Title

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Permalink
https://escholarship.org/uc/item/5j012931

Journal
Perspectives on sexual and reproductive health, 55(2)

ISSN
1538-6341

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Publication Date
2023-06-01

DOI
10.1363/psrh.12226

Title: "She should support me, she's my doctor:" Patient perceptions of agency in contraceptive decision-making in the clinical encounter in Northern California

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Preliminary results were presented at the American Public Health Association Annual Meeting, Nov 2019, Philadelphia.

Word Count: **4,714**

Acknowledgments: We would like to thank Felicia Rodriguez, Grace Chang, Katiana Carey-Simms, Lia Garman and Miriam Parra for study activities; Rosalyn Schroeder, Aleka Gurel, Kaitlyn Morrison and Heather Gould for study oversight; and the UCSF Preterm Birth Initiative Community Advisory Board for guiding our focus group and interview content. We thank the study sites and participants for sharing their views on contraceptive decision-making. The findings and conclusions in this article are those of the authors and do not necessarily reflect the views of Planned Parenthood Federation of America, Inc.

Funding: This work was supported by The Society of Family Planning under Grant [SFPRF9-6]; the Eunice Kennedy Shriver National Institute of Child Health and Human Development, Office of Research on Women's Health, Building Interdisciplinary Research Careers in Women's Health program under Grant [K12 HD052163].

Abstract

Introduction: Agency in contraceptive decision-making is an essential aspect of reproductive autonomy. We conducted qualitative research to investigate what agency means to patients seeking contraceptive care to inform the development of a validated measure of this construct.

Methodology: We held four focus group discussions and seven interviews with sexually-active individuals assigned female at birth, ages 16-29 years, recruited from reproductive health clinics in Northern California. We explored experiences in contraceptive decision-making during the clinic visit. We coded data in ATLAS.ti and by hand, compared codes across three coders, and used thematic analysis to identify salient themes.

Results: The sample mean age was 21 years, with 17% of participants identifying as Asian, 23% as Black, 27% as Latinx, 17% as Multiracial/other, and 27% as white. Overall, participants reported active and engaged decision-making in their recent contraceptive visit but noted experiences that had undermined their agency in the past. They described how non-judgmental care allowed them to communicate openly, affirming their ability to make their own decisions. However, several mentioned how unexpected contraceptive side effects after the visit had reduced their sense of agency over their decision in retrospect. Several participants, including those who identified as Black, Latinx, and/or Asian, described prior experiences where pressure to use a contraceptive method had undermined their agency and where they had switched providers to regain agency over their contraceptive decisions.

Discussion: Most participants were aware of their agency during contraceptive visits and how it varied in different experiences with providers and the healthcare system. Patient perspectives can help to inform measurement development and ultimately the delivery of care that supports contraceptive agency.

Key words: Contraceptive agency, contraceptive decision-making, reproductive autonomy

INTRODUCTION

Agency in contraceptive decision-making is a key component of reproductive autonomy or a person’s ability to decide about pregnancy and childbearing.[1,2] While agency in contraceptive decision-making is most often investigated in the context of sexual partners,[3-7] it is also essential in a clinical visit for contraceptive care, especially for contraceptive methods that require provider interaction. However, agency has been understudied in the context of contraceptive clinical care. In this study, we conducted formative qualitative research to explore patients’ perceptions of their agency in contraceptive decision-making during the clinic visit. We defined contraceptive agency within the clinic visit as an individual’s ability to make choices about contraception, including whether or not to use contraception and, if so, which method to use. Kabeer describes the concept of agency as a woman’s ability to make strategic life choices and takes into account communication, decision-making, and freedom from coercion, among other factors.[8] How patient agency manifests in reproductive health decisions is important to study given hierarchies between the provider and patient and ways in which institutionalized racism, reproductive inequities, and bias in the healthcare setting are expressed.[9-11] Research has shown that when healthcare providers treat patients differently based on their race/ethnicity, these differences can undermine agency and contribute to inequities in health outcomes.[10]

Research on contraceptive care has identified key features of the provider-patient interaction characterizing high quality care. A recently-developed measure of the quality of interpersonal care during family planning counseling (IQFP) shows that respect, care, eliciting personal preferences, and giving sufficient information to patients are salient components of quality care.[12-14] However, the related concept of agency is an important missing piece that has not yet been characterized for contraceptive care. An in-depth exploration of agency and what it means in patient care is essential to achieve overall reproductive autonomy, particularly for marginalized patients.

In the United States (US), contraceptive agency has been especially constricted in certain patient populations, both historically and in the present day.[16-18] Immigrants, people of color, Indigenous people, members of the lesbian, gay, bisexual, transgender, and queer+ (LGBTQ+) community, those living in poverty and/or with disabilities, and individuals who are incarcerated, among others, have often experienced mistreatment and abuse in healthcare settings, including forced or coerced sterilization.[16,19-21] Individuals living on low incomes have reported feeling pressured to use contraception to limit their family size,[22] while Black and Latinx women and those with lower education levels have rated reproductive health visits less positively.[17] In addition, Black and Latinx women have reported receiving more contraceptive counseling than white women, with Latinx women receiving more counseling on sterilization, which may be due to provider bias.[23] Given these experiences, there is a need for increased focus on patients' rights to agency in contraceptive decision-making and a provider's responsibility to uphold those rights, with an emphasis on experiences of people of color and marginalized communities. Systems changes are integral to reinforcing patient agency.

The field of sexual and reproductive health has begun to recognize the importance of measuring concepts of reproductive bodily autonomy and agency as essential elements of reproductive health, and metrics have been shifting towards the patient perspective.[24-26] Patient voices are paramount in describing the elements of care that enhance or undermine agency over contraception. However, we have limited data on the operationalization of the concept of agency among patients seeking contraceptive care and how provider bias about certain methods or types of patients has affected their agency. Active decision-making with the provider is important in contraceptive care, especially when patients are considering new or unfamiliar contraceptives.[27] This study explores how patient agency, and conversely provider bias or coercion, manifest during a clinical encounter, and how contraceptive agency increases or diminishes, with the goal of informing the development of a psychometric scale to measure patient contraceptive agency.[28] Describing agency from the patient perspective and having a robust scale can help us to move beyond a focus on contraceptive uptake and continuation, measures that fall short of capturing whether patients are not being coerced and are making their own contraceptive decisions.

METHODS

In 2017-2019, we conducted this qualitative study, including both focus group discussions and in-depth interviews, as the formative research for the development of a psychometric measure of contraceptive agency.[28] We conducted focus group discussions to capture perspectives and viewpoints that might uniquely emerge from interpersonal exchange. We then conducted interviews to ensure confidentiality and capture depth of experiences in a one-on-one setting. The community advisory board of the University of California, San Francisco Preterm Birth Initiative – with community members from the San Francisco Bay Area, including San Francisco, Oakland, and Fresno, California – reviewed the study design and instruments prior to data collection. Community members provided feedback and advice on the study design, important content areas to explore in the study, and draft topic guides.

We recruited participants from three reproductive health facilities in Northern California at the time of their visit. To be eligible for the study, participants had to be aged 15-29 years, be biologically capable of becoming pregnant, have had sex that could result in pregnancy in the past 6 months, have had prior experience with clinic-based contraceptive services, and be able to speak English or Spanish. While we offered to conduct interviews in Spanish, in the end all participants chose to speak in English. At check-in, front desk staff informed patients that a focus group discussion or interviews were going to be conducted at the clinic. A Research Assistant approached patients in the clinic waiting room to describe the study and, if they were interested, screened them for eligibility. At the start of each focus group discussion or interview, the Research Assistant confirmed eligibility, answered questions, and obtained written informed consent. The eligibility criteria were the same for the two modes of data collection and participants did not overlap.

We divided focus group discussion participants by age and held separate discussions with adolescents (15-19 years) and young adults (20-29 years). Trained facilitators used a semi-structured focus group discussion/interview guide informed by the literature to explore broad issues related to agency in contraceptive care, including communication, freedom from coercion, and active decision-making.[8,29] Topic guides with open-ended questions covered participants' experiences making contraceptive choices and interactions in their most recent clinic visit, as well as in their prior experiences with other providers, in order to explore how experiences might evolve over time. Participants filled out a brief demographic survey with information including age, gender, self-identified race/ethnicity, health insurance status, education, marital status, number of children, current contraceptive method use, and external (male) condom use at last sex. Focus group discussions lasted approximately one hour and 15 minutes, and participants received USD100 in remuneration. Interviews lasted about 45 minutes and participants received USD50 in remuneration. We provided childcare free of charge. We audio-recorded focus group discussions and interviews and used an independent transcription service; members of the team reviewed the transcripts for accuracy. The University of California, San Francisco, Institutional Review Board approved this study.

Data analysis

We used a thematic analysis approach with the focus group discussion and interview data to examine experiences, social interaction, and decision-making processes.[30,31] We collected and analyzed data concurrently, first for focus group discussions and then for individual interviews, and we completed data collection once we achieved thematic saturation. Two researchers (CH, IM) independently coded the transcripts by hand while one researcher (LR) coded the transcripts in ATLAS.ti. All used deductive codes informed by the literature, as well as inductive codes based on emergent content and ideas.[32] Members of the research team (LR, IM, CH) met several times, using an iterative process to discuss the initial codes, make decisions for different coding, and identify overall themes. This analysis explores common and divergent themes essential to patient agency in contraceptive decision-making during the clinical encounter, specifically focusing on the patient-provider interaction. We present results from the focus group discussions and interviews together.

RESULTS

Overall, 30 individuals participated in the qualitative study. We conducted four focus groups discussions, two with adolescents (for a total of 10 participants) and two with adults (for a total of 13 participants). We then conducted seven in-depth interviews with adolescents (n=3) and adults (n=4). The average age of participants was 21 years and the sample included individuals who identified as Latinx, white, Black, Asian, and multiracial. Most participants were uninsured or publicly insured, with one-fifth privately insured. Most participants were single and the majority did not have children. Most participants, but not all, reported currently using contraception. However, in a different question, half of those who did not report a current contraceptive method did report using an external condom *at last se*x (see Table).

Participants described important aspects of their contraceptive decision-making processes in relation to agency in the three overarching domains, including communication and realistic expectation-setting, freedom from coercion or pressure, and a non-judgmental approach that allowed the space for patients to exercise agency over their decisions. Themes identified under communication included accessible language used in the clinic visit, realistic expectations about side effects, and the ability to connect with the provider over time as needs changed. Under freedom from coercion, participants expressed the importance of leading their own decision-making and how they at times switched providers when they needed to realize greater agency. Participants also discussed how it felt when they had experienced coercion and how that stayed with them over time or dissipated, depending on new experiences. Finally, they relayed how their agency felt stronger in non-judgmental care.

Patient agency and communication

Participants universally cited the importance of clear and comprehensive information about contraceptive methods in order to have agency over their contraceptive decisions. When communication was rushed or language too specialized, participants became confused. One participant, describing an experience where her provider used medical jargon said, “I was kind of lost, because she was using vocabulary I’m not familiar with. And she repeated it three times, but I was like, “I don’t get what you’re talking about” (*Age 22, Latinx, using oral contraceptive pills (OCPs), focus group discussion*). Speaking too quickly also limited the patient’s ability to digest information, as one participant said, “They talk really fast, that could be overwhelming, like, okay hold on.” *(Age 21, Latinx/Black, injectable, interview*). A non-native English speaker described that having her provider make sure she understood, even reiterating key points, was helpful for her to actively participate in contraceptive decision-making: “She repeated herself a few times so I could be sure to understand…Because sometimes, I don't, you know, understand everything….so, it was nice.” (*Age 26, white, external condoms, interview*).

Expectations about side effects and changes in patient agency

Several participants were distressed about the times when method side effects had not been adequately described at their visit. In these cases, participants ended up with a diminished sense of agency after the visit, as they realized that their method experiences differed from what they had anticipated from the information they had received during contraceptive counseling. Many of these cases were related to having different experiences with bleeding than expected. A participant selected a copper intra-uterine device (IUD) because she did not want hormones, but after bleeding for months when she first got it, she described the decision-making process as not focused on her needs: “We probably talked about, just the different options but not necessarily what would be easier for me or what would benefit me in the long run or you know, that type of thing.” (*Age 22, Black, copper IUD, focus group discussion)*.

One participant had been previously told by a clinician that her periods would be “irregular” with the injectable but ended up having her period for the entire time that she was using it. The next time she saw a provider, she was distrustful about the information conveyed: “I’ve talked to my doctors about it and they’re like, ‘No, for most people, the Mirena [IUD], you don’t even have a period.’ Well, that’s what they told me about the Depo shot [injectable]...” *(Age 18, Black/white, no contraceptive method, interview).* After this experience, she decided to stop using contraception entirely, mistrusting her doctors about other method options because she felt initially misled.

Many participants emphasized that understanding different methods and side effects played an essential role in agency over their decisions. Agency was dynamic and often required sustained engagement over time. Many wanted to learn about the multiple options available to them in case one method did not work out:

> I’m starting a new form of birth control [contraception] which I hope works out for me, because oral contraceptives after a few months, it just wasn’t working for me. Actually, we discussed a lot of options, and I really liked my visit with my doctor, because I hear a lot of people complain that their doctors don’t seem to be as informative. But I felt like mine was really informative of all the possibilities of each type of form of birth control [contraception], and what to expect and not to expect. (*Age 21, Asian, OCPs, focus group discussion*)

Participants described a sense of agency over their method choice when their side effects were acknowledged and normalized by their providers and they were given latitude to make a switch if they wanted. One adolescent using OCPs experienced mood changes but ended up feeling in charge of her ultimate decision to continue with the method because her provider understood her concerns, offered her alternatives, and left it in her hands. Her provider had explained to her: "'It's up to what you want to do. You could change the pill and switch to a different method, but it's completely up to you.'" (*Age 19, white/Pacific Islander, OCPs, external condom at last sex, interview*).

Leading decision-making: patient versus the provider

Most participants preferred to be given information and advice and to be the one to have the final say. As one participant stated: "It was my decision, but the doctor helped me" (*Age 26, white, external condoms, interview*). Several others reflected on positive experiences where they appreciated the provider's expertise and were allowed to make the decision themselves: "They of course gave their advice but they left it up to me…so that's what I liked about it, it was not forced on me" (*Age 21, Latinx/Black, injectable, interview).* An adolescent described how it felt to have made her decision herself: "It was like the first time I ever did anything for myself like that, so I felt kind of independent in a way" (*Age 17, white, contraceptive patch, focus group discussion).* Some adolescent participants mentioned feeling uncomfortable asking questions or opening up with their provider and some adults likewise described how they had asked fewer questions when they were younger, due to embarrasment or concerns about confidentiality. Notably, participants did not report that their reluctance to ask questions when younger made them feel any less a part of the decision-making, as long as their providers presented information and then supported their decision. Several mentioned having a woman provider helped them to feel less guarded in a contraceptive visit.

A few participants had decided prior to the visit which method they wanted and, in some instances, felt their agency over their contraceptive decision was undermined by questioning at the visit about their choice. In one instance a participant described how she felt strongly about her preferences and would prevail against push-back from providers, but worried that they might encroach on the agency of other patients:

> I already know what I came for…I already know the questions they're going to ask, for the most part generally, so I already know like what I'm going to say…And when they question me, I think wait…should I? No I'm just going to do what I wanted to do…I just feel like for me I already know what I want. Other people might be a little more difficult, they might mess with their head maybe. (*Age 25, Black, no contraceptive method, external condom at last sex, interview).*

In the interviews, it became apparent that negative experiences with healthcare providers could have residual impacts over time with patients, leading them to feel that they had to be extra vigilant to have agency over what occurs in a clinic visit. The same participant described an experience with reproductive health care when it felt like the provider was not listening to her about her own body:

> I remember I went to a doctor and I was concerned about something that was going on down there and they were just trying to tell me like, no it's not that, it's not that. But I'm like...I'm telling you what I feel, and I felt this before, and it feels the exact same way and you're telling me that it's not it. Like I had to beg for some medicine. (*Age 25, Black, no contraceptive method, external condom at last sex, interview*)

This participant, wary of what can transpire in a clinic visit, explained that if she cannot trust what a provider is telling her, she takes matters into her own hands by going to see another doctor.

Contraceptive coercion

A few participants said that they had felt pressure from their providers to use contraception in general, and others that their providers favored certain contraceptive methods. Most of these participants then chose to go to different providers in order to find support and regain agency. In one occurance, a participant who had been using OCPs for five years and wanted to stop was told by her provider, "'You have to have something; you can't just go off of it.'" The participant then switched providers. Aware of her agency, she reflected:

> It was kind of discouraging for her to tell me that, because she should support me since she's my doctor, and it's my body, it's my choice. But then I came here, and everyone was really nice and supportive. I felt like there I had no options really. *(Age 19, Asian, diaphragm, focus group discussion)*

A different participant described an experience where she wanted to have her implant removed because she thought the hormones might be affecting her depression, but faced pressure from her provider to keep it in:

> My health is getting affected by all these side effects, so at the moment I feel pressured by her because she kept pushing the option about not removing it. She still didn't make my appointment for taking it off, but I'm in the point where I'm just tired. I just want my body to get back to normal or just give a break from birth control [contraception]…I changed my provider and I will go in and talk to another person. *(Age 23, Latinx, implant, focus group discussion)*

A few participants felt that their providers were pushing specific contraceptive methods on them or were just giving them "default" methods. They described being given OCPs in their initial clinic visits and only being informed about other methods later. "When I first started, I didn't have any clue what to say or talk about. So they just ask questions, and I just got oral contraceptives." *(Age 21, Asian, OCPs, external condom at last sex, focus group discussion).* An adolescent participant experienced little to no agency in her contraceptive method choice at a visit in the past with a different provider:

> I feel like my provider, she didn’t really read or explain to me about the birth control [implant]. The one she put in my arm, and it was like, she didn’t explain, she basically, I don’t know how you say it. It’s somebody’s like forcing… (*Age 17, Black & Native Hawaiian or Pacific Islander, injectable, focus group discussion)*

Another participant stated that she felt that doctors had a bias toward their patients using the IUD:

> I felt really pushed for a while for the IUD...I have nothing against it, like different things work for different people, and it’s just the way that it is with any medication that you take. But I just really had this feeling that it would be not right for me…I went to three different doctors, and they were all ‘You should do this’. (*Age 26, white, vaginal ring, focus group discussion*)

Non-judgmental care and patient agency

In contrast, freedom from coercion or pressure was apparent in participants’ descriptions of non-judgmental care. Many participants stated that they valued non-judgmental interactions with their provider, which allowed them to communicate openly, affirming their ability to make their own contraceptive decisions:

> My doctor was very nonjudgmental…I don't know if it's because she kept a straight face, but she was very not judgy about anything that I had brought up in the conversation. So, definitely her being welcoming and nice made me feel way more comfortable to open up” (*Age 19, white, copper IUD, interview*)

Similarly, another participant stated, “I think every time that I share information, they listen. Yeah because here, I don't feel judged. So, I think that's why I'm more open” (*Age 26, white, external condoms, interview*). Participants discussed how a comfortable and welcoming atmosphere helped them to not feel judged at a clinic visit. An adolescent noted: “I’ve always felt comfortable every time I’ve had an appointment here” (*Age 19, Latinx, no contraceptive method, focus* *group discussion)*. The emotional tenor of the patient-provider interaction many times helped the participants to be able to navigate their health concerns and contraceptive choices. A few patients felt comforted when their providers normalized their concerns with contraception:

> I was very emotional and worried last week, and then [my provider] talked to me and explained to me it's actually a very common thing and then it calmed me down. It's really helpful which is calming because I was emotional and crying…actually it took a lot of courage to come here. The doctor there is really friendly, they are really helpful, supportive so I was like okay I trust you…I feel comfortable. *(Age 24, Asian, no contraceptive method, external condom at last sex, interview)*

Several participants mentioned that talking about contraception can feel vulnerable and that providers can often help to steady them so they can make their decisions. As one participant said: "I was going through a moment and it really helped me. And they were like, 'If you need to talk more about it you can always come back and talk to us.' So it was comforting." (*Age 24, Black, implant, external condom at last sex, focus group discussion*).

A few participants described feeling judged by their provider, which was off-putting and led to them being less engaged or second-guessing their decisions. A participant, when thinking over her treatment over the years, explained:

> I do feel a little bit judged when they keep asking…like I just wonder… if they're judging, you're too young, what if you get pregnant? Then what are you going to do?... You better take this. Almost something like that. Like if I were you I would take this. Are you sure? You sure you don't want that? (*Age 25, Black, no contraceptive method, external condom at last sex, interview*)

DISCUSSION

In this study exploring how contraceptive agency is experienced in the clinical setting, participants generally described active decision-making and agency about their contraception during their recent visit. Most participants said that they made their decision with their provider's help. At the same time, when thinking about prior care throughout their reproductive-aged years, they reflected upon some common experiences that enhanced or limited their agency. Agency increased when providers communicated with clear and simple language, free from medical jargon, and conveyed specific information about contraceptive methods, especially side effects. Participants also emphasized that it was important for them to have the latitude to choose among different methods and to decide whether to use a method at all. Many participants noted how a non-judgmental approach from providers helped them to experience more agency in contraceptive decisions. Other participants, including Black and Latinx patients, felt pressure to use contraception or a specific method.

Our research also found that some participants did not want their decisions to be repeatedly questioned. However, these participants did not necessarily lack agency and often advocated for their contraceptive choices in spite of frustrations with provider interactions. Participants expressed frustration when providers overlooked their past experiences and tried to influence their choices. Research has found that in many contraceptive visits, providers are not actively engaged in shared decision-making,[33] but use a foreclosed approach where they only discuss options the patient brings up, or the informed choice approach where information is given without patient participation in decision-making.[25] Our findings align with research indicating that patients prefer to make the final decision about their method, but many want active involvement from their provider in the form of collaborative decision-making.[26,34] Participants did not wish for providers to question their ultimate decisions, which they interpreted as bias for or against different methods.

We found that past experiences, not surprisingly, can continue to have an impact over time. Several participants had been pushed to continue using contraception when they were unsure whether they desired to do so. Others felt exhorted to use a particular method; some “succumbed,” while others felt relieved that they were strong enough to advocate for themselves, or able to seek out another provider with whom they could make decisions that stemmed from their individual preferences. Other research has revealed that providers may be biased toward certain methods or may desire for their patients to keep using a method, and do not necessarily perceive their practices as coercive.[35] Many participants described how they gained agency over their contraceptive decisions at a later clinic visit by switching providers. When presenting for a clinic visit, many participants had already had instances in which they were not able to enact their contraceptive method choices or had heard of others for whom this was the case. In this study, data from participants including adolescents and women of color revealed how important each clinic visit is as an opportunity to restore and support their patient agency.

Notably, our results showed how agency is dynamic and changes after the clinic visit as well, depending on expectations and experiences with methods. Participants had diminished agency when realizing they were not fully informed of side effects or tried to switch methods but could not. Participants wished that they heard frankly about side effects associated with different methods prior to starting a method, which is in line with recommendations for providers to have candid discussions about side effects.[15,36] One study found that only 38% of patients who chose the levonorgestrel IUD were told about associated side effects,[37] while a qualitative study found that patients question their providers’ inclination to convey the negative aspects of contraception.[26] Patients' expectations that providers will share what they know with them has been shown to be important for patient trust in other areas, including with elderly and primary care patients, and here was also seen as necessary for participants to feel agency in their contraceptive decisions.[14,38,39]

In our study, some participants who identified as Black, Latinx, and/or Asian described experiences where providers did not listen to their preferences, ignored expressions of discomfort, questioned their contraceptive choices, and tried to convince them to use different methods. These findings are consistent with prior research suggesting that Black individuals may feel more pressured to use contraception or specific methods,[17,40,41] and are often undertreated for pain.[42] A collective history in the US of reproductive health traumas, including lack of bodily autonomy for Black women[29] and forced sterilizations among Latinx women,[20,43] means that contraceptive agency may be all the more important for these patients. Allowing for patient agency over contraceptive decisions is an essential step in addressing racism and structural inequities in healthcare.[44] These results highlight the importance of understanding, and counteracting, the impact of racism on patient agency in the clinic visit.

This study has limitations. We recruited participants from three clinics in California, a state with higher reproductive access compared to many states.[45] The quality of care received and perceptions of agency may differ among individuals living in different regions; thus the transferability of our findings may be limited. Additionally, although our inclusion criteria allowed for gender diversity if the participant had the biological capacity to become pregnant, the sample did not have transgender men or gender non-conforming participants, whose intersecting identities may affect the care they receive and their perceived agency. The two Research Assistants leading data collection were native Spanish speakers and offered to conduct focus group discussions and interviews in Spanish, but everyone in our study sample chose to participate in English. Therefore, we did not capture the experiences of people who do not speak English and who may experience greater provider bias in the clinic visit, as seen in studies of contraceptive and pregnancy care.[46,47]

Conclusions

Participants generally described their most recent contraceptive decisions as “their own”, appreciating support from providers. However, they also described past experiences that stayed with them and that either propelled them to find new providers or left them with a contraceptive method they did not want. Pressure to use a specific contraceptive method or to continue using contraception in general and unexpected side effects undermined patient agency. Attention to contraceptive agency, especially for patients facing racism and socioeconomic inequities, may help to contribute to health equity. A greater understanding of how different patients exercise their agency in contraceptive decisions can inform measure development for this important aspect of care. Our findings also highlight the unique role and opportunities of the provider in making space for patient agency in contraceptive decision-making as a standard of care.

Table. Focus group discussion (n=23) and interview (n=7) participant characteristics* (N=30)

	n	(%)
Gender, n (%)		
Female	30	(100)
Age (mean ± SD)		21 +- 3.5
Race/Ethnicity, n (%)		
Asian	5	(17)
Black	7	(23)
Latinx	8	(27)
Multiracial	5	(17)
White	8	(27)
Currently in school	21	(70)
Completed education, n (%)		
Less than high school	6	(21)
High school	16	(55)
Technical/vocational school	3	(10)
2-year college	2	(7)
4-year college	1	(3)
Graduate/professional	1	(3)
No response	1	(3)
Health insurance, n (%)		
Private/employer	6	(20)
Medicare	9	(30)
None	10	(33)
Don’t know	10	(17)
Partner in last 3 months, n (%)	25	(85)
No response	1	(3)
Married, n (%)	2	(7)
Living with partner, n (%)	3	(10)
Children, n (%)	3	(10)
Current contraceptive method*, n		
Diaphragm	1	(3)
External condom (sole method)	2	(7)
Implant	4	(13)
Injectable	3	(10)
Intra-uterine device (IUD)	5	(17)
Oral contraceptive pills (OCPs)	6	(20)
Patch	1	(3)
Vaginal ring	2	(7)
None	6	(20)
External condom used at last sex,	9	(30)

*This question did not capture information about dual use

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