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Provider perspectives on patient-centered contraceptive counseling for Latinas in Baltimore, MD

Diana N. Carvajal[a,*], Kristin G. Bevilacqua[b], Martina T. Caldwell[c], Ruth E. Zambrana[d]

[a] Department of Family and Community Medicine, University of Maryland School of Medicine, Baltimore, MD, United States
[b] Department of Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, United States
[c] Department of Emergency Medicine, Henry Ford Health System, Detroit, MI, United States
[d] Harriet Tubman Department of Women, Gender and Sexuality Studies, University of Maryland, College Park, MD, United States

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ABSTRACT

Objectives To explore: 1) provider narratives of their contraceptive counseling practices with Latina patients within the context of patient-centered care (PCC); and 2) provider perceptions about the barriers to the provision of patient-centered contraceptive counseling in general and more specifically, with Latina patients in Baltimore, MD.

Study Design We conducted 25 semistructured qualitative interviews with physicians and nurse practitioners from four specialties who provide contraceptive care to Latinas in Baltimore, MD. We analyzed data using directed content analysis. We discuss findings with attention to major constructs of PCC, applying a reproductive justice framework.

Results Providers described a contraceptive counseling approach focused on pregnancy prevention as the primary goal. Most respondents used a tiered-effectiveness approach, even while noting the importance of PCC. Providers noted health system barriers to PCC, including time constraints and insurance status. Provider-reported patient-attributed barriers included low patient education/health literacy, culturally-attributed misconceptions about contraception, and language discordance.

Conclusion Providers described knowledge of and intention to practice PCC but had limited integration of it in their own counseling with Latinas. Responses suggest tension between an expressed desire to provide PCC and paternalistic counseling paradigms that prioritize pregnancy prevention over patient preferences. Inequitable health system barriers also interfere with true implementation of contraceptive PCC.

Implications Translating contraceptive PCC into practice, especially for marginalized communities, is paramount. Training should teach clinicians to recognize systems of structural inequity and discrimination that have informed approaches to counseling but are not reflective of PCC. Institutional policies must address health system barriers that also hamper PCC.

1. Introduction

The Institute of Medicine defines patient-centered care as, "providing care that is respectful of, and responsive to, individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" [1]. Extant literature on provider perspectives demonstrates that clinicians consider elicitation of patient preferences, information exchange, compassion, and good communication skills to be critical components of patient-centered care (PCC) [2,3]. Clinicians also recognize and contend with health services delivery and access barriers to implementing PCC including financial limitations related to patient socioeconomic status – especially for those with no or inadequate insurance coverage [2,3]. Additionally, clinicians cite time constraints of patient visits as a crucial barrier to PCC given their competing responsibilities. These constraints can be further compounded by patient-provider language discordance as well as racial/ethnic discrimination [3] that some populations face when interacting with the health system. These known obstacles can interfere with the application of PCC in practice.

Within the context of contraceptive provision, a PCC framework of contraceptive care urges equity by insisting the health care

* Corresponding author.
E-mail address: dcarvajal@som.umaryland.edu (D.N. Carvajal).

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system and its clinicians meet a person's contraceptive needs across the continuum of their care (i.e., before, during, and after patients interact with the health care system), and are supportive and respectful of patient preferences and choices for the duration of their relationship with the patient [4]. Moreover, contraceptive counseling and provision within a PCC framework recognizes historical, social, political, systemic, community, and familial factors that affect sexual and reproductive health care (SRH) in the U.S. [4]. For example, the U.S. has a long history of controlled reproduction, including forced and government-sanctioned sterilization campaigns and coercive research practices through the mid-20th century, targeted toward people living in poverty and communities of color [5–7].

Recently, the propagation of a tiered-effectiveness approach to contraceptive counseling that prioritizes counseling about the most effective methods of pregnancy prevention, notably long-active reversible contraceptives (methods of LARC) [8], has been reexamined through the lens of PCC as a potential contemporary manifestation of population control for certain communities.[9] This is because LARC-focused programs have disproportionately targeted Black and Latina women [9,10]. Recent studies have also demonstrated clinicians' frequent resistance to LARC removal, further prompting concerns about population control of racial/ethnic groups [11,12]. These dynamics reflect a kind of medical paternalism in which providers believe they know better than patients what is best for them [13]. Such paternalism may be rooted in structural racism that promotes stratified reproduction, or the belief, conscious or otherwise, that non-White populations should not have children.[14] This kind of paternalism can perpetuate injustice, marginalization, and medical mistrust. As such, it is crucial to understand America's history of abuse and coercion within SRH and the current context of oppression and structural racism to provide just and equitable PCC [15].

While there have been past and recent calls by medical professionals for the provision of patient-centered contraceptive care for all communities [4], especially those historically and currently disadvantaged [4,9,16], more research is needed to improve and integrate this approach into practice [12]. Among Latinas, research has shown a desire for more trusting and communicative relationships with contraceptive care providers and support for a PCC approach to counseling that focuses on patient preferences [17,18]. However, provider perspectives about a patient-centered contraceptive counseling approach among this population are understudied. This study explores provider perspectives on their contraceptive counseling practices with Latina patients within the context of PCC. A reproductive justice (RJ) lens, which recognizes the historical and contemporary context of devaluation of the reproduction of non-White populations, is employed to contextualize providers' perceptions about the barriers to provision and implementation of a PCC approach in general and more specifically, among Latinas in Baltimore, MD.

2. Material and methods

2.1. Study design, settings, sample, and recruitment

We conducted semistructured qualitative interviews with physicians (MD/DO) and nurse practitioners across four medical specialties: Family Medicine, Internal Medicine, Pediatrics and Obstetrics/Gynecology. Participants were recruited from four health care facilities in Baltimore, MD and were eligible if they reported providing contraceptive counseling to Latina patients. Facilities serve predominantly low-income/uninsured patients or those with public insurance and included a federally qualified health center (FQHC), a city-funded reproductive health site, and two academic medical practices. The proportion of Latino/a patients seen for each site ranges from 35% to 75% of their respective patient populations. A significant portion of the Latino/a population in Baltimore is comprised of immigrants whose preferred language is Spanish [19]. Using convenience sampling [20], we recruited clinicians during facility staff meetings and via email after the implementation of COVID-19 restrictions on in-person research activities. Overseeing Institutional Review Boards approved all study procedures.

2.2. Data collection & instrument

We conducted interviews in-person and virtually (following implementation of COVID-19 restrictions) from February 2020 to January 2021. We developed a semistructured interview guide (available upon request) based on previous research conducted by the research team [17,21] employing a PCC conceptual framework [1]. The guide explored providers contraceptive counseling approaches and experiences providing contraceptive care for Latina patients; it was piloted with five clinicians prior to use. A trained research assistant (second author and doctoral student who is a White cisgender woman with extensive reproductive health and qualitative research experience) conducted the interviews. Interviews lasted approximately 60 minutes, and participants received gift cards as compensation. Interviews were audio-recorded and transcribed verbatim. We conducted 25 interviews, reaching thematic saturation at 20 interviews. Additional interviews were conducted to honor previously-scheduled interviews and to attain a more diverse sample with regard to race/ethnicity, sex, facility, and specialty. Additional interviews were also used to confirm saturation.

2.3. Analysis

Two researchers (DC and KGB) independently coded each transcript using a directed content analysis approach [22] to develop a coding scheme. Both researchers are trained in qualitative methods and have considerable experience in qualitative data collection, analysis, and dissemination. DC and KGB conducted independent memo writing and identified themes through a line-by-line analysis of the data. Investigators iteratively interpreted findings and developed thematic codes, guided by the major PCC constructs including elicitation of patient preferences, information exchange, and communication. As a PCC framework of contraceptive care calls for provision of equitable care and recognition of historical, social, and political factors that affect SRH. We applied an RJ lens that takes into account how stratified reproduction and medical paternalism influences contraceptive counseling to data interpretation. RJ was developed and named by Black feminists rooted in the understanding that access to the material and nonmaterial resources that allow for just, safe, dignified, and autonomous fertility management, childbirth, and parenting is a fundamental human right [5,23].

KGB and DC reviewed transcripts and developed a coding scheme that grouped text into a long list of initial codes that were then merged when overlapping to generate a shorter list of codes. They then organized data by emergent themes (e.g., counseling approach, barriers/facilitators of PCC) and connections among constructs were identified. KGB conducted member checking during interviews by referencing themes discussed in previous interviews to identify confirming or disconfirming evidence to validate findings. DC also completed member checking with one provider-participant with expertise in PCC following completion of data collection. Member checking during and following data collection was confirmatory, with providers across sites and specialties citing similar challenges to patient-centered contraceptive counseling in general and among Latinas in Baltimore.

Table 1
Demographic characteristics of a sample of providers ($N = 25$) in Baltimore, MD.

Demographics	% (*N*)
Training	
MD/DO	72 (18)
Nurse Practitioner	28 (7)
Specialty	
Family Medicine	16 (4)
Pediatrics	44 (11)
Ob/Gyn	36 (9)
Internal medicine	4 (1)
Race/ethnicity[a]	
Black/African American	20 (5)
Latino/a/x	12 (3)
Asian-American	4 (1)
White/Caucasian	68 (17)
Gender	
Cis female	92 (23)
Cis male	8 (2)
Spanish-speaking	40 (10)

[a] sum > 100% as providers could select more than one race/ethnicity.

2.4. Reflexivity

All investigators are keenly aware of their societal positionality in terms of gender identity and race/ethnicity and the effect of these social constructs on their lived and professional experiences; positionality was discussed throughout data collection and analysis. As with any researcher conducting qualitative analyses, this positionality and lived experience can unintentionally (or intentionally) influence data analysis (reflexivity) [24,25]. DC is a cisgender Latina physician who provides contraceptive counseling and provision in Baltimore. KGB is a cisgender White woman who is currently a doctoral student in public health. MC is a cisgender Black, RJ-focused health equity physician-researcher. Throughout data collection DC and KGB met to debrief following each interview. During data analysis, DC and KGB met weekly to review coding schema and discuss their respective analytic memos. MC consulted on the organization and presentation of results.

3. Results

Almost three quarters of participants are physicians (72%). Most providers are pediatrics (44%) or ob/gyn trained (36%). The majority of providers identify as White/Caucasian (68%). Twenty-one percent are Black/African American, 12% Latina/x, and 4% are Asian-American. Forty-four percent are Spanish-speaking. The majority of providers (92%) are cis women (Table 1).

3.1. The health care delivery system as an antagonist of PCC

Providers described a health care system that is antagonistic toward the delivery of PCC. The most frequently described barriers to PCC were time constraints and patient insurance status which reflect difficulties with health services delivery and access, respectively. Providers often expressed not having the time to thoroughly counsel patients regarding their range of options, potential side effects and personal preferences. For some, contraceptive counseling is squeezed into a preventive care visit or a visit with other specific objectives (for example, prenatal visits or chronic/acute care). Consequently, providers find themselves with little time to spend on patient-centered contraceptive counseling.

> *Now, if they're coming in for blood pressure or diabetes and I've already dealt with five other issues, I just realistically don't have the time to have the conversation and then send them…to get, you know, a urine pregnancy test and get all that taken care of. It's just we have 15 minutes. That's it. (*White family physician*)*

> *… we are constantly dealing with time oppression and depending on all the various things that we feel like we need to do within the constraints of a 15-minute visit… a real conversation about contraceptive options is going to take potentially a whole 15 minutes… so time is, is definitely a constraint. (*White obstetrician-gynecologist*)*

> *The ideal [counseling] number one [barrier is], time. Um, because it's very hard to really set everything aside to do the ideal thing, um, when you have pressure with appointments. The appointment schedule is not my choice. That's what it is. (*White pediatric nurse practitioner*)*

Providers also overwhelmingly expressed under-insurance/lack of insurance among Latina patients as a barrier to contraceptive PCC, which ultimately burdens patients with high costs. Providers felt limited in terms of the options they could discuss with patients given that some methods are not available to patients based on insurance status.

> *Going back to barriers, insurance, …it is incredibly expensive. And I mean, to the point of being impossible for patients to be seen if they are, if they are self-pay… (*White obstetrician-gynecologist*)*

> *I don't feel like it's responsible to focus on something like pills or patches or a NuvaRing because I think it's likely that those are going to be out of their price range… if I know that a patient that I'm seeing has no insurance to cover prescriptions… I'm really spending my time on the LARCs or depo, because those are things that can be provided… (*White pediatrician*)*

> *… there were certain eligibility criteria to receive a grant LARC device, um, which… tended to be either for the uninsured or the underinsured people… I think it was heavily impacting the under or not insured patients because otherwise the patients that had insurance where that wasn't such a barrier probably were getting more level or more neutral counseling. (*White obstetrician-gynecologist*)*

3.2. Patient attributes as incompatible with PCC

Providers described patient-attributed barriers to the provision of care for Latina patients including low patient health literacy and education, 'cultural' misconceptions about health and contraception, and language discordance. Providers also pressed beliefs that Latina patients have generally little knowledge about health, their own bodies, or contraception.

> *And for that [Latina] population, the third obstacle is the educational barrier, the literacy barrier. Like how much are they really getting and how much can they really explain to somebody else? Because, you know, most of them have not completed even, you know, lower school, so…(*Black/African American obstetrics-gynecology nurse practitioner*)*

> *[There is]…just [a] lack of basic education about their bodies…. A lot of, you know, just cultural myths… And a lot of that is among Latinas, Latinx population… … (*White family medicine nurse practitioner*).*

> *I was talking about the socio-economic problem that the group that I talked to you about, whether they're Latino or African-American or White or whoever they are, but they have this complex of lower education, lower income, lower health literacy. (*White obstetrician-gynecologist*)*

Providers often attributed Latina patients' contraceptive misconceptions/myths to 'cultural' factors.

*I think [Latinas] are really focused on wanting to have children someday, and they have heard from a lot of people in their community that birth control will make them not be able to have kids, that tends to be, like, a perpetuating rumor in the Latina community…(*White pediatric nurse practitioner*).*

*I hear things … like, "Oh, I got fat, or I got headaches," and I'm like, "Okay, yeah, I mean, I – I understand," … but the other stuff is like they're injecting testosterone, or, you know, things that are a little more whacky… (*Latina pediatrician*)*

*I always personally wanna know, like, why are my patients, I guess, of cultural, you know, of – why are they so resistant to birth control and … the myths that I feel like are more prevalent in the Latino culture around birth control related to, you know like about, future ability to bear children…(*White pediatric nurse practitioner*)*

Notably, when probed about potential reasons for patient misconceptions, providers rarely cited medical mistrust or historical reproductive abuses as potential root causes of such beliefs but instead often attributed misconceptions to culture (ethnicity) and educational status.

Finally, almost all non-Spanish speaking providers indicated that the discordance with patient's native language is a barrier to PCC. Providers reported the inconvenient, time-consuming, and sometimes impersonal nature of relying on an interpreter during counseling.

*So, if you were to do it as comprehensively as we do with English-speaking clients, I mean, theoretically, it should at least double, if not more, the time, and we do not spend that much time. So, all of that detail that I gave you here is for English-speaking clients, I will be honest. (*White pediatrician*).*

*You try to get all of their [Latina patients] questions answered, so that, you know, that will limit, um, you know, any follow-up because it is just difficult to line everyone up to, to answer their questions as opposed to someone who speaks your native language. (*Black/African American obstetrician-gynecologist*)*

I admit it even myself when I see patients who are non-English, non-Spanish. There's only so much time that I have, you know? … It's just you have to make concessions because when you have a different language, everything is double time. And so I feel – you know, I know that, you know, every provider has the best of intentions but do they really – will they ever really do a sit down with a translator and go through every single method? There's just not enough time to do that. (Latina/x internist)

3.3. Medical paternalism in counseling

While providers were familiar with PCC and generally expressed a desire to practice it during contraceptive counseling, inherent in the counseling approach of many were paternalistic beliefs about what is best for the patient.

*Sometimes they, will come in, like, sure that they want to take the pill, and I make sure that they kind of know that it really requires a lot of work and effort on their part to use that method. So, like, when – if they ask me what I think is, like, a good choice, I typically will suggest… that, you know, Nexplanon or an IUD, or even depo tend to be the best methods… (*White pediatric nurse practitioner*)*

*… I always make sure that they know that we can always take it out [LARC] if they don't like it, but I typically do encourage them to keep those for – like, commit to keeping them for six months, and then, we'll kind of work with the side effect issue because sometimes, I'll put them in, and then I have girls come back, like, 2 weeks later, and they're like, "Yeah, I had been bleeding for two weeks"…I'm like, "No!" (*White pediatric nurse practitioner*)*

Other forms of medical paternalism were more subtle.

… there have been girls who, you know, I've said "Okay, they need to come back, like, this amount of time," or I call them, and I say, "If they haven't come back in yet, I'm keeping an eye –" you know… because I'm like, "I know they're at risk with what they're doing, and I need to get – I just want to see them more frequently." So…if you are making a decision, which I feel like may not be congruent with your – what you've told me your desire is, that that's what you want to do, I'd say that's your choice, but at the same time, I'm going to sort of create some sort of follow-up thing to keep a closer eye on you, because I know that that risk is still there. (Latina/x pediatrician)

*I feel like a patient who has a malpositioned IUD and has to go to the OR because it wasn't able to be removed in the office… they'll be like, "Oh, my IUD was in the wrong place and I had to have a surgery." Where it, really, you know, it was an outpatient kind of procedure. They had good birth control for the five years, and as a clinician, I think that's actually not the worst outcome. (*White obstetrician-gynecologist*).*

Sentiments expressed in the previous quote dismiss the patient's concern and highlights what the provider thinks is most important.

3.4. Conflict between PCC and tiered effectiveness counseling

Relatedly, dissonance between the expressed importance of PCC and the practice of tiered effectiveness counseling [9] was common among providers. Providers often described their contraceptive counseling approaches as focused on patient preferences, respecting patient autonomy, involving information-exchange, and being noncoercive (consistent with PCC). Yet, simultaneously, many of the same providers also described a counseling approach that focuses on and prioritizes the most effective methods (LARC).

*I think just giving a patient their options, discussing everything that's available, providing them with, like, pros and cons of each, trying not to kind of sway any direction… although, I do tend to guide them towards what I feel to be the more effective methods… (*White pediatric nurse practitioner*).*

*I… tailor [contraceptive counseling] to their preferences. But, still I'm a strong proponent of thinking about long-acting contraceptives, for teens… So, I don't think there's ever a case where I don't have a conversation about long-acting contraceptives. (*Black/African American pediatrician*).*

*Look, it doesn't matter what I think is best… Okay, in terms of most effective that would be the LARCs, but if you're really against a LARC then that doesn't matter, you know? …So, it's like, yes. I mean, so that's what I first turn to. I'm like, "What are the best? Well, the most effective are these." (*White family medicine nurse practitioner*)*

*As a starting point… I always talk about long-acting methods as being what we have found the most effective for teenagers because … it works… So, yeah, yeah, I mean, I push long-acting all the time. (*White pediatric nurse practitioner*)*

Most providers seemed unaware of this incongruity in their approaches, as their statements indicated that both PCC and 'effectiveness-first' counseling (despite patient preferences) could be employed simultaneously. This dissonance suggests providers' understanding of PCC may be incomplete and inadequately translated into practice.

*… shared decision-making, now, is the more common type of counseling method that's being used… So, I tell them [patients], we do these cards, let's put the most effective at the top, it's kind of –it's kind of a no-brainer, right? (*White pediatrician*).*

4. Discussion

Study results reveal four significant themes about provider perspectives on contraceptive PCC for Latinas. Providers described the health care system itself as an antagonist of PCC as they consistently noted delivery and access-related barriers including time constraints and patient insurance status as it relates to contraceptive cost. Next, providers noted several patient characteristics that they perceived as being incompatible with PCC including low health literacy, patient-provider language discordance, and patient cultural misconceptions. While providers expressed familiarity with PCC and a desire and intention to practice it, a concurrent paternalistic focus on pregnancy prevention at times curtailed patient preferences. Lastly, many described using a tiered-effectiveness approach even as they identified the importance of centering patient preferences. Thus, permeating most discussions was a tension between an expressed desire to provide PCC and paternalistic family planning paradigms that prioritize the prevention of unintended pregnancy over patient preferences.

Unsurprisingly, providers described time constraints as a barrier to PCC, a common dilemma in the American health care system [26]. Financial motivations often impinge on the time needed to provide PCC, especially in federal/state-funded facilities which are often located within socially and economically disadvantaged communities and frequently have high patient volumes due to limited resources, provider shortages, and broader access limitations [27,28]. Considering an RJ framework, time constraints are reflective of the inequity in health care that disallows equitable time allocation for the provision of PCC for some patients –most often un/under-insured racial/ethnic minorities. An RJ framework recognizes the importance of a human rights approach that promotes the necessary conditions for all people to make autonomous decisions that optimize wellbeing [5,10]. Within this context, a health care system that precludes adequate time and health insurance for disadvantaged populations, is in direct opposition to equitable provision of PCC in SRH.

Providers also described specific patient attributes as incompatible with PCC including low health literacy and language discordance. While these have been observed as barriers to contraceptive use and continuation among Latinas in past research, more recent data suggest that Latinas, specifically in Baltimore, often have knowledge and understanding of their contraceptive options and how to access them [17,21]. Other studies have failed to demonstrate that Latinas perceive language discordance with their providers as a barrier to contraceptive care or decision-making [17,18,29]. Therefore, these provider-reported barriers to PCC may not be congruent with those of patients but instead may reflect biased perceptions and/or stereotypes [21]. Such deficit-focused clinical practice ignores the agency and self-efficacy that Latinas demonstrate in their contraceptive decision-making abilities [17,19] and can add perceived complexity to patient encounters, especially within racial/ethnic discordant patient-provider interactions. Providers also described culturally-attributed contraceptive misconceptions or "myths" as barriers to PCC. However, participants rarely acknowledged that so-called myths are often rooted in generational knowledge of America's history of forced/unconsented sterilization which has played a significant role in engendering contraceptive misconceptions and medical mistrust [5,6,23]. Failing to recognize this relationship by attributing misconceptions to 'cultural' factors can perpetuate false notions about Latinas, that also impinge on agency [19]. Moreover, it is inconsistent with provision contraceptive PCC and RJ principles.

Prior research suggests clinicians often believe they both understand and practice PCC [30]. Similarly, participants in this study often described their counseling approaches as being PCC-driven (focused on patient preferences, patient autonomy, and noncoercive information-exchange). Notably, participants concurrently described a paternalistic approach to counseling which includes prioritizing methods of LARC, convincing or influencing patients to use or keep certain provider-preferred methods and minimizing potential contraceptive side effects and risks. Prior research has affirmed the tensions between what clinicians believe is delivery of PCC in contraceptive care and the care that is actually being delivered [12], and that providers often grapple with the friction they perceive between patient autonomy and patient compliance [31]. Analogously, our data reflect tensions between provider intentions to provide PCC and a degree of paternalism which postulates that compliance with contraceptives that optimize pregnancy prevention is paramount. Such counseling can diminish opportunities for patient expression of preference and in turn, may undermine their decision-making autonomy.

Providers are often educated to promote methods of LARCs as 'first line', yet this encourages clinicians to prioritize what they think patients should use over patients' preferences [9,11]. Additionally, provider partiality toward the most effective methods is an example of how the medicalization of unintended pregnancy can affect contraceptive counseling [32] and can undermine PCC when the focus is on pregnancy prevention as the most important outcome. While pregnancy prevention is often the purpose of contraception, for some it may not be an outcome to be achieved at the expense of intolerable side effects or a disregard for current and historic abuses. The controlled reproduction of Latina, Black/African-American, Indigenous and other marginalized communities has set the stage for the current mistrust of the medical system [5,33]. Black and Latina women are more likely to be pressured to use contraception than White women –specifically methods of LARC [34,35]. Therefore, historic and contemporary contexts of SRH for racial/ethnic communities necessitate a truly noncoercive, trust-based, preference-focused and supportive approach for contraceptive counseling, in keeping with PCC. Provider recommendations and advice should be discussed with a focus on patient preferences, not despite them.

Applying an RJ framework, we consider how deeply rooted American sociopolitical systems of structural racism and classism have served to establish and perpetuate who should and should not have children [3,21]. These are reflected in larger institutional policies that provide subsidies to promote methods of LARC in specific communities. To improve contraceptive PCC, clinicians must prioritize patient preferences and provide continuous support as patients interact with the health care system. This includes abandoning tiered-effectiveness counseling approaches and instead supporting patient decisions about which methods (if any) are best for them. Moreover, the authors and others [4,23] strongly argue that implementing PCC in contraception provision requires an understanding of current and historic reproductive injustices.

4.1. Limitations

Findings are not transferrable to all U.S. SRH providers; however, qualitative results are not meant to be generalizable [20]. The unique characteristics and lived experiences of providers in our sample inform their distinct perspectives. Still, the lack of geographic diversity, information about provider's length of time in practice and provider age, can represent potential study limitations. The absence of patient perspectives and objective accounts of patient-provider interactions (such as audio/video recordings)

also present additional limitations. Provider-only reports can be biased and thus limit the extent to which we are able to understand the roles of covert and overt racism and xenophobia, thus potentially limiting the credibility of our findings. Data collection is currently underway for a study that incorporates objective observations of patient-provider interactions during contraceptive counseling as well as quantitative and qualitative assessments of patient perspectives about the counseling. Providers did project honesty both about the barriers they face in providing care and many facets of their counseling, even if not always patient-centered, which suggests some trustworthiness in describing their own clinical practice. Notwithstanding, findings provide insight about clinician perspectives, intentions, and practices regarding contraceptive PCC with focus on an often-marginalized population. While results are not generalizable, the recommendation that SRH providers understand the historical context of U.S. medical care as they strive to provide patient-centered contraceptive care, *is* generalizable.

5. Conclusions

Study findings suggest a need to reframe approaches to contraceptive PCC that include a clearer understanding of RJ. Medical education often instills that the most effective methods are 'best,' yet this assessment may be presumptuous, value-laden and misaligned with patient preferences. Training programs should instead work to teach provision of patient-centered contraceptive care with the goal of achieving patient satisfaction with care, rather than a unilateral focus on attaining pregnancy prevention. Notwithstanding, larger institutional policies must work to address health delivery and access barriers that interfere with patient-provider relationships, notably time constraints and insurance coverage, that are reflective of structural racism and classism and continue to hamper implementation of PCC.

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