

Protection of Human Subjects

Institutional review board approval by the Committee on Human Studies at the University of Hawaii was received prior to the interviews. Written consent for the interviews was obtained from the participants (See Appendix C).

Interviewees were given written information about the purpose, procedures, risks and benefits of participating in the study. Efforts to maintain confidentiality included assigning the participants a code number, keeping the tapes and transcription in a locked cabinet, and erasing the tapes after dissertation defense. Participants were given the opportunity to withdraw their consent at any time during the study.

Besides loss of privacy, embarrassment was another potential risk. If the participant indicated possible embarrassment, the researcher was prepared to use one or more of the following strategies: ask if the participant would like to talk about it, change to another question or discontinue the interview. As

concerns emerged through observation of the participants, counseling and referral to appropriate community resources was offered. Possible community referrals included mental health counseling, domestic violence hotline, sex assault hotline and family planning clinic, all of which are free to access.

Interview Guide

A semi-structured interview guide was used based upon the concepts that emerged from the literature review (See Appendix D).

Data Analysis

Prior to beginning data analysis, a mock interview was done to role-play data analysis with faculty direction. First word-by-word and then phrase-by-phrase coding were done separately and then together to confirm competency on data coding. Peer review of coding by faculty occurred throughout data analysis to verify accuracy.

Interview transcripts were read and listened to as a whole to gain a perspective of the entire interview and to ensure accuracy of transcription. A conscious attempt was made to view the data from different perspectives, as a nurse, woman, birth control user, sympathetic listener, and researcher. The different perspectives of feminism, medicalization and grounded theory provided different lenses from which to view the data. The data was coded by hand using the methods of open, axial, and selective coding (Strauss & Corbin, 1998) using constant comparative analysis (Glaser and Strauss, 1967). NVivo™, a qualitative software package, was used to aid in data management. Analysis was verified via member validation of codings. Observational, theoretical and

methodological notes were kept by the researcher to aid in the analysis of results and to document the process of interpretation (Schatzman & Strauss, 1979). Observational notes are recordings about what occurred during the interview, based upon watching and listening, with little interpretation. Theoretical notes attempt to analyze observational notes. Methodological notes are reminders to the researcher about the research process and can be observations of the researcher and the methodology.

In open coding, data are broken down into discrete parts and examined for the thoughts and meanings that lay beneath. Activities, happenings and objects that are conceptually similar are grouped into categories, which represent phenomena. Properties and dimensions of the categories are developed. Properties are the characteristics that define the categories and give them meaning. Dimensions are the ranges of a category along a continuum and can include timing, frequency, number, duration, extent, intensity and trigger.

In axial coding, categories are related to sub-categories that answer questions of when, where, why, who, and with what consequences. Properties, dimensions and categories are analyzed for linkages. The organizational format used to analyze categories was to identify for each category:

- causal factors or influences
- the context, or background in which the category happens or occurs
- describing the phenomenon, through answering, "What is going on here?"

- intervening conditions that impact the category
- action/interactional conditions or strategies used
- consequences or results

In selective coding, major categories are integrated and refined to form a larger theoretical scheme. The central or core category, which represents the main theme of the research, may evolve from the research. Given enough data, the research findings center on a basic social process, which can then take the form of a theory.

Using the constant comparative method of data analysis, incidents within a category are compared to each other and to other incidents in other categories. Data collection, coding and analysis are concurrent, and proceed from the first interview not at the conclusion of data collection (Becker, 1993). Categories and properties are then integrated to form larger concepts. As this process, which is called reduction, continues, underlying similarities in the categories may emerge, which can limit the quantity of terms, producing a smaller set of higher-level concepts. When the categories becomes theoretically saturated; that is, further incidents no longer add to an existing category or create a new one, the process ends and the theory is developed.

Procedures for Establishing Trustworthiness

A member check was carried out to increase trustworthiness of findings and to validate the accuracy of interpretation. Participants were invited back at the conclusion of data collection to verify and clarify interpretation of the results. Peer review with faculty advisors to confirm emerging themes also helped to

support dependability of results. All materials (transcripts, notes and analysis of both) are available for audit, supporting dependability and confirmability of the analysis. Theoretical saturation and constant comparative analysis support transferability of results.

Summary of Data Collection and Analysis

Advertisements were placed in a local newspaper to run weekly in the community calendar. A television advertisement was shown on local cable channel. An email announcement in campus mail was posted to all students, faculty, and staff. Fliers were posted at community neighborhood centers, YWCA, family practice and women's health clinics throughout island.

Respondents were screened for inclusion criteria. Information was provided about the study. Information was retained about the reasons why women were excluded. Contact information was obtained and an appointment was set in a mutually agreed upon confidential setting.

At the beginning of the interview, information about the research study was provided, questions were answered, and written consent was obtained. At that time, audio-taping of the interview started. After the interview was completed, participants received their stipend. Tapes were then submitted for data transcription. Coding and analysis occurred after transcription of each interview. The same procedure was repeated for the second and subsequent interviews. Data analysis from each interview was compared to former interviews and helped to guide future interviews. Interviewing, coding and analyzing continued until thematic categories were saturated. When categories

were saturated, two more interviews were performed to verify saturation. A group member check occurred and results revised as indicated. The study concluded and the results reported.

Chapter 4. Results

This chapter presents the results describing the process of contraceptive decision making in women. Included within this chapter are the description of the sample, the results of analysis of data, development of the model, and summary.

Description of Sample

Sixteen women were interviewed from August, 2002 through January, 2003. A total of nineteen women were recruited for the study. Two women were excluded as they had been sterilized for longer than one year. A third woman was excluded, as she had not been using any contraceptive method within the past year. Theoretical saturation was reached after the fourteenth interview and was confirmed after completing two more interviews. Two of the sixteen women could not be contacted for follow-up; seven of the remaining fourteen women attended the member check meeting, which was held in February, 2003, and validated the results of data analysis.

Women ranged in age from 20 to 48, with a mean of 31.44 years. Nine of the women were in their twenties, four were in their thirties and three were in their forties. The mean years of education was 14.63 years, with a range of 12-18 years of education. Six of the women were Caucasian, six were mixed/non-Hawaiian, three were Hawaiian/Part-Hawaiian, and one was Filipino. See Table 3 for a demographic description of participants.

Table 3

Participant Demographics

Demographic	Range	Frequency	Mean
Age	20-48	9 – Age 20-29 4 – Age 30-39 3 – Age 40-49	31.44
Education	12-18	2 – 12 Years 4 – 13 Years 1 – 14 Years 2 – 15 Years 6 – 16 Years 1 – 18 Years	14.63
Ethnicity	N.A.	6 Caucasian 6 Mixed/Non Hawaiian* 3 Hawaiian/Part-Hawaiian* 1 Filipino	N.A.

* Other ethnicities represented include Filipino, Portugese, Japanese, Caucasian, Chinese, Mexican, Native American, and Korean

Core Category

The core category that best describes the process of contraceptive decision making in women is “finding the best fit”. Women choose a method or methods to prevent pregnancy based on their knowledge, experience, and

evaluation of what would be the best fit within the context of their current life situation. This choice is not of the best possible method available, but the best within the context of a woman's current situation. In fact, women may move from a more effective method to a less effective one, because of influences other than effectiveness. Choices, and the context in which these choices occur, are very individualized and may change as women's situations change. Many of the women interviewed were clearly able to articulate this when asked what advice they would give to someone who is deciding on a way to prevent pregnancy.

Anastasia recommended:

I just think that decisions, I mean, of course, people make decisions differently, but decisions have to be made on your own terms. You know? You can be influenced by a variety of different things, but you have to think about how you're going to deal with it for your individual self.

Lehua suggested, "It's what fits best into your schedule." Cheyenne agreed, "I would advise them to seek out professionals or do a lot of research on birth control methods and find out which is the best one for them". Cassie advised women to "use what works for you because everybody's different. They need to read up on everything, know what's out there in order to make a good educated decision, I think is important. And what fits their lifestyle."

Major Categories

The major categories within the core category of "finding the best fit" are "becoming aware", "weighing what's best for me" and "navigating a course". In "becoming aware" women become aware of options and/or resources for

preventing pregnancy. In “weighing what’s best for me”, a woman evaluates one or more methods for preventing pregnancy in order to choose one that is most suitable within the context of her current life circumstances. In “navigating a course”, women contend with access to and use of one or more birth control methods.

Becoming Aware

The phenomenon of “becoming aware” is best described as “becoming aware of options and/or resources for preventing pregnancy”. See Table 4 for the organizational framework for “becoming aware”. The degree of becoming aware may be quite limited or extensive depending on a number of factors that will be discussed below. For example, Lehua compared her decisions now at age twenty-eight with her decisions at age eighteen.

The fact that I’m more aware of it...And more aware of the different types that’s out there. So now I actually do as if I look back, I feel like I didn’t have a choice at eighteen because that’s all I knew...was about the pills. And now I have a choice and I’m choosing the Depo even though I know that there’s a lot of other types of birth control out there now.

Table 4

Becoming Aware

Causal Conditions	Context	Intervening Conditions	Action/Interactional Strategies	Consequences
Finding out how body works	Having a sexual relationship where pregnancy may be a consequence	Interest or desire to explore	Becoming more comfortable in talking about it	Learning about one or more methods
Finding how pregnancy occurs	Needing to start a method	Embarrassment	Having a dialogue with others about methods, resources	Finding available and/or confidential resources to obtain methods
Becoming aware that one is at risk for pregnancy	Needing to change a method	Having support	Reading or watching television	Becoming aware of more options and resources
Not wanting to be pregnant	Having a pregnancy scare	Being exposed to information	Observing others' experiences	Developing judgments about methods that may be accurate or inaccurate
Needing to choose a way to prevent pregnancy	Getting pregnant	No health insurance	Finding resources	Weighing information to make choice
	Needing to pay for method	New, better, or improved methods available		
	Needing to find new resources to obtain method			
	No health insurance or change in insurance			

Causal Conditions

The causal conditions that were identified in this study as triggering this phenomenon were finding out how the body works, finding out how pregnancy occurs, becoming aware that one is at risk for pregnancy, not wanting to be pregnant, and needing to choose a way to prevent pregnancy. Women learned about sex, reproduction, and birth control from a variety of sources. Realizing that they were at risk for pregnancy and not wanting to be pregnant generated their search for a birth control method.

Context

The context in which women became aware included having a sexual relationship where pregnancy may be a consequence, needing to start a method or needing to change a method, having a pregnancy scare or becoming pregnant, needing to pay for the method, to find new resources to obtain the method, or if there was no health insurance or a change in health insurance. Sometimes women needed to begin a search for a new method if they began to have problems with the method they were using or were concerned about the health effects of the method they were using. Deciding they needed a more effective method or protection against STDs were also circumstances associated with becoming aware. Seeing a method that was easier, perhaps through advertisements on television or in magazines or from other women's experiences, sometimes was a reason for changing a method. At times, a woman needed to search out new resources to obtain a method if either she or her provider moved or if there was a change in health care insurance.

Intervening Conditions

Intervening conditions that impacted becoming aware were the woman's interest or desire to explore, level of embarrassment, having support, being exposed to information, lack of health insurance, and the availability of new, easier, or improved methods.

Interest or desire to explore. Laura, 48, who has been satisfied using condoms for many years, had not been interested in exploring new methods. Asked how she would go about choosing a new method if she had to, she stated, "To look I'd probably go on the internet and research it first. And see what's there because it would be so new to me because I haven't had to do this for a really long time." Part of a desire or interest to explore is the woman's readiness to hear and ask questions. Women talked about vaguely remembering birth control talks in middle and high school but not remembering details. As Anastasia remembered, "it just didn't seem serious at the time". Laura said, "I think I relied a lot on what other people told me before, not that I don't think that was correct, but I would ask a lot more questions now for sure." As Cassie related:

I guess when I went on the pill it was... I knew what I knew and that was enough for me. I didn't do any investigating or anything. But if I did choose something new, I would definitely read up on it and find out everything I need to know - everything I could know about it.

Level of embarrassment. Embarrassment may play a key part in becoming aware particularly for young women, who may not want to be known

as sexually active. This may be a cultural or age-related issue. Leilani remembered not learning in high school because "I was too shy to talk about it." Many women learned the lesson from their families, particularly their mothers, that sex and birth control were embarrassing topics that were not discussed.

Laura recalled:

We didn't even talk about periods. I remember when I got my period my mom gave me a pamphlet and my sister sort of showed me where the pads were. It was just kind of like, it was, more of an embarrassment ... she was embarrassed or something. And I know that had an influence on me.

Having support. Having support was a strong influence for many women in becoming aware. Women who had support valued it and those that didn't wished they had it. Women identified many sources of support: mother, father, sister, partner, partner's father, friends, aunts, cousins and health care providers. Components of having support were being shown, being taken, being given and going/learning together. Cassie, Anastasia, Eva, and Sheri, all women in their twenties, identified their mother as a strong source of support in becoming aware about birth control. Anastasia, 26, felt that her mother has had the most influence on her decisions about birth control.

When I was young - I mean maybe pre-teens, my mom came home with... I don't know where she got everything for me, probably Planned Parenthood at the time, a whole bunch of pamphlets, condoms, and she talked to us about it (my sister and I) and she showed us how to use

condoms, and that's how I first learned about birth control. She was real open about everything.

In talking about her mother, Sheri shared:

We're very close. I mean she's always been very open with the facts and so forth. I think it's very important. Our relationship and our closeness has allowed me to ask when I wanted to go on birth control pills, you know. I was comfortable with saying, "OK, I want to go on birth control pills".

Mary, 20, who didn't have such support from her mother, wished she did.

When asked what would have made her experiences and decisions about birth control easier for her, she replied:

I think if my parents understood the world today and not the past. If they understood how my boyfriend and I are, how committed we are and stuff. I think my whole family should just see how life is really and that would help.

For Mary, her partner has been the most support. "In our relationship he's been very helpful. He's been with me the whole time and he was part of protection and preventing pregnancy. He was supportive."

For some women, their mothers were a source of information but not necessarily of support. Although their mothers shared information, the women didn't feel they could approach them when the time came. Celeste related, "She (her mother) wasn't really supportive in helping us get birth control, but she

informed us about it.” Celeste believed it would have made things easier for her if her mother had been more supportive.

She gave a lot of information, but you could kind of still sense that she didn't quite want you to take it [laughing]. So, you know, it was more of her like, “ok, I'll give them, but I really don't know want to know what they're doing” kind of sense, so. Instead of just, you know, even just to say, “well the Planned Parenthood is here if you needed to go, go ahead.” She just wouldn't say that. She said, “well, this is - if you think of this” she would say, “come to me first”, but of course that never happens.”

Some of the women interviewed were mothers and, reflecting back on their experiences with not having support, discussed how they were not going to repeat their experiences. Leilani, a mother of two teens, said:

The awareness for teenagers is important. I mean I have two teens at home [laugh]. Well, my daughter's only twelve, but she's almost there. And then the other one's a junior in high school - he's going to be sixteen next week. So, I sometimes bring condoms home for him. And he's too embarrassed. “I don't want that. I don't need that.” But then, you know, at least I'm trying to talk to them to make them aware of it whereas I didn't have that when I was young.

Lehua, a mother of a small son, thought about helping a future daughter.

You know, I can kind of see, like, how I would want my daughter - bring her in from high school...to start, you know, sometimes maybe even before high school just to come in and talk to somebody about the

different types of birth control. Not meaning she has to start. She can start when she wants to - but at least she knows all the different options.

Cheyenne, a 33-year-old single mother said:

I'm raising two teenage boys and when they were at a young age I started talking to them about sex and their responsibility if they're going to enter a sexual relationship. Because my son is in a steady relationship at this time. We're open enough where he tells me he's not a virgin and then I constantly instill in him that he needs to be responsible for himself and it's not just the young woman's responsibility. So hopefully it's getting stuck in his head that it's his responsibility to make sure there's some kind of birth control method. You know for him there's only condoms right now on the market, I believe, for him but you know that's what I want to make sure he's aware of. Because when I was growing up as a teenager none of that was ever told to me. Nobody ever talked about sex in my home. Some women also had support from health care providers. Anastasia

said:

My doctor now he's real open to talking to me about - like I discussed with him the question of my boyfriend's faithfulness and he's talked to me about alternate methods. Like, that's why I started using condoms again with him. ... but as far as like if I have concerns or anything about how my pills are affecting me he's always open to like, change the dosage, look into what's going on. So he's really been supportive about everything.

For Gloria:

I went to that clinic and all the options were just laid out for me and no judgment. You know it's just like "this is how this works, this is how this works, this is how this works". You know, not one was better than the other as far as the clinic went. You know they just had you examine your lifestyle - what would work best for you. And that's how I got influenced.

You know really looking at what would work best for me.

For Eva, a nurse at the university health clinic was a source of support. She expressed:

I was at the University and the school nurse provided - like you'd go in just for something and every girl she just handed a package of condoms and was like "just use this and even if you don't use 'em, take 'em and give 'em to your friends". I went to the nurse and talked to her she helped me out - figure out to go to a doctor in Hilo and do all that kind of stuff. The school nurse had really a lot of information.

Being exposed to information. Women became aware by being exposed to information. Classes were a frequent way that women were exposed to information about birth control. Women had classes in elementary school, middle school, high school and college where they learned about sex, health, female physiology and birth control. After having a teen pregnancy, Maile was transferred to a teen pregnancy high school. She remembered:

Well within sex education, in the sixth grade and ninth grade, they explained things but then after the fact that I was pregnant I went to a teen pregnancy school and they talked more about the different types of birth

control. Like sixth grade and freshman year in high school was more, you know, birth control pills and condoms. And then after the fact that I got pregnant they talked more about the different...birth controls that there were.

Women weren't just students, sometimes they had teaching experiences where they had to learn about birth control in order to teach it to others. Eva related:

In high school I was very involved with our peer mediation class and talked a lot about different ways to prevent pregnancy. That was a class that I took. It was called 'peer mediation' and we actually went into elementary schools and junior high school and taught them about birth control and how to be safe and everything like that. But I learned a lot of information of different types of contraceptives.

Laura also had a similar experience in college.

I remember because I was interested in health, I worked at the (college) Health Clinic and actually one of the first volunteer things I had was to teach a clinic. So I had to go to class at Planned Parenthood. I was really uncomfortable [laughing] because I was really young, yeah? So I think, actually, I picked up more information because of that experience which was something different and a lot of people didn't have.

Teresita and Eva also had similar teaching experiences in college. Dorm events may also be a source of information in college. Jane, who attended a college in California, recalled:

I had already been to a rubber-wear party. I went to (college in California) and they did this thing called rubber-wear parties where volunteer students would take a bunch of freshman and make it kind of fun to demonstrate the need for it... was like an HIV prevention.

Working or volunteering in a medical environment was also a context for becoming aware. Lehua, who is a licensed practical nurse working in a family practice clinic, said, "when I came into working in the profession, then I learned a lot more about Depo and all the different types that they have now". Leilani found out about Depo-Provera® when she worked for a time ordering supplies for a physician's practice.

Oh, I heard about it (Depo-Provera®). I used to work with Doctor [name] and I did all his ordering. I ordered the pill and then I ordered the syringes and everything and then...it was a long time ago. And then we found out, 'oh there's this shot that you take it and you don't have to take the pill every day and it lasts three months. Oh, I want to try that.' So Dr. [name] gave me a shot.

Gloria became a volunteer at a free women's clinic.

I volunteered at a free women's clinic in my early twenties. And that's where I really became aware of all the different options. Yeah at the free women's clinic, as I started going there and that's when I started learning about it as a patient. And then I went in to do volunteer work and then I really learned about it and taught other women about it.

No health insurance. Needing help accessing resources, such as not having health insurance, was an impact for women to become aware of resources within their community for free or low-cost birth control. Maile, who had a teen pregnancy, was initially covered under her mother's insurance. "Then there was no insurance but it wasn't a problem, because I knew about the free clinics and stuff, so I could go and do that - the family planning clinics and all that". Then, Maile moved from Los Angeles to Hawaii.

In L.A. it was easy. Here in Hawaii, when I came, it was hard to find cheap birth control. Because insurances don't cover, no free clinics, no this or that, so it was more a financial problem than when I was in L.A., it was a little bit easier.

Availability of new, easier or improved methods. Seeing new, easier or improved methods may also influence women to learn more about these methods. Some women have seen advertisements for the birth control transdermal patch and would consider trying it because as Cassie shared, "Like a patch would be easier for me. So I don't know maybe I could try it." Angela reconsidered the IUD after learning that it had been improved and become safer.

Action/Interactional Conditions

Action/interactional conditions, or strategies that women used to help them to become aware included becoming more comfortable in talking about it, having a dialogue with others about methods and/or resources, reading various materials, watching television, listening to and/or watching others' experiences, and finding resources in the community. Women also assessed their sources of

information and tended to use different sources of information at different times in their lives.

Becoming more comfortable. As women mature and have more experiences, they may become more comfortable in talking about birth control and take a more active role in becoming aware. Laura talked about how her experience in having to teach a class about birth control and how it not only increased her awareness but her comfort level in talking about sex and birth control.

You know, it was that kind of situation that I think made me more comfortable to talking to other people and...then myself becoming comfortable with talking about birth control. 'Cause I have to tell you when, the way I was raised, it was something that you know, you just didn't talk about or think about. Or at least, tell your mom or dad that you were, 'cause they were totally uncomfortable. So it was, yeah, just the situations, being put in different things. They increased your comfortableness and awareness.

Gloria talked about becoming more aware of what other women were doing as she moved into her twenties. As a teen, it was something not talked about either at home or in school. She became more comfortable not only because she got older but because she moved to a place where there was more openness in talking about sex and birth control.

And because I guess my mom didn't talk about, I didn't feel comfortable talking about it with her, bringing it up with her... As I got older then, you

know like twenty-one, that's when I really started learning more, more what other women were doing or I think I felt more comfortable too then to talk more about it too as I got older. Kind of taboo in high school you know. In Oklahoma that's where I was in high school. In San Francisco is where the free women's clinic was. And so I turned, I was twenty-one when I moved to San Francisco. And that's where I was, lots more information available, lots more tolerance and acceptance.

Having a dialogue. Having a dialogue with others, either about methods or resources, helped women become aware. Women talked to many people: mothers, sisters, aunts, cousins, friends, friend's mother, teachers, partner, clinics (particularly college and Planned Parenthood), health care providers (advanced practice nurses, physicians), and clergy.

Anastasia had dialogues with her mother.

I think because my mom was so supportive of everything that I don't think that it could get it any easier. Because I never had to hide things, you know? I could always talk to somebody about it. And I don't feel like, you know, I just feel like I've always been supported in what choice I make.

Sometimes, women have to initiate the dialogue to become more aware. Leilani wasn't aware there were different types of birth control pills and tolerated bloating and weight gain for several years.

I thought that was all there was that kind of pill and that's it. I think I finally complained to one of the doctors one year that I was getting a PAP smear, you know, about the weight. And he said, "Do you want to try something

different?” And I’m like, “yeah I didn’t know there was something different.” I thought they were all the same, the amount.

Reading and watching television. Women learned through reading and watching television. Reading material included books, magazines, pamphlets, the internet and advertisements. Leilani learned by reading pamphlets as she’s waited for her physician’s appointment. Lehua and Eva saw more advertisements now on television and in magazines than ever before. Eva said:

I’ve seen advertisements of different types of birth control in magazines and I’ve gone and asked my doctor about it. Like how it compares to what I was taking or like especially when I first was trying out new pills.

On television, women saw advertisements, news reports, and television characters. Eleanor recalled, “I remember the sponge thing being out for a while and that being a big thing and I think it wasn’t until (the) Seinfeld show that I had more curiosity about what that was all about.” Teresita explained how she and her husband learned about natural family planning.

We had known about it - we had heard about it, but didn’t know anything about it or where to go, where to find the information, so we did a search online. And found a book and it was called *The Art of Natural Family Planning*. And so we ordered it and we got it. We looked through it, then just decided to go for it from there.

Observing others’ experiences. Women learned a lot through observing and hearing about others’ experiences, not only with birth control but also with pregnancy, STDs, health problems, and/or children. Both Anastasia and Cassie

saw others' experiences with Depo-Provera® and decided not to use it.

Anastasia remembered, "I considered the Depo shot at one time, but I heard like testimony from a lot of people about the bad, you know, the bad side of it."

Cassie said, "Thought about it (Depo-Provera®) but then I heard too many stories. And a lot of people that I heard of had gotten pregnant on it." Women frequently recalled hearing "horror stories" about getting pregnant on a method or developing severe side effects. In high school, Mary talked about the impact of seeing friends who were not using birth control get pregnant.

And the rest of my friends got pregnant in high school, so...not doing anything. That kind of brought out why I shouldn't have a child at the time because I noticed how my friends were, well, not really suffering, but how they fell behind their work and stuff.

Teresita remembered her friends and sister's experiences with sexually transmitted diseases.

Seeing, you know, friends of mine get, you know, sexually transmitted infections. My sister, we don't know that it is, because of the Chlamydia, but there's a probably, you know, pretty good likelihood that it is, that she's infertile now...You know, there's just such a huge amount of STDs that ... it definitely influenced that.

Women saw other women's experiences with health problems that may have been related to the use of birth control. Eleanor talked about becoming aware of health concerns about birth control pills.

My girlfriend had surgery due to cancer in one of her breasts and then it ended up being both breasts and the only thing foreign she said she's ever taken in her life, that she would have introduced to her body as far as on a regular basis, was being on the pill. So that was disconcerting.

Both Anastasia and Sheri were influenced by their mothers' experiences as a single parent. Anastasia shared:

She did the great honor of having two children when I was in high school, two more. And I took care of them all through high school because she's a single mom. So that was like, harsh reality. This is what I would be doing, every day, plus what my mom does, you know what I mean? So I told her, that's the best birth control she could ever have given me.

Finding resources. Women became more aware by finding resources in the community. They would seek out a resource after seeing it advertised or driving by it in their community. They also assessed the accuracy and knowledge limits of the sources of information that they used. Cassie compared the learning from her friends with learning from her mother. "I didn't get as good answers as if I talked to my mom, you know. The friends, it's all hearsay. And not very accurate". Laura talked about recommending that women, particularly young women, seek out a health care provider for help when selecting a birth control method.

And, I think there's a lot of people that are willing to share information, but I don't always know how accurate it is. That scares me sometimes among young people. I'm not the kind of person that says, "go talk to auntie or

uncle” or, you know, because I don’t know always you’ll get the best health advice.

Some women recognized the knowledge limits of the people they sought out for information. Both Eva and Sheri are close with their mothers but realized the extent of their knowledge. Sheri said, “Oh, I would ask her. But, she doesn’t really have that much experience with anything else other than her birth control (pills) or a diaphragm.” Eva stated:

She wasn’t able to have children so she never had to use birth control, so she didn’t have information for me about birth control or she obviously had a child, but she wasn’t supposed to, you know so she didn’t have any prior knowledge to it except for what she had heard.

Sources of information tended to change as women got older. Younger women tended to use friends, school and family members more as sources of information while older women learned by reading and talking to their health care providers. Lehua talked about how she would decide if she had to change to a new method. Her health care provider would have the most influence. As for family and friends:

No. Went through that and didn’t really - when I started the Depo they were telling me all the negatives of the Depo. And I still went on it, so. That didn’t really influence me. I mean, I listened to it, but not to the fact where I would just base my decision on taking whatever method they wanted me to take or they were taking ...now [laughing]. Maybe back when I was eighteen it would’ve had more...

Consequences

Consequences of becoming aware were learning about one or more methods, finding available and/or confidential resources to obtain methods, becoming aware of more options and resources, developing judgments about methods that may be accurate or inaccurate, and weighing information to make a choice. In this major category women became aware of one or more methods of birth control as well as options and resources to obtain them. They began to develop judgments about methods that influenced choice. Thus, women may then move to the next major category, “weighing what’s best for me”, to begin to weigh this information to make a birth control choice or to the third major category, “navigating a course”, in order to find available and/or confidential resources for methods before deciding on a method.

Weighing What’s Best for Me

The phenomenon of “weighing what’s best for me” is defined as evaluating one or more methods for preventing pregnancy in order to choose one that is most suitable within the context of her current life circumstances. Cheyenne talked about how she chose Depo-Provera® after developing side effects from the birth control pill. “Because I was getting nauseous and sick then my doctor gave me a pamphlet on other birth control, the good and bads of each. And I just weighed it out and saw what was best for me.” As in “becoming aware”, “weighing what’s best for me” may also be limited or extensive. See Table 5 for a complete description of “weighing what’s best for me”.

Table 5

Weighing What's Best for Me

Causal Conditions	Context	Intervening Conditions	Action/Interactional Strategies	Consequences
<p>Not wanting to be pregnant</p> <p>Needing to choose a way to prevent pregnancy</p> <p>Becoming aware of options</p>	<p>Age</p> <p>Current relationship(s)</p> <ul style="list-style-type: none"> • seriousness • stability • frequency of sex • partner's willingness to participate <p>Personal preferences/beliefs</p> <p>Child-bearing plans</p> <p>Past experiences with methods</p> <p>Protecting oneself</p> <p>Protecting others</p>	<p>Cost</p> <p>Method properties</p> <ul style="list-style-type: none"> • effectiveness • messiness • interference with sexual pleasure • side effects • convenience • provides validation that it's working • provides additional benefits 	<p>Assessment of risk/fear</p> <ul style="list-style-type: none"> • STD • pregnancy <p>Seeking information</p> <p>Prioritizing/reconciling possible conflicting influences</p>	<p>Choosing a method(s)</p>

Causal Conditions

Causal conditions delineated in the interviews are not wanting to be pregnant, needing to choose a way to prevent pregnancy and becoming aware of options. Some women talked about not wanting to be pregnant as the most important influence in deciding on a method. As Celeste said "Sort of the main reason (not wanting to be pregnant) to get on a method, yeah." Eleanor agreed:

Well, that would be my biggest motivator (not wanting to be pregnant) [laughing]. So, that influences my decisions as far as, "ok you gotta start be back on the pill and, you know, otherwise you're gonna pay the price" so, yeah. I think that is my biggest motivator.

Context

The context within which weighing what's best for me occurred included a woman's age, current relationship(s), personal preferences and beliefs, child-bearing plans, one's own and others' past experiences with methods, needing to protect oneself, and wanting to protect others.

Age. The women in general felt that as they got older they had more access to information and options. Lehua compared her decision-making at age eighteen with her decisions now ten years later.

When I went to the doctor, I didn't even really know what was available so I thought...only was pills. So I think if it was more on the public like how it is now on TV or offered through clinics and programs more widely available I think I would've had maybe different choices back then as like how now I know that this is my choice. I choose this amongst all the rest.

Back then it was just, "I guess that's what I'll take because that's all I know."

Anastasia felt similarly.

I think now, since I have more resources, I just, you know, really look into things. Like before, you know, I had some resources, but I kind of like just went into it. Like now I'm kind of more information-oriented as far as how I learn. I want to know what the effects are. I want to know what the possibilities of what and what consequences of whatever. So I think just because I have more resources now, it's better for me as far as decision-making.

Cheyenne talked about using condoms as a teenager because:

It was the only thing I felt that was available to me...Again the access to it, as I got older, it was much more readily available, you know like the Depo or the pill. More options were made available to me as I got older.

Current relationship(s). A woman's current relationship or relationships provided a background for what was best for her regarding contraceptive method. Many women changed a method in relation to the seriousness and stability of the relationship, the frequency of sex and the partner's willingness to participate with or use a method. Usually women moved from a barrier method, most commonly a condom, as a relationship became more serious. Part of this was due to the frequency of sex but it was also done to demonstrate trust in the partner and commitment to the relationship. If a relationship became unstable, a woman may return to using condoms, such as in Anastasia's situation when she

began to suspect that her partner was having sex with someone else. She moved back to using condoms to protect herself from sexually transmitted diseases. "Well, the only time that I stopped using condoms was with the boyfriend I have now, because I believed it was a monogamous relationship...And so for the past about three years, we haven't used condoms. But I started using them again, because I questioned his faithfulness". Some methods were deleted from consideration if a partner would not consider using that method, particularly male sterilization and, sometimes, condoms, as well. Leilani said, "If my ex-husband wouldn't use a condom, then I'd be definitely taking the pill. He wouldn't want to use it, so I would definitely take the pill to prevent pregnancy." Her current partner refuses to consider a vasectomy or what Leilani calls "fixing up".

Well, they're definitely non-supportive, of fixing up. My boyfriend, now, he would never be...I've been trying to talk him into it for I don't have to take this pill. He can go for - it's out of the question. So that type of birth control would be no for them. "They're not going to touch me."

Celeste and Eleanor had similar experiences with their partners refusing to consider a vasectomy.

Other women had very supportive partners. Mary has had a steady boyfriend for six years who has been very supportive of the use of condoms and then pills. Laura, who has been married for many years, and her husband have been using the condoms for over ten years and he has been very supportive. Teresita has been using natural family planning for about nine months. "He's

completely for it...He would not want me to be on birth control. He doesn't want to use condoms for religious reasons, but also for, you know, the other reasons."

Personal preferences or beliefs. Women, and sometimes their partners, had personal preferences or beliefs that provided a lens through which a method was evaluated. At times these perceptions were inaccurate. Women talked about wanting a method that was natural or made them feel normal. Some methods were perceived to be intrusive, invasive, foreign or "weird". Typically, these were implants, like the IUD and Norplant, and barrier methods, such as a diaphragm. However, some women eliminated the birth control pill from consideration as too foreign or chemical. Gloria stated:

I knew then I didn't want to take the pill. I was never into the idea of the pill...I think the pill to me is invasive because it's changing your internal hormones... I didn't think it was right to mess with your hormones like that on a synthetic level. You know I feel like our bodies do what they do because they're supposed to do that. And I just wanted to find another way rather than manipulating my hormones.

Said Jane:

I never wanted to use the pill or anything like that... I read all about other things and Norplant® and Depo Provera® and all those and, it just basically came down to, I don't want to mess with my hormones. I just want to keep my body natural the way I think it was intended to be...

Similarly, Teresita talked about what influenced her decisions about birth control: "wanting to be as natural about it as possible, not putting different things

into our bodies to prevent something that our bodies already can prevent if you just pay attention.”

Laura echoes Jane’s concerns about chemicals. “They’re putting things in their arms and stuff and that sounded really sore to me. And it also sounded still full of chemicals.”

Sometimes women stopped using the pill for a period of time to give their body “a rest”. Cassie recently switched back to condoms from pills after she broke up with her boyfriend.

And because I wanted to get my body back to normal. I figured I’d give myself a rest off of the hormones...I guess my break from my birth control pills - I think that’s partially my belief of why I’m off of it for a while. Just wanted to get my body back to working on its own.

Even women who eventually chose a method had concerns about interfering with normal functioning. Cassie, who used oral contraceptives, stated “It’s something else I’m putting into my body and it’s hormones that’s not working the way my body normally does, so I guess it is a little unnatural. But necessary. I believe it’s necessary”.

When asked what method she would never consider using, Cassie replied:

Norplant®. Those are just weird... And then they got the new 3-one or something (three-rod implant). I don’t know, I just think it’s weird. Yeah. An implant. I just think that it’s a little too freaky. I don’t know, personal preference, I guess.

Leilani agreed when asked what method she wouldn't consider using. "Probably IUD - invasive. Putting, using, putting something inside and leaving it there, that's foreign."

Eleanor stated:

I didn't like the way those things that were implanted looked like they had a fan inside your arm. So no. That wasn't a good thing to be walking around with. I didn't want anything inside protruding like that. And, it's, I don't know, it seemed kind of like you're branded walking around with something like that. And it seemed kind of barbaric to me, but, you know, some people chose that.

For Anastasia:

I think, it's, like, psychological. Because too, I don't like sticking things up there myself, you know? I can't use tampons and stuff, because I don't like sticking things up. So, just diaphragms, getting them in there I don't feel I could do it. I don't want anything up there, you know?... No way. I couldn't handle that (insertion of an IUD). It's not modesty, but it's uncomfortable and like OK, for example, if I use a tampon, which I've tried to do, in my brain, I know it's down there. And even though I'm not supposed to feel it, it's like I can feel it, you know? And I don't like the feeling of anything foreign up there.

Laura recalled seeing her sister's diaphragm.

And I asked her, how do you ever get it in? So she was explaining and I just thought, oh my goodness...that that large thing was going to fit there, I

just don't think so [laughing]. And I eliminated it. It was like one conversation, that was, that was gone.

Another personal preference was if a method interfered or promoted normal functioning, such as menses. Some women chose the pill because it made their cycles regular and this promoted a sense of feeling normal. As Leilani recalled:

I was very irregular. I didn't really start my menses until sixteen. And then sometimes I wouldn't get it for three to six months. And then I had it one day and then not. And the birth control made it you know, regular. Sort of you still get it every month. It just made me feel more normal as a person, I don't know. You feel normal getting a period. A lot of my friends got their period regularly and I didn't.

Other women eliminated a method, such as Depo-Provera®, if it interfered with their menses. Some believed that a regular menstrual period was cleansing and interfering with that was not normal. Leilani stopped using Depo-Provera® because "just the feeling of not being normal. I didn't get a period and it made me feel very irregular." Cassie wouldn't use it because she didn't like the idea of not getting a period. "I think that's unnatural... it's the whole flushing out and it's not flushing."

For Teresita, as she became more religious, religion became the context for making birth control decisions. "And our being Catholic, that also because with the contraception and Catholicism, they don't really go together. So we're trying to kind of walk in line with our religious beliefs."

Another personal belief was a woman's trust in a method. Some methods were eliminated from consideration if a woman didn't trust its effectiveness.

Anastasia didn't trust the diaphragm. "And I question the effectiveness of it as well as like the ring, number one, and the diaphragm, you know. Because you know, stuff happens." Cassie recalled, "I never considered the diaphragm or the caps or any kinds of things like that because I didn't trust them." Lehua talked about her consideration of vaginal contraceptive film:

When I first seen that I was thinking, "Oh, that looks something interesting to use." But then I was thinking, "Oh, doesn't look that effective, you know." It's just a film and if you just look at it, it's not like a shot or something that's in you or you take a pill and the hormones is in you.

Maile agreed with Lehua about the contraceptive film. "What's that one they have now, the film or whatever it is? That doesn't sound very effective [laughing]. It's like, 'yeah right'."

Partners sometimes have similar beliefs about methods that may influence a woman's choice. Jane's current partner is also concerned about her using a method that isn't natural. "My partner now is very much into being natural in a way...say I wanted to go on pills now he'd probably try and convince me not to...he would probably say, 'oh, you sure you want to do that to yourself?'"

Childbearing plans. Present or future childbearing plans play a part in evaluation of a method. Lehua, who is planning to have another child, grappled with when to stop the Depo-Provera®.

But I know that with the Depo they were also saying you should be off of it a couple months before you decide to plan to conceive again. So I'm battling with that issue, stopping the Depo and going back to condoms. But I'm still on Depo now. I just got another shot recently. So, still thinking about when to stop.

Sterilization, either male or female, is eliminated as an option for women who are still indecisive about whether to have another child. Eleanor, in discussing female sterilization said, "that's not a good option for me. I'm hoping to have another child in the future."

Past experiences. Not only one's own, but others' past experiences, were a context for future decisions. If a woman had a particularly difficult experience with a method, she would exclude that method from future consideration. Lehua, who is now on Depo-Provera®, previously used condoms and the birth control pill.

Well I had no real problems with the condoms, so I know if anything I would always go back to that without even thinking, you know, hesitate. But the pill, I would have a really hard time going back on the pill, because I just remember how I felt and I didn't like that feeling. And the fact of not remembering to take the pill. So I think a lot of it has to do with remembering the side effects I've had from the pill.

Laura also had side effects on the pill and wouldn't reconsider them, "no more pills...exhausted that method".

Other times women may have had problems with a method, even getting pregnant while using it, but reconsidered it at a future time. If a woman had success with a past method, she would consider using it again if necessary. Celeste, Maile and Eleanor got pregnant while taking the pill and went back to using it at a later time. Both Celeste and Maile seemed to be taking it correctly although Celeste feels that she may not have been taking it the same time each day. Eleanor was missing days because of an unstable living situation. Celeste returned to taking the pill because:

Why did I choose the pill again? I think I was afraid of the Depo. Actually the pill the second time I took it after my first pregnancy it wasn't actually for birth control method. It was to regulate periods. So I just kept taking it, I guess. So that was the main reason for going back on it.

Her doctor told Maile that she might have gotten pregnant on the pill because "he said because I was just turning eighteen, systems changing and the pills probably were too weak." She went back on the pill at a later time because "I believed what the doctors said about being too low of a dose."

Eleanor lived between her boyfriend's house and her own and was taking the pill as she terms it "half-ass" and became pregnant, which she terminated. After having problems with condoms and spermicides, she returned to the pill. This time, "I was way better [laughing]. I had learned my lesson. I was really good (about taking the pill)."

Protecting oneself. Protecting oneself was another part of the framework for deciding upon a method. Women may need to protect themselves from

sexually transmitted diseases, being found out, being mistreated physically or emotionally, having to face the consequences of being pregnant, interference with one's life plans, and the effects of a method on one's health.

Awareness of the need for protection against sexually transmitted diseases caused women to consider condoms as their birth control method. For example, in the early eighties, as AIDS became more of a concern and Gloria became knowledgeable about sexually transmitted diseases, she decided to change from a diaphragm to condoms.

Having to protect oneself from being found out that one is sexually active or using birth control, most commonly by one's parents, influences the choice of method and may actually limit available options. As Teresita remembered, "I don't think I felt like I had access to anything besides condoms because my mom didn't know that I was having sex." Celeste had limited knowledge of health care services for birth control as a teen:

When I was a teenager, I didn't know anything about those things and (that) probably influenced me not to get on any other method besides the condoms because I wasn't sure about if they would tell my parents or I didn't want it to be billed to my parents or all those kind of stuff like really freaked me out.

Laura recalled the impact as a teen of needing to hide the need for birth control from her parents.

I tell you, though, if I had ever gotten pregnant and if I ever had to put HMSA, let's say, on the thing to get an abortion or something, that

would've been a crisis. I just really fortunate I didn't...Because so long as you didn't have to tell your parents...I was real concerned. I remember going to the health center and, "is this going to be on the HMSA bill?" when they asked for my card. I did not want to (give it to them). I was ready to walk out.

Mary talked about her fear of being found out and how that limited access to health care services for her.

I was sixteen at the time and I didn't want my parents to know and I didn't want anything to go under their insurance...at the time I didn't feel comfortable to see a nurse or a doctor, so we decided on a condom for a while. My cousin worked at the hospital at the time and I was afraid that she would give the information out to her friends, family and other people, so that's why I didn't feel comfortable to go to the hospital or anything like that.

Sometimes women are in abusive relationships that spill over into issues surrounding contraception and then become a lens for how women make contraceptive choices. Eleanor shared a story about one partner who tried to sabotage her use of birth control pills because he wanted to have children.

There was only one partner that was not wanting me to be on birth control...and so, that relationship ended [laughing]. But it was everything else was, you know, for the most part good, but I didn't want to go there with him. But he was very, very adamant about it...I mean, I found when my pills had been like popped open and they were dissolved like

something had been poured on them. So “you’re disturbing me with your stuff here. You need to go.”

Maile had four unintended pregnancies with four different partners. Her first partner, when she was a teen, would not allow her to use birth control.

Well, in the beginning I didn’t want to get pregnant at all anyway. But, because of the abuse in the relationship, I was not allowed to take any birth control precautions, because he would say, “no, there’s no way, because then you can just go cheat on me” and this and that, so it was more of the relationship, you know there was so much control being taken over. I was being controlled on what to do at the time...It was a very weird situation. But then I woke up and was tired of it and was able to get out of it and go on with my life.

In her most recent relationship, Maile’s partner left her for another woman when their child was just two. As soon as she could arrange it, she was sterilized.

Cause ain’t nobody making me have any more children [laughing]. That was my reasoning...I’ve had four children with four different guys. The last one really broke my heart. We were together six-and-a-half years. He left me for a twenty year old and it hurt a lot. So I decided “ain’t nobody gonna make me feel that way, make me feel like a baby machine again. You’re gonna love me for me and just the way I am, what I have.” They want babies, they can go somebody else... I had people keep, you know, “are you sure, are you sure, are you sure?” But , I mean, it’s a big

step, you know, it's a big step, because yeah OK what if I do finally meet Mr. Right who wants the little white picket fence and all of that but I just been burned too many times so that's my choice. I'll have the white picket fence with the kids I have [laughing].

Women were concerned with protecting themselves from having to face the consequences of getting pregnant, particularly facing the option of abortion. Some women had experienced an elective abortion and did not want to go through that experience again. Cassie stated, "Because I really don't want to get pregnant. And at this point in my life I wouldn't want to be faced with the decision of what to do."

Religion seems to play more of an influence here than on the issue of whether to use contraception itself. As Anastasia expressed, "The most religious influence has been the possibility of getting pregnant and then weighing the option to keeping it." Another participant, Eleanor, said:

Probably religious beliefs had a huge impact because of having an abortion and then not really understanding the impact that it was going to have on me after the fact. And, going into it with, you know, a different mind set and coming out with a different mind set. Really not to put myself in that situation again. And having to be diligent and go to, you know, whatever needs that I needed to go to make sure that that didn't happen.

Laura echoed these concerns:

I think not wanting to get pregnant because I was raised in a Christian home. It was real important because abortion was something that

would've been really, really, really difficult. So, perhaps getting pregnant was one thing... that you wanted to avoid. And then having to decide, if you did get pregnant, about the issue of abortion was the second.

Women also had life plans that pregnancy would interfere with. Celeste talked about "Going to college and making sure I didn't get pregnant [laughing]. That was the main thing. I wanted to stay there and finish school". Anastasia expressed, "That is my biggest fear, is getting pregnant.... Because it's something I would have to live with for a long time."

Eva poignantly stated:

I'm believing that I can do a lot with myself and do more than just get pregnant at fifteen and be a mom for the rest of my life. I think had a lot knowing that I wanted to go do stuff and see things and I wanted to be married and financially, not that you're ever ready for children, but at least have some kind of stability and so I think just having all that in my mind really made me pay attention to what was going on.

Jane is deciding whether to have a child at this point in her life. "But, at the same time, there's still so many things I want to do with my life before I have a kid."

Women also want to protect themselves from the health effects of a method, particularly long-term and unknown effects of hormonal methods. Cassie, Leilani, and Eleanor talked about their concerns with being on the pill for many years. Leilani questioned, "But I was concerned about...being on the pill for like your whole life, basically... what's too long?" Eleanor stated, "I've been

on it (the pill) for a long period of time, that influences me to not want to be on it because I feel like, wow, that it's enough. You know, it's enough, it's enough, it's plenty of years." Eleanor also developed a skin discoloration on her face that her dermatologist ascribed to the effects of the birth control pill. Eleanor stopped the pill because, "Well if it's doing that, what else is going on? I mean, this is really subtle and I would have never equated it and I just didn't know what else was going".

Protecting others. Wanting to protect others also provided a backdrop for choosing a method. Others to protect included potential children from not being born at an optimal time, one's partner from an unplanned pregnancy, parents from the shame, worry and disappointment that may accompany an unintended pregnancy, and protecting a child who was being breastfed from hormonal effects.

Women were not only concerned about protecting themselves from an unwanted pregnancy; they also considered the impact on their potential child or their partner. Maile who had much financial and emotional turmoil in her life, including homelessness, talked about why she chose Norplant®.

I just didn't want to be pregnant and have another child when, you know, not being married and secure. You know, I just didn't want it happening again...I was raising two kids on my own already at the time, so that's why I just didn't want to put another child through the struggle.

Sheri stated: “And I know that right now, I don’t want a baby. I love children and I can’t wait to have one of my own, but it’s not fair to me or the child or my partner to have one.”

Some women also talked about protecting their parents from the shame, worry, or disappointment an unintended pregnancy might bring. For Sheri and Anastasia, their mothers didn’t want them to repeat their experiences with single motherhood. Sheri said:

I think it makes my mom rest easy to know I’m on the birth control pill. Sometimes she asks me, “Sheri, you’re still taking your pill, right?” I say, “of course I am.” Because, she wants me to have the opportunities she didn’t have...And I guess my mom’s always kept me up-to-date, ‘cause she had me when she was seventeen and that’s the last thing she wants for me to do is have a child when you’re that age.

Laura felt that not only would her parents have been ashamed if she had a pregnancy before marriage but also that “my parents would just have felt that they did something really, didn’t raise me correctly if I ever had gotten pregnant before I got married.”

Breastfeeding is a context for selecting certain methods. Lehua talked about the reasons she selected Depo-Provera®.

After I gave birth to my child it was the fact well, actually there’s two that’s equal, the breastfeeding that made me choose it and the effectiveness. Yeah, because I know Depo has a high effectiveness and yet I could do it while I was breast-feeding.

Intervening Conditions

Intervening conditions that influenced weighing what's best for me were the cost of the method and method properties.

Cost. The cost of a method can be a strong influence for some women. Anastasia expressed, "I was really, really upset because just the fact that they're (pills) expensive, you know, and I don't have an income now, and if you don't have medical, it's like you don't have access to anything". Both Maile and Eleanor changed from birth control pills to condoms, in part because of the expense. As Eleanor stated, "Well, at this point in time I don't have insurance and at this point in time there really is no Planned Parenthood on the island to go to either. So, the options are limited".

Method properties. Method properties seemed to play a large part in influencing women's considerations of a method. Particular properties that were found in this study were effectiveness, messiness, interference with sexual pleasure, side effects, convenience, if a method provides validation that it's working, and if it provides additional benefits that are useful to a woman.

The effectiveness of a method was one of the most influential properties of a method. When asked about the properties of an ideal method, most women talked about effectiveness as a property. Laura stated, "Oh yeah the pill was because I wanted the ninety-nine point [laughing] assurance that if I took it everyday I would not get pregnant. That was what was a little bit scary about the condoms". One of the criteria used to eliminate a method from consideration was if it wasn't thought to be effective. Teresita talked about methods she would

never consider using. “And withdrawal, of course. Just that it’s not very effective. The risk is too high.”

Barrier methods, such as the sponge and diaphragm, and spermicides were the methods that were most likely deemed messy and interfering with sexual pleasure. Barrier methods interfered with sexual pleasure not only because they were messy but because they interrupted sex. Spermicides may interfere with oral sex because of the taste. Condoms may decrease sexual pleasure because of the decrease in feeling for both partners. Cheyenne stopped using condoms because “I felt what it was like without the condoms [laughing]”.

As women learned about side effects associated with a method, they may eliminate them as potential choices. Celeste related, “Thought about the IUD once but (it) didn’t sit well with me with the increase with menstrual cramping because I already have really bad cramps with regular periods”. Lehua recalled why she eliminated Depo-Provera® at one point.

I was also hearing bad incidents about the Depo so I just didn’t want to do anything, put anything in me or take anything ‘cause I didn’t want to deal with any of the side-effects. Depo, I was hearing about weight gain and I didn’t want to gain any more weight.

Convenience of a method that women considered included easy to use and easy to access. The diaphragm was considered a hassle because a woman had to put in before sex and leave it in for a specified time after. Sometimes determining that a method is easy to use appeared to be a very individualized

decision. For example, some women considered the pill easy to use because it was easy to remember to take it every day. Leilani remembered, "To me, that's one of the simplest methods is just taking the pill. It's not hard to do; it's a little thing". For other women, it was a hassle to remember to take it every day. Some women considered Depo-Provera® easy to use because it was only one shot every three months. As Cheyenne said "I like the fact that you take one shot and you don't have to worry about anything, about getting pregnant for a couple of months." Anastasia disagreed, liking the idea of a monthly shot better than one every three months.

So I need something more consistent, more visible, more in a closer time range. You know, like three months is a long time for me. To think in three months I got to remember to go in and get a shot. That seems like a long time for me. Versus every month if I go in on this date every month, I know when I need another shot.

Ease of access was another factor that influenced choice. Condoms were felt to be easy to access, particularly for younger women. Prescription methods were considered more of a hassle. Anastasia's first method was a condom because:

It's more easily available than having to go through a PAP smear, and having the birth control pills, so yeah, it was condoms...they're not very expensive. At the time, I had medical, so I could have gone to the doctor's about birth control. But it was a time issue. You know, I mean, like how

long does it take. I got to go there, and get all that done and then get the pills...

Eleanor stated:

I find it a drag to be going to get a prescription and then going to (a pharmacy) and standing in line. I didn't like that. I want one place to go to and that's it. I want to take it home there. You wait there (clinic) and wait there (pharmacy) and nothing's ever easy, nothing's ever fast.

Another method factor that influenced choice was if it provided some sort of validation that it's working. Some women thought that if they took Depo-Provera® and didn't have a period, they would worry that they were pregnant.

Anastasia expressed:

That's another thing about Depo. I forgot about that. I'd be super-paranoid. You know what I mean? That I was pregnant if you're not getting your period. So, I kind of like the consistency. I'm a consistent kind of person. I know what day I'm going to get my period. You know what I mean? I know how long it's going to last...

Cassie talked to some teenage mothers who had become pregnant on Depo-Provera®. "And a lot of the teenage girls are like, 'well I didn't think I didn't have my period anyway,' so why it was just then you have to look to other signs. So, yeah that would freak me out." Mary expressed a similar concern.

Some of my cousins that were taking the Depo said that they wouldn't have their period for three months or they would have their period for the whole month. If I didn't have my period for three months then I would be

worried about that. I would think that I would be pregnant. And, I'm a person that really gets worried so I didn't want to take (Depo) and be more worried.

Sometimes, a method that's not readily visible causes concern to the woman if it's actually working. Gloria eliminated the IUD from consideration because it wasn't visible and she was unsure if it was working correctly. "It's where you can't see it (the IUD) whereas the diaphragm was something I could see and put in and take out."

Additional benefits that were found useful in the choice of a method were regular periods, less or absence of menstrual flow, acne therapy, protection from ovarian cysts, less menstrual cramps, and an increased knowledge of the body. Sometimes these benefits precipitated the choice of the method and other times these benefits were not realized until the method was used. Sometimes these were expected benefits that never materialized. As Cassie stated:

I was very irregular, younger in my younger years. I think that probably had a little bit of influence knowing and I had really bad cramps too and they said that birth control pills would help that. It didn't really help that much, though. But it did help make it more regular.

Some women started birth control pills specifically because their periods were heavy or irregular or for acne treatment and then secondarily for birth control. Anastasia said, "I actually chose it (the pill) because I had heavy periods and it really helped with keeping it regular." Cheyenne and Leilani were

also initially placed on pills because of irregular periods. Cheyenne chose the birth control pill:

Because I learned that your periods would get regular. Actually it was not more so the birth control aspect... it's...because my periods were irregular ...So the intent wasn't birth control at that point. And then I figure I kill two birds with one stone, you know.

Although Depo-Provera® wasn't selected for this reason, Cheyenne and Lehua stopped having periods and they both liked that aspect. As Lehua said, "It wasn't where I went on the Depo thinking, 'I'm not going to have my period'. I always thought I would still have it. But, now that I don't have it, ...that's a plus".

Sometimes it's a combination of additional benefits. For Mary:

I just thought the birth control pills would do best for me since I had irregular periods. The nurse that helped me told me that since I had irregular periods it would be best to use the pill. Also, I had an ovarian cyst and I have another one in my other ovary, so ...I think at first I did want to use the shot. But then when the nurse brought it out that it's going to benefit me and my ovarian cyst and my irregular period then that's when I decided to take the pill.

Sheri chose birth control pills to help her acne.

And where I got my first set of birth control pills was actually from my dermatologist because we were going to try to use it for my acne and it did help a little...I was using it both for sexual activity and then for my acne.

Gloria and Teresita found an additional benefit from natural family planning of an increased knowledge of their bodies. Gloria stated:

And I think it's good because it's just that awareness, and body awareness that you don't always get if you're just popping a pill or whatever. I had really regular periods and I was already conscious about my body and my health is important to me. So it just seemed like the best method because I wanted to become more aware of my female self.

Teresita echoed these benefits:

It's taught me so much about myself. I have such a better understanding of my cycle and my moods. I mean, everything, from breast tenderness to mood swings. I completely understand all...and why, you know, based on my cycle. It's a great thing. I love it.

Action/Interactional Conditions

Strategies which women used in this category, or action/interactional conditions, included assessment of risk/fear of sexually transmitted diseases and/or pregnancy, seeking information, and prioritizing and/or reconciling possible conflicting influences.

Assessing risk/fear. One strategy that women use in selecting a method is assessing their risk of being exposed to a sexually transmitted disease as well as their risk of becoming pregnant. Their fear of getting pregnant also played a part in selection of a method. When asked how her decisions about preventing pregnancy have been influenced by different partners, Cheyenne replied, "Well,

the condoms would be with people I wasn't sure I could trust. Or, you know, with a not so appealing background.”

In addition, assessment of one's risk of getting pregnant linked with one's fear of pregnancy sometimes motivates women to select a more effective method or to use a method better. Sometimes, this occurs after a pregnancy scare or an unintended pregnancy. Jane told about a pregnancy scare that influenced her to move from withdrawal to a diaphragm.

So what happened was we'd been good about condoms, using them every time, but we started to experiment with withdrawal. And one time he didn't actually withdraw and I freaked out and cried. I remember it was the first time. I thought I was instantly going to get pregnant, you know...It was the first time that had happened. And the next day we went right away to or, maybe it was the next day or as soon as we could get off of work we went to Planned Parenthood and did a pregnancy test and I remember they showed me under the microscope all his semen swimming around like they'd taken a sample and I was like, “oh my God”. And that's when I got a diaphragm.

Mary and her partner moved from withdrawal to using condoms because of her fear of pregnancy. “I was afraid of being pregnant. Before we moved on to condoms, I did several pregnancy tests and they were negative. And since I was so scared I just told him, use protection (condoms) at the moment.”

Seeking information. Women may seek out more information at this stage in order to come to some decision. They may look to various sources such as

talking to their friends or getting recommendations from their health care provider. However, this information is weighed by the woman in making her decision. Anastasia related how she learned from her sister's previous experiences with birth control but made up her own mind. Her sister had a negative experience with birth control pills and a positive experience with Depo-Provera®. Despite this, Anastasia chose birth control pills as best for her.

Basically I just share stories, experiences, and then I make my own judgments. I normally take into consideration what they say, but it's a matter of how I feel. And I also, just because my sister says the Depo shot works, doesn't mean I'm going to do it, because then I'll go read about it and say, "well, what about these effects?" And then she's like, "yeah, well..." So I weigh both opinions from people versus this factual information from a book or the Internet... all kinds of different things to take into consideration.

Prioritizing/reconciling influences. Women sometimes need to prioritize and reconcile various influences, some of which may be in conflict with one another. As in the situation above, sometimes women are advised to use a method but, using their own judgment of what would be best for them, select another. Lehua related:

When I started the Depo they (friends) were telling me all the negatives of the Depo and I still went on it, so. That didn't really influence me. I mean, I listened to it, but not to the fact where I would just base my decision on taking whatever method they wanted me to take or they were taking.

Women prioritize the advantages and disadvantages of a method. For example, they may weigh their concerns about the side effects of a method with its effectiveness. Eva, Sheri, Cassie, and Celeste all expressed concerns about the health effects of the pill but used it anyway because they wanted an effective method. Higher priority influences win out. For Cassie, the effectiveness of a method was the most important influence for her in making decisions about birth control.

In other situations, women may reconsider a method they previously eliminated as they learn more or as their situations change. Angela had previously eliminated the IUD from consideration because of hearing about serious side effects. However, she reconsidered it after childbirth when she was breastfeeding and wanted a reliable method.

I remember prior to having an IUD inserted I remember thinking “that’s not good, oh the bleeding oh, the pain well that’s something I’ll never do”. But then soon as I gave birth and I was in that vulnerable postpartum period and it was suggested as a good alternative by my health care provider who I trusted very much. Boom, I changed my mind. Had it; had it for 10 years. You know so it’s interesting how I had that “that’s too weird, I’m not doing that, that’s a foreign body” and then turned it around just like that.

Women also reconcile religious beliefs with the reality of their behaviors and experiences. Laura remembered the dilemma:

So to prevent pregnancy was real important. But saying that’s somewhat hypocritical because I have to tell you that, for whatever reasons, I didn’t

choose to have sex until I was suppose a legal adult. Umm, the religion obviously is not to have sex until you got married and I did [laughing] so you know, it's like, duh.

As Teresita and her husband became more religious, she reconciled her contraceptive choices to be in line with her religious convictions, moving from using condoms and birth control pills to natural family planning.

And, the last two years for both of us, we've really started to sort of hone in on the focus, have really just come more into ourselves and into our religion. And, so that's what was happening at the time. We just both really feel strongly about it.

Consequences

The consequence of weighing what's best for me was choosing a method. Women may then begin to use a method and move on to navigating a course. They may also select a method and then seek information about how to access it. On rare occasions, women may select a method and then find it is not available to them and then return to the process of choosing another method.

Navigating a Course

The phenomenon of "navigating a course" can best be described as contending with access to and use of a birth control method(s). See Table 6 for a complete description of "navigating a course". The term "navigating" was chosen because it seemed to best describe women's experiences, some of which were expected and others which were unanticipated. For example, women knew they needed to obtain or learn how to use a method but perhaps

Table 6

Navigating a Course

Causal Conditions	Context	Intervening Conditions	Action/Interactional Strategies	Consequences
<p>Choosing a birth control method(s)</p> <p>Desiring to become aware of resources to help with decision-making and access</p>	<p>Being in control</p> <p>Having the responsibility</p> <p>Familiarity of method</p>	<p>Living situation/place</p> <p>Change in partner/lack of regular partners</p> <p>Cost and availability</p> <p>Development of method problems</p> <ul style="list-style-type: none"> • Taken off market • Doesn't always work correctly • Side effects 	<p>Managing access</p> <p>Negotiating with partner</p> <p>Fine-tuning</p> <p>Paying attention to body</p> <p>Forming habits</p> <p>Being prepared</p> <p>Sticking with what works</p> <p>Trying something new to see if it works</p> <p>Realizing it's no longer working</p>	<p>Self or partner using a method(s)</p> <ul style="list-style-type: none"> • correctly or incorrectly • better or worse <p>Having an easy time, having a difficult time</p> <p>Deciding to stop</p> <ul style="list-style-type: none"> • Changing to a new method • Believing no longer at risk for pregnancy • Desiring to get pregnant <p>Pregnancy and its consequences</p>

also had to negotiate unexpected side effects or a sudden change in access to a method, such as losing health care insurance. Women needed to navigate both known and uncharted waters.

Causal Conditions

Choosing a birth control method or methods was a causal condition for navigating a course. Another causal condition for navigating a course was a desire to become aware of resources to help with decision-making and access.

Context

The context for navigating a course was the control of decision-making, having the responsibility for decision-making, and the familiarity of the method.

Control of decision-making. Most of the women interviewed had the control over use of the method; some of them felt very in control of which method they used with little influence from partners or providers. Jane echoed some women's sentiments about the influence of partners on contraceptive decision-making. "Ultimately it would always be my decision, like I've never let someone tell me what to do if I wanted to do something differently." Eva felt similarly, "I think I was pretty set in what I felt and believed in that I didn't really care what they thought [laughing]. How horrible is that but it's my body, I can do what I want." Lehua talked about if she had to change to a new method:

Probably I would say it'd be more my decision and his decision wouldn't really change my mind, because it's something that I'm either putting on myself or taking or doing myself. As long as we both agree that we're not

going to have another child at that time then I think the choice for whatever birth control I do should be my choice.

In contrast, at particular points in a woman's life, she may not feel as though she had much control. When Maile was in an abusive relationship, she did not feel as though she had much control over her situation. Teresita talked about an experience as a teen when her parents found out she was having sex.

I just remember my mom just saying, "you're going to get on the pill now." Maybe I just wasn't old enough to realize that I could make my own decision. Or maybe she had still had such an influence on my life that I felt like what she said was the way that it was.

Some women liked methods such as natural family planning, the diaphragm, or condoms because they could control them as opposed to hormonal methods that required more medical control. Gloria stated, "The ideal way is, for me, fertility awareness because you're not dependent on any outside or external things". Later, she said, "I just liked the idea of the diaphragm. It's just easy and it was something I could control". Other women talked about knowing what they wanted before seeing their provider. As Eleanor explained, "I think they (health care providers) just pretty much go with what I say."

Laura talked about when she and her partner switched from years of oral contraceptive use to condoms and the initial difficulty she had in giving up control.

And then, you know, we started to realize as long as we had it (condoms) there then it was in our control. But at the beginning, that was a little bit

freaky because it was a big change of me not being the one and my husband having to be prepared [laughing].

Having the responsibility. Women also bear most of the responsibility for contraceptive decisions and use. As Cheyenne said about her partners' decisions differed from hers, "I don't think they really cared. [laughing]"

Anastasia talked about her current partner:

He just lets the woman figure it out. That's where it is. It's like he just lets the woman figure it out and takes their word for it, you know? If you ask him, "well how do you know, you know, you don't have a kid somewhere?" And he's like, "well, because they said they're on something." Oh, OK, whatever. [laugh]

Sheri talked about how not only do men have limited responsibility but women have the ultimate responsibility.

All guys feel they can do is have a condom, pretty much. It's most of the women's responsibility for unfortunately. But, you know, if they did take a birth control pill, they'd need a woman to remind them to take it [laughing].

Familiarity with method. A final context was a woman's familiarity with a method, which takes time to develop. Some women talked about becoming better at taking pills correctly over time. For example, Leilani, in talking about her oral contraceptive use, said, "It's a habit now. It's more of a habit. I put them in the same spot and I do it every day, yeah. Yeah. Definitely easier than it was." It took Gloria a while to become comfortable with natural family planning, or as she calls fertility awareness.

So now it's just something I know daily. We check with myself and the calendar still, as far as my cycle goes. And using the diaphragm, the reason I chose that, was to have a back-up because it took a while to get used to fertility awareness. I probably took probably a couple of years before I got really comfortable with it where I knew exactly what was going on and could tell. It's funny, though, because I started it so long ago that it's just a part of my life now, you know, it's kind of like when I get up and do things for breakfast, it's just a part you know of it. It's not even something that I have to think about or like that's been the beauty of it for me.

Intervening Conditions

Navigating a course was influenced by women's living situation or place, a change in partner or lack of regular partners, cost and availability of the method, and the development of method problems. Cost and method properties were also intervening factors in "weighing what's best for me". In that category, these were potential or hypothetical influences that women considered; in this category, they are actual influences that impact women as they tried to use a method.

Living situation or place. The stability of a woman's living situation influenced her access to and use of a method. If she lived at home with her parents and needed to hide her contraceptive use also influenced access. Unstable living situations described in this study were living between two places and homelessness. Eleanor described how living between two places contributed to her problems in effectively taking oral contraceptives.

Not waking up in my home and being at my boyfriend's house and not having them with me and I had (an) erratic schedule. I think the lack of transportation to get back to my house, because we had to go to school or go to work or whatever. And then just one day turns into another day. It didn't really become a habit until we lived together. Then I was there and could take the pill and wake up in the same place instead of my home, his home, and that whole thing. And I just didn't carry them with me.

Maile was homeless for a time and had no health insurance. Her supply of birth control pills had run out. She was able to access condoms through a homeless outreach van. "They just always made sure if you were homeless you had it. It didn't matter [laughing]. 'Here, this is in your stash'."

Another aspect of a woman's living situation was the degree of openness and amount of resources available. Angela and Gloria talked about living as teens in small towns with little contraceptive resources and a lack of openness in discussing such matters. Gloria compared this to when she moved to San Francisco.

I was twenty-one when I moved to San Francisco. And that's where I was - lots more information available, lots more tolerance and acceptance... There was just a flow of information. Whereas where I had been before, so many things were taboo, you know, especially being young, having sex, and so I didn't feel as free to go searching for anything I needed. Whereas when I got to San Francisco there was just this open flow of information.

Change in/lack of regular partner. A change in partner may instigate a change in method or a lack of a regular partner may inhibit developing familiarity with a method. Women sometimes would revert back to using condoms with new partners because of concern about sexually transmitted diseases. Gloria talked about her experience with the diaphragm. “It seemed kind of awkward, using the diaphragm, because I didn’t have a regular partner. I think if I had a regular partner using the diaphragm it wouldn’t be so awkward but I didn’t have a regular partner at that time.”

Cost and availability. The cost and availability of a method were also influential in determining use and access. Just as cost is an intervening condition to “weighing what’s best for me”, it can be a strong influence in determining access to a method, particularly in conjunction with the availability of health insurance. As Anastasia stated, “Right now, I don’t have medical insurance, and I was having the darndest time trying to get my pills”.

A method may also not be available because of refusal of health care providers to offer it. In this study, Maile desired a tubal ligation initially at age 25 but her provider would not offer it to her at that age because she was considered too young.

Method problems. Method problems may impact use of a method. Methods, such as Norplant® and the vaginal sponge, are not available to women because they have been taken off the market. Other method problems are if a method doesn’t always work correctly or if a woman develops side effects.

Side effects that women in this study developed included weight gain, nausea, abdominal pain, bleeding/spotting, skin changes, emotional/mood changes, and decreased libido from oral contraceptives. Cycle disruption and bleeding/spotting were cited as side effects from Depo-Provera®. Arm numbness was reported from Norplant®. A final side effect of allergic reaction was reported for condoms and the vaginal sponge. Sometimes, women tolerated side effects in exchange for other qualities. For example, Lehua tolerated mood changes and weight gain with Depo-Provera® because she desired its effectiveness and acceptability with breast-feeding. Multiple side effects or ones that became too troublesome triggered a change in method. Laura developed breakthrough bleeding and weight gain on the pill and was also becoming concerned about long-term health effects. “Because I changed all doses, different doses and I know at one point I had breakthrough bleeding when it got too low and it just became a really big hassle and then I guess that was it.”

Action/Interactional Conditions

Strategies women used to try to successfully navigate method use were managing access, fine-tuning, paying attention to one’s body, forming habits, being prepared, negotiating with partner, sticking with what works, trying something new, and realizing it’s no longer working.

Managing access. Women managed access by finding free or low-cost clinics or obtaining free samples of oral contraceptives. Many women described accessing Planned Parenthood, college health clinics, or women’s health clinics where they could access contraception for free or a sliding-scale basis. Cassie,

Anastasia, and Leilani talked about getting free samples from providers or relatives who worked in a health care setting. Leilani, who had variable work hours that caused her to lose health care insurance, had her prescription filled when she was on insurance. Women adapted to the health care system by accommodating to the insurance company formulary for oral contraceptives. Eva described her experience when she changed insurance plans.

(My husband) and I were just like pay for it, thirty-five dollars. I was like, "oh my gosh, we're going to go broke for a whole, once a month like that" and then I spoke to my doctor after I got that and she said I could switch to another pill that was pretty similar that my insurance did cover. And then it went back down to like five dollars or seven-dollar co-pay.

Sometimes women did not have health care insurance to cover the desired method. They accommodated to the system by using another method until insurance coverage was available to cover the desired method. For example, the second time Maile sought a tubal ligation, she had to wait a year until she had health insurance to cover the costs. She used condoms until she was covered by health care insurance.

Fine-tuning. Fine-tuning strategies consisted of changing pill or condom types to minimize side effects. For example, Sheri stated:

And I did change from OrthoTricyclen® to Alesse®, because I was finding the Ortho that I was just my moods were just changing too much from extreme, from being happy and content to just extreme sadness. I was feeling really sad. And with Alesse®, it's leveled out more.

Eleanor and her partner switched from latex to lambskin condoms when she developed an allergic reaction to the latex.

Forming habits. Forming habits helped women to more successfully negotiate contraceptive use. Women talked about getting in the habit of taking pills regularly or, for women who were using natural family planning, getting in the habit of monitoring their body. Leilani kept her pills by her bedside while Eva took them when she brushed her teeth. When asked if using natural family planning is getting easier for her, Teresita replied, "It definitely is. Like sometimes I think I could just stop doing it because I'm so regular".

Paying attention to body. Women who used natural family planning paid attention to their body in order to discern when they were ovulating. For example, Teresita monitored her basal body temperature and cervical mucous to determine ovulation. Women on other methods also monitored their bodies for the development of side effects. For example, both Eva and Teresita experienced a decreased libido on oral contraceptives. Initially, they were unsure if it was due to the pill. As Teresita remembered, "I never really enjoyed having sex with him. And after kind of realizing that and wondering if that was the reason, I decided to get off the pill and it turned out to be that." Eva switched pill types and "it really helped a lot....it made me like a normal person."

Being prepared. Being prepared helped women to better negotiate access to and use of a method. Women talked about making sure they had a supply of condoms or pills. Sheri described an incident of an unexpected sexual encounter when she had forgotten to refill her oral contraceptives. A condom

was used but broke. Now, "I want to make sure that I have my prescription filled all the time. Like, even before I'm on my last case or I'm at the beginning of my last case. I want to make sure that I get that refill."

Negotiating with partner. Sometimes women needed to negotiate method use with their partner. Aspects of negotiation included saying no, getting tested, and changing from a condom to a non-barrier method. Sometimes women would refuse to have unprotected sex if a partner didn't have or want to use a condom. Cassie stated, "If there was anyone who didn't want to use something, it wouldn't happen. They don't like it, then 'bye-bye'." Some women talked about getting tested for sexually transmitted diseases before stopping condoms. Cheyenne explained, "Well, as a relationship progressed, I had my partner and I get tested for the HIV virus to make sure we were both clean before we decided to stop using the condoms." Said Eva:

Both my boyfriend and I went and got tested for everything that we needed to get tested before I would like stop using a condom. And, then since I decided we're in a long-term relationship and we both had been tested, then we decided to use birth control (pills).

Sheri described her experience, "At the beginning of this relationship that I'm in, he kind of like, 'can we try it without one'? I wasn't ready to so I didn't and then when I was ready he was very excited about it [laughing]." Jane and Gloria talked about how they negotiated with partners who didn't want to use a condom. For Jane, "He never ejaculated inside of me, but he basically didn't want to use

condoms.” In Gloria’s situation, “And if it was during a time when I was ovulating then we knew we had to use the condom.”

Sticking with what works. Some women preferred to stick with what was working for them until it no longer worked. As Anastasia explained:

I’m also the type of person that if something’s working for me, then I’m going to keep on it until...I’m not one that’s going to change. Like I don’t want to bounce around and try all different methods of birth control. I want to stick with what’s working for me. And hopefully it will keep working for me. And if something happens, then I’ll switch.

Trying something new. Others would be willing to try something new, particularly if it appeared more convenient for them. Lehua tried the Depo-Provera® and Angela tried the IUD to see if it would work for them. Mary also talked about trying the Depo-Provera® “just to see how that works”.

Realizing it’s no longer working. Ultimately, sometimes women had to realize when a method was no longer working for them. This usually occurred when the scales tipped against a method – too many problems developed or using the method became too much of a hassle.

Consequences

Consequences of navigating a course were the woman or partner using a method(s) correctly or incorrectly, better or worse; having an easy time or having a difficult time; deciding to stop; and pregnancy and its consequences.

Women and their partners could use a method correctly or incorrectly. Aspects of incorrect use were intermittent or partial use of a method or the

method not working properly. A method might not be used every time or a condom might break. Jane explained:

My boyfriend and I at the time, a different boyfriend than I have now and we'd been like having our worst fight ever and we were traveling in Japan actually. And, you know, he's like leaving me. And then all of a sudden we made up and we had sex and make-up sex type thing. And he ejaculated in me. And I wasn't thinking whatsoever, you know, at the time, being very emotional. But very soon after, like the same day, I realized, "Oh my God, I think I'm ovulating today." And it did turn out that I got pregnant.

A woman might not take pills correctly. Eleanor forgot to take the pill:

A lot of times. It was a problem that now I'm not really the ninety-nine point nine safe anymore. And, regardless, I was still having sex and now we're not using the condoms because I'm supposed to be on the pill and was half-ass, but I was [laughing]. So that did turn into a problem eventually, 'cause I did get pregnant, I think, because of my lack of diligence to take the pill on a daily basis.

Women might only use a partial component of natural family planning. Jane used withdrawal and allowed her partner to ejaculate inside her "only when I'm actually on my period... I know that there's other things you need to do but I don't do them."

Some women talked about using a method better with time; however others talked about not using a method as well with time. Cassie reviewed her experience taking oral contraceptives:

From the beginning to the end, I think now I use it better. Because back in the olden days I wouldn't take it always the same time so it was kind of iffy and there was a time when I didn't (take it)... I'm a more effective user now. Yeah. Definitely.

Eva explained a different experience with oral contraceptives:

At first I think I was so nervous that it would actually work that I made sure it was like, I brush my teeth and I took it. At first, it wasn't a problem at all, because I was so nervous that I didn't think it would really work. And then, I started getting slack about it or later on, maybe a year or two or so, I would forget and then take two or something and got lazy, I think. Or we'd go on a trip and I'd forget to take it with me. So at first it wasn't hard, just because I was so scared.

Women could have an easy time or a difficult time with a method; some women never had a difficult time with contraceptive use while others frequently had problems. In Teresita's experience, "It was always easy. The condoms were readily available, the birth control pill was cheap enough." Eva had a similar experience: "I was pretty lucky to have a nurse at our University that was super into promoting it. And I think I was also taking those classes. So I don't know what would've made it easier." Other women, like Maile, had much more

difficulty, such as problems with method failure, access problems, and more troublesome side effects.

Deciding to stop using a contraceptive method may occur if a woman decides to use a new method, if she believes she no longer at risk for pregnancy or if she desires to get pregnant. Angela, who is 47, had her IUD removed last year and is still having periods. She is not using any method because she feels she has a low risk of pregnancy.

Pregnancy and its consequences can be an outcome of contending with method use and access. Some women in this study reported unintended pregnancies. Some women were having problems using contraception consistently and got pregnant; others who believed they were using it correctly became pregnant. Some of these unintended pregnancies ended in abortion.

In summary, analyzing the data with a grounded theory approach identified the core category for women's process of contraceptive decision-making as "Finding the best fit". There were three major categories of "becoming aware", "weighing what's best for me", and "navigating a course". The data was also analyzed from a feminist perspective to identify power differentials that impact how women make decisions about birth control.

Feminist Concerns

Power differentials in contraceptive decision making were evident in this study between women and men, between women and health care providers, and particularly for young women as they negotiate finding their own voice, whether it be their interaction with parents or with society, in general.

Women recognized the difference in their responsibility versus their partner's. Gloria described the difference:

And that it's just as much the male's responsibility... So that's when I became so aware of the fact that "wow, it's not just all on the women, you know, it's on the man too." And it's so not pronounced in our society. It's starting to be now but so often, especially I think when you're younger, the men expect the women to be taking care of it... I think that it's really important that men realize that it's half their responsibility. Shouldn't be all on the women.

Gloria and Celeste expressed that part of this difference was that women were more fearful of pregnancy than men. Gloria shared:

Well I think a lot of times or sometimes the partners that were using condoms were a lot of times more thinking about not spreading a disease than getting pregnant it seems like whereas my decision to use it all was for both reasons.

Celeste expressed, "I think it goes still back to that fear of being pregnant. I think the females are more, well, I was more afraid of it than they were, I think."

Eleanor described a reverse situation than the usual that she would like to see happen.

I would want him to have his operation. Is that reversible [laughing]? And then he can worry about it when he wants it reversed instead of being on me without it having to affect me like a condom would. So I want you to do what you need to do where I don't have to be affected by it.

When the research findings were shared at the member check meeting, Sheri replied:

It would be interesting to see like asking a bunch of men the same (questions). It would be a lot shorter, I know. I was having a conversation with my uncle last night. He compared humans with lions and the lioness does the hunting, she takes cares of the kids and you know she's doing all the work and all the men do is look big and protect. And I'm like "that's exactly what it is, that women do have to bear the responsibility to make sure everybody gets fed, even the father, that is a big responsibility".

Even if there was a birth control for men, I'd almost want to take birth control too because you don't know how responsible they're going to be about it.

Maile's experience with being unable to get a tubal ligation at age twenty-five demonstrates that medical control over access to methods was evident in this study. Medical control was also evident by the control health care insurance companies have over access to methods. As Eleanor stated when talking about access to vasectomy for her and her partner, "But then it's always up to the insurance company and what insurance plan do you have...because they dictate health care."

Women, when younger, seemed to have different experiences based upon the support they received, particularly from mothers. Women who did have support seemed more empowered while women who didn't have support, or had to keep contraceptive use a secret, felt they had limited options. Cassie and

Teresita shared their experiences as teenagers. Cassie explained, “My mom and I had a very open relationship and, since we real young, my sister and I were free to ask kinds of questions about anything and we always got honest answers. And, so she pretty much gave us our options.” In contrast, Teresita said, “I don’t think I felt like I had access to anything besides condoms because my mom didn’t know that I was having sex.” Young women who have support are shown the way while women who didn’t have help have to find their own way. Leilani was living on her own as a sophomore in high school. “I was on my own, basically. I didn’t have parental support, so I didn’t feel financially I could have a child. So I knew I needed to do something because I didn’t want to be pregnant in high school. I paid rent during high school. I couldn’t afford a kid.” Later in the interview she stated, “I didn’t really know about those things, what the different types of contraceptives were when I was younger.”

Model Description

The model of the process of contraceptive decision-making in women is depicted in Figure 1. The trigger in the initial process is “becoming aware” represented by the arrow to the left of “becoming aware”. Women may then move to “weighing what’s best for me” (for example by comparing different methods) or to “navigating a course” (for example, seeking out resources for a method before choosing).

Later decisions may be initiated by any category. For example, a woman who is using birth control pills sees an advertisement for the transdermal patch (becomes aware). She thinks this may be an easier method for her (weighing).

She may either move to becoming aware to learn more about the patch or to navigating a course to try to obtain the method at low-cost. Or a woman may develop side effects on the birth control pill and initially try to change pill types to resolve the problem (navigating). Then she may decide that it's no longer working for her (weighing). This may cause her to seek information about new methods out there or she may revert back to a method previously used without seeking new information.

Another woman may develop religious convictions that cause her to reevaluate the method she is currently using (weighing). She may try to learn about natural family planning to see if it would work for her or revert to a method previously used such as withdrawal. Thus, the process can become dynamic at any point in time and, once begun, at any point in the model.

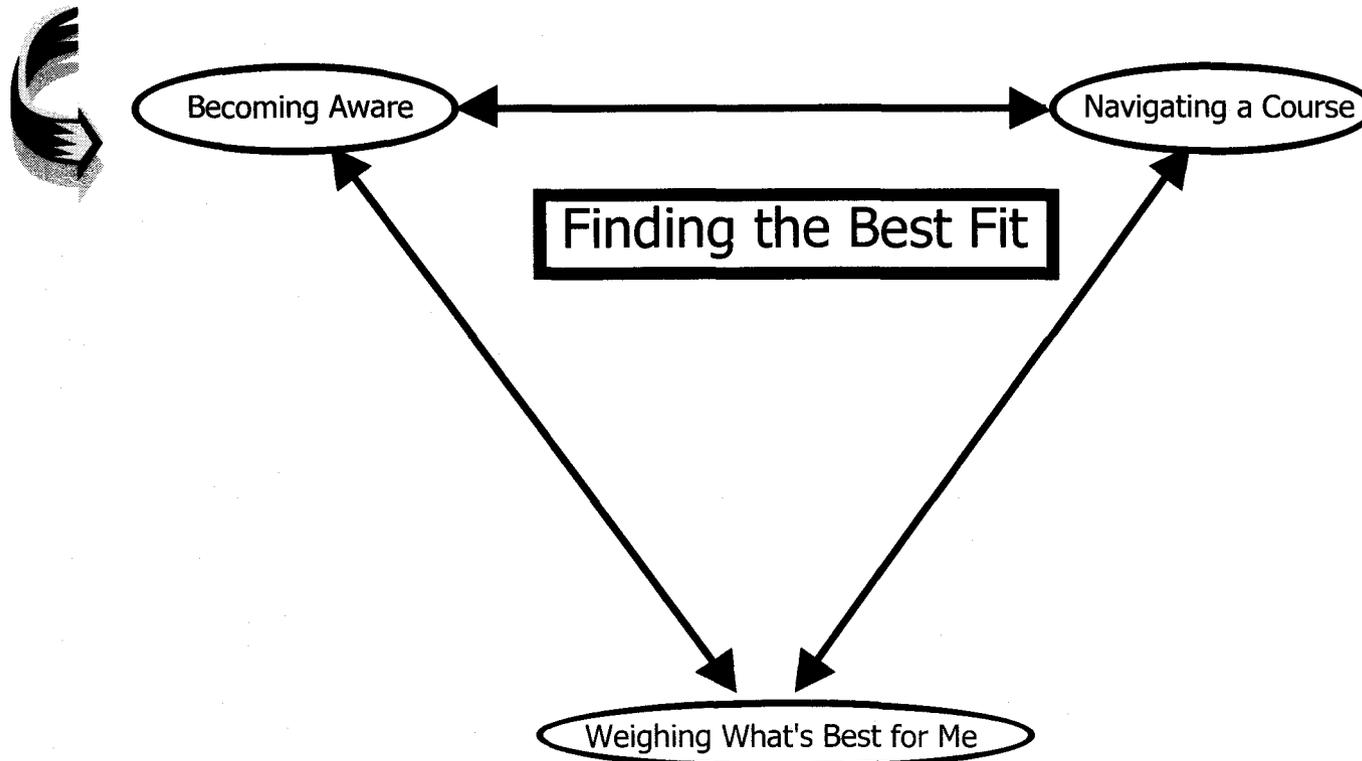
Summary

This chapter presented the results of data analysis of interviews with sixteen women about how they made decisions about birth control. The core category, Finding the Best Fit, was identified with three major categories: Becoming aware, Weighing what's best for me, and Navigating a course. Causal conditions, context, intervening conditions, action/interactional conditions, and consequences were delineated for each major category and were supported with direct quotes from the interviews. The data was also analyzed with a feminist perspective to identify possible power differentials within society that may affect contraceptive decision-making in women.

Figure 1

Model Description

The Process of Contraceptive Decision-Making in Women



Chapter 5. Conclusions

This chapter reviews the findings of this study in light of the literature review of contraception and decision-making, current feminist perspectives, and the conceptual orientation of symbolic interaction theory. Limitations of this study are discussed as well as implications for nursing practice and recommendations for future research.

Relationship of Results to Literature Review

Contraception

The contraceptive themes apparent in the literature review on contraception were found to varying degrees in this study. The method properties delineated in the literature review were all found in this study. Women weighed issues such as effectiveness, ease of use and access, lack of interference with lifestyle (particularly sexual activity), side effects, and additional benefits in considering a method. Safety issues, particularly severe side effects, long-term and unknown health effects were a concern for most women interviewed. Although duration of method was not a strong influence in this study, it was a factor some women used when evaluating a method.

External influences discussed in the literature review were also seen in this study but varied in individual situations. For example, a strong influence found in the literature review was the health care provider. However, in some women's experience the health care provider had little influence in their decisions about birth control. Some external influences were directly seen, such as the influence of family, friends, media and educational classes, while others, such as

medicalization, political influence, and the influence of neighbors were indirectly attributed from women's stories. The influence of culture and religion seemed more of an influence on the impact of an unintended pregnancy than on the issue of contraceptive decision-making itself.

All relationship dynamics, except male health problems, were found in the study. Similar to provider influence, partner influence on contraceptive decision-making varied in individual situations. For some women, partners had a great deal of influence in decisions while, for others, partners had little or no influence.

Personal characteristics as an influence on contraceptive decision-making were also evident in this study. Women's perceptions of methods seemed a much stronger influence in this study than has been discussed in the literature. The influence of formal educational level was not fully delineated in this study but women seemed quite influenced by their informal level of knowledge about contraceptive methods.

Themes identified in the literature review seemed more to focus on the "what" rather than the "how" of contraceptive decision-making. Specific influences that impacted women's decisions were identified in the literature but this study added the dimensions of how women become aware and the area of support for their knowledge and decisions that were not readily apparent from the literature.

In summary, most themes from the literature review on contraceptive decision-making were found in this study. However, this study identified that certain themes, such as partner and provider influence, are very individualized to

the degree they play in each woman's situation. Other themes, such as perceptions, were more visibly apparent than appeared in the literature. Major themes identified in this study, such as becoming aware and having support, were not readily obvious in the literature.

Decision Making

The results of this study added to current knowledge of how women make decisions about contraception. The results support the naturalistic and gender-based decision-making models, which posit that decisions are made within a dynamic personal and external context. This study demonstrates that women's decisions are complex, multidimensional and individualized. Women may spend minimal to extensive amounts of time and effort in each of the categories of contraceptive decision-making identified in this study.

The contraceptive decision-making process identified in this study had similarities to many of the studies that recognized personal preferences and one's past experience as themes in decision-making. The range of desired role preference as identified by Degner and Sloan (1992) was not found in this study. Women either played an active or collaborative role in contraceptive decision-making. Passive decision-making (having the provider make the decision) was not found in this study. However, this study differed from most studies that looked at role preference in that illness was not a part of the decision-making context and contraception is both within and outside medical control.

A corollary of role preference is women's ways of knowing as described by Belenky, Clinchy, Goldberger, & Tarule (1986). There was little evidence in this

study of silent women, who depended on external authority for direction. There was evidence of women using received knowledge from others to make decisions, women as subjective knowers who made their own decisions despite potential contrary information and advice and connected knowers, who integrate others' knowledge with their own to make decisions. It was also apparent that women may change their way of knowing or decision-making with time and experience. Most women, in comparing how they made decisions now with how they made them in the past, talked about how they would investigate more and felt they now had more available options and resources.

In comparing this study's results to the literature on the use of heuristics, the influence of personal preferences, particularly the perception of some methods as "foreign" or "weird". These perceptions were subjective and perhaps simplified decision-making by eliminating those methods more easily as choices. Some women had difficulty describing why they perceived such methods in that manner.

Other variables that influenced decision-making, such as cost and availability of resources, were clearly factors in this study. The role of cultural influence was less clear. The issue of locus of control was identified in this study as an influence; women discussed both an internal locus of control and control from their partner, parents, the health care system, and society. Personality characteristics as influences in contraceptive decision-making were not clearly delineated in this study.

In summary, the findings in this study supported naturalistic and gender-based decision-making models that identify decision-making as occurring within a dynamic personal and external context. Patterns of contraceptive decision-making in women are complex, individualized, and change with time and experience.

Feminism

In this study, power differentials in contraceptive decision-making were evident related to gender and class distinctions. Women overwhelmingly bear the responsibility for and labor of contraceptive use as compared with men. They also bear the ultimate responsibility when contraceptive failure occurs, that of needing to deal with an unintended pregnancy.

The issue of medical control over certain aspects of contraception was also seen in this study with access denied to some women because of age or ability to pay. Medical control was not only applied by providers but by insurance companies as well.

Using women's experience as the framework for this study helped to make apparent issues and concerns that may not be readily obvious to health care providers in their daily practice. Some women in this study rarely interacted with the health care system for their contraceptive needs. It can be extrapolated then that there may be many women who do not access health care providers for contraception. The concerns women in this study expressed about long-term or unknown health effects of certain contraceptives as well as different perceptions, such as foreignness or weirdness that women expressed, may not be the

concerns and issues health care providers hear in their practice. For example, a recent monograph of a symposium called *Individualizing Contraception: Integrating Lifestyles with Contraceptive Options* (Freeman, n.d.) focused overwhelmingly on Depo-Provera®. The only options discussed in this monograph were hormonal contraceptives. Health care providers seem to be focused on only a section of women's contraceptive experiences.

In summary, interpretation of the data with a feminist perspective provided additional information that would not have been apparent with solely a grounded theory analysis. Use of a feminist lens was helpful in identifying gender and class power differentials and exploring women's experiences with contraceptive decision-making that is far broader than current medical and nursing practice.

Relationship of Results to Conceptual Orientation

Use of symbolic interaction theory as the conceptual orientation for this study seems well suited to the results. Taking Blumer's three premises of symbolic interaction theory (Blumer, 1969), one can readily see how this can be applied to examples from the interviews. The first premise states that people ascribe meaning to events and act on them in a certain way as a result. Women definitely attributed meanings to events surrounding preventing pregnancy and acted on them; for example, a pregnancy scare, an unintended pregnancy or an abortion were interpreted by most women to be avoided causing them to act in using a method better or choosing a more effective method. Women also ascribed meanings to certain forms of birth control such as convenience or weirdness. Women ascribed different meanings to different situations. For

example, some women liked not having their menstrual period while on Depo-Provera® while that was the reason why some women eliminated it as a choice or stopped using it.

The second premise, that meanings arise out of an interactive, social process, was also evident, particularly by the category "Becoming aware". Women learned from and were influenced by interacting with partners, other women, and health care providers. Text, as a form of social interaction, was also utilized in various reading materials women used to become aware.

The third premise, that the person interprets and modifies the meanings and redefines them over time, was also apparent. For example, some women talked about advice from other people about a method but decided not to take the advice offered. Other women talked about reconsidering a method previously eliminated because of other influences.

Thus, through the lens of symbolic interaction theory, one can see that the process of contraceptive decision-making in women is a dynamic process. The value of symbolic interaction theory in understanding how women make decisions about preventing pregnancy is to identify the meanings women use to define and interpret contraception.

Limitations of Study

One limitation of this study is that women were asked to recall events that, for some, could have occurred thirty years before. This may have been the first time that women thought about how they made decisions. As Laura, age 48, stated, "I haven't thought about this for a really long time". Eva explained, "It's

cool how many decisions you actually make and you don't realize you're making them or why you're making them [laughing]. I...just never really thought about it.” Some women expressed difficulty remembering or were unsure of events or the sequence of events. For example, initially Jane could not remember how or why she chose the diaphragm. Then, she recalled it being because she had a pregnancy scare and talked vividly about going to the clinic and seeing the sperm under the microscope and how fearful of pregnancy she was. Perhaps other women could have forgotten such meaningful events. This may have impacted the accuracy of findings.

Another limitation of this analysis is that it was conducted in a relatively geographically isolated place, on the island of Kauai. Although many of the women interviewed had lived as adults on the mainland and on other islands, the experience of living on Kauai may have a specific influence on how these women made decisions about contraception.

A third limitation of this study was that the women interviewed were generally well-educated. All of the women interviewed had completed high school and most had some college as compared to the population of Kauai, which has 83.2% of the population age 25 or older who completed high school (Hawaii Census 2000). However, information about these women's decision-making patterns before completion of high school and attendance at college was incorporated into this study. Although the literature is unclear regarding the effects of education on contraceptive decision-making, lack of women with less than a high school education as participants may have influenced the findings.

Implications for Nursing Practice

Based on the findings of this study, it is important to obtain a thorough contraceptive history for women, with attention to their positive and negative experiences with methods previously used. In addition, it would be helpful to find out which methods, at this particular point in time, the woman would and would not consider using.

It is important for health care providers to realize that women may have different perceptions of methods. These should be explored since inaccuracies can be addressed and providers can have an understanding of the basis for decisions. Providers should also be aware that there are some women who have concerns about the health effects of methods. While providing current scientific information may alleviate some of these concerns, providers should also explore becoming more knowledgeable in counseling women on methods such as natural family planning.

It is also recommended that providers identify their biases, not only about methods, but also about client-provider relations, to determine if there is an impact on offering or withholding services to women. Creating a practice that not only offers a wide range of methods but empowers women to make decisions and access their chosen methods is recommended.

Another implication from this study is that women learn about preventing pregnancy in a variety of ways. In response, providers should offer a wide range of educational materials. For example, since younger women learn more from each other, multiple copies of educational material could be given to a young

client so that she may share that information with her friends. Creating partnerships with community and educational settings to provide information on birth control may better assist women in becoming aware. For example, a nurse may be utilized to do outreach to high schools. Since so many of the women had experience teaching other women about birth control, women can be recruited to teach other women in their community. A parent self-help group can be created to discuss with parents how to talk to their children about sex and birth control.

Access to certain methods is limited for some women by the cost of the method. Providers need to address this issue by creating partnerships with agencies that offer low-cost methods, such as purchasing through a consortium, and lobbying at a state level to ensure that insurance companies reimburse for a wide range of methods. Providers should continue to explore ways to influence the political process and economic decision-making of the health care system, particularly advocating for those women who are not low-income but do not have health insurance.

Recommendations for Future Research

It is recommended that the category of “becoming aware” be further explored through interviews with teens and young women, focusing on the issue of how support is given. Another aspect of this recommendation would be to interview parents to illuminate the ways that they have had success and failure in dealing with talking with their children about sexuality and birth control. This knowledge can then be used to develop models of how to help parents talk to

and offer support to their children about birth control, which can be implemented and tested.

Creating or adapting models that provide support to women, particularly young women, in assisting them to learn about and access methods to prevent pregnancy would be a further recommendation for future research. For example, successful models, such as the Malama program, have been created using community partnerships to improve perinatal services (Affonso, Korenbrot, De, and Mayberry, 1999). Adapting such a model to preventing pregnancy may be helpful to women as they move through the process of contraceptive decision-making.

Knowledge also needs to be further developed regarding the perceptions some women have about the invasiveness or foreignness of a birth control method. The effects of these perceptions on decision-making, what may stimulate a change in these perceptions, and interventions regarding reframing these perceptions may be helpful.

Since this sample was fairly well educated, it is recommended that this study be repeated in women of different educational backgrounds. This may help to further illuminate the role of formal education in contraceptive decision-making.

A difference in men and women's decision-making seemed apparent from the interviews. This difference needs to be further explored. How men make decisions about birth control and how this differs from women's patterns of decision-making is another area for further research.

The continual introduction of new contraceptive methods impacts the process of contraceptive decision-making in women. The birth control transdermal patch and vaginal ring have just been introduced. A new method of natural family planning called the Standard Days Method™ (Arévalo, Jennings, and Sinai, 2002) has been developed. It is unknown how these and other potential new methods may influence how women make decisions about birth control. It was also evident that younger women generally had more support than their older counterparts. If this trend continues, the impact on the process of contraceptive decision-making in women is unknown. Therefore, it is recommended that this research study be repeated in five to ten years.

These recommendations will add to and update knowledge on the process of contraceptive decision-making in women. In addition, they will begin to explore this process in men and illuminate differences.

Summary

Themes found in the literature review related to contraception were also found in varying degrees in this study. Provider and partner influences in contraceptive decision-making in women varied according to an individual woman's situation. Results of this study less evident in the literature were women's perception and how women made decisions about birth control, such as becoming aware and having support.

Many of the themes from the literature review on decision-making were found in this study. This study identified the complexity and individualized nature

of women's contraceptive decisions. The results demonstrate that contraceptive decisions occur within a personal and external context.

Applying a feminist lens to data analysis in this study helped to identify gender and class power differentials. Power differentials between women and health care providers were also apparent. Placing women's experiences with contraceptive decision-making at the center of this study made it clear that women have a wide range of experiences, perceptions and concerns of which providers may not be aware.

The use of symbolic interaction theory in serving as the conceptual orientation seemed particularly appropriate to this study. The results reflected and supported the underlying premises of symbolic interaction theory. Women attached meanings and definitions to issues surrounding preventing pregnancy based upon their interactions with others. They interpreted and re-evaluated situations and acted on them as a result.

Limitations of this study included that some women had difficulty remembering events surrounding decisions about contraceptive decision-making. Another limitation was that living on a somewhat geographically-isolated place may impact how decisions were made in this sample. A final limitation was that the women in this study were generally well-educated.

Implications for nursing practice identified from this study were that providers should conduct a thorough contraceptive history and that they should identify perceptions about methods that a woman has. Providers should also identify personal and clinical practice biases. Lastly, providers should offer a

variety of educational materials and explore ways to link with community, educational and political agencies to offer educational programs and increase access to services for birth control.

Recommendations for future research include further knowledge development in the areas of becoming aware, having support, and women's perceptions of methods. Other recommendations are to extend this study to women of different educational backgrounds and in men as well, compare differences in how men and women make decisions about birth control and repeat the study to update knowledge about contraceptive decision-making in women.

Appendix A

Research Contact Form

Name: _____ Phone: _____

Date of First Contact: _____

Recruited by: _____

Meets Inclusion Criteria	Yes	No
Eighteen or older		
Speaks English		
Has used 2 or more contraceptive methods		
Has not reached menopause		
Has used a contraceptive method within last year		
Has not used sterilization longer than one year		

Date of interview: _____ Code #: _____

Consent on file: Yes No Received incentive: Yes No Attended member check: Yes No

Appendix B

Recruitment Information

Electronic Mail and Flier

Please Contribute to Health Care Knowledge About Preventing Pregnancy

Aloha, my name is Joanne Noone and I am attending the University of Hawaii to get my PhD in nursing. I have lived on Kauai for 15 years and teach nursing at Kauai Community College. I am also a family nurse practitioner and practice at the college's Wellness Center.

My area of study is how women make decisions about preventing pregnancy. I am looking for women who are interested in talking to me about their experiences with preventing pregnancy.

If you are:

- 18 or older and have not reached menopause (change of life)
- English-speaking
- Have used at least two different ways to prevent pregnancy
- Have used a way to prevent pregnancy within the last year
- If using sterilization as a way to prevent pregnancy, have used it for less than one year

please call 652-1200 (or respond to this email) for further information.

Interviews will be conducted in private and will last about 45-90 minutes.

You will receive \$25.00 for participating.

Television and Newspaper Advertisement

Please Contribute to Health Care Knowledge About Preventing Pregnancy

A nurse researcher on Kauai is interested in talking to women about their experiences with preventing pregnancy. Interviews will be conducted in private and will last about 45-90 minutes. You will receive \$25.00 for participating.

Please call 652-1200 for further information and to see if you qualify.

Appendix C

Consent Form

*Agreement to Participate in The Process
of Contraceptive Decision Making in Women*

Principle Investigator: Joanne Noone, 3-1901 Kaumualii Highway, Lihue, HI
96766 652-1200

1. The purpose of this research is to gain an understanding of how women make decisions about preventing pregnancy. You will be interviewed for approximately 60 to 90 minutes to discuss how you made decisions about preventing pregnancy. With your permission, the interview will be audio-taped and written out. A second interview of 30 to 45 minutes will occur to allow you to confirm the correctness of how the first interview was interpreted.
2. Potential risks to you in participating in this study are 1) the invasion into privacy and 2) the risk of embarrassment in discussing sexual information.
3. You will be assigned a code number known only to Joanne Noone. What you say will be kept confidential, to the extent allowed by law. Your name will not be used. Tapes will be stored in a locked file cabinet and erased after the study is completed. Since this interview may involve a discussion of sex, there is the possibility of embarrassment during the interview. You are free to stop the interview or skip a question at any time with no consequences.

4. Although you may not receive any direct benefit, you will contribute to the understanding of how women make decisions about preventing pregnancy.
5. Information obtained from this study will be included in a dissertation written by Joanne Noone. If you have any questions about this research, please contact Joanne at 652-1200. This may be used in future research, publications and presentations by her. Your name will not be used in any publication or presentation. You will be given a chance to see the results of this study.
6. I certify that I have read this agreement and that I understand what it says. I have been given satisfactory answers to my questions concerning this study. I have been told that I am free to stop participating in this study at any time with no consequences.
7. With this, I give my consent to participate with the understanding that such consent does not give up any of my legal rights. My consent also does not release Joanne Noone or the University of Hawaii or any associated employee or agent from responsibility for negligence.

Signature:

_____ Date: _____

Signature of individual participant

(If you cannot obtain satisfactory answers to your questions or complaints about your treatment in this study, contact: Committee on Human Studies, University of Hawaii, 2540 Maile Way, Honolulu, Hawaii, 96822. Phone: (808) 956-5007).

c: Signed copy to participant

Appendix D

Semi-Structured Interview Guide

1. How old are you?
2. Are you?
 - _____ Hawaiian/Part Hawaiian
 - _____ Japanese
 - _____ Filipino
 - _____ Mixed/Non Hawaiian
 - _____ Caucasian
 - _____ Other, please describe _____
3. Highest grade completed: _____
4. Describe what you think would be the ideal way to prevent pregnancy?
Some people call it birth control, contraception or family planning.
5. How/where did you first become aware of ways to prevent pregnancy?
Did you learn about it in school? Within the family? From your friends?
In the community?
6. Were you aware of what other women did to prevent pregnancy, like your mother, sisters, aunts, friends or other women in your neighborhood?
7. Please tell me about your experiences with preventing pregnancy starting with your first experience.
 - a. What made you decide to choose this way?
 - b. Who helped you with that decision?
 - c. What sort of a relationship were you in at the time?

- d. How did you go about finding that help?
 - e. Did you use any other sources of information, such as books, magazines, or the internet?
 - f. What was happening in your life at that time that may have influenced your decision?
 - g. Can you think of any financial concerns that may have influenced your decision? Did you have access to health insurance or a clinic that helped with costs?
 - h. If you stopped using that way to prevent pregnancy, what were the reasons?
 - i. Please tell me about your experiences with other ways to prevent pregnancy (asking a through e again).
8. Please tell me about the ways to prevent pregnancy you thought about using and then decided not to?
- a. What made you decide against using them?
 - b. Where did you get the information that helped you with your decision?
9. Tell me about a time when you decided on a way to prevent pregnancy and then found that it wasn't available to you. Why wasn't it available?
10. Which way of preventing pregnancy have you learned about and knew you would never consider using? What made you decide against it?
11. How do you think your decisions about ways to prevent pregnancy have been influenced:

- a. by different partners?
 - b. by friends and family members?
 - c. by health care providers?
 - d. by the availability of health care services or insurance coverage?
 - e. as you got older?
 - f. with your experience with using different methods?
 - g. by the costs for the method?
 - h. by the media? For example, books? Magazines? TV? Ads? the internet?
 - i. by your fear of getting pregnant?
12. How do you think that the way you made decisions about not getting pregnant were different from your partner(s)' decisions? Has your partner ever been non-supportive of your choice of a method?
13. Looking back at your experiences with using different ways of not getting pregnant, what would have made those experiences or decisions easier for you?
14. If you had to choose a new way to prevent pregnancy, how do you think you will go about choosing?
- a. What method(s) might you consider? Why?
 - b. Who would you seek out for information and help?
 - c. What other sources of information would you use?
 - d. How much influence would your partner have on the decision?
Your friends or family? Your health care provider?

- e. How do you think your deciding on a new way would be different from your past decisions?
15. How do you think your beliefs have influenced your decisions about birth control? Beliefs such as cultural? Religious? Beliefs about your body? Beliefs about birth control?
16. If you had to choose one thing, what has had the most influence on how you have made decisions about preventing pregnancy? Why?
17. What advice would you give to someone who doesn't want to get pregnant and is deciding on a way to prevent pregnancy?
18. Is there anything else about your decisions about birth control that you think is important?
19. Other: related questions to help participants to expand on their comments.

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