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## The role of the social network in contraceptive decision-making among young, African American and Latina women

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### Abstract

**Purpose**—Understanding reasons for contraception decisions is critical to improving our ability to reduce rates of unintended pregnancies. We used an in-depth qualitative approach to examine the contraceptive decision-making process, with special attention to the role of the social network, among a group of young, postpartum urban minority women.

**Methods**—Brief surveys and semi-structured interviews were conducted with 30 consenting postpartum women. In-person one-on-one interviews were then reviewed for themes using an iterative process. Qualitative analysis techniques identifying emergent themes were applied to interview data.

**Results**—In this cohort of African American (63%) and Hispanic (37%) women (median age 26), 73% had unplanned pregnancies. The social network, including friends, mothers, and partners, were key sources of contraception myths, misconceptions, and vicarious experiences. Women also utilized media, including the internet, as an additional source of information. Information relayed by the social network had a direct influence on contraceptive decisions for many women.

**Conclusions**—The experiences and opinions of the social network influence contraceptive decisions in this population of young, minority women. The social network, including friends, family members, and media sources, are a key source of contraceptive information for many women. Comprehensive contraception counseling should explore the experiences and opinions of the patient's social network to the extent possible.

### Keywords

contraception; social network; qualitative analysis; contraception misconceptions and myths

## INTRODUCTION

In the United States, as many as 49% of pregnancies are unintended, with a significant proportion of unintended pregnancies ending in abortion. There has only been a small long-term decline in the abortion rate from the 1990s through 2005 [1,2,3]. Consistent use of contraception can significantly reduce the likelihood of unintended pregnancy, yet many women experience gaps in contraceptive use even during times in which they are sexually active [4]. Understanding reasons for contraceptive non-use and facilitating women's knowledge and use of family planning methods is critical to improving comprehensive women's health care.

Literature suggests factors for contraceptive nonuse or gaps in use while remaining at risk for unintended pregnancy which include: ambivalence about avoiding pregnancy; less than a college education; being black; being older; infrequent sexual intercourse; not in a current relationship; dissatisfaction with a contraceptive method; and beliefs that health care providers are unavailable for questions [4]. Additional literature suggests that the degree of motivation to avoid pregnancy has been shown to be related to women's ability to contracept effectively [4,5,6]. In a New Zealand qualitative study of adolescent mothers and in the National Longitudinal Study of Adolescent Health, indifference to the possibility of pregnancy and perceived invulnerability to pregnancy were barriers to contraceptive use [7,8]. Further, qualitative work has shown that misinformation, misconceptions about side effects, and fear of health consequences to be additional obstacles to consistent and effective contraceptive use [9]. Misinformation and misconceptions, importantly, are often transmitted via a woman's social network [9]. Improving our understanding of the role of social network-propagated knowledge in contraceptive decision-making may help reduce this risk of unintended pregnancy.

Young women commonly rely upon advice about contraceptive methods from family and their social network. On the basis of this network, women make their decisions with information about contraceptive effectiveness, side effects, safety, or use instructions [9]. The vicarious experiences of the social network are often highly valued sources of information and misinformation. Myths, such as those about hormonal contraceptive methods causing birth defects, stunting growth of teenagers, or causing infertility, may influence decisions [10,11]. Attitudes of and information from one's social network may be considered more reliable and convincing than information from health care providers, particularly in regards to side effects. In two qualitative studies, Latina and non-Latina women perceived their personal safety and side effect-related experiences and those experiences of their social network to be more valuable and relevant than those of medical providers [9,12].

We know little about the importance of the social network in an individual's contraceptive decision-making process. Although we know that the social network is a source of information to young women, there is little literature on how this information received from the social network affects contraceptive decisions. Thus, the purpose of this exploratory study was to apply a qualitative methodology to better understand the myths, vicarious experiences, and other social network factors that influence contraceptive decision-making among a specific population of young, urban, minority women. Using brief surveys and one-on-one semi-structured interviews to specifically explore the role of the social network, we attempt to more fully understand the complexity of the contraceptive decision-making process in an at-risk population.

## METHODS

### Participants

Thirty women in the immediate postpartum hospitalization were recruited from a large academic medical center in Chicago. All English-speaking women over 18 years of age who had attended the women's outpatient ambulatory care clinic for antenatal care and who delivered at this hospital were eligible for participation. This clinic serves a group of low-income women who receive Public Aid assistance and are cared for by the residents in the Department of Obstetrics and Gynecology at this medical center. In this clinic, over 90% of patients are English-speaking and over age 18, so the inclusion criteria included a majority of women receiving care. Patients were primiparous or multiparous.

Recruitment was conducted as a non-probability convenience sample of the women who attended this clinic, were currently hospital inpatients on the postpartum unit and who fit the inclusion criteria. Women were approached by the study team during their hospital stay, and participants received a \$10 gift certificate to a local grocery store upon completion.

Between December 2007 and February 2008, 39 patients were approached. Nine patients approached declined participation (23%); reasons included feeling ill, having too many guests, not liking surveys, or no interest. Ultimately 30 women participated in the study. Sample size was determined based on the goal of saturation in qualitative research, in which the data collected captures the range of experiences and variation in responses in a population. Each interview was transcribed immediately after it was conducted. Groups of three to five interviews were reviewed as the study progressed to iteratively code common themes and to examine if saturation of themes had been achieved. By the time 30 interviews had been collected and reviewed through this iterative process, all members of the study team agreed that data saturation of the themes of interest was achieved. All participants provided written informed consent. This study was approved by the Institutional Review Board of Northwestern University.

### Procedures

Two methods of data collection were used. First, to identify demographic and obstetric data and to quantitatively assess contraceptive use history, patients completed a short survey. The survey consisted of eight demographic questions regarding age, parity, education, ethnicity, and relationship status, as well as six items about contraceptive use history. For this research question on the role of the social network, only the demographic data and two contraceptive use history questions (regarding use of contraception at the time of this conception and pregnancy intendedness) were utilized. Participants then participated in a semi-structured, face-to-face, interview. A single member of the research team with prior interviewing experience conducted all interviews. Interviews lasted approximately 30 to 45 minutes. Women were asked about their obstetric and contraceptive-use history, attitudes towards contraceptive methods and the role of social network influences on contraception decisions. Interviews were conducted privately in patient rooms, and participants were encouraged to speak freely about their opinions. Participants were informed that: there were no right or wrong answers; answers would not affect their medical care; and that they were free to not answer any questions.

### Data Analyses

Interviews were recorded using a digital audio recorder. Sessions were transcribed verbatim by the investigative team immediately after interview completion. Informal analysis of themes from early interview transcripts informed later data collection; we performed an iterative process of interviewing and reviewing the interview responses until saturation took place. Early review of interview responses allowed for clarification of themes during later interviews.

Responses to survey questions were analyzed using simple descriptive statistics using SPSS (Chicago, IL) software. Qualitative data analysis, including coding, data management, and text retrieval, were conducted using NVivo (a qualitative data analysis software program). Formal data coding was conducted by both investigators to organize the data by themes; themes were not pre-developed, but rather emerged during the exploration of interview data. NVivo software was utilized to electronically organize coded data. Coded transcripts were reviewed and discussed by both authors for agreement; discussion between investigators was utilized to resolve inconsistencies of interpretation. Emergent themes were then identified using illustrative quotations and descriptive statistics.

## DEMOGRAPHIC DATA

Thirty patients were interviewed during the immediate postpartum period. Median age was 26 (range 19–35); mean age was 26.6. Table 1 describes population demographic characteristics. [TABLE 1] Mean and median gravidity among participants were 3.07 and 2.0, respectively. Mean and median parity were 2.17 and 2.0, respectively. Nine (30%) participants were primigravid, whereas 14 (46.6%) had experienced two to four pregnancies and seven (23.3%) had experienced five or more pregnancies. Nine (30%) had experienced one or more elective abortions. Twenty-three women (77%) did not use contraception at the time of conception, and twenty-two (73.3%) reported that this pregnancy was unplanned. Thirty (100%) desired postpartum contraception: intrauterine contraception (IUC) (10), sterilization (6), oral contraceptive pills (OCs) (8), DepoProvera® (3), condoms (3).<sup>1</sup>

## QUALITATIVE RESULTS

Women in this study discussed both individuals and media sources that helped them with their contraceptive decision-making. In analyzing interview data, three major themes emerged. First, women strongly considered individuals in their social network to be important sources of experiences and information. Here, we use the phrase “vicarious experiences” in the same manner as used by Guendelman et al to describe the stories of close friends and family, whose experiences were often valued as if they were a woman’s own [12]. Second, although some information relayed by the social network was informative and accurate, women also heard myths about contraception via their network; some of these myths will be discussed below. Third, media played an additional frequent source of information for these young women.

### Role of the social network

Individuals within a woman’s social network were important source of contraception information and vicarious experiences. The opinions of friends, mothers, and sisters were considered more valuable or more “true” than the recommendations of clinicians, who were considered impartial bearers of information without personal experience. Fourteen women cited friends or extended family as valuable resources, particularly when, as one described it, “they had the hands-on experience with birth controls.” Women liked receiving first-hand information about side effects, safety, and efficacy from “other people that actually use these things.” A 23 year-old mother of three felt:

The thing is, that it’s always better that people that do it from experience. Because they [doctors] tell you the percentage what could happen, but if you actually hear from somebody that did happen, then you realize what it [the side effects and efficacy] really is.

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<sup>1</sup>As some of these contraceptive methods were to be provided at a later date, it was not possible to assess if all women actually received their desired postpartum method.

Several women had specifically utilized or rejected a method based on their social network's opinions and experiences. A 20 year-old first time mother specifically chose IUC because:

I been asking around to some friends, a lot of my friends do the IUD. And one of my friends do a 10-year, another one do a 5-year....So I just was asking around...Then they told me that the IUD was pretty good and I looked at it compared to the other things, it was like really high [efficacy] ....And it was like, okay, I think I try that... And I got pretty positive feedback from like a lot of people about it.

Nine women in stable relationships, defined as women reporting they were married or unmarried but partnered, reported their partner as an active participant in the decision-making process. For three women, this was a matter of respecting a partner's desires regarding family size and timing, such as the 24 year-old mother of three who said "My husband's opinion definitely matters to me! Because like, I want to respect his opinion just as much as he wants me to respect his." Some partners gathered contraceptive information. One 28 year-old mother of one said, "I ask, ask him what he thinks. He reads up a lot on anything I ask him about, and he'll tell me what the side effects are or what people are getting sick from it..."

Second to partners, mothers and sisters played a key role in contraceptive decision-making. At least five women had discussed contraception extensively with their mothers, with many others involving mothers to a lesser extent; a majority felt mothers were supportive of contraceptive use. A 26 year-old mother of two felt:

My mom...I can talk to her, and you know, she kinda recommends what she thinks is best, and for the most part, it is...She's just, a lot of knowledge, and gives good pieces of advice.

Two women reported starting OCPs because, in the words of one, "My momma said 'go get the pills, the birth control pills...And then I did, because she said that.'" Others said their mothers or sisters had tried IUCs in the past and could provide personal advice. One 19 year-old first-time mother chose an IUC on her mother's recommendation because, "She liked it, and it helped her. Because she said she tried everything else and it didn't work, that's why she got my little brother." Nine women listed mothers and seven listed sisters or other family members as helpful sources of information for decisions. Some women noted that their mothers were "old-fashioned" and were only comfortable with specific methods: abstinence, OCPs, or sterilization. Two women reported mothers who told them contraception was unsafe; one was told IUC "carries blood clots" and another was told that all methods were "not safe."

In addition, we explored the differential role of the social network among different demographic groups. Because of limitations in our sample size, it is difficult to make meaningful comparisons across race/ethnicity. However, we did note that African American women were more likely to list family or partners as preferred sources of information than Hispanic women, who were more likely to utilize friends. Among the 19 African American females, seven expressed a preference to obtain contraceptive information from their partners, eight from mothers, and seven from sisters. Among the 11 Hispanic women, only two included partners as sources of information, and two specifically stated they did not utilize partners. Six of these 11 Hispanic women cited friends as resources, compared to seven of the 19 African American women. In comparing multiparous versus primiparous women, many similarities were noted; friends, sisters and mothers were equally common preferred sources of information. Notably, however, of the women who included partners as an important source of information, seven were multiparous and only two were primiparous.

## Myths and Misconceptions

Although some information provided by the social network was accurate, myths and misconceptions about contraception were frequently cited. The vicarious experiences and misconceptions of the social network largely related to efficacy, safety and side effects concerns, which were cited by our participants and in the literature as common reasons for method switching and gaps in use. These stories often played a strong role in patients' openness to a contraceptive method; women did not have to experience a method themselves in order to "buy into" the rumors and misconceptions. Table 2 demonstrates some of the misconceptions and vicarious experiences relayed by the social network. [TABLE 2]

## Other sources of information

Women reported that performing one's own research was an important supplement to the information they heard from friends and family, as in the words of the woman who said "I don't just take other people's word, I just learn on my own." Participants named multiple methods of seeking out information: reading provided information (n=15), talking to physicians (n=15), watching television commercials (n=8), and using the internet (n=20). Fifteen women spoke of reading pamphlets, handouts, magazines, or other written materials provided by trusted sources, including physicians. In assessing for ethnic differences in resources used for contraception information, six of the Hispanic women reported seeking information from health care professionals, whereas African American women were more likely to cite television and the internet. Comparison charts that evaluated multiple methods of contraception, including side effect information, were perceived to be helpful.

Twenty patients reported using the internet for contraceptive information; the privacy of the internet made it an ideal resource. Most women used standard search engines, such as Google®, to locate information. Other popular web-based resources included WebMD®, birthcontrol.com®, or websites of specific contraceptive methods (eg mirenaus.com®); one patient also used YouTube® to watch videos on IUC insertions and other procedures. Eight women had utilized television for contraceptive information; one referenced news shows about health, whereas the other seven found commercials to be helpful. One woman learned about the NuvaRing® on a commercial and stated, "That [changing every month] was convenient and easy for me. So when I saw the commercial, then I jumped on that." Another woman saw an advertisement for OrthoEvra® and used that commercial to stimulate further discussion with her physician; she ultimately chose that method after utilizing television and the internet for information. Several women (n=4) had spoken to a health care provider, looked up internet information, or called hotlines about contraceptive methods after seeing a television commercial.

## DISCUSSION

This study explores contraceptive decisions in a population of African American and Latina women in the immediate postpartum period, a majority of whom experienced an unintended pregnancy. Our data point to the complexity of contraceptive decision-making and provide new insight into the role of an individual's social network in assessing and executing family planning decisions. Although decisions about contraception are influenced by a number of factors not explored here, we gathered a rich collection of individual perspectives that support the idea of the importance of the social network in women's family planning decisions. Many of the experiences described here parallel those found by other qualitative studies of contraceptive use in low-income, minority communities [9,13]. Gilliam et al, for example, found that misinformation about contraceptive side effects in a community of young Latina women was commonly due to receipt of information from informal sources, such as friends

and family [9]. They likewise found that women felt these informal sources were more reliable than health professionals, as noted in our population.

Women described their social networks as highly influential in gathering contraceptive information and in their decision-making. Friends, mothers, and family with first-hand experience were sometimes considered more valuable resources than physicians. Physicians were felt to be reputable sources of facts but inadequate sources of personal experiences. Rumors, myths, and vicarious experiences supplied by the social network had a direct impact on contraceptive decisions for a number of women. Many women rejected an effective contraceptive method available to her entirely because of a myth relayed through her social network. The prominent myths and misconceptions were largely focused on issues of safety, efficacy, and side effects of methods. Skepticism about method efficacy, often with stories of failed contraception use, and fear of side effects, were pervasive. On the more encouraging side, however, some women chose a method specifically because of the positive experience of their friends and family. Beyond the interpersonal social network, media sources such as the internet and television provided important contraceptive information that either sparked further discussions or supplemented information received verbally. This interest in online media could perhaps be cultivated in order to connect women to reliable online resources.

From these findings, we hope to improve our understanding of how to best counsel young women seeking contraception. First, we can more clearly begin to understand the importance of directing contraceptive education and information not just toward reproductive aged teens and women, but also toward those important persons who participate in their decisions. We recommend that comprehensive contraceptive counseling explore the role of the patient's social network to the extent possible. In a typical clinical interaction, however, it is not feasible to fully analyze a patient's social network. Instead, we recommend that providers begin to address a patient's comprehension of a method's side effects and efficacy. Asking simple questions about a patient's knowledge of contraception, where she gets information, and who helps her make decisions may improve the quality of patient-centered contraception education by inviting a discussion of her social network-derived beliefs. Providers may further invite patients to bring an important member of their social network, such as a mother, sister, or best friend, to a contraceptive counseling session.

Our findings regarding the importance of the social network also highlight the need to include social network-based counseling in community education efforts. For example, it may be beneficial to consider group counseling sessions with women of similar demographic backgrounds in order to foster discussion about contraception beliefs in the community. Not only does this teach providers about common beliefs in the community, but it also provides an opportunity for accurate information to be disseminated to the group, who then are likely to relay this information to other women. Peer-led sexual health promotion interventions for adolescents can produce improvements in knowledge, attitude, and intentions [14]. We also know that adolescents who are exposed to information about desirable reproductive health behaviors among their social network, such as condom use, are more likely to engage in those behaviors themselves [15]. Thus, finding opportunities to teach accurate information in a group setting may positively affect uptake of effective contraceptive methods and may uncover rich information about the contraceptive rumors prevalent in a community.

This study had a number of limitations. Our participants were primarily Latina or African American, and thus it is impossible to make comparisons between these groups and the American population in general. Although our findings are informative regarding the practices and beliefs of the women in this population, they are not generalizable to a broader population. Second, it is difficult to fully compare the experiences of primiparous and multiparous women, as the multiparous women have had more opportunities to experience pregnancies and periods

of contraceptive use and nonuse. However, we did begin to find some differences in use of the social network between demographic groups including: African American women were more likely to list family or partners as preferred sources of information than Hispanic women, who were more likely to utilize friends; and multiparous women were more likely than primiparous women to seek advice from their partners. Further comparisons of these subgroups would be an important part of future research.

In addition, this study is a cross-sectional in design. As a result, there is no way to assess long-term outcomes or causality. For example, although we are beginning to understand that misconceptions in a social network influence contraceptive decisions, it is still not known if these myths ultimately have an effect on repeat unintended pregnancy rates. Although our study sample parallels that of other urban, low-income women seeking care at Public Aid-funded clinics, findings drawn from this single hospital with a discrete group of resident physician providers and faculty physician mentors are not generalizable to different clinical settings. However, we consider these limitations to be acceptable, as our qualitative data reached thematic saturation in this population, and one purpose of qualitative work is to generate a framework for deeper discussion in an understudied area.

Finally, we also recognize that this population of women is somewhat older than the typical adolescent or young adult population. Indeed, five women were over the age of 30, and thus not in the young adult range. However, we also know that adolescent girls and young adult women similarly use their social network for reproductive health information. Gilliam et al, for example, found that a population of minority women ages 18–26 reported strong cultural and social influences on the decision to contracept [13]. We believe that the themes that emerged regarding the importance of the social network, the myths and misconceptions propagated by the social network, and the role of media sources, are relevant to some populations of younger women. We propose that the findings explored herein undergo further investigation among a younger age group. Further, secondary pregnancy prevention is an important topic for sexually active women across a spectrum of ages; although not generalizable beyond our specific population, these findings potentially provide tools for improving the quality of counseling in a young population. However, an important part of understanding contraception decision-making in a younger population will need to include similar research with adolescent women.

Future work may apply greater quantitative study to this population in attempt to more fully understand the specific common myths and misconceptions about contraception in this community. We hope to better understand how to overcome common misconceptions in this community, and whether counseling, educational interventions, or media-based interventions could contribute to a more fact-based understanding of effective contraceptive methods. We hope that the findings that emerged in this exploratory study can ultimately be used to improve the quality of contraceptive counseling and care for women in similar communities. This work provides a preliminary rationale for implementation of provider-generated social network-related questions and discussion in the area of family planning.

Our data suggest that this population of women makes contraceptive decisions based on a number of factors, including the opinions and vicarious experiences of the social network. Myths and misconceptions communicated via the social network can have a significant impact on acceptance or rejection of effective contraceptive methods. Insightful contraceptive counseling for this population should address these factors to the extent possible.

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**Table 1**

Descriptive characteristics for study participants (N = 30)

Characteristic	N	%
Race or ethnicity		
Hispanic	11	36.7
African American	19	63.3
Marital status		
Married	5	16.7
Member of unmarried couple	10	33.3
Single	14	46.7
Divorced or separated	1	3.3
Education		
Less than high school	4	13.3
High school graduate	6	20.0
Some college or technical school	13	43.3
College graduate	7	23.3

Table 2

Contraceptive myths, misconceptions and vicarious experiences (N = number of women who were aware of this contraceptive method)

All hormonal contraception	<p>"My mom always says it's not safe...She has more belief that you got to count your days, more safer for your body." (23y.o., mother of 3)</p> <p>"You know my mom and my sisters always told me horror stories of birth control so I was a little...um...reluctant... Just basically that it was synthetic hormones and if you're not that active...that your body is never the same, a lot of women have issues that aren't publicized." (34y.o., mother of 1)</p>
OCPs (N=30)	<p>"So, my friend was using birth control pills, she took them every day, the same time and everything...but then she ended up pregnant a month later. So it really didn't help her." (19y.o., mother of 1)</p> <p>"And then the four periods of a year? My friend has that, and she don't know if she's pregnant right now! So I think some of it is good, and some of it is like, do you really want to risk it?" (27y.o., mother of 2)</p>
OrthoEvra® (N=24)	<p>"I heard it's not a high, like the pills is 90-something percent, like I heard the percentage is really low, that you still have a chance of getting pregnant. And, with it [the patch] coming off, and I mean, I don't know, it's hard for me to trust it." (26y.o., mother of 1)</p> <p>"The patch, well I have a sister-in-law that came out pregnant on the patch...I was like, I'm not going to be taken, I won't be on the patch and get pregnant, when I don't want to be pregnant." (23y.o., mother of 3)</p> <p>"The patch, my sister had it and she said that, um...it would cause her, like, I mean I know birth control is different for every person, but for her it would cause her nausea, nauseating, and everything...and then I heard on TV too that that wasn't good anymore because they found that it was cancerous or something like that? I don't know, I heard something like that on TV." (20y.o., mother of 2)</p> <p>"And then my cousin knew someone who was on the patch and she had the same symptoms that my friend had and she went to the hospital, and they couldn't figure out what was wrong with her, with her head. She ended up passing away, and they was supposed to do an autopsy to see if the patch had anything to do with it, but I never asked my cousin what happened about that, so I don't really know." (22y.o., mother of 1)</p>
NuvaRing® (N=17)	<p>"By just being in my body for awhile and in my, I just feel like, just me not being able to control it, it might be my lack of knowledge as well. But, I don't, I don't feel like I want anything to go wrong, it pops out of place or something comes loose." (21y.o., mother of 1)</p>
DepoProvera® (N=23)	<p>"I wasn't into the Depo® because I seen the effects it did to other people. It was like, dang! She got excessive weight gain, she lost half of her hair...I like to know my body. I like to see my menstrual coming here, and I know these things, I'm happy with my body. And with the Depo®, I don't know what's going on with my body because I'm not bleeding or anything like that, so it's like, what's going on inside of me?! Anything could be going on and I don't know!" (24y.o., mother of 2)</p> <p>"They have, the doctor has told me that the shot works really good, it's every 3 months, but I have heard it actually gets you a little hungry, so it makes you gain, actually it doesn't make you gain weight but it gets you hungry, you want to eat more. And the majority of girls gain weight. And I don't want to gain weight after I have the weight I gained." (23y.o., mother of 3)</p> <p>"And the shot doesn't help you, doesn't help certain people, like certain girls." [i.e., some girls get pregnant using DMPA] (19y.o., mother of 1)</p> <p>"Because I had a friend who had that, and she got a rash. It's a three-month thing, right? Yeah it's a three-month thing, she said she got a rash around the injection area and she never got used to it. Another reason why I don't do it." (23y.o., mother of 1)</p>
IUC (N=25)	<p>"I was like, I didn't know - you're putting a - a little, it looked like copper, I don't think it was the plastic flexible one, from what I can remember...I'm like, man that's gonna get rusted, give me an infection, it can get moved." (24y.o., mother of 3)</p> <p>"I haven't tried the others but my friends have, and like, one got the UID [IUD] and she was like, it's uncomfortable. She felt it was uncomfortable, and I'm like, I'm not into getting things inserted inside of me, you know?" (24y.o., mother of 2)</p> <p>"For one, I didn't like the fact that it's something that's just automatically there, and it comes like with a string like a tampon, right? Kinda, sorta. So I don't like that. And just seeing how some women say it can be irritating or can cause infection, from what I heard. So it wasn't something I wanted to go through. Like urinary tract infections, it might give me a lot of those, and those are like the most annoying infections you could possibly get!" (31y.o., mother of 5)</p> <p>"Bad things! Just like the infections, also...my boyfriend was telling me...we were separated for awhile, and he went with some other girl that had the IUD, and he said that during sex he would even hurt her sometimes because she had the IUD in her. And it caused her bleeding sometimes through intercourse, and things like that. And I was like "oh, really! That sounds like fun! That sounds really good!" And it's kinda irritating for most girls that are telling me, and just like the infections and that." (26y.o., mother of 2)</p>
Norplant® or Implanon® (N=11)	<p>"My sister had that. And they ended up taking it out because it actually got tangled with one of her nerves, and she ended up getting pregnant off, when she was on it, and then they took it out and it caused her...because all the liquid it had in there, and they had to untangle one of her nerves, it caused something with the baby, so they ended up operating on her when she was 6 months pregnant. So that was dangerous for the baby." (23y.o., mother of 3)</p>