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Examining Origins and Reasoning for Beliefs Surrounding Contraceptive Practices in College Women

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Examining Origins and Reasoning for Beliefs Surrounding Contraceptive Practices in College Women

An Honors Thesis submitted in partial fulfillment of the requirements for Honors in Anthropology

By
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Under the mentorship of Dr. Jennifer Sweeney Tookes

ABSTRACT

This research project studies how students' perceptions, actions, and thoughts around contraceptive practices develop over time and through college. The literature addresses how the environment of college and American culture affects how women develop contraceptive practices that are convenient not only for their bodies but their schedules. Research focuses on how educational background, religion, culture, and relationships influence contraceptive choices among students, especially women. Social factors influencing availability of contraception and education about contraception potentially lead to confusion about the most effective ways to prevent sexually transmitted infections (STIs) and pregnancy. I focused exclusively on the Georgia Southern University community, examining how education, political affiliations, and relationships influence students' views and use of contraception. I conducted in-depth qualitative interviews with four women and distributed 24 anonymous surveys to examine intersectionality in students' use of contraception. I studied the intersection of women's identities and how available resources, enculturation, and education reveal patterns among students' contraceptive use.

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Introduction

The purpose of this research is to determine how female college students view and utilize contraception. The literature on students and contraceptive use indicates that college is an influential time in which students begin experimenting more freely with contraception, and this research corroborates that finding as well as considers the ways in which individual women struggle to find a birth control method that fits their lifestyle. Women entering college have decreased parental supervision and increased sexual freedom, so it is important to investigate how they prevent pregnancy. To address this, I inquired whether students used contraceptives and how they felt about them in the context of their college experiences. I examined how the intersectionality of backgrounds, ethnicities, religions, and other individual perspectives come together during college years to potentially create new opinions and practices related to preventing pregnancy, as these may indicate if the new living and learning environment and increased socialization with a larger and more diverse college population leads to change.

Literature Review

The literature on contraception provides a variety of definitions of abortion and contraception, along with issues regarding women's choices on when to have children. Many researchers claim that an abstinence-heavy educational background leads to confusion about sexual health and one's ability to obtain contraceptives (Buhi, Marhefka, and Hoban 2010, 343; Reed et al. 2014, 255; Wohlwend et al. 2014, 267). Other research points to students knowing about contraceptive options and choosing not to use them based on convenience or the lack of desire to continue using birth control once it has been

started (Bearak 2014, 506; Fullerton et al. 2013, 207; Walsh et al. 2014, 78; Wright et al. 2015, 950). Even though conflict about the motivators behind contraceptive use—or lack thereof—continues, researchers agree that there is no simple answer to predicting whether people will use contraception.

Situating Contraception

There have been methods of contraception around for thousands of years, although the exact time of widespread practice is debated (Briggs, Kovacs, and Guillebaud 2013, 18-19). The 1960s brought about an evolution on perspectives about contraception in the United States, because rapid social change occurred in American culture. Women were struggling to gain access to contraception and proper healthcare that suited their needs, and they began to push for education about reproduction and availability of contraception (Morgen 2002, 4-7). Before the invention of the hormonal birth control pill that revolutionized women's sex lives, it was believed that a diaphragm (a rubber dome inserted into the vagina) covered in a spermicide jelly was the most effective means of preventing pregnancy. It was described by a pamphlet in 1959 as "the most reliable method" (Guttmacher and Gould 1959, 10). This pamphlet provided the public with debunked myths about pregnancy and contraception, as well as brief descriptions of abortion and sterilization techniques. It mentions types of birth control that are effective and others that are not. The diaphragm, condoms, and vaginal suppositories are all on the approved list whereas sponges, tampons, wishbone pessaries (an early form of an intrauterine device), and withdrawal were all discounted as being ineffective (Guttmacher and Gould 1959, 14-17). It is important to note how few methods were available at the time compared to today, and even more surprising that this pamphlet is just under 60

years old. In the ensuing years not only has the United States faced massive cultural shifts but also political ones that have affected contraceptive practices.

The Politics of Women's Healthcare & Global Perspective

It is crucial to note the sparse number of women in key areas of United States government today, because women influence policy in meaningful ways and therefore greater numbers correlates to more legislation relating to issues that directly affect women. In Congress, of the 535 members, only 105 women—19.6%—hold seats. In the Senate, there are 21 women who comprise 21% of the positions held (Center for American Women and Politics 2008). While these numbers are already small, their implications are impactful because the fewer women present, the less legislation is passed on women's issues (Volden, Wiseman, and Wittmer 2013, 327). This is examined in governmental processes, as women were found to put forth not only more bills than men did, but also more likely to introduce bills on women's issues (Kittilson 2008, 323; Kittilson 2011, 68; Volden, Wiseman, and Wittmer 2013, 327). These "women's issues" primarily affect women, such as healthcare, childcare, family policy, maternity leave, and more.

Women's healthcare today includes multiple contraceptive choices such as the popular hormonal birth control pill. In 2003, the Food and Drug Administration (FDA) debated whether emergency contraception (a pill taken after coitus that stops an egg from ovulating, thus preventing sperm from being able to reach it) should be available over-the-counter (OTC) or remain prescription-only. Their final verdict was that emergency

contraception should become OTC; however, they did not implement this until 2005 (due to Republican officials' pushback), when it was readdressed (Wynn and Trussell 2006, 304).

Representatives from the groups that attended the FDA hearing on emergency contraception included Planned Parenthood Federation of America, National Family Planning and Reproductive Health Association, Concerned Women for America (CWA), the Catholic Medical Association, the American Life League, Human Life International, and the National Organization of Women (NOW), as well as citizens who had opinions or personal testimonies on the subject (Wynn and Trussell 2006, 301-302). These groups presented a battery of science and evidence. They provided evidence both in favor of and against the classification of emergency contraception as an abortifacient and they debated how ease of emergency contraception availability could influence culture and sexuality (Wynn and Trussell 2006, 300-302).

This example of the FDA's decision-making process demonstrates how United States' culture forms our ideas about women's sexuality, contraception, and body autonomy. Their hesitation to definitively make emergency contraception easily available demonstrates reluctance to actively provide women with an opportunity to prevent pregnancy. The national debate of whether emergency contraception counts as an abortion also illuminates the reality that there is still significant confusion on what contraception is and how it functions. This ambiguity negatively affects women who are

trying to prevent unintended pregnancy and make appropriate choices regarding their sexual practices.

Anthropology studies the ways that various cultures interact with contraceptive methods and their relationship with sexuality and pregnancy. The range of contraceptive use and accessibility varies widely across the world, and anthropological studies provide a framework for the many ways in which this process functions.

As exemplified by the FDA discussion of emergency contraception, a culture's economics, politics, gender roles, and healthcare factor into how women prevent unintended pregnancy. Ethnographic studies that were conducted around the globe contextualize how contraception and family planning differ from one culture to the next (Browner 2000; Krause 2012; Rivkin-Fish 2004; Sanusi, Akinyemi, and Oniviran 2014). Partner influence, women's healthcare, cost of raising children, and other aspects can have an impact on the decision to avoid pregnancy by using contraceptives (Reed et al. 2014). These anthropological examinations of how culture and society influence contraceptive choices will be discussed below.

Easily accessible contraception and government intervention can strongly influence women's contraceptive choices. In Russia, for example, the government's early attempt at implementing a family planning agency failed as there was a great decline in birth rate after World War II, and family planning was denounced because of the significant need for "demographic sustainability" (Rivkin-Fish 2004, 286). Even if they wanted to avoid

pregnancy, Russian women did not even have low-hormone birth control pills (that caused fewer side effects) until the 1980s and 1990s, making such contraception harmful prior to this availability (Rivkin-Fish 2004, 286). Because there were no other options for contraception, the government made it clear that Russia was desperate for an increase in population, and due to the nature of family planning (i.e., allowing options other than pregnancy), Russian leadership decided to completely end the previously established program to ensure more births.

While such government interference may impact whether a woman can use birth control, factors closer to home (e.g., relationships) may be more influential. Partners are indeed a substantial influence in contraception use, as demonstrated by a study on Nigerian men by Sanusi, Akinyemi, and Oniviran (2014). They investigated whether knowing about birth control made men more aware of and involved with their partners' contraception choices. They found that men who had partners using modern birth control methods tended to be more involved in those contraceptive choices, ergo implying that men's involvement with contraception could heavily influence whether women used it or not (Sanusi, Akinyemi, and Oniviran 2014, 112). This frames the important influence that partners can have in a relationship regarding contraception use.

Contraceptive choices can be affected by one's partner, and the power balance in a relationship can be dependent on culture. Browner's (2000) study of Latino communities in three cities argues that Latino culture expects women to be passive and rely on men economically, socially, and in other key aspects of life. Due to rampant economic

inequality between men and women in Latin America, lack of trust in male partners, and women's inability to rely on kinship ties to care for children, abortion was a common solution (Browner 2000, 777). In Latino communities in the United States, where females have a wider range of freedom than women in the other communities (since they are not as dependent upon men for money and support), Browner (2000) found they could more easily make their own reproductive choices. In the United States, for instance, some women made the reproductive decision to test for birth defects in their fetuses, with or without male input (Browner 2000, 779).

In many countries, smaller families are becoming more normalized, and culture acts as a powerful influence over how women view and plan conception. Krause's (2012) study aimed to discover why, with Italy's low birth rate and the need for population growth, there are so many women who claimed their pregnancies were not planned, but were "accidents" instead. The reality was that they *did* want children—and *intentionally* stopped using birth control so that they could conceive; however, the stigma of having additional children led to embarrassment among women with more than one child. Krause (2012) learned couples knew that raising a child would be expensive; therefore, they did not make active plans to have babies even if they wanted them. The "unplanned" aspect of children related more to their belief that enthusiastically desiring pregnancy was unthinkable (Krause 2012, 370). Once the first child was born, women were often strongly encouraged by other women, relatives, and society to have no more, since children are financial burdens and violate the Italian ideal of small families (Krause 2012, 367).

Cultural norms for family size and sexuality strongly influence availability and use of contraception; this is demonstrated not only in governmental processes but also in women's daily lives as they navigate through the often-confusing landscape of contraceptive choices. In the United States, the college campus is a microcosm of American culture that adheres to cultural expectations while also fostering new opinions and knowledge (Bearak 2014, 487). Education—or lack thereof—about sexuality and contraception mean students may be naïve in their exploration of sex as they enter the college campus.

The Conundrum of Couplehood & Relationship Status

Relationship status can greatly influence a woman's contraceptive choices. Research indicates when a woman has sex with a partner for the first time, she might be much more likely to use contraception as a protection method rather than use it during the hundredth time the couple has sex (Walsh et al. 2014, 79).

Romantic relationships often precede sexual relationships, and romance's interaction with sexual behavior must be examined. De Munck (1998, 37 & 43) theorized that the distribution of prophylactics would make it easier to be a ludic lover—someone who views love as a game, moving between sexual partners without the intention of love—because it lowers the chance of STIs (sexually transmitted infections) and unintended pregnancy. A partner who is unsupportive of contraception, for example, may be unappealing to a woman who does not desire to become pregnant or prefers to use

hormonal birth control. A partner who is supportive of using contraception could be appealing to a woman who feels the same way. Especially in those cases where women are more reliant upon men for economic protection, women may want to use contraception but are more likely to succumb to the man's preferences to maintain the relationship (Baum et al. 2016; Bearak 2014; Browner 2000; De Munck 1998; Walsh et al. 2014).

The literature on contraception use and development of contraceptive practices commonly focuses on seriousness, duration, and efficacy of relationships (Baum et al. 2016; Bearak 2014; De Munck 1998, 22; Reed et al. 2014; Walsh et al. 2014). Reed et al. (2014, 246) find that the convenience of birth control is a primary factor for use rather than seriousness and duration of relationships. Their argument is furthered by Baum et al. (2016), who determined that relationship duration is not as important a factor in women's unintended pregnancies as is obtaining contraception regularly. In contrast, Pereira et al.'s (2014, 32) study of Brazilian undergraduate students revealed that a stable relationship meant greater use of birth control pills, although they did not discuss the use of them in combination with condoms. Overall, the literature is ambivalent about a relationship's impact on contraception use.

Contraception & Emergency Contraception

Within the literature, the term "contraception" is used to talk about both barrier methods (such as condoms) and hormonal birth control that prevent pregnancy. There are numerous contraceptive methods available in the United States. Intrauterine devices

(IUDs), the hormonal birth control pill, the birth control shot (Depo-Provera), condoms, sterilization, the implant (Nexplanon), the birth control sponge, cervical caps, diaphragms, female condoms, withdrawal, physical monitoring of temperature and time of menstruation, spermicide, and vasectomies are some of the options women and men can choose for how they want to prevent pregnancy and STIs (Planned Parenthood, n.d.). This variety of usage is examined closely in the current literature, but methods range from demographic scales to more in-depth qualitative analysis (Baum et al. 2016; Bearak 2014; Boone 2015; Buhi, Marhefka, and Hoban 2010; Fullerton et al. 2013; Reed et al. 2014; Walsh et al. 2014; Wright et al. 2015; Wohlwend et al. 2014).

Contraceptive Methods

The birth control pill is a hormonal birth control method taken orally. To be effective, it must be taken every single day without fail, or chances of becoming pregnant increase (Planned Parenthood n.d.). Birth control pills are the most popular form of pregnancy prevention among 15- to 24-year-olds, followed closely by latex condoms (Daniels, Daugherty, and Jones 2014, 3). The third most common are long-acting reversible birth control methods, such as the hormone-releasing IUD (Daniels, Daugherty, and Jones 2014, 3), sold under brand names such as Skyla, Mirena, Kyleena, and Liletta. Paragard is a copper IUD which does not release hormones but prevents pregnancy with great effectiveness and can act as emergency contraception. IUDs last up to 12 years and can be removed at any time should a woman choose to become pregnant. The IUD is the most effective form of birth control, with a rate of 99.9% pregnancy prevention (Planned Parenthood n.d.). The NuvaRing is a flexible ring placed inside the vagina that slowly

releases hormones to prevent pregnancy. The Depo-Provera shot is an injectable form of hormonal birth control that is administered once every three months to prevent pregnancy. Withdrawal, also known as pulling out or coitus interruptus, is only about 78% effective if used regularly and involves retracting the penis from the vagina before orgasm is achieved to prevent pregnancy from occurring (Planned Parenthood, n.d.).

Compared to female hormonal contraception options, there are limited ways men can contribute to contraception: condoms, withdrawing, or vasectomy. Condoms are reliable protection, whereas withdrawal is not. Vasectomies are generally irreversible and will prevent reproduction later in life should a male then decide he wants to father children (Briggs, Kovacs, and Guillebaud 2013, 232-233). The unavailability of male hormonal contraception might be a major reason women change their opinions about birth control in college; they simply may not trust their male partners to be responsible with or provide the sole means of birth control (e.g., condom, withdrawal).

Dual Method

Using both hormonal birth control and condoms at the same time to assure protection from both pregnancy and STIs is called "dual method." Dual method is endorsed by Planned Parenthood (n.d.) and studied by Walsh et al. (2014). In research on participants' last intercourse experiences, they found that 33% of women used dual method inconsistently, and only 14% of the women claimed consistent use (Walsh et al. 2014, 77). The study does not examine context of the sexual activities (i.e., if it was a hook-up

or sex in a committed relationship) and only studied first-year female students in college, but it does provide a unique glimpse into experiences of freshmen.

Emergency Contraception

Wohlwend et al. (2014, 258) discuss the use of emergency contraception in detail. Plan B One-Step, Ella, and NextChoice are all oral emergency contraceptives for when condoms or other methods (including non-use) of contraception fail (Planned Parenthood n.d.). Emergency contraception acts as a preventative measure to inhibit fertilization of a female ovum. Women who are unsure about the function of emergency contraception might not use it. This is evidenced in a survey that found that 72% of students answered that emergency contraception is the same thing as an abortion (Wohlwend et al. 2014, 264). Emergency contraception is an extension of contraception in general, but as Wynn and Trussell (2006) explain, differing opinions about its effect on the female body complicates matters of accessibility and understanding about what the drug actually does.

Development of Contraceptive Practices & Demographics

> Attending a four-year college or university substantially shapes social structure in ways that may affect sexual behavior. Students have reduced parental supervision while adjusting to a new social environment. Many students are exposed to new behaviors as the socioeconomic characteristics, and even the gender balance, of their peer groups, change (Bearak 2014, 487).

Bearak (2014) investigates college students over a four-year period, conducting research on contraception use among lower- and upperclassmen. His use of "social structure" argues that universities act as a melting pot. Most college campuses are environments where students interact with peers who they might have never met in any other situation. As freshmen, they are often required and encouraged to go to parties, join clubs, and introduce themselves to others to establish connections around campus.

Universities draw people of diverse backgrounds and demographics. Demographics are especially useful in determining trends related to contraceptive use. Basic features most commonly addressed include race, age, socioeconomic status, environment, and gender (Baum et al. 2016; Bearak 2014; Buhi, Marhefka, and Hoban 2010; Fullerton et al. 2013; Reed et al. 2014; Wright et al. 2015; Wohlwend et al. 2014). Examining the intersection of these identities and how they affect available resources, enculturation, and education reveal tendencies of students and their use of contraception.

Race

Race is a social construct—an incredibly powerful one. It can affect contraception use. The literature finds that African Americans may have more trouble acquiring birth control compared to white people. Landau, Tapias, and McGhee (2006, 467) find that most women would prefer if hormonal contraception was OTC, and that African American women would be more likely to use emergency contraception if it was available without prescription. Buhi, Marhefka, and Hoban (2010) argue that race is a significant determinant on whether adolescents use contraceptives and condoms to

prevent STIs. They found African American students were more likely to use condoms during sex, to test positive for STIs, and to become unintentionally pregnant (Buhi, Marhefka, and Hoban 2010, 343). These trends may be due to the intensive and time-consuming process to obtain a prescription for hormonal birth control and higher incidences of not using condoms during last event of intercourse.

Like Buhi, Marhefka, and Hoban's (2010) research on black women, Baum et al. (2016) highlight this struggle for birth control with their qualitative study of women of color and their desire for an over-the-counter oral (OTC) contraceptive (the birth control pill). This need for easily acquirable oral contraceptives demonstrates that African-American women find the process of getting a prescription arduous. "Women explained that OTC access would remove barriers associated with an appointment such as wait time, transportation, cost, and needing to take time off from work" (Baum et al. 2016, 149). This lends itself to women of color representing more unintended pregnancies, since they are less likely to be able to take time off from work to get a prescription. When unintended pregnancies occur in students of any race, it can lead them to drop out entirely or stall their quest for a degree (Wohlwend et al. 2014, 257-258). Since more students of color than those who are white unintentionally become pregnant, the differences in education levels can influence the educational pursuits (or lack thereof) of future generations (Wright et al. 2015, 932).

Socioeconomic Status

Women's available financial resources affect their access to birth control options,

especially if the birth control is expensive or if they do not have insurance. Women who have more money can pay for emergency contraceptives more readily, and even pay for abortions. On the other hand, women of lower socioeconomic status may not have available resources. At a community college, Baum et al. (2016) looks at the struggles for low-income women and their obstacles in obtaining contraception. They find that women who cannot afford to take time off work or school would readily use OTC oral contraception (Baum et al. 2016, 151). Issues with convenience act as a significant barrier for women, especially due to the complicated process of prescription access.

Environment

Bearak (2014, 499) states that more often, when women outnumber men on campus, they are the empowered gender that makes more dominant decisions regarding intercourse. This ratio of students affects environment and women's exploration of sexuality more so than if men were the majority at a university (Bearak 2014, 499). This power balance is notable in that it sways the balance toward females in some cases, where they can feel more autonomous in sexual choices.

Reimold (2010) examines sex columns from various university magazines, showing that university campuses are fascinated with sex and sexuality. According to one sex columnist:

> I had plunged head first into an entirely new world of sexile [banishing one's roommate for privacy during coitus], ridiculous alcohol consumption, no parents

> … it's possible, if not probable, to not know if you're dating someone, or conversely to spend every night with someone monogamously when neither one of you 'wants a boyfriend/girlfriend.' I don't pretend to understand it; it's sex and the university (Reimold 2010, 10).

This illustrates the way that universities are unique environments in which students can develop—and change—their own practices and ideas about sex.

Gender

Gender roles evolve and fluctuate over time in every culture but remain constant in their presence as humans are expected to learn their expected roles and act a certain way (Manago et al. 2014, 199). Culture and society shape how we express our gender, and the roles that adults must adhere to involves differing traits that affect sexual practices (e.g., in some Western cultures a man is praised for aggressive sexual behavior while a woman is encouraged to be coy and demure). Reed et al. (2014, 246) finds that women in college are expected to take charge of hormonal birth control methods, while men are expected to purchase condoms and use them during sex.

Education

Education is a keystone in our lives, with the average American student spending over 8,000 hours receiving instruction in primary and secondary education alone (OECD 2011, 428). Students generally begin schooling on sex and health in middle (secondary) school and continue to learn about it through college. While there have been attempts to

regulate sex education across the United States, reforms are pushed back by abstinence-only education supporters, making the road to homogenous sex education a rocky one that is inconsistent (Helmy 2015, 98). Researchers tend to agree that education about contraception plays a role in shaping students' actions and opinions, and that unintended pregnancies from lapses of protection hinder women's education (Baum et al. 2016; Boone 2015; Buhi, Marhefka, and Hoban 2010; Reed et al. 2014; Wright et al. 2015; Wohlwend et al. 2014). Such spotty sex education can have lasting effects. The most common variations of education in the United States include abstinence-only and comprehensive sex education. For example, 18 states mandate instruction about contraception while 26 states mandate that abstinence must be stressed (Guttmacher Institute 2016). This enormous variation in sex education can become especially evident in college, as gaps in knowledge about sex are often seen (Bearak 2014, Reed et al 2014; Wohlwend et al. 2014). Sharing information and personal anecdotes about which contraceptives work best can lead students to try new options or broaden their perspectives about sex in general, as seen in Jones' (2018) study of teenagers and communal learning about sexuality in a class environment.

Abstinence-Only

Abstinence is the most effective method of avoiding pregnancy and STIs but teaching abstinence-only fails in preparing students for conducting sexual activities in a safe, consensual way. This gap in information can often lead to confusion later when they do become sexually active. Adolescents who do not have well-rounded, accurate information often risk their sexual health because they do not use, or do not know how to use,

contraception (Wright et al. 2015, 935). Part of the reason that this information is withheld is because of the premise that sexual education leads to a liberation of sexuality that will then lead teenagers to become promiscuous (Briggs, Kovacs, and Guillebaud 2013, 12). Especially in more conservative regions such as the southern United States, students who do not receive accurate sex education often experience higher rates of STIs and unintended or teenage pregnancies (Guttmacher Institute, 2016; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2016).

In the United States, Massachusetts has the lowest rate of teenage pregnancy while rates of unintended pregnancy are highest in Arkansas, Oklahoma, Mississippi, Texas, and New Mexico (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2016). It is not surprising that four of the five states also require emphasis on abstinence-only education and are not required to teach about contraception (Guttmacher Institute 2016). Students' ignorance of contraceptive choices and safe-sex practices leads to misuse of condoms and more unintended teenage pregnancies. The concern that an absence of education about safe sex in general leads to unawareness about how to effectively use a condom and other methods of contraception.

"Results also suggest that abstinence only programmes do not effectively encourage abstinent behaviour but instead are ineffective for preventing or decreasing sexual activity among most participants" (Underhill, Montgomery, and Operario 2007 ,8). This lack of condom use can be attributed to not knowing how to use them and due to outside influences, such as peers and media, students are still likely to engage in sex.

Women educated in abstinence-only programs who have unprotected sex with their partners might experience confusion because they were taught that the risk of pregnancy without condoms was extremely likely—so when they did not become pregnant, they perceived their risk to be smaller.

> Messages in sex education intended to encourage regular contraception backfired; women had heard that pregnancy is very likely if you have unprotected sex regularly for even a short period, so when no pregnancy occurred they figured one of the partners was infertile." (Reed et al. 2014, 252)

The authors state that women were often wrong about their verdict of infertility, but that gap of understanding in sex education remains.

Comprehensive Sex Education

Comprehensive sex education provides more accurate and thorough information about sexuality and contraception. In comprehensive sex education, abstinence is discussed as an option but is not emphasized; condoms are always encouraged as a means of safety (Guttmacher Institute 2016). This is also emphasized by the Planned Parenthood website which tells people searching for information about hormonal birth control that a condom should always be used to prevent STIs.

Using Emergency Contraception

Both abstinence-only education and comprehensive sex education might not teach about the options of emergency contraception, in the form of Plan B, Ella, and NextChoice

(Planned Parenthood, n.d.). Women who are unaware of how these emergency contraceptives work, or do not know about them at all, might not use them as a resource. Even if sexually active students have this information, obtaining emergency contraceptives may be difficult (Wohlwend et al. 2014).

Importance

The literature provides a set of factors that can influence contraception based on studies conducted in other cultures around the world, and within college campuses in the United States. This research project investigates how Georgia Southern University students think about and use contraception based on their background and individual beliefs. The current literature, which focuses on obstacles to obtaining birth control and contraception, and how students use it, does not as often focus on women's individual experiences and struggles. Contraceptive use can be affected by the individual challenges a woman faces, as well as her religion, her relationship status, and more—it is worth noting these aspects when researching contraception use, because using birth control is a premeditated action that requires mental planning and physical effort.

Methods

Recruitment & Population

Recruitment for this project took place through Unite for Reproductive and Gender Equity (URGE at Georgia Southern), the Anthropological Society, and Wesley Foundation. I shared a letter on Facebook, via email, and through Folio, requesting women to contact me for private interviews. The survey was linked from a Folio page for

a women and gender studies class, on the Anthropological Society Facebook page, and accessible via an anonymous link sent through email to URGE.

Interviewed participants are Georgia Southern University students who are biologically female (cisgender). This set of criteria was chosen to narrow the research study because it allowed for a concentrated sample size while also giving time to closely examine reasoning behind each choice and belief the women have. To obtain a general scale of the use of contraception on campus, I distributed a survey to many students and received 24 responses, 19 of which are fully completed and valid. I interviewed four women. All interviews were confidential as pseudonyms were used, and all surveys were completely anonymous.

Methodology

The interview questions asked about each woman's educational background, region where she was raised, opinions of birth control and contraceptive use, and whether she had used birth control (See Appendix A: Interview Questions). Since the interviews were semi-structured, I also asked for elaboration upon certain stories the participants told me, as well as gathered as much information regarding contraceptive use as possible. I will keep the information, transcriptions, and audio recordings from the interviews until April 2020, at which time I will destroy all records.

I used questions from my semi-structured interviews to create a survey that was distributed to students via anonymous link. The survey was made using Qualtrics, a

Georgia Southern University-hosted survey program. The surveys asked questions about the students' demographics as well as their sexual activity and contraceptive use (See Appendix B: Survey Questions).

Before each interview was conducted and at the beginning of the survey, I explained the informed consent document (See Appendix C: Informed Consent). Interviewees could skip any question with which they felt uncomfortable and they could end the interview at any time. They could either choose a pseudonym or be assigned one. I requested permission to audio-record each session and transcribed the interviews into Microsoft Word once completed. All participants allowed audio recordings to be taken.

Analysis

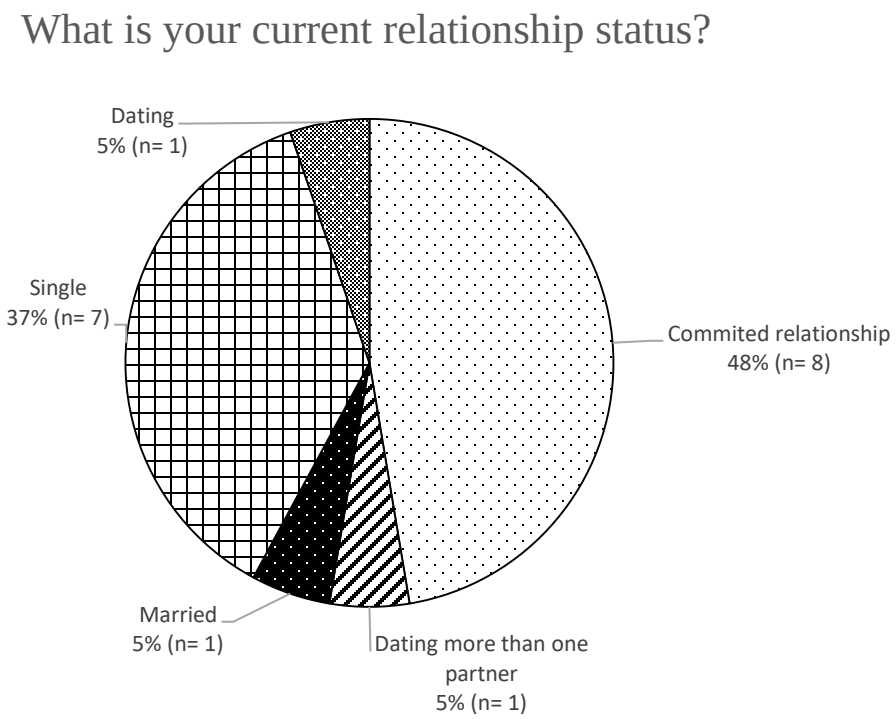
Transcriptions were printed and coded manually, with colors that identified set themes that were found in the literature, as well as common topics among the interviewees. Surveys were coded using the Qualtrics data analysis program that provided numerical and quantitative graphs. Among both interviews and surveys, themes that emerged included changes in contraception use since beginning college, political affiliation, struggle of birth control, lack of education about contraception, and relationships.

Results

The following sections are results from the research, discussing demographic information such as relationships, religion, types of birth control used, college status, age, influence of education, gender, race, and political affiliation.

Demographics

Relationships



Of 19 survey responses, nine respondents were in committed relationships (one of whom was married), seven were single, one was dating more than one partner, and one was dating. The distinguishing factor between "dating more than one partner" and "dating" is the number of partners a respondent is courting at the time of the survey.

Three of the four interviewees were in relationships. Monica was engaged to her boyfriend of five years; Lydia was in a relationship of about a year; Magda was married to her second husband; Jane was single. All participants had previously been in relationships of varying lengths and importance.

Upperclassmen (juniors and seniors) were in committed relationships or relationships of

any kind far more often than lowerclassmen (freshmen and sophomores). Of upperclassmen (both survey and interview participants), 72% were in some form of relationship, and of the lowerclassmen, 75% were not in a relationship.

Religion

Christianity was the religion most identified in the survey, although responses were less consistent on levels of devoutness. Others were Seven Day Adventist (1), and Druidistic & Agnostic (1). No respondents reported being extremely devout. Only 12 respondents answered this question. This is a significant figure because it accounts for almost half of the survey responses, and the dearth of religion will be addressed later in Discussion. Some of the respondents (20.8%) identified as neutral to their respective religions, and others reported being more devout in faith (37.5%).

Among interview participants, both Lydia and Jane identified as Christian, although Jane was more active in church and beliefs. Monica identified as agnostic, and Magda identified as pagan; neither Monica nor Magda indicated being especially spiritual.

Birth Control

Among survey respondents, the most commonly reported methods of contraception were the birth control pill (8), condoms (8), and "pulling out" (6). The pill and withdrawal were often used in tandem, as reported by several respondents. Two respondents had the Nexplanon or implant, one had an IUD, one had the NuvaRing, and one had no reported method of contraception. Of all respondents, four seniors had used emergency

contraception. The use of emergency contraception did not correlate with race, age, or relationship status of the respondents who had used it.

Half of the interviewees reported using birth control. Magda could not use hormonal birth control due to the hormone's severe negative effects on her body, and Jane did not use birth control because she was not in a relationship and did not feel a need to do so, although she had used the pill during high school to treat her acne. Monica uses the IUD for its convenience and lack of hormonal side effects, although she had tried the mini-pill, the combined birth control pill, NuvaRing, and several forms of the IUD. Lydia uses the implant for its convenience and long-term effectiveness, paired with fewer side effects. None of the interview participants had used emergency contraception.

College Status & Age

Most survey respondents were upperclassmen, with 12 seniors and two juniors. There were five lowerclassmen, with three freshmen and two sophomores. Graduate students are also considered seniors for the purposes of clarity. The oldest respondent was 29 and the youngest was 18.

Of those interviewed, Magda, Lydia, and Jane were all upperclassmen, and Monica was the only lowerclassman. Magda and Lydia are both graduate students, therefore somewhat older than undergraduate seniors. Magda is the oldest of any participant in the study (43), and our interview focused on her earlier undergraduate years. Lydia is 23, Jane is 21, and Monica is 19.

Influence of Education

The survey results showed that most education and information received in all subject areas was from the internet. From the subject areas (birth control, sex, abortion, and emergency contraception), 10 or more respondents reported learning about them from the internet: 13 for birth control, 15 for sex, 15 for abortion, and 10 for emergency contraception. It is apparent that online researching yielded more information than any other source. The second most-cited source was doctors, but only for information on birth control.

Each interview participant had received some form of sex education in school, albeit at various times. Participants reported they learned sex education in high school, although detailed information was omitted; sex education in middle school and elementary school was scarce and less frequent. All of them reported their schools emphasizing abstinence as the sole method of avoiding STIs and pregnancy. None reported being taught about birth control in school.

Gender & Race

Eighteen of the 19 counted survey responses were from females. Twelve females identified as white and five as black. One respondent indicated she was black, white, and Asian, and two (1 male, 1 female) indicated that they were both black and white. All interview participants were white females.

Political Affiliation

In the survey, respondents could indicate their political leanings on a sliding scale of liberal to conservative. Sex education, healthcare, and abortion were the three subjects addressed in the question, allowing for participants to identify as liberal or conservative independently on all three. Most of the survey responses indicated more liberal attitudes, with the exception being healthcare, as respondents were much more likely to report being more conservative. Of 19 responses, only two reported being conservative regarding sex education. Both respondents were also conservative on other political issues.

Survey participants who reported being conservative about policy on abortion were Christian (6 total). While some Christian survey participants were conservative about abortion, not all were, as three reported being on the liberal side of abortion. Of the other religions reported, no respondents reported conservative feelings on abortion.

After being asked about political party choice, every interviewee hesitated to respond, appearing reluctant to immediately identify with one or the other. After prodding, they elaborated upon their political choices and how they would select to vote for one candidate. Invariably, they reported they would not choose a candidate based on their political party choice (e.g., a Democrat solely voting for a candidate because they are a Democrat) but based on individual qualities and qualifications.

Discussion

The results from the survey and interviews led to three main findings, discussed in detail below. For the purposes of discussion, survey and interview results will be grouped together.

1. Participants who used contraception struggled to find the best one for themselves, and those in relationships were less likely to use dual method.
2. Participants felt that religion, politics, and college experience were significant factors in shaping of their views on contraception.
3. Few participants had formal education about contraception and had to seek out information from other sources.

The following sections will address these three results in more detail.

Participants who used contraception struggled to find the best one for themselves, and those in relationships were less likely to use dual method.

Contraception Use Among Participants

Of 23 participants, 19 (82%) reported using some form of contraception, and of those 19, one (5%) was single. The four participants who did not report using contraception were also single and did not report having sex within the last month. There were eight single participants, and of those eight, two reported using the pill and one reported using the implant. Overall, there was a significant trend toward using contraception while in a relationship, although use of birth control was not exclusive to people in relationships. One participant who was single reported the use of condoms and no form of hormonal

birth control. This wide variety of responses show that, while participants in relationships were more likely to use contraception, most reported use of birth control regardless.

Four survey participants reported using emergency contraception; no interviewee had used emergency contraception. All four were female seniors, between the ages of 21 and 29. Each participant reported learning about emergency contraception from the internet, television, or did not report learning about it from any source. Three of the four interviewees reported learning nothing about birth control in school, and only two reported learning about sex in the school setting before college. Magda was vehement in her disapproval for this, saying "They talked about STDs … they talked about reproduction, not *one* of [the classes] talked about birth control." This dearth of knowledge and understanding might have resulted in their need to use emergency contraception, but since the survey did not specify time of emergency contraception use, there is no way of knowing if that was the case.

The Struggle of Birth Control

All four interviewees discussed their history with birth control. All had used hormonal birth control, and their descriptions of it were usually trial-and-error, because women have varying reactions to the hormones. None of the women remained on their original birth control selection due to negative side effects. Jane, for example, had to cease using birth control pills because it made her periods heavier and made acne worse. Monica initially used the NuvaRing but stopped when the hormone made her breasts ache. In her undergraduate years, Magda had the most struggle with her birth control choices because

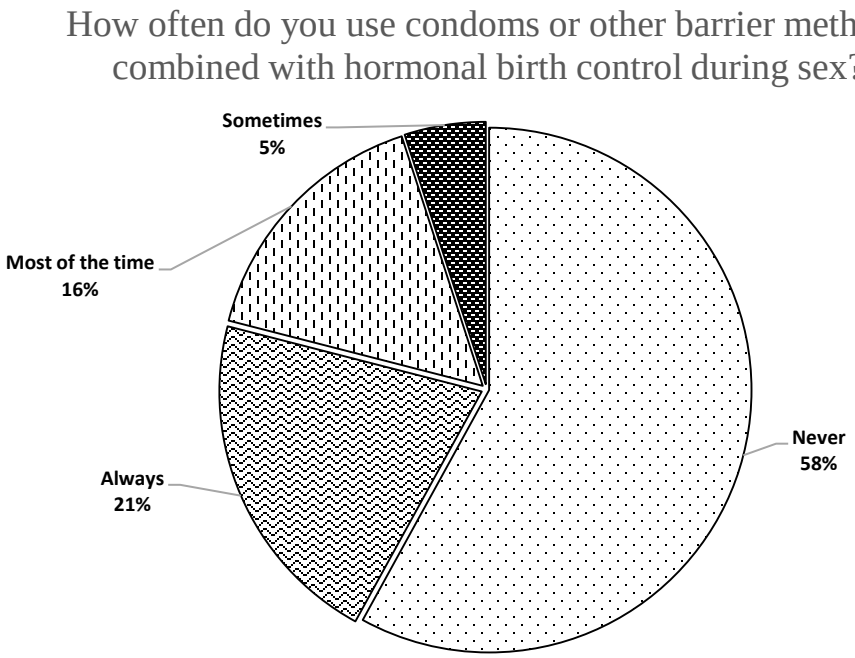
her body rejected the hormone from the birth control pill even at the lowest dose: "I … started this at like 17. By the time we finally gave up the ghost, I was 25. We tried, like, everything. We tried shots, we tried various pills … we'd have to cycle me off and on to something different and it just … didn't work."

This universal struggle to find an effective birth control with minimal side effects was particularly striking in comparison to the survey results, because while the question did specify any birth control the women had ever used, only one reported trying more than one hormonal birth control. Unlike the survey, in which the pill was used most often (8 of 19), the interviewees varied widely. All had tried the pill, but none had continued with it for extended periods of time. Part of this involved moving to longer-lasting, more effective types of birth control, like the IUD and the implant. Monica uses the Paragard copper IUD since it is 99% effective, lasts for years, and is not hormonal. Lydia chose to use the implant because it lasts up to four years, is also 99% effective, and provides her with very minimal side effects. The move to the implant was also influenced by Lydia's discomfort with the pill: "When I first started birth control I tried the pill; I *hated* it. It made me so moody. I was crying all the time, over nothing, and I gained a lot of weight on it because it made me hungry–and so I would just eat. And I was on it for six months."

Dual Method Use

Few (5 of 23) individuals in the survey reported always using hormonal birth control in combination with barrier methods. Survey participants who reported using dual method sometimes used two distinct types of contraception, such as withdrawal and condoms—

although whether at the same time was not specified. Only five participants reported always using dual method (26%). This is consistent with Walsh et al. (2014, 77) who found that a very slim number of undergraduates reported using dual method recently.



Two of the four interviewees used both condoms and hormonal birth control. Lydia and Monica both used dual method due to fear of pregnancy. While both women used some of the most effective types of birth control (implant and IUD respectively), they still made sure to use condoms. Lydia even took it a step further: "I keep a stash of pregnancy tests in my bathroom, just in case." This adversity to pregnancy revolved around the women's eventual goals of graduating.

Relationships: Influence or No?

Almost one half of the participants were in relationships (13 of 23) while the other half

were dating or single. As mentioned above, people in relationships tended to use contraception in some form. Long-term birth control was more common among people in committed relationships, although one participant who was single reported using the implant. Seven respondents reported that a relationship influenced their contraceptive choices. Others noted that their partners did not influence their contraception, although one participant said she and her partner hated using condoms. This is, in and of itself, evidence of some influence; there is a possibility that, had the partner been more in favor of condoms, use would have increased. One survey participant remarked on his use of condoms: "[I] ain't trying to get the clap, ain't trying to have no kids. Can't afford that nonsense" which speaks of a vehement lack of desire to have children or get STIs.

Upon being asked about relationship impact on their contraceptive choices, Jane and Magda did not feel as if their partners had much of an influence. Jane, upon being asked what hormonal birth control she would most likely take while in a relationship, speculated that she would most likely use the IUD. "I guess I would want their opinion … but I think ultimately I would most likely choose what I want to do." She was not on hormonal birth control and was not eager to try it again after the pill made her acne worse and made her skip periods. One survey respondent who did not use birth control methods was married and reported having unprotected sex often, therefore might be attempting to get pregnant.

Participants felt that religion, politics, and college experience were significant factors in shaping of their views on contraception.

Politics & Contraception

Both the survey and interview participants had a lack of political alignment to parties, especially in a political and cultural climate where Democratic and Republican ideals seem to be very polarized. All interviewees identified as some manner of liberal and only a handful of survey responses reported being more conservative. Nine of the 23 research participants reported being conservative in some form, although only one was conservative on all three political issues (healthcare, sex education, and abortion). Interestingly, those who did not answer the religion question always reported liberal attitudes on abortion.

Jane specified that in high school she took a quiz to determine where she fell on the political scale, and it identified her values to be closer to those of Republicans. Upon taking the same quiz in college, it determined her to be more Democrat. She remarked that she had become more educated on issues that were not as prevalent in high school and remarked; "For me personally, I'm not gonna pick a political candidate based off a party they're in but based off the qualifications I see in them."

Magda had this to say: "One of the big things I have issue with any politician is [how] they deal with contraception and abortion. Honestly, I'm pro-choice but I'm more pro-choice because I don't think it's anybody's doggone business." Several of the participants did align more closely with Democratic Party values such as greater access to contraception and better sex education. Lydia posited, "I'll probably never vote Republican. Unless that Republican said, 'We need better birth control access! We need

better women's health education and sex education!' Stuff like that. But that's not gonna *happen*, come on!"

This difficulty of aligning oneself on political issues comes amid a tumultuous political climate. When asked about their opinions on the current administration, all were dissatisfied in some way. Monica, Lydia, and Magda all mentioned contraception as a political topic and expressed displeasure at attempts to limit opportunities to obtain birth control. Monica, who uses the IUD, was worried about future costs of healthcare due to Republican-fronted healthcare changes. "[My IUD] was completely covered by my insurance because it was under the Affordable Care Act … but with the new plan that they're trying to do make[s] it so expensive to get birth control, [that] no one is going to be able to use birth control." This discontentment with the government's approach to women's healthcare and birth control is perhaps related to findings from Kittilson et al. (2008) and Volden, Wiseman, and Wittmer (2013) about the deficiency of women in government. Kittilson (2011, 68) surmises that since women are likely to bring up issues that shaped their lives (e.g., birth control, sex education, and women's healthcare), they may be catalysts for making meaningful change in legislation on those topics.

Jane remarked on the current administration: "I wanna be for people … I want people to deserve everything they deserve … I'm not okay with [President Trump's] policies on things and the way he treats certain people." Jane was unhappy with President Trump's attempts at removing the Affordable Care Act since she appreciated its coverage of women's healthcare issues and contraception. She and Lydia were both raised in rural,

Christian communities and were more conservative before coming to college; they were raised with Christian views about stifling the need to speak about sex and contraception. Lydia expressed the difficulty: "Oh my God, I had the hardest time when I was ready to go on birth control and start having sex … keeping the two things [being a good Christian and sexual autonomy] that I believed, even though [I thought] they were opposite beliefs."

Surveys did not display the same trend of ambiguous political affiliation, as most upperclassmen (8) identified as liberal on all three political issues, signaling acceptance of educating about sex, legalization of abortion, and healthcare coverage; the remaining upperclassmen (6) were conservative or neutral on the issues in some aspect. Of lowerclassmen, opinions were across the board. Two identified as liberal in all three political issues, two had a mix, and one was entirely conservative.

Perspective Changes

Surprisingly few participants in the survey reported notable changes in their opinions about birth control since beginning college, although every interviewee described some change. Due to the nature of face-to-face interviews, elaboration on the changes experienced during college were discussed more easily. In the survey, nine said they had some level of change. The participants who were more likely to have experienced modification of opinion since beginning college were upperclassmen (10 of the upperclassmen reported change, and 4 did not; no lowerclassmen reported change since

beginning college). Relationship type did not have a profound effect, although since most seniors were in relationships there could be correlation.

In contrast to the survey results, most interviewees had differing opinions about contraception since starting college. Jane, for instance, said she was exposed to many new points of view about birth control and other political ideas upon entering college. She stated that these differences in opinion intrigued her, since she came from a smaller rural town where her high school had been built "in the middle of a cow field." Lydia had been more conservative when she arrived at college, but slowly became aware of issues like women's healthcare and became more liberal. Monica had been using birth control for most of her young life, so her viewpoints had not changed much because she had never considered birth control an issue.

Religion's Influence

Nine survey respondents reported being Christian in some form, and the interviews yielded similar results. All interviewees reported being raised Christian, but not all of them remained so into adulthood. Only Lydia and Jane still identified as Christian. Religion is often closely linked with political affiliation and the noticeable lack of religion in the survey responses could account for the across-the-board liberal attitudes about birth control and sex education.

Monica, Lydia, and Jane came from small towns steeped in Christian religion, strewn with churches. When asked about their upbringings, it is telling to note that Monica's

experience was in sharp contrast to her peers. When asked about contraception, she said: "I know a lot of people that were like really afraid to get on birth control or even ask their parents because they did not want to tell their parents that they were sexually active." She also had a close friend who was paranoid of her parents finding out about her sexual activity, and actively avoided going to the gynecologist to evade being asked if she was sexually active in the presence of her mother.

When asked about her hometown and its religious climate, Lydia told me that a woman in her town often stands on a busy intersection holding a sign proclaiming: "Abortion is murder!" This was humorous to Lydia, because there is not even a women's health clinic in her town to protest. As demonstrated in the FDA meeting to determine emergency contraception OTC status, the Catholic Medical Association and American Life League both argued that such contraception is an abortifacient because it prevents sperm from reaching the ovum (Wynn and Trussell 2006, 301), as they believe that life begins at conception. Similarly, Jane's hometown was highly religious: "Everyone there says they're religious or Christian even if they're not," she said. "It's just kind of the popular thing to be of religious faith there." The need to identify with a religion in the southern United States may be a factor in political affiliation, since the Republican party aligns closely with Christian ideals. Magda was not raised in Christian communities, because her Army family changed locations often. Her mother was in seminary and presented a religious influence in her life, but Magda's spirituality did not align closely with Christianity.

Few participants had formal education about contraception and had to seek out information from other sources.

Education & Impact

Education was a key component in this research, and the survey specifically inquired about sources from which participants learned about birth control, sex, emergency contraception, and abortion. Overwhelmingly, participants reported getting information about the subjects from the internet.

None of the interviewees had received formal education about birth control. Jane reported she still did not know much about it—she'd never used contraception because she had not had sex yet, which explains the lack of experience with it. In fact, Jane's school had been reluctant to even discuss sex: "Maybe in one of my classes we talked about it … our teacher was like, 'Don't laugh at this, [like] I'm gonna say the word "sex."'"

Unvaryingly, the interviewees (who were all from Georgia) were taught about abstinence as the only option to prevent pregnancy, since this is the requirement of Georgia's education system (Guttmacher Institute 2016). This meant a lot of information input from other sources. Magda and Monica said they'd learned at least a bit about birth control from their doctors, and Lydia "had to do a lot of self-educating." They all cited initial teachings of sex education from middle school (about puberty), in which girls and boys were separated to watch videos on hormonal and bodily changes they would soon experience. The interviewees giggled as they recollected, as none of them had ever talked

with their male peers about the video they had watched and vice versa. The mystery was still ongoing, even as adults.

Six survey participants reported learning about sex from pornography. Pornography is an enormous industry but may give an erroneous representation of contraception use (e.g., non-use of condoms of any kind, withdrawal as routine, etc.) (Jones 2018). When consulting a class of teenagers about their knowledge of sex with "Porn Jeopardy," Jones (2018) found some hadn't been taught about items as rudimentary as lubricant and were unclear about genital anatomy. Pornography does not educate about the basics of sex, so despite its popularity, it fails in being valid as a means of perpetuating contraception use among those who watch it (Jones 2018). For example, porn actors tend to use withdrawal as a common method, which Planned Parenthood (n.d.) states is only 78% effective—if used perfectly.

Formal education about contraception is critical. Birth control can be trial-and-error, because one size does not fit all. Gynecologists and other medical professionals often do not represent the full spectrum of opportunities of birth control to women (Dehlendorf et al. 2011). According to Jane's experience: "I went to my mother's gynecologist … we just sat in his office and he just went over the pill, like that was kind of the only option." Those who have not been educated on all options might believe there are a limited number of birth control options and therefore might not seek out another type.

Significance

This research has provided a sample of university students who diversely use contraception to prevent pregnancy and STIs. Birth control is an essential component of many women's lives. Understanding contraceptive use during the time of increased freedom and experimentation which college provides gives us a snapshot of contraception perspectives and practices. Such cultivation of knowledge and ideas about birth control in the college context becomes a foundation for how young women and men will use it throughout their lives.

The literature on the impact of relationships on birth control usage mirrored results from Georgia Southern University students, in that they tended to make choices based on convenience and their own body's reactions to the birth control. Although having partners did influence when women chose hormonal birth control, they did not consult their partners on which type they chose. This research examines a subset of college students in America, but provides evidence that women continually make decisions and think about contraception in the framework of the culture around them. Interview participants were less concerned about STIs than pregnancy, which is worth examining in the future. Although "hookup culture" is more prevalent than ever, monogamous, long-term relationships in college must be considered as well. This research adds to the literature by giving qualitative information regarding college women's motivation to choose types of contraception, based on cultural influences but also on individual aspects such as demographics and ideology.

Implications for Future Research

From this research, more examination could be done on respondents' political views and their use of contraception. Interviewees tended to respond that they were liberal, although did not want to explicitly align with Democrats or Republicans when they were asked about their choice of political party. The literature did not discuss potential impact of political affiliation on contraceptive choices, therefore it could be worth investigating further. Further research can be done upon perceived political leanings and how they might affect choice of contraception.

A guiding research question in this project addressed relationship effect on contraceptive choices. The data shows that women often reported that their relationships determined whether they used *condoms*—not necessarily hormonal birth control, despite many participants using it during relationships. Many respondents reported that their relationships did not impact their choice of contraception, which confirms theories and research previously done in the literature. Convenience did not appear as significant a factor, compared to personal issues with different types of hormonal birth control. Women from the interviews and the surveys reported individual challenges with types of birth control, with physical side effects more powerfully affecting contraception choice than convenience. If a woman experiences rapid weight gain, terrible acne, and other negative effects, she probably won't continue a birth control even if it is convenient. This struggle to find the correct hormonal birth control should be examined in more detail.

On a related note, examining male's ideas about contraception use could unveil new information on how men might deal with a partner who is facing negative side effects from hormonal birth control. As one interviewee noted, her partner was reluctant to even speak of birth control in public; looking at the way men view birth control would allow researchers to fully comprehend how men contribute and interact to contraception use. Since men have no hormonal birth control, they must contribute in often separate ways from women, which makes their exploration of sexuality during college years potentially noteworthy due to changes they face as well.

The goal of this research was to investigate how college students chose contraception based on their individual backgrounds, demographics, and experiences. Through interviews and surveys, students appeared to determine use of birth control based on their education about contraception and convenience and side effects of their selected methods. This study of college students provides insight on the diverse ways that culture and individual experience impact their use and selection of contraception methods.

Appendix A: Interview Questions

1. Do you believe that birth control is easily accessible?

2. What do you think about birth control and its effects, if any, on how our society today treats sexual relations?

3. Have your opinions surrounding contraception changed since you've come to college? If yes, how so?

4. Do you use a method of birth control? If you do, why do you choose that method?

5. If you use birth control, do you receive reactions from others you know?

6. If you have a partner, how active are they in your decisions regarding birth control and other contraception?

7. In the past month, have you had sex without contraception?

8. Did you receive sex education? Can you describe it?

9. Did you receive any education about birth control? What did it include? When did you learn about birth control and from who?

10. Have you ever used an emergency contraception, like Plan B?

11. Can you tell me where you are from, and describe the community?

12. Were you raised with any particular religion?

13. Do you believe that how you were raised affects how you view contraception today?

14. Is there a particular political party you identify with?

15. What is your age? How long have you been at Georgia Southern?

16. Are you currently in a relationship? If yes, how long have you been together?

Appendix B: Survey Questions

1. What is your current relationship status? Check all that apply.

2. The following graph will address your education about sex. Select 'yes' or 'no' depending on when and if you received sex education during the various levels of school. ONLY indicate yes if you learned about the subject directly from a class. If you do not remember, select 'unsure.'

3. What birth control do you use or used, if any?

4. Where have you obtained most of your information about birth control and sex?

5. Have you ever taken an emergency oral contraceptive, such as Plan-B, Ella, or Next Choice?

6. How often do you use condoms or other barrier methods combined with hormonal birth control during sex? (i.e., using a condom and the pill at the same time)

7. In the last month, how many times did you conduct sexual acts that could have led to pregnancy?

8. In the last month how often have you had sex that could have led to pregnancy without using contraception?

9. If you are currently in relationship, what impact (if any) has your partner had upon your contraception choices?

10. Would you say your opinions about contraception have changed since you've come to college? If so, how have they?

11. Do you identify with a religion? Please list any below.

12. Here is a 7-point scale on which the political views that people might hold are arranged from extremely liberal (left) to extremely conservative (right). Where would

you rate yourself on this scale in regards to topics related to healthcare, sex education, and abortion?

13. Choose one or more races that you identify as:

14. Which of the following best describes your sexual orientation?

15. What gender do you identify as?

16. How old are you?

17. Which year are you in college?

Appendix C: Informed Consent

GEORGIA SOUTHERN UNIVERSITY

COLLEGE OF Liberal Arts and Social Sciences

Department of Sociology and Anthropology

INFORMED CONSENT

1. My name is Katie Keith. I am a senior anthropology student at Georgia Southern, and I am conducting this research to gain an understanding of how college-age women view and utilize contraception.

2. Purpose of the Study: The purpose of this research is to examine how women in the university have come to use and view contraception during their college careers. This research will complete my honors research project.

3. Procedures to be followed: Participation in this research will include an audio-recoded discussion of how participant's beliefs about contraceptives, birth control, and abortion.

4. Discomforts and Risks: You could potentially be uncomfortable talking with me.

5. Benefits: You will be contributing to my original research for my honor's research.

6. This interview will take 30-45 minutes.

7. Statement of Confidentiality: This study will be confidential, and I will not share any identifying information (such as your name) with anyone. All information I gather will be without identifiers and on a password-protected computer. After the honor's theses presentations, I will destroy this information in May of 2020.

8. Right to Ask Questions: You have the right to ask questions and have those questions answered. If you have questions about this study, please contact the researcher named above or the researcher's faculty advisor, Dr. Jennifer Sweeney Tookes at (912)478-6587. For questions concerning your rights as a research participant, contact Georgia Southern University Office of Research Services and Sponsored Programs at (912)478-5465.

9. Compensation: There is no compensation for participating in this study.

10. Voluntary Participation: You do not have to participate. You may refuse to answer any and all questions, and can end the interview at any time.

11. Penalty: There is absolutely no penalty for not participating in this study.

12. You must be 18 years of age or older to consent to participate in this research study.

13. You will be given a copy of this consent form to keep for your records.

You will be given a copy of this consent form to keep for your records. This project has been reviewed and approved by the GSU Institutional Review Board under tracking number H17211.

Title of Project: Examining Origins and Reasoning for Beliefs Surrounding Contraceptive Practices in College Women
Principal Investigator: Kathryn Keith, (404)414-3545, Georgia Southern University, kk03526@georgiasouthern.edu
Faculty Advisor: Jennifer Sweeney Tookes, (912)478-6587, 1018 Carroll Building, jtookes@georgiasouthern.edu

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