“This Method, I Think, Can Shed New Light”: Haitian-American Women’s Reflections on Risk, Culture, and Family Planning Decisions From a Short-Term Trial of a Cervical Barrier (Femcap™)

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Abstract
Improving the reproductive health of immigrant populations requires understanding the specific context of risk and need. As part of a field trial of the FemCap™, a woman-initiated cervical barrier contraceptive, we conducted postintervention focus group discussions (FGDs) with 20 women (five FGDs) of Haitian background, the majority of whom were born in Haiti and spoke Haitian Créole at home, at a community health center in south Florida. Participants discussed the role of religion and inequitable gender norms in Haitian traditions about family planning decisions and provided important insights into the gender-power nuances of their partnership dynamics vis à vis the use of female barrier methods. Encouraged by more equitable gender norms in the United States, participants were eager to serve as health education agents, with strong altruistic sentiments toward other Haitian girls and women who they felt could be encouraged to negotiate for greater reproductive decision-making power.

Keywords
Haitian-American women, Femcap™, female barrier methods, contraception, family planning, immigrants, gender, reproductive health multipurpose prevention technologies

Providing quality, up-to-date reproductive health (RH) and family planning (FP) information and services for women in low-resource areas including immigrant settings is an important global objective and part of national and international conventions.1,2 In the United States, many immigrant communities experience less than adequate health information and health care for numerous reasons—including a poorly resourced community, language barriers, and trust barriers—resulting in isolation of the community from the level of medical and public health know-how and technology available to the larger society.

In particular, the menu of FP methods for immigrant women is often narrow, and women are routinely channeled toward long-acting methods—such as long-acting reversible contraception (LARC)—including hormonal implants and the intrauterine device (IUD)—or hormonal injections, all of which minimize the role (and even the understanding) of users and involve a long-term medication strategy, often with side effects, that are unacceptable to some users. The reproductive justice shortcomings of limited FP choices for poor communities of color has been an enduring problem, and a recent round of literature has discussed this topic anew in light of the flurry of pharmaceutical developments and the RH field’s heightened promotion of these methods, especially to poor and minority women.3–6 Prior studies7–13 including our own14,15 have demonstrated that many women from low-resource, immigrant, or otherwise low literacy environments are eager to learn about and try simple, coital dependent barrier methods, such as diaphragms and cervical caps, who may prefer them for numerous reasons—including incompatibility of cultural values of health with side effects (e.g., delayed return to fertility, bleeding irregularities, as above, or bad blood from hormone
administration\textsuperscript{16}, impact of hormonal side effects such as weight gain, fatigue, headache on women’s often triple burdens of childcare, paid work, and domestic responsibilities, inability to immediately terminate \textit{medium term} (e.g., 3 months) hormonal methods such as injections when side effects become intolerable, limited access to care thus limited control over securing removal of methods such as implants or IUDs,\textsuperscript{3} historical mistrust of FP programs due to the legacy of eugenics,\textsuperscript{3–5} experiences of racial/ethnic discrimination,\textsuperscript{3–5} and hierarchical and patronizing attitudes during prior FP program interactions (including belittling of women’s experiences, fears, and concerns about method side effects).\textsuperscript{3,16} Despite this clear need for expanded choice in a FP menu, female barrier methods are often not promoted or available in such communities, and there is a documented provider bias based on the concept that women cannot successfully understand or use them.\textsuperscript{17–19} This continuing health disparity takes on even greater importance because the female condom—a female barrier method—remains to date the only demonstrated highly efficacious, women-initiated option ensuring autonomous protection against sexually transmitted infection (STI)/HIV. The development of future multipurpose prevention technologies (MPTs)\textsuperscript{20,21} will surely include female barrier methods as a mainstay; two recent trials confirmed a female-inserted, tenofovir-loaded vaginal ring to be effective in reducing risk of HIV, and development is underway for the ring to combine both contraceptive with disease-reducing properties.\textsuperscript{22,23} Thus, health-care providers must integrate vaginally inserted methods as a resource in reproductive and sexual health counseling with women, offering clients opportunities to learn their use.\textsuperscript{24}

Our Femcap field trial, which served as the context for this qualitative study, was conducted in an area of Miami densely populated by Haitian immigrants. The aim of the trial was to assess initial reactions to a discreet female barrier as a first step to further introduction of such methods into FP practice in the community and as an incremental step toward wider promotion of safe, female-initiated barrier contraception in U.S. minority communities. Cervical barriers may be especially welcomed by Haitian women because of the side effects associated with hormonal methods including menstrual irregularities, which challenges cultural values of body cleanliness,\textsuperscript{16} and due to the discreet nature of these devices, allowing women to avoid pregnancy and potentially violent confrontations with partners forcing unwanted sexual intercourse.\textsuperscript{14} In addition, barrier methods allow for a high level of control (i.e., interrupting use) when pregnancy is desired—an important feature in Haitian culture where, for women, childbearing is an obligation and represents an important strategy in securing relationships between men and women.\textsuperscript{16,25}

We have previously shown that women enrolled in this Femcap\textsuperscript{TM} field trial had mainly positive experiences during their short-term experiences with the method and wished to continue use following the study.\textsuperscript{14} The present study, through qualitative research, examines focus group discussion (FGD) data collected during the pilot study. Postintervention interviews are often used to further the cultural adaptation and tailoring of a behavioral intervention, to maximize cultural relevance, and to improve effectiveness and impact. We were eager to learn more about partners’ needs and reactions to these programs and to more fully illuminate the range of perceived barriers for women who might have impeded enrollment into our pilot study or attendance at the community clinic where it was held. Finally, we were interested in the level of network communication about the program, and the potential of such a mechanism to be harnessed as a health promotion strategy to further penetration into the community.

### Methods

**Recruitment and Study Sample**

Institutional Review Board approval for this study was obtained from the Florida International University Institutional Review Board. All women underwent informed consent procedures in Haitian Créole, or English if preferred, and provided written consent. Twenty Haitian and Haitian-American women were recruited from a free primary care clinic located in the Little Haiti section of Miami, and from the surrounding community, through word-of-mouth and posted flyers. Enrolled women were counseled, fitted for a Femcap\textsuperscript{TM} device at a clinical site, and followed for several weeks following device fitting. The Femcap\textsuperscript{TM} is a small, flexible silicone device inserted onto the cervix that adheres via gentle suction and can be worn for 48 hours continuously to provide contraceptive protection. One initial application of spermicide inside the device is required prior to placement.\textsuperscript{26,27}

Women were enrolled if they agreed to insert the Femcap\textsuperscript{TM} at home and provide initial user reactions at a clinical visit shortly thereafter. Women were not required to agree to use the device during intercourse or to talk to their partners about the study or the device. We primarily sought women’s reactions to the insertion, removal, and wear of the device at home. User feedback was also sought regarding experience of the device during intercourse for those women who reported it. Study counseling encouraged women to continue their usual contraceptive practice, if any, during the period of study involvement. We stressed the importance of concurrent male condom use for protection against STI/HIV. Although cervical barriers have long been thought to reduce risk of HIV/STI by impeding access to cervical tissue (and the upper reproductive tract),\textsuperscript{26,29} study funding on this prevention pathway has been poor, well-designed studies have been few, and data interpretation in the one large, well-designed trial hindered by differential adherence.\textsuperscript{30,31} Our counseling indicated to women that the evidence was as yet insufficient to warrant use of the device for this purpose; we demonstrated in anatomical diagrams how male and female
condoms provided the most complete protection of genital mucosa against infection.

Eligible women were between the ages of 18 and 45 years, heterosexual, active, self-identified as Haitian or Haitian-American, and literate in Haitian Créole. Women were excluded if they were pregnant or seeking pregnancy; up to 3 months postpartum; or had cervical abnormalities, clinical signs of cervicitis, or a history of toxic shock syndrome.

**Study Procedures**

Study procedures included two study visits. The first visit included the administration of an interviewer-administered questionnaire by a trained staff person and collection of demographic, RH, and sexual risk information. A small discussion group was also conducted by the same staff person during which information was presented on women's anatomy, contraceptive options, proper use of the device (including spermicide use), risks and benefits, effectiveness, and comparisons with other contraceptive methods. The approach was modeled on prior work with a woman-focused body empowerment intervention. The counselor invited interactive questions and answers. Participants then individually underwent a clinical (speculum) examination and were fitted with a cervical cap by a health provider. During this examination, the provider fitted the correct size Femcap™ and then required the participant to remove and reinsert the device at least once correctly before she left the office. Women were offered additional practice with the clinician if desired throughout the study period. The clinician reviewed rules of correct use and answered questions. The women were supplied with a device as well as a tube of spermicide, for home use, consistent with standard practice for this device. The duration of Visit 1 ranged from 2 to 4 hours due mainly to waiting time; the clinical visit itself was approximately 30–45 minutes.

Visit 2 occurred generally 3 to 4 weeks (mean 24.3 days) after the first study visit. At the second study visit, women first completed a short, interviewer-administered questionnaire (administered to women individually) on their perceptions/preferences with regard to cap use. We have reported on the results of the quantitative assessments in prior publications.

Participants then attended a FGD, conducted by one of the qualitative researchers (J. D. and M. J. G.) mostly or completely in Haitian Créole. The qualitative interviewers were not involved in prior study procedures. FGDs were audiotaped to collect qualitative material to complement the quantitative data on adherence and to contextualize women's responses to the device. Two trained staff persons (a physician not associated with prior study procedures and on one occasion, the study counselor) also made note of representative comments during the FGD. These helped to complement audiotaped material where comments were inaudible or on occasion, not easily attributed to a specific participant. Women were allowed to keep their devices for continued use after the study if they wished. Following the FGD, any misconceptions or misinformation about how to use the Femcap™ or the type of protection it provided were addressed by the group leader (e.g., the misconception that the cap protected against sexually transmitted diseases). Study participation was then terminated after the second visit.

Participants were compensated for each visit with U.S. $20 cash. We attempted to maintain group cohesion and consistency over the study calendar (i.e., scheduling the second visit with the same group of women as for the first visit); however, this was not always possible. The 20 women participated in five focus groups ranging in size from four to six persons.

The audiotapes were transcribed verbatim (in Haitian Créole) and then translated into English by a bilingual study team member of Haitian background with nursing and public health degrees (SPS-R). The three-person qualitative analysis team first independently read the translated passages (and for two researchers, referred when necessary to any ambiguous passages in the Créole transcripts) and then met together to code responses by major theme. We used open coding to explore and organize the transcript data within the broad conceptual domains used in the focus group guide (see below), allowing for the empirical data to guide our organization of themes below, and particularly when responses comprised more than one focus group guide domain.

Our focus group guide targeted 10 thematic areas: (a) reasons or motivations to enroll in the study, (b) concerns about the cap before experiencing use, (c) concerns about the study overall, (d) overall experience trying the cap, (e) partner reactions and sharing with partners, (f) sharing with people other than partners, (g) prior use of other vaginal devices, (h) barriers to use of vaginally inserted protection, (i) circumstances or reasons that increase Haitian-American women's risks for unplanned pregnancy, and (j) impact of study participation.

**Results**

**Profile of Study Participants**

The mean age for the 20 participants was 32.6 years (range 19–45 years). The majority of the participants were born in Haiti (75%) and spoke Haitian Créole as their primary language (80%). Most had lived in the United States for at least 5 years and had at least a high school diploma (85%); approximately a quarter had college degrees (25%). Most women were married and almost all had children (mean parity, 2.8). The majority (80%) reported having a primary sexual partner in the prior 3 months. Two women had both primary and nonprimary partners. Most were unemployed (70%) and lacked any form of health insurance (80%). Very few women (5-10%) reported prior use of the female condom, cervical barriers or spermicide; a greater percentage reported prior use of Norplant (hormonal injection; 15%) and of oral contraceptives (25%). Most women reported some prior use.
of male condoms (90%). All women (as per study inclusion criteria) indicated they were not seeking pregnancy soon; however, two thirds reported recent unprotected sex. Few reported either a recent medical visit for contraception or recent FP counseling.

**Reasons for Study Participation**

Reasons for study participation generally revolved around the desire to plan pregnancies; for most, this meant limiting further childbearing, but the women brought different contexts to this motivation. One woman mentioned that she could not have additional children for health reasons; others noted their desire to continue their studies. A younger, nulliparous woman wanted to avoid becoming pregnant too soon; an older woman with four children mentioned that it was not good to continue becoming pregnant after a certain age.

The kids... the first one is 15. The second one is 12. The third one is 8 and the fourth one is 3. I thank God for them. I am very happy for the help you are providing me with the birth control to stop having kids. When you’re getting older it is not good to keep having kids. I thank you for that.

Another woman, who had seven children, spoke about wanting to become educated so that her children did not have to go through what she went through.

A number of women mentioned health concerns in connection with methods they had either used prior or had heard about, including constant bleeding and weight gain with injectables and fear of the IUD.

I've tried the injectable Pilplan, but I didn't feel well with it.

Because I'm not consistently sexually active I stopped taking the shots.

You know the thing that they put in you... hum... IUD. I have a family member who have used it and had side effects. They had to go to the hospital. I didn't want to deal with anything like that because I still want to have children.

Less frequent was the response that simple curiosity motivated study participation.

**Experiences With the Femcap™**

Although prompted to speak about any prestudy concerns regarding the device or study protocol, women did not volunteer any responses on these subjects; instead, they eagerly moved right into their experiences with the device. The discussion therefore generally progressed from initial thoughts and reactions (upon viewing the Femcap™); to actual experiences learning use of the device, followed by overall feelings about the method.

Initial. Initial reactions upon viewing the Femcap™ ranged widely, from fear to curiosity to doubts about efficacy. One woman said at first she was scared but then after the nurse explained its use and insertion, she realized it was not hard to insert. Others had doubts:

I knew it was going to get lost.

[I doubted that] a little thing like that could prevent someone from getting pregnant.

Some women wanted to get the go-ahead from the obstetrician-gynecologist on site before continuing with the study.

First insertions. Most women, not surprisingly, had difficulty the first time feeling comfortable with insertion and removal of the Femcap™ and appreciated provider’s help and feedback. More difficulties were had with removal because of the need to find the correct place to put pressure with the finger to break the cap’s suction seal and because of the initial frustrations at feeling like the device was stuck. These initial difficulties did not prevent women from trying the device again or seem to serve as barrier to continued use. Of note, women did not mention any conflicts with cultural values in touching their genitals; nor did we note any references to body cleanliness issues with cap insertion of removal, this last aspect standing perhaps in contrast to the expressed notion in other work16 regarding the vaginal bleeding side effects from hormonal products as representing lack of cleanliness in Haitian culture.

One woman recalled her reactions to the cap adhering strongly after first placement:

It didn't want to come out. I didn't like that experience but I don't really hate it.

For numerous others, the first insertion, though requiring training and feedback, proceeded without problem. A typical comment was:

Putting it on was a breeze. Taking it out took time.

Extreme overweight sometimes posed a problem for cap training, likely owing to the limited leverage obtained in positioning the hand and fingers to place and remove the cap, as well as the greater resistance of the vaginal walls and pelvis. One obese woman complained that she put it in correctly, but the study clinician could not remove it at first, and that created some doubts.

Overall, women’s comments endorsed the idea that the initial experience of insertion and removal at the clinic was a key feature in feelings of self-efficacy when trying the device at home.

In describing their overall feelings about their several week trial of the device, women often returned to the theme of side
effects or fears with other methods, especially hormonal. One woman spoke at length about side effects of hormones, such as facial hair, and the fact that the cap did not involve those possible side effects. She felt the cap’s two-step protection to be very intuitive and liked that feature:

One, you have the cap to prevent sperm from entering.
Second, I like the spermicide that kills sperms on contact . . . .

it helps you twice not only once . . . . I love that barrier.

Another woman mentioned that she saw no chemicals, only plastic and that made her feel comfortable. Others echoed this feeling that one did not have to worry about side effects, calling the device natural.

One woman, who stated that she got her last pill (oral contraceptives) prescription filled but did not take the pills because of side effects, said she felt lucky to have found the study. She had no difficulties with the device except for some effort required in taking it out.

Numerous women mentioned the convenient aspects of a device that could be worn for several days and provide constant contraceptive protection.

No, it won’t cause any problem. Some people sleep with it.
After you have sex, the earliest you can take it out is 6 hours.
But, if you want to go to sleep, shower, do regular activities for up to 2 days . . . .

Because the device is durable for several years, it was considered economical compared with other contraceptives.

Women also mentioned that it was easy to clean.

**Partner Communications**

Women reported different dispositions with respect to partners. Overall, women stated they wanted to be the one controlling the decision about getting pregnant, some adding that they sought to avoid a long discussion about it with the partner, with one stating, “That is how I got my second child.” Some tried with partners to make oblique reference to using possible contraception but did not specify or get into lengthy discussion. A majority of women endorsed the view that since the woman pays the consequences of pregnancy, it was her decision, her business, and her responsibility to manage her body not to have any more children.

It’s always women who have kids, not men. So, the problems are not for the men. Men don’t need to know everything.

While some did inform the partner about the study and cap use, a number of women did not disclose this information—sometimes in order to see whether the partner could feel the device once in place. Experiences here were variable. One woman quipped humorously about global rating of the device:

From a scale of 1 to 10, I give it a solid 9. It would have been a 10 except he found it.

Others were able to conceal it from a partner, but some informed partners later. For example, one woman told her partner about the study and the device after the second study visit, in the hopes that he would support her decision. When the partner reiterated that he wanted to have children, she told him she would stop using the device. In the FGD, however, she said she intended to keep using it due to her ambivalence about having children.

A number of women mentioned that their partners had positive views of the device or the study. One woman, who had a latex allergy, said her partner was supportive because he “was tired of pulling out.” Another had a partner who did not want to use condoms anymore and who drove her to the clinic. Yet a third had a partner in the allied health field who was positive and supportive.

A few women expressed the idea that the partner should be informed about cap use.

I haven’t had sex while wearing it. I feel comfortable with it, though. However, I told my husband. If I am using it for sex he would know, since I told him about it since the first day.

**Communications With Others**

Women enthusiastically shared their experiences with others (not sexual partners) in their social networks, both male and female. Sharing with others was a universal behavior, unlike sharing with partners. Women systematically reported sharing information about the method and the study with female friends and family members, such as sisters, aunts, cousins, as well as younger members such as nieces, referencing concerns for their need.

It’s a good way to help women.

A younger participant spoke of her reason for recommending it to young friends.

I feel like getting pregnant this early is not something a person that age . . . I am 19 and they’re younger than me, so that’s pretty young. Somebody that age shouldn’t be getting pregnant so early. Even though . . . let’s say, MTV promotes it for ratings, but no, getting pregnant early is not as glamorous as seen on the TV since you realize it’s all the rich, white families on that show.

Some participants also spoke with male friends or acquaintances. One woman spoke with a male friend who had multiple sexual partners and instructed him to show the method to these women. Other participants spoke to church members, both male and female, without specifically referencing the fact that the device was for contraception. Women also reported sharing their experiences with classmates and coworkers.
Prior Use of Vaginally Inserted Protection Including Tampons and Obstacles to Their Use

Knowledge of female intravaginal methods of contraception was extremely low and none of the women reported their prior use. Some women were familiar with the female condom but expressed concerns that it was unaesthetic and visible to the partner. One woman said she had heard of the diaphragm. Women had, however, used other products inserted vaginally such as douches. When asked about their prior tampon use, responses were variable with some women preferring tampon use to sanitary napkins and others having no experience with tampons. Numerous women indicated that Haitian women were wary of tampon use because of their association with sexual experience.

They [parents] think as soon as you use a tampon, you’re no longer a virgin. I myself don’t believe that. Me, I just used it. I was comfortable with it. I didn’t even feel it inside of me.

When I first started going to middle school... like 8th grade, I used a tampon for the first time 'cause that was the only alternative there... and when I got home, I told my mom and she was like, “don’t use this... next thing you know she’s gonna be having sex!” Little did she know...

Another obstacle mentioned was the fear of inserting something in the vagina, due to lack of knowledge about female reproductive anatomy. One woman summarized her frustration:

There are some stuff we are supposed to know... People can be 100 and die without knowing their body!

One exchange was particularly instructive regarding cultural barriers.

Participant: My mom never talked to me about stuff like that. It was me as a young adult who started using tampons.
Moderator: But, how did you get access to tampons? Friends talked to you about it?
Participant: White roommates! [laughing]

Haitian Women and Risk of Unplanned Pregnancy

Participants had multiple and overlapping reactions to our question on what kinds of issues might make Haitian-American women more vulnerable to unplanned pregnancy than other women. Many cited the cultural value that children were the riches of the poor—*Pitit se byen pòl malere*—and that their care is important for their parents in old age, providing a type of social security. Religion was mentioned to play a large role: “God says don’t use anything.” A frequent reply concerned men’s expectations of women and the rigid sex roles involved in unions. Women mentioned that men will “keep the girl at home in order to keep having kids,” and that women were expected to give a child to the male partner in order to have a father for her older children. A common related theme was that women had no decision-making power in the couple as long as she was not economically independent.

Yeah, sometimes when it’s only the man working, women are not allowed to do what they would want to do... They pay the bills... they are responsible for everything. You don’t have the right... you can’t say anything, nothing at all.

When you are married or in a union, if the man wants to have sex 24/24, the woman cannot stand in front of him to say no. It’s like she’s his object.

If the guy is supporting them, they would do anything to please their men.

Others placed traditional gender-based expectations in a more positive light.

I think it’s respect. You know, a lot of Haitian women, they have respect for their husbands... [it’s] the way they were raised.

Women commonly mentioned men’s lack of honesty about their sexual behaviors.

We gave our lives to Christ together. However, that does not mean he is not cheating.

You are at higher risk because the men, they sleep with other women. They sleep with other men, too. They just won’t tell you.

Women expressed anger and frustration about gender-based power imbalances, and many said that living in the United States opened up opportunities for women because of the great difference in societal norms.

My husband could disrespect me in Haiti; but here, he has to control his words. There are laws and consequences.

We are 2 adults, not an adult and a kid... [it should be] equal!

It’s just like here in the U.S., women work and men work. Some women work even harder than men.

On the issue of unplanned pregnancy and childbearing, negative and judgmental views were regularly expressed toward women and couples who continued to have children beyond their means. One woman made an impassioned case citing children’s difficult lives, especially in Haiti, focusing
on the occasional practice of the poor sending children to work in other households in exchange for food and shelter (restavek).

They don’t have even have anything to offer the kids, but still want to have them. The kids are the ones who suffer. They send them to live with other people thinking they’re helping the kids, but it’s not really to their benefit. These kids don’t get to experience joy. A kid needs to be happy to feel the full effect of being a kid. On the contrary, at these other people’s houses, these kids are being put to work. They don’t know what it is to feel like children. They’re no longer in the children stage. They act like adults. I mean, it would be great if this program could reach Haiti. They’ll know they have something to preserve. They’ll protect it not to end up with more kids.

Overall, there was considerable self-talk about empowerment, with some women accenting their personal agency to change power dynamics in relationships, irrespective of economic power.

Truly there are some men who want to have control over women. You understand? But me, what I have come to learn in life is that regardless if a man is supporting you or not, you shouldn’t give them control over your life. You should have control over yourself even if they are taking care of you. But, when I was younger, I thought that it was ok for a guy to have control over me. You understand? But now that I am older, it doesn’t matter if the person is supporting me or not. You should be in control of yourself!

Impact of the Study

When asked about how the study might impact their lives, responses were overwhelmingly positive, with women expressing their happiness and satisfaction. Many women cited the availability of education, about their bodies, and about controlling the process of reproduction, especially in relation to acculturation and opportunity. Here, there was routinely a melding of personal responses with a sense of solidarity and even agonizing position women found themselves in on the threshold of transformative life changes yet held back by profound structural impediments and an entrenched, male-dominated culture and set of customs that would demand a longer time frame to fully evolve.

Further, the notion that limiting child birth in and of itself will expand educational and economic opportunity for women—rather than a primary focus on bringing structural change to improve women’s status while also ensuring high quality, accessible FP without coercion—is part of a long legacy of population control policies still strongly influencing international development approaches. Thus, the negative and judgmental comments about other women expressed here can be seen in some measure to recapitulate this dominant policy discourse, conveying the extent to which study participants have absorbed the heavy message of women’s responsibility for bodily control and thus the fate of their communities.

I would say that this is a good experience. I can’t wait for you guys to take this down there [Haiti] because ... we’re going to have a lot of women having children for men who do not want them to use protection.

I am going to pray that God continue to inspire you to reach out and educate us and for us to give back to you as well.

Discussion

Our study explored women’s reasons for enrolling in this field trial, their experiences seeking to plan pregnancies, and their reactions to study procedures, including enhanced, small group counseling and access to a female-initiated, coitally dependent, nonhormonal method of contraception. Overall, women expressed very positive experiences with the counseling and study device and provided important insights into the nuances in their partnership dynamics that would support the use of a female-initiated method. Participants uniformly expressed enthusiasm about promoting RH knowledge and diffusing awareness about female barrier methods.

Women passionately shared their views about the importance of limiting family size to maximize opportunities for women’s (and children’s) education, quality childrearing, and women’s economic and career development. Testimonials highlighted both the opportunities afforded by migration to a culture where gender norms were more equitable and opportunities expanded for women as well as the challenges in changing the mind-set of partners and the larger community. Judgmental opinions of other Haitian American women’s behavior—including what was described as sexually promiscuous behavior and indifference to FP—were frequently expressed. These comments demonstrated the high levels of frustration and even agonizing position women found themselves in on the threshold of transformative life changes yet held back by profound structural impediments and an entrenched, male-dominated culture and set of customs that would demand a longer time frame to fully evolve.

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Harsh comments expressed about Haitian women and families’ lack of responsibility also extended to the treatment of children and the foster care system of restavek where families
send children to work as domestics with the intention to improve their quality of life. However, this practice often results in children working long hours, missing school, and experiencing physical abuse.

Discussions among women in this study regarding partner negotiation with the Femcap™ were revealing. Numerous women used the device while concealing it from the partner, and we did not hear significant concerns about partner retribution (although forced sex has been documented as a factor in unplanned pregnancy in Haitian women). In fact, some partners were informed after the concealed acts, and, for one or two women, the partner found the device without apparent adverse consequences for the women. It is certainly possible that study women represented a select group that anticipated less retribution as a consequence of discreet use. Also, it is possible that male partners were generally positively disposed toward device use because of less pressure to use male condoms (although we continuously counseled on this point, as stated earlier). Nevertheless, the recounted experiences of women here suggested a certain fluidity of partner communications and the importance of trusting clients’ own sense of their relationship possibilities—a finding also suggested by other work and providing further support for women-centered care. Partner relationships can potentially evolve with greater access to knowledge, a full method menu, greater involvement of men, and changing sexual power norms; FP programming should also be nimble enough to evolve together with these dynamics. We have already witnessed such a situation with the introduction of the female condom, where the mere presence of a female barrier served as a springboard for couples’ discussions about women’s bodies and promoted improved negotiation of safer sex.

A clear and hopeful theme arising from our work was that of women as messengers to spread education and awareness about this device and about women-initiated barriers and the existence of contraceptive choice more generally. Women expressed strong altruistic sentiments toward other Haitian girls and women who could be helped with greater promotion of body knowledge and simple, nonhormonal contraception. Indeed, for some, the act of giving back to other women seemed to represent the major impact of study participation. These women conveyed a painful sense of hopelessness or skepticism about improving gender equity and communication in their own partnerships but clearly derived pleasure at the prospect of bequeathing to others what they could not achieve in their lifetime—being actors against a backdrop of frustratingly limited autonomy. Gender differences in helping behavior and altruism, favoring women, have been documented in a vast prior literature. Less well studied is the impact of acculturation on prosocial tendencies and how this might vary by gender. Our very preliminary work suggests that for women, at least, the experience of cultural transition (and the paradoxes that it presents) enhances basic sympathy and altruistic tendency even further. Our findings support a prior observation that acculturative stress does not always necessitate negative or high-risk tendencies. The feelings of altruism and a desire to help found here among the women participants of the study indicate important potential
resources in public health partnerships aimed at empowering communities and improving health by maximizing diffusion of RH information, including new “multipurpose prevention technology” soon to arrive on the market in the wake of recent successes in vaginal barrier HIV prevention.22

Limitations to this study include the following. We interviewed a small number of women (n = 20). These women also represented a generally more educated selection of the Little Haiti community, and perhaps those with more mobility than other community women, and disposable time, as our study visits of 2 to 3 hours imposed constraints on participation. Our monetary incentive of $20 per visit, though in keeping with other like community studies, was relatively small for the time dedicated; work opportunities or childcare costs (although we accommodated women with children) may easily have competed with this sum. We, nevertheless, through our experiences speaking with some of a larger set of behaviorally eligible women from the clinic waiting room,15 as well as friends of those initially enrolled, who also eventually enrolled themselves, feel that the themes raised by our participants, though perhaps not an exhaustive list, were highly relevant for many community members and point the way for future interventions.

Conclusions

In these FGDs conducted among women of Haitian background living in south Florida who successfully completed a field trial of a cervical barrier contraceptive, women spoke positively about the study’s learning experience and integration of the method into their lives. They endorsed the difficulties in negotiating FP decisions with partners, due to cultural- and gender-based assumptions, but revealed insights into the nuances in their partnership dynamics that would support the use of a female-initiated method. Women testified to the sense of autonomy and safety in FP practice brought by a vaginal barrier. Importantly, the women conveyed a strong impulse to be part of a movement that taught other Haitian and Haitian-American women about their bodies and about female-initiated technologies to use for contraception. This small trial laid a first foundation toward further interventions in the community to expand knowledge of and access to barrier technologies, including those with multipurpose technologies (MPTs)—providing clear affirmation that women value and need these choices, as well as pointing directions toward further work to expand access to these tools via clinic-based interventions.

Declaration of Conflicting Interests

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