Attitudes of 30 American Indian Women Toward Birth Control

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SINCE the Navajo Indian Reservation was founded in 1886, the population of the Navajo tribe has trebled despite an infant mortality rate almost three times the national average (74.7 per 1,000 live births as opposed to 26.3 per 1,000 live births for the rest of the country). The Public Health Service reports an annual increase of 2.3 percent in the Navajo population, while the national average is 0.9 percent per annum, reflecting predominantly the increased Navajo birth rate—38.7 per 1,000 compared with 25 per 1,000 for the general population. Nearly 60 percent of the Navajo are under 20 years old (median 18.8), while more than 50 percent of the general population are over 30 (median 28.2) (*1*).

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For a tribe trying to scratch out a living on a piece of land, most of which is arid, barren desert, the ever-increasing problem of over population is indeed grave and sorely in need of remedy. Toward this end, a project was undertaken in summer 1970 to study the knowledge, attitudes, and opinions of Indian women concerning birth control.

Method

I interviewed 30 women who had delivered at the Gallup Indian Medical Center (GIMC) 2 to 3 days following their delivery before they left the hospital. In each instance the interview was conducted in private, except when a bilingual obstetrical nurse was needed as an interpreter. When it was impractical to conduct the interview at the bedside, for example, in the four-bed wards, the patient was interviewed in a treatment room because the apprehension aroused by morning to a private room for a special conference was outweighed by the advantage of not conversing in front of other women.

The interview was kept as open ended as possible, and an attempt was made to avoid a routine question and answer session. In addition, I tried to make the interview informational for the patient by explaining the types, function, and method of operation of birth control whenever the need arose.

Thus, as with any good research project, the investigational process had a direct and immediate beneficial effect on the interviewee while the relevant data were being collected. I did make it clear, however, that I was not trying to push birth control on the women, and that my purpose was only to discern their opinions, describe what was available, and answer their questions. The interview sessions, as a rule, lasted 25–45 minutes and went smoothly, considering the intimate subjects discussed.

After each interview, I tried to objectify the material obtained during the session by filling out a questionnaire that I had previously devised (see box). The final summary of data was obtained from these questionnaires.

Results

The study group. A general note is in order concerning the bias of the sample selected for this study. Several of the variables, for example, distance from the patient's home to a paved road; her age, religion, education, and language preference; her acculturation in general—hence her life style—reflect that the study was done among patients at Gallup Indian Medical Center. The Center encompasses the largest hospital close to the reservation.

Since the Center serves Gallup, N. Mex., the largest town near the reservation, in addition to handling referrals from the outlying clinics, the patient population comprises primarily Indians who live in and around Gallup and who are more likely to be acculturated to the Anglo way of life than their counterparts deep within the reservation. These factors should be kept in mind when the selected results are subsequently interpreted.

The ages of the interviewees ranged from 18–40, with a mean of 25.4 years. Of the women interviewed, 26 were full-blooded Navajo, one was Hopi, one was Zuni, and two were of mixed Indian blood. I found no particular differences among the tribes in their attitudes toward birth control, but the sample was obviously too small to support any firm conclusions.

Of the 30 women, 23 were married, five were single, and two were unmarried but maintained a stable relationship and had plans for marriage in the near future. Although difference in attitudes toward unwed pregnancy in the Anglo and Indian populations is not the focus of this report, few, if any, of the seven single women with whom I talked were ashamed of their out-of-wedlock pregnancy. Even the most sophisticated Indian women felt that only an intention to marry, however indefinite, was sufficient justification for having the child. Most of the unwed women did not even feel the need for such an intention but accepted the child or children with little or no guilt feelings.

The women interviewed had an average of 9.8 years of schooling ranging from a maximum of 3 years of college to a minimum of no formal academic training. Navajo was the sole language of six women, 11 were conversant in either Navajo or English, and 13 preferred to speak English.

Twelve sexual partners of these women held semiskilled jobs, seven had skilled occupations, three were in military service, two were students, one was unemployed, and two women did not know what jobs their partners held. The male partners were the sole support in 13 families, six couples had both man and woman working, five couples were supported in total or in part by parents, four families received some welfare assistance, and two women were self-supporting.

The men involved were in the following categories: 23 were married to the women interviewed; two were single but intended to marry the woman in the near future after finishing their military service; and five were unmarried, did not cohabit with the women involved, and had no plans for marriage. Usually married couples had the same educational level; however, this was not necessarily true for the unmarried women and their partners. The ages of the men ranged from 19–48 years.

Effect of other relationships on patients' attitudes. The average number of children of the women interviewed was 3.2. Considering that many of the women were in the hospital for their first pregnancy and desired to have more children, this figure will be somewhat higher when the number of children in each family is complete. For example, the average was 5.3 children in the families of the seven women who had definitely decided that their families were large enough. Among the 30 women there had been 102 pregnancies, including six miscarriages, one induced abortion, and one set of twins. The interviewees were the daughters of women with an average of 7.3 children.

I tried to evaluate how close the patients were to their parents and to their husband's parents and how these relationships might affect their opinions about birth control. In summing up the answers received, only one woman was detached from both sets of parents, and only seven of the 30 did not have at least one parent to whom they were particularly close. The Navajo indeed depend heavily on a closeknit family structure. However, parental influence does not seem to be a primary factor in attitudes toward birth control, since a large proportion of the women do not discuss birth control with their parents, their friends, or even their husbands!

For instance, when asked how their friends, parents, and spouse felt about birth control, the interviewees gave the following answers.

Relationship to patient	*Positive*	*Don't know*	*Negative*
Women friends	11	15	4
Mother	11	16	3
Father	8	19	3
Husband or boyfriend	15	12	3

Few of the women I talked with felt any pressure from parents for or against birth control, and those who guessed there would be parental opposition did not bring up the subject. I was surprised by the number of women who, although they knew about birth control methods and had just had a baby, had never discussed contraception with their spouse. Perhaps this reflects a traditional Navajo belief (which I believe is on the wane, but which nevertheless colors Navajo female thought) that a woman is of no worth to a man unless she can bear him children. Rather than risk being left without a husband, the woman does not raise the issue of birth control. I observed that when the husband was consulted, the decision often rested with him. The women would not make a move without assurance that the husband was in complete agreement.

Twenty women said that they wanted to have this baby, and seven said that they definitely did not want this baby. Three young single women said in almost identical words that they were initially unhappy when they found out they were pregnant. As the pregnancy progressed, however, and they got moral support from their parents, grandparents, and other older relatives more firmly embedded in traditional Navajo beliefs, they wanted the baby more and more, and they accepted it without question or guilt. These three women were examples of the confusion so common among Navajo youth that is caused by the clash between Anglo and Navajo cultures.

When asked how many children they ultimately wanted, 19 women wanted no more than four children. The calculated average came out to be 4.4 which is significant when compared with 7.3, the average number of siblings in the families from which these women had come. Twenty-five interviewees felt they had the right to determine how many children they would have, only two thought that they should have as many as they got (without interference), and three were undecided.

At several points in the interview, I asked the women their opinions about other women and what was best for other women. A striking number of interviewees did not want to speak for or about others. Comments such as "I don't know," "Whatever they want," or "It's their business" were frequent responses to these types of questions.

Often the women said the number of children depended on income, and that the ability to support a family should be the sole determinant of its size. Only one woman had more children (four) than she felt a couple should have (two). Eighteen women responded, "Yes," when asked if the Navajo as a rule have too many children for their area and income, while five said, "No," and six were undecided. One woman gave a brief insight into Navajo thought when she responded to this question, "Yes, but they're happier that way."

History With Birth Control

Nine of the 30 women had used some form of birth control, and four of the nine had used more than one type. Seven women had used the pill, four had tried the IUD, two had used the rhythm method, and one 40-year-old had used a Navajo herb medicine which she claimed had kept her from getting pregnant for the past 3 years.

Of those on the pill, three had no side effects; two had such severe side effects that they stopped taking it; one thought she was pregnant, stopped, then did get pregnant; and one forgot her pills on her vacation and got pregnant during that time. Of the four women who used the IUD, one had minor problems with it, two had to stop because of side effects, and one claimed to have gotten pregnant with it in place. One of the two women using the rhythm method became pregnant, and the one woman on Navajo medicine claimed no ill effects from the potion.

Therefore, of the 14 times that a contraceptive method was stopped, twice it was intentionally to get pregnant, four times it was because of side effects; once the woman "just wanted to change methods," three pregnancies occurred because of apparent contraceptive failure, and four pregnancies occurred because of misinformation or misuse of the method. The last two categories are alarming because they show that half of the efforts to practice birth control by women in this sample led to pregnancy.

BIRTH CONTROL QUESTIONNAIRE

1. **Name**
2. **Address** **Miles from paved road** **Condition of road**
3. **Birthdate** **Age**
4. **Navajo** **Zuni** **Hopi** **Laguna** **Other** **Mixed**
5. **Religion** Traditional or regular Sunday participant
6. **Marital status** Married Single Divorced Separated Widowed
   Unmarried but living in a stable relationship with one man
7. **Occupation** Housewife Work at home Hold job
8. **Education** 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4+
9. **Language preference** English Navajo Other
10. **Husband's or boyfriend's age**
11. **Husband's or boyfriend's occupation**
12. **Husband's or boyfriend's education (years)** College
13. **Number of children**
14. **Ages of children**
15. **Source of income** Husband's job Self Job Welfare Social security Parents

Health History

16. **Pertinent hospitalizations or operations**
17. **Number of pregnancies**
18. **Number of miscarriages**
19. **Number of induced abortions**
20. **Number of brothers**
21. **Number of sisters**
22. **Position in family**
23. **Closeness to mother** Detached Average Close
24. **Closeness to father** Detached Average Close
25. **Closeness to husband's family** Detached Average Close

Birth Control Attitudes

26. **What problems did you have in this pregnancy** None Minor Major
27. **Who was the father?** Husband Cohabitor Other
28. **Did you want to have this baby?** Yes Undecided No
29. **How many children do you want to have?**
30. **Do you want to have more?** Yes Indifferent Undecided No
31. **How many children do you think a person should have?** Number As many as she wants
32. **Do you think the Navajo have too many children for their area and income?**
    Yes Undecided No
33. **Do you think a person should be able to determine how many children she should have?**
    Yes No opinion No
34. **If yes or no, do your women friends agree?** Yes Don't know No
35. **Your mother?** Yes Don't know No
36. **Your father?** Yes Don't know No
37. **Your husband?** Yes Don't know No
38. **How did you feel when you found out that you were pregnant?** Positive Indifferent Negative
39. **Have you ever used a form of birth control?** Yes No
40. **If yes, what kind?** Pill Intrauterine device Condom Withdrawal
    Foam Diaphragm Sterilization Hysterectomy
41. **If yes, how long?**
42. **Were there any side effects?** None Minor Major Cause to stop
43. **Why did you stop?** Still in effect To get pregnant Side effects Other
44. **Were you using it when you became pregnant?** Yes No
45. **What other methods of birth control do you know about?** Pill Intrauterine device Condom Withdrawal Foam
    Diaphragm Sterilization Hysterectomy Other None
46. **Will you be on any form of birth control after leaving the hospital?** Yes No
47. **If yes, what kind?** Pill Intrauterine device Condom Withdrawal Foam Diaphragm
    Sterilization Hysterectomy Other None
48. **How does this make you feel?** Positive Undecided Negative Depressed Afraid Relieved
49. **If not, why not?** Against religion Against culture Want children
    Tried birth control but stopped Afraid of side effects Other
50. **What do you think about women who use birth control?** Positive Indifferent Negative Describe
51. **Do you know what sterilization is?** Yes No If so, what?
52. **If you are not on birth control, would you consider it?** Yes No
53. **If so, what kind?** Pill Intrauterine device Condom Withdrawal
    Foam Diaphragm Sterilization Hysterectomy Other
54. **What kind of birth control is best for other Navajo women?** Pill Intrauterine device Condom Withdrawal
    Foam Diaphragm Sterilization Hysterectomy Other None

The women were asked what methods of contraception they knew about, and the following table summarizes the answers they volunteered.

Birth control method	*Number who had heard about it*
Oral contraceptives	25
Intrauterine device	18
Sterilization	13
Rhythm	2
Hysterectomy	1
Navajo medicine	2
Condom	1
Spermicidal foam	1
Diaphragm	1
Knew of no methods	2

Only two women out of 30 sampled had ever heard of more than three types of contraception.

Post Partum Planning

When asked whether they would use any form of birth control after leaving the hospital, 16 said yes, five said definitely no, and nine were undecided but were considering it (mostly waiting to discuss it with their husbands). Nine of the 16 who said yes were planning to use the pill, two were going to use the IUD, four would be sterilized, and one did not know what type she would use.

The group that did not want contraception or were still deciding about it gave the following reasons for their refusal: I judged that four felt it was against their culture, although they did not say so outright; one woman had had trouble with birth control devices and was unsure about resuming their use; five feared side effects; one woman "just didn't want them"; and one woman wanted another child right away. Among the 30 women, 17 said they knew what sterilization was: 11 were correct, five had a vague notion, and one woman thought it prevented intercourse. Only two of the 17 mentioned that sterilization was a procedure that could also be applied to men.

General Observations

I feel that the sample in this study is far too small to try to evaluate birth control attitudes statistically in relation to each individual variable. My work should perhaps be considered a pilot study for a more complete, indepth effort along my guidelines. I have tried to point out statistical correlations when they were pertinent and obvious, but a detailed analysis would be beyond the scope of this project both in intent and feasibility.

What can be gleaned from this information though, is a description of the six types of women interviewed. This categorization is by no means exhaustive, but each category is distinct, and the range of all six seems to cover this sample fairly well. I believe this can be an adequate framework from which to look at this female population's attitudes toward contraception.

TYPE 1. These three Navajo women were typically traditional in their dress, customs, and ideas. To them birth control is part of the Anglo world in which they have little interest. Contraception is not an issue to be discussed openly, and the use of any form of birth control is absolutely out of the question. They know little about birth control methods and do not care to know more. They often come from a large family and have one themselves. They usually are in their 30's or early 40's, married, and quite set in their ways. For them, the number of children they "decide" to have is the number they end up with, since pregnancy cannot and should not be tampered with.

TYPE 2. These two housewives, aged 24 and 31, were acquainted somewhat with one or two methods of birth control but were against them in principle. Because of cultural or moral convictions, they felt contraception was wrong and they were a little reluctant to discuss the issue. Particularly since they had not had their full family yet (one and four children, respectively), they did not really want to confront the issue, and so they will postpone any final decision until the matter is critical. They do not have much to say about birth control because they are trying not to think about it. Their backgrounds are coming into conflict with their practical needs, and it is not a comfortable situation.

TYPE 3. In the third category were seven women, moderately young, single or married, who had done some reading or thinking, or both, about contraception. They were not against it in principle but were afraid of the side effects, both physical and mental. Purportedly they are afraid of thrombophlebitis or possible harm to future pregnancies, but if the conversation continued, these women claimed to accept birth control in principle but revealed guilt feelings about tampering with something forbidden. Usually these women had never tried birth control and had only the popular press as a source of information regarding the effectiveness, dangers, and techniques of contraception.

These women often had many questions, and I was particularly helpful in resolving problems for this group. This type of woman would like fewer than four children and saw the way to achieve this goal, but was afraid to take the big step to contraception. After much deliberation and counseling, most of these women will try some form of birth control.

TYPE 4. The seven women in type 4 accepted the principle of birth control and had usually tried one or more methods. However, because of contraceptive failure, misinformation, or side effects, they were confused about which method to use after having a baby. Here again, I felt I helped the women by explaining why their method failed (often it was misapplication of the technique) or by describing alternative methods to those who desired to change. These women wanted to space their children and limit the size of their families but lacked sufficient information.

TYPE 5. The women in category 5 comprised the "swingers" and the "jet set" of the Indian population. These seven women were young, college-educated, quite acculturated to Anglo ways, and for them, birth control is an accepted procedure—"the thing to do," as one told me. Theirs is the new morality of which the pill is an important, if not essential, part. Although most of these women knew a sufficient amount about contraception, more than once I was told stories like the one about the woman who forgot her pills on her month-long vacation, but naively continued sexual intercourse, resumed her contraceptives when she got home, and then reported to the clinic 3 months later embarrassed and pregnant.

TYPE 6. Category 6 included four women who were convinced that they had enough children and who wanted to have their tubes tied. Their attitudes toward birth control ranged from the woman who believed firmly in birth control, had tried three different methods (all of which failed), and then turned to sterilization—at age 30—as a last resort after her 10th child to the woman who did not believe in other birth control methods, but was sure that eight children were enough, and decided that sterilization did not conflict with her values. Burdened with many children, these women saw sterilization not as something for which they had planned, but as a final effort to rid themselves of continual pregnancy. Relatively few of these women came to the clinic asking to be sterilized but when the possibility was presented to them and the consequences were carefully spelled out, they became convinced that it was right for them.

I am not implying that sterilization is forced on every grand-multipara who delivers at Gallup Indian Medical Center. However, as with any form of birth control, a large measure of explanation, patience, and reassurance is necessary so a woman can have all the facts and make up her own mind without the pressure of groundless fears.

Conclusion

As I recall my experience in Gallup, I see a pressing need at GIMC for a full-time, bilingual specialist in family planning. The inadequacies in the explanation of the birth control methods available, how they work, what to expect, and the risks involved are apparent.

The staff of the obstetrics and gynecology department cannot be held responsible for this information gap because they could not possibly have the time to spend the half hour to 45 minutes with each patient necessary to discuss the subject completely. Contraception is too personal and too fragile a procedure to undertake without the fullest understanding, cooperation, and desire of the patient.

A specialist in family planning, preferably a woman, who could advise women during their prenatal visits, and again in depth after their delivery, is needed to help solve some of the birth control problems of the GIMC patients. (As a result of this project, an effort is now underway to obtain a substantial grant from the Federal Government to fund such a position at Gallup Indian Medical Center).

Perhaps more important than any general theory that can be asserted because of this work is the manner in which this study was carried out. For the women, the interviews were educational and profitable experiences. The patient benefited from her participation in this research both in the short run and the long run. She gained in the short run by direct airing of opinions, prejudices, false beliefs, and queries. I hope all the patients will gain in the long run by an increase in Federal money to employ a full-time bilingual specialist in family planning. Positive benefit for each participant in any project should be the goal and concern of every researcher who plans a study.

REFERENCE

(1) Kluckhohn, C., and Leighton, D.: The Navajo. Doubleday & Company, Inc., Garden City, N.Y., 1962, pp. 51–53.