Contraceptive Justice Project at EverThrive Illinois:

Understanding the Patient/Client Perspective through Focus Groups

*Culminating Experience – Northwestern University Master of Public Health*

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Abstract

Introduction: EverThrive Illinois has been working alongside partners and members to identify and address systemic causes of health inequities in Illinois affecting women, children, and families, through lasting policy changes. Recently, they initiated the Contraceptive Justice Project to increase access to all forms of contraception, while considering the impact of ten social determinants of health. As part of the patient/client assessment, a literature review was conducted that revealed common facilitators and barriers to contraceptive access, and major themes related to a number of social determinants of health. The literature review also revealed gaps in data regarding access to contraception for immigrant populations and the transgender community.

Methods/Analysis: Four focus groups (N=57) were conducted at various community organizations in Chicago in order to address the gaps in the literature. Focus group notes were analyzed using grounded theory and an iterative process of comparison. A de-identified, open-ended, demographics questionnaire was administered and analyzed using descriptive statistics.

Results: Sample consisted of presumed ciswomen (79%) and gender-expansive folks (12%) who self-identified as Latinx (51%), Black (16%), and white (21%). Four major themes emerged from the focus group discussions: sexual and reproductive health, sexual health education, physician experience, and contraception experience. Discussions revealed multiple sources of sexual and reproductive health information and that experiences of trauma were common. Sexual health education yielded positive experiences when curriculum was inclusive, comprehensive, and taught in multiple modalities. Patient-physician experiences were influenced by language, feelings of distrust, and confidentiality. Finally, when discussing contraceptive experiences, participants often mentioned side effects and cited several barriers to access to their preferred
method including insurance/cost, providers “pushing” contraception methods, or being offered limited options.

Discussion: In order to increase access to preferred methods of contraception, people seeking contraception must have access to comprehensive, inclusive, trauma-informed, and age-appropriate sexual health education. The patient-physician relationship also must be strengthened by improving communication, using understandable and inclusive language, and respecting people and their choices. Finally, contraception counseling should be RJ informed.

Background

For years, EverThrive Illinois has been working alongside partners and members to identify and address systemic causes of health inequities in Illinois affecting women, children, and families, through lasting policy changes. More recently, EverThrive IL initiated the Contraceptive Justice Project, a new contraceptive access project using the frameworks of Reproductive Justice and Collective Impact. Sexual and reproductive health services are crucial to healthy people and healthy families. There can be societal barriers for people with marginalized identities who experience unintended pregnancy and do not have the same supports and resources that people with many privileges do. The Reproductive Justice (RJ) movement was founded by Black women to address these intersecting barriers that can eliminate access, choice, and power. The RJ framework recognizes the history of institutional reproductive oppression in health care and policy and actively works to repair the harm, change structural power inequalities, and address the root causes of health inequities.

The Contraceptive Justice Project aims to increase access to all forms of contraception using the guiding principles of Reproductive Justice to create a comprehensive approach that includes sexual and reproductive health education (SRHE), advocacy around patient rights,
training and support for health care professionals, and policy recommendations. The project recognizes that access to contraception is a social issue. Determinants such as race, sex, gender, sexual orientation, age, income, ability, immigration status, primary language, and geographic location all underlie disparities in health and health care. Furthermore, realization of complete contraceptive access requires alliance between and mobilization of key stakeholders that include community organizers, advocates, providers, educators, policy makers, activists, and more to create real change that is accessible all communities. For this reason, the Contraceptive Justice Project also utilizes the collective impact model, which encourages stakeholder collaboration to address a social issue and is facilitated by four components: governance and infrastructure, strategic planning, community involvement, and evaluation and improvement. This model has guided ongoing community involvement and the creation of the Contraceptive Justice Coalition.

The approach of combining the Reproductive Justice framework, the collective impact model, and community voice in order to address contraceptive access is novel, making the Contraceptive Justice Project the first of its kind.

The landscape assessment of the project explores three components to gain an in depth understanding about contraception access in Illinois: policy, provider perspective, and patient/client perspective. In order to further develop the patient/client component, a literature review was conducted focusing on the barriers that patients/clients face in gaining access to their preferred contraceptive method and their attitudes and behaviors in relation to contraceptive use. Additionally, six focus groups were conducted across the state with the maternal and child health family councils that EverThrive Illinois convenes for people who have utilized Title V services, the results of which are not discussed in detail here. The literature review has generated common themes in several different sectors regarding reproductive health and contraceptive access:
facilitators, barriers, and contraception counseling. Before discussing findings from the literature review and this research, it is necessary to draw attention to the language that is used throughout this paper. The intention is to use language that is as inclusive, affirming, and accurate as possible without misrepresenting the data presented in the literature. Therefore, transwomen are included in the general use of the term “women”, and terms such as “ciswomen”, “gender expansive”, “nonbinary”, “transwomen” and “transmen” will be made explicit where appropriate.

In regard to facilitators, the type and quality of patient-provider relationships have a great impact on women’s access and uptake of the contraceptive method that is best for them. A strong patient-provider relationship appears to be both a mediator for health outcomes and a preference for women undergoing contraceptive counseling.\textsuperscript{1,2} Women tend to describe a good patient-provider relationship as one that entails culturally-sensitive communication, promotes patient autonomy by offering information on all contraceptives, and does not assume heterosexuality.\textsuperscript{3,4,5} Another facilitator is familial or social support. Women look to their friends and family as important sources of information and “vicarious experiences” in the decision-making process which could serve as encouragement for women to find the contraceptive method that is the best for them.\textsuperscript{6} In the case of young people, a majority cited that their parents/guardians knew that they were seeking reproductive health care services and were sometimes referred to the clinic by a parent/guardian.\textsuperscript{7}

On the other hand, if a strong patient-provider relationship is not present, this can serve as a barrier to access to contraception. Women have cited that situations where they felt ignored, discriminated against, or coerced by a provider negatively impacted their perception of postpartum contraceptive counseling and resulted in less satisfaction with the decision-making
process and the contraceptive method chosen. In some cases, social/familial involvement may actually serve as a barrier rather than a facilitator. In the case of young people, this is due to confidentiality concerns. Studies have suggested that mandated parental notification is likely to increase rates of condomless sex and unlikely to promote abstinence. For both young people and adults, misinformation and the propagation of myths by friends, families and inaccurate sexual health education like abstinence-only education, especially about side effects, may discourage people from trying new methods. On a related note, lack of accurate knowledge on contraceptive methods is another barrier. Women often note difficulty in finding reliable information and dissemination of information does not always parallel the use of technology by young people. Finally, structural barriers may include insurance and eligibility requirements, scheduling issues, and time constraints for counseling and placement of IUDs.

The literature review also brought to light suggestions for improving contraceptive counseling. In the case of postpartum contraception, women preferred to have multiple provider-initiated conversations about contraceptive options throughout pregnancy. The length of these counseling sessions should vary according to women’s knowledge about contraceptive methods and should provide information about all contraceptive methods in different modalities to cater to each learning style. Additionally, although it is important to recognize that effectiveness is often a major consideration for the contraceptive method of choice, counseling that is tiered should have a balance between LARC-first and RJ. In other words, women should have access to LARC if they want it, but also access to its removal.

In addition to overall barriers and facilitators, the literature review helped generate key themes related to contraceptive access according to specific factors that underlie health disparities: race, sex assigned at birth, gender, sexual orientation, age, income, ability,
immigration status, primary language, geographic location, and intimate partner violence (IPV). Although each of these factors will be discussed individually, it is important to note that they often intersect to create unique experiences for individuals. Therefore, no one factor can completely explain disparities in reproductive health and contraceptive access.

**Race**

There is extensive research on the reproductive and sexual health disparities that exist in relation to race. For example, both Black women and Latina women experience higher rates of unintended pregnancies than white women, even when stratified by income. Furthermore, Black and Latina women are more likely to experience contraceptive failure. Interestingly, despite the high rates of unintended pregnancy among African American and Latinx communities, Asian women generally rely on less effective contraceptive methods compared to other races. Racism at all levels plays a role in these disparities in sexual and reproductive health. For African American women in particular, racism at the individual level increases their risk for HIV and other STIs, pregnancy-related mortality and morbidity, stress and internalized racism, and factors at the interpersonal level, including mass incarceration and sexual and domestic violence, also affect health outcomes. Furthermore, racism at the neighborhood and institutional levels have resulted in unequal access to healthcare. Overall, the effects of racism have made it difficult for African American women and Latina women to feel that intended/planned pregnancies are feasible and may explain their higher levels of distrust and discomfort with modern contraceptive methods compared to white women.

The distrust that African American women may have towards certain contraceptive methods and family planning have been present for quite some time. Interviews conducted in the
early 1970s revealed concerns among African American communities that family planning was a mechanism for eugenics. Currently, distrust with family planning or certain contraceptive methods become more apparent with negative encounters with contraceptive counseling. Women characterize negative experiences by feelings of being ignored, underlying tones of coercion, and racial discrimination. Similarly, poor patient-physician encounters for Latina women may be due to language and perceived cultural insensitivity. This poor communication is likely to contribute to non-adherence to contraception and lack of knowledge. Given the historical distrust in family planning and experiences of poor communication or coercion, it is no surprise that the social network, consisting of friends, family, and partners, serves as an important source of information about contraception and vicarious experiences for African American and Latina women. In fact, women often feel that these sources are more reliable than their health professionals.

*Sex Assigned at Birth*

In regard to differences in contraceptive access by sex assigned at birth, there is a clear need for increased sexual and reproductive health education that focuses on all contraceptive methods and their use for males. In a study looking at perceived responsibility for contraception and condom use among African American male youth, results revealed that there was increased perceived responsibility in committed relationships, but many respondents had low levels of contraception knowledge to act on. Another study also showed the effect that lack of knowledge has on consistent condom use: male youth that lacked enabling resources, such as sex education, had half the odds of using condoms at first sex and using them consistently. On the other hand, condom-based health education programs in school were associated with lower rates
of STI diagnoses and increased testing among men.\textsuperscript{21} In general, programs that allow for students to practice skills, such as condom use, are better for skill acquisition than programs that rely solely on demonstrations.\textsuperscript{22}

\textit{Gender}

Many disparities in health care and access exist for transgender and gender-nonconforming (TGNC) communities, including access to primary care.\textsuperscript{23} For example, high rates of HIV/AIDS disproportionately affect transgender women of color which are likely due to economic marginalization, social stigma, and limited access to healthcare and HIV screening.\textsuperscript{23} Despite the fact that HIV status is likely the best-characterized preventable health condition among transgender populations, there still remains a large gap in the research regarding terminology and language, population characteristics, rates of HIV, sexual behavior and HIV, HIV screen practices, barriers to HIV care and HIV interventions, cholesterol screening, tobacco use, Pap tests, insurance status, and other primary care gaps.\textsuperscript{23} Furthermore, discussions with health-care providers about fertility and reproductive health are uncommon, even though TGNC youth have expressed interest in multiple family building options and have recognized the need for information in order to do so.\textsuperscript{24} In addition to more research, contraceptive access could be improved for TGNC populations with highly individualized medical care, the use of non-stigmatizing language, and provision of accurate information about all contraceptive methods.\textsuperscript{25}

\textit{Sexual Orientation}

There is a lack of research on sexual orientation and its implications on contraceptive access, generally. Research does indicate that many general practitioners struggle to discuss
sexual orientation with their patients because of lack of comfort and confidence in the topic. This could be improved with training and education. In order to improve contraceptive access, it is also recommended that clinicians should not assume heterosexuality in young people’s sexual and reproductive health services. Additionally, lesbian and bisexual (LB) women’s sexual orientation should not be used to make assumptions about fertility and childbearing preferences. However, providers should be able to provide appropriate information, discuss pros and cons of all kinds of pregnancy, and direct LB women to sources of help.

**Age**

The first potential barrier to reproductive health services for young people, and in turn contraception, is mandated parental notification. Despite the fact that many states allow young people to access reproductive health services without parental consent, federal or state funding might be the most apparent threats to limiting contraceptive services for young people. Young people have voiced the negative repercussions of mandated parental notification. In one particular study conducted at 33 different Planned Parenthood clinics in Wisconsin, 47% of the sample stated that they would discontinue using all Planned Parenthood services if parents were notified that they were seeking prescription contraception and young people in another study stated they would switch to a less effective method of contraception or engage in condomless sex. Although health-seeking behaviors would change with parental notification, 99% of young people reported they would remain sexually active. These changes in behavior have negative health implications including the increased risk of unintended pregnancy and spread of STIs.
Another common barrier for young people to access or uptake of certain contraceptive methods is lack of knowledge. In a series of focus groups of African American young people, participants were concerned about side effects and apprehensive of long-term consequences of using continuous hormonal methods. Furthermore, they expressed fear of contraindications related to chronic diseases. This is consistent with another barrier that was identified by providers serving the Black community in the South Side of Chicago; providers noted that young people often had to rely on peers for information regarding sexual health which often perpetuated myths, misinformation, and stigma.

Although there are plenty of barriers that may influence contraceptive and reproductive service access for young people including those not discussed here, there are also several noteworthy facilitators to young people’s access to these health needs. One major facilitator is the patient-physician relationship and staff relationship, which also may be important in reducing disparities in reproductive health of young people of different racial and ethnic backgrounds. Women of color are less likely to seek reproductive health care services, and when they do are less likely to have satisfactory visits. Factors that may improve physician – patient interactions, particularly for low-income African American young people include forging strong relationships with teens, working collectively amongst other staff members to provide care, and seeking opportunities to provide contraceptive counseling.

Voluntary parental guidance in the decision-making process could be a facilitator. Positive parental communication and relationships have been shown to have several benefits in the reproductive health of young people. For example, parental support is associated with later first intercourse, infrequent intercourse, and lower sexual risk taking. Additionally, girls whose mothers discussed contraception with them were three times more likely to use effective
contraception and half as likely to engage in sexual activity as girls that did not discuss contraception with their mothers.\textsuperscript{30}

\textit{Income}

The effects of economic factors on reproductive and sexual health of women have been relatively well studied. A study using state-level data from 1978-1988 showed that birth rates are sensitive to Aid to Families with Dependent Children benefits (AFDC), so much so, that a 10\% cut in AFDC benefits could reduce birth rates by 1 per every 212 people on welfare.\textsuperscript{31} More specifically to contraceptive access, income-level is associated with use of certain methods over others and serves as a barrier to preferred methods of contraception. In general, disadvantaged women are less likely than others to use oral contraception.\textsuperscript{32} One study by showed that 1 in 5 low-income women would utilize oral contraceptives if they were made over-the-counter, but less than half would be willing to pay over $20 for them.\textsuperscript{33} In this way, cost of oral contraception still plays an important role even when the burden of a prescription is removed.

In the case of LARC, its use is strongly associated with all socioeconomic characteristics, while also being more common among Black and immigrant Latinx women.\textsuperscript{32} This is not the sole example of the intersection between race and socioeconomic status in relation to contraception use and access. In fact, physicians are more likely to recommend IUDs to Black and Latina women of low socioeconomic status (SES) compared to white women of low SES, but less likely to recommend it to white women of low SES than white women of high SES.\textsuperscript{34} Minority women with low incomes also face barriers to postpartum sterilization including poor physician staff relationships that result in women electing to cancel the procedure; clinical
factors such as medical delays and complications; and institutional or systemic barriers such as a lack of valid Medicaid consent form.\textsuperscript{35}

\textit{Patients with Disabilities/Chronic conditions}

When it comes to the reproductive health of people with disabilities, studies show that both males and females are at least as sexually active as their peers without such conditions.\textsuperscript{36} However, disparities exist in the receipt of certain reproductive and sexual health services. For example, although young adult women with disabilities in one study had similar reproductive health outcomes to those without disabilities, they were less likely to have had a Pap smear in the last year.\textsuperscript{37} Furthermore, less than 20\% of men with disabilities were tested for STIs in the past year.\textsuperscript{37} This is concerning given that women with chronic conditions or disabilities report higher rates of STIs than women without, and both women and men with non-visible conditions are more likely to experience sexual abuse than people without conditions or with visible conditions.\textsuperscript{36}

Another service for which disparities in receipt exist are contraceptive services. Community contraceptive services have served those with disabilities for many years, but very few women with disabilities know that these services exist or feel that they have the opportunities to make their own family planning decisions.\textsuperscript{38} This is especially problematic given that in one study, 39\% of women with disabilities were at risk of unintended pregnancy, and of those a majority (3 in 4) were at risk of nonuse of contraception.\textsuperscript{39} Furthermore, women with disabilities were 40\% less likely to use moderately effective and highly effective contraceptive methods than women without disabilities.\textsuperscript{39} These statistics exemplify the high unmet reproductive and contraceptive needs of people with disabilities. However, in order to improve
the reproductive health of people with disabilities, other determinants of health disparities such as poverty, lack of insurance, lack of education, etc. must also be addressed.39

Primary Language

Health literacy is an important factor to consider when examining the effect of primary language on contraceptive access and unmet need. One study explored the relationship between women’s health literacy and perceived understanding and use of a contraceptive method.40 Results showed that despite having perceived high understanding of contraceptive method and at least a high school literacy level, there was only 53% agreement with the patient’s plan and physician-reported plan at postpartum discharge. Patients were more likely to understand how to properly take pills, and least likely to report good understanding of the IUD.40 More research is necessary on how primary language impacts contraceptive access.

Geographic Location

One jarring example of how geographic location can provide insight into reproductive health was provided in a study by Gunaratne, Masinter, Kolak, & Feinglass (2015) that looked at young people between the ages of 15 – 19 years who gave birth in Chicago between the years of 1999-2009. Census information showed that although the youth birth rate in Chicago had declined within the past decade, there was great variability in rates between the 77 community areas studied that were strongly correlated with changes in youth population, unemployment rate, crowded housing, high school dropouts, poverty, black or Hispanic racial/ethnic background, and annual income below $50,000.41 Just as a number of neighborhood factors can affect health outcomes in different community areas in an urban environment, so can rurality and availability
of clinics or hospitals impact contraceptive access in certain locations. In the case of isolated rural towns of the Midwest, low IUD demand and lack of trained IUD providers served as barriers for patients to obtaining IUDs. In the case of other hormonal contraceptive methods, on-site provision was more common in urban areas compared to rural. Furthermore, fewer clinics offered walk-in appointments and there was less availability on weekends in small rural towns compared to urban areas.

Even the type of hospital or clinic available in a location could impact contraceptive access, especially for young people. One study showed that nonmetropolitan hospitals and freestanding clinics are more likely to have parental notification policies in place and multiple procedures to obtain consent. Similarly, accessibility to EC varies by pharmacy type and state: national chains were more likely to stock EC, have EC available on a shelf, and allow one to come in to purchase EC without a doctor’s prescription, parental approval, or a photo ID. National chains also had a lower median price than individually owned pharmacies and provided accurate information about when to take EC. Additionally, California provides greater access to EC to young people than Arizona. Overall, only 28% of pharmacies contacted in the study had completely accessible EC, and the most significant barrier was cost.

*Intimate Partner Violence*

History of intimate partner violence (IPV) also known as domestic violence is associated with a number of reproductive health consequences. Young people who experienced dating violence were at greater risk for sexual health concerns and pregnancy. Additionally, women who experience IPV have 53% reduced odds of reported contraceptive use and reduced use of partner dependent methods. Postpartum contraception use is also negatively associated with
history of IPV; non-Hispanic white and non-Hispanic Black women who experience IPV around pregnancy are less likely to use contraception postpartum even after prenatal contraceptive counseling compared to those who do not experience IPV.\textsuperscript{47}

The reduced odds of contraceptive use and increased risk of pregnancy associated with IPV is especially concerning given that pregnancy is not a protective factor against IPV.\textsuperscript{48} According to a study examining pregnancy-related deaths in Maryland, prevalence of intimate-partner homicide was greatest during the first trimester of pregnancy at 25\% and reduced to 8.5\% in the third trimester.\textsuperscript{48} Given the serious risks associated with IPV, domestic violence should be screened for before, during, and after pregnancy.\textsuperscript{48} Further, women should be informed of the risks of IPV during pregnancy, as it could encourage them to get help and help those currently in abusive relationships from becoming pregnant in the hopes of breaking the cycle of abuse.\textsuperscript{48} Family planning services should be able to provide information on all contraceptive methods including those that are not partner dependent.\textsuperscript{47}

Despite the extensive research related to contraception that is available, there continues to be a dearth of information related to language barriers, immigration status, and transgender populations. The purpose of this research was to address some of these gaps in order to create comprehensive recommendations and an action plan that addresses disparities and unmet contraceptive needs.

**Methods**

*Study Design*

In order to address the gaps in the literature, four focus groups were conducted at three community organization sites: two at Mujeres Latinas en Acción, one at Illinois Caucus for Adolescent Health (ICAH), and one at Howard Brown Broadway Youth Center (BYC). Consent
was obtained during the recruitment process and most focus groups were not audio recorded due to privacy concerns and to protect confidentiality. The focus group protocol was modified from a previous protocol that was used in a project with the maternal and child health councils that EverThrive IL convenes. We met with leaders of community organizations who were partaking in the focus groups to modify and tailor the language and content of the protocol (Appendix 1). Additional focus group materials included a contraceptive methods chart by the Reproductive Health Access Project that was provided in both English and Spanish (Appendix 2). The focus groups were 120 minutes in length and took place at the site from which participants were recruited. They were co-facilitated by the Reproductive Justice Manager at EverThrive IL, and a community organization leader of the specific site. A designated note-taker was present at each focus group, and notes taken by facilitators were consolidated immediately following the focus groups. Focus groups at Mujeres Latinas en Acción were conducted in Spanish. A poll of which contraceptive methods people are familiar with, have tried, or never heard about was conducted during three focus groups using the contraceptive method chart as a guide. A de-identified, open-ended, demographics questionnaire was administered at the end of the focus groups in order to collect information about sex, race/ethnicity, age, income level, immigration status, preferred language, location, and parity. In the case of participants from Mujeres Latinas en Acción, a staff member administered the survey during recruitment prior to the focus group.

**Participant Recruitment**

Participants for focus groups were recruited from Mujeres Latinas en Acción, ICAH, and BYC. The participants from Mujeres Latinas en Acción were recruited by staff members and were primarily clients. Clients were encouraged to invite their friends and families to participate,
as well. Participants from ICAH were recruited by leaders of the community organizations and were primarily sexual health education facilitators. Participants for the BYC were also recruited by a community organization leader and the focus group took place during a regularly scheduled session. Size of the focus groups varied from 6-25 participants. Participants were given a stipend of $60 in cash as compensation for their time and to cover cost of transportation. On-site child care costs and food were covered by EverThrive IL.

Analysis

The de-identified demographics questionnaire and contraceptive method use poll was analyzed using descriptive statistics. The notes taken during the focus groups by the note-taker and facilitators were collected and organized into a single document. Notes taken during the focus groups conducted in Spanish were double-checked by the community organization co-facilitator for accuracy. Additionally, phrases and words in Spanish were translated to English by the community organization co-facilitator. The notes were analyzed using grounded theory and an iterative process of comparison. I first assessed responses for themes then created a categorical system consisting of overall themes, categories, and sub-categories. Overall themes consisted of Sexual and Reproductive Health, Physician Experiences, Sexual Health Education, and Contraception Experience. Select examples for themes and categories are presented in Table 1. I then convened with the Reproductive Justice Manager of EverThrive IL to present the themes and the categorical system in order to reach consensus and assess the adequacy of the categorical system. Additional codes and categories were created as necessary to incorporate themes that were not initially captured. Appendix 3 displays the categorical system that was created.
Results

Sample Characteristics

The total sample size was fifty-seven. Participants self-identified as transgender (4%), cismale (2%) or gender-expansive (12%), and the rest were presumed to be ciswomen (79%). The mean age of participants was 35 years. In regard to race and ethnicity, participants self-identified as Latinx (51%), Black (16%), white (21%), Native American (2%), multi-racial (7%), or other (2%). Almost three-quarters of the participants had an annual income of below $15,000 and about 86% lived in Chicago, Illinois. Furthermore, a majority of participants were immigrants (58%). The primary languages reported by participants included Spanish, English, or both. Table 2 provides a summary of the sample characteristics.

Sexual and Reproductive Health

The focus group conversation started with a general discussion about sexual health and education for which participants were eager to share their experiences. Participants reported a number of different sources for sexual health information including family, friends, media, school-based sexual education and physicians. Of these sources, family and school-based sexual health education were mentioned most often. Some women also reported learning about sexual and reproductive health through experience and observation. Three women across both focus groups at Mujeres Latinas en Acción mentioned that they did not know about the birthing process until they were giving birth, and a couple participants stated that they did not learn what sexual intercourse was until they were in a relationship or married.

The general discussion also shed light on stigma surrounding sexual health within the Latina immigrant community. Six participants described situations in which they felt they had to
hide their bodies or reproductive processes. One woman reported that, “everything was hush hush and you were not supposed to talk about periods, sex, etc.” Another woman shared feeling depressed when she would start her menstrual cycle because “no one should know about it.” This stigma did not seem to fade as women grew older. In fact, a couple women noted that even as adults they still feel that they cannot talk to their mothers about sex.

The conversation also revealed a high prevalence of childhood trauma related to sexual abuse, often perpetrated by family members. Among participants of the Mujeres Latinas en Acción focus groups, ten participants shared stories regarding their own history of abuse, or that of someone they knew. One participant shared that at the age of 13 she moved in with a man that was 24 years old who would hit her and force her to have sex with him. However, when she left him and returned home, she was “shunned and told not to be around other children because I could hinder them since I had already had sex. I experienced so much stigma I went back to the abusive relationship and had a child at 13.” Examples such as these portray the long-term adverse consequences of trauma, and that feelings of stigma are especially apparent following experiences of trauma.

*Physician Experiences*

Participants reported several different factors that impact their relationships with their providers: confidentiality, language, and distrust. In regard to confidentiality, two participants among the ICAH focus groups recalled experiences in which their confidentiality was not respected. These breaches resulted in a negative experience for the participant and had a negative impact on the patient-physician relationship. For example, one participant shared that, “I had chlamydia and they told my mom…and since then I’ve had a bad relationship with my provider.”
Some participants also expressed distrust for their providers. In some cases, participants found it difficult to trust physicians because they believed they were being paid to promote certain contraceptive methods or medications. In other cases, participants noted underlying feelings of racism or classism. One participant wondered “if they would ask this if I was rich and white” when recalling a visit in which they were asked about their sexual health.

Particularly among the gender-expansive participants, language was an important factor in their physician experience. One participant talked about a positive experience with a gynecologist: “I could tell they were not comfortable working with transgender people. I could tell they did not know what language to use, so I would jump in with the words and answer the question. But, they left space for me to do that and let me use words I’m familiar with.” In general, there was a consensus about the need for de-gendering questions around sex and changing intake forms to accommodate gender-expansive folks.

*Sexual and Reproductive Health Education (SRHE)*

Participants were asked about their perspective on their school-based sexual health education and other forms of sexual health education received through the community organization. The participants in the focus group at ICAH were peer educators and shared three primary reasons for positive experiences with the sexual health curriculum at ICAH: it is inclusive, the information is comprehensive, and the curriculum is taught using a variety of teaching modalities. Participants mentioned that they liked that the curriculum was gender inclusive and included intersex anatomies, and that it took place in an environment with people of shared identities. One participant stated that they appreciated the “acknowledgement of
trauma in experiences, like for women of color” and another participant noted that they liked “that the education is for everybody.”

Participants of the ICAH focus group were also eager to share the variety of topics that were covered in the curriculum, such as STIs, contraception, pleasure, and intersex anatomies, exemplifying its comprehensive nature. In the case of STIs, one participant mentioned that they appreciated “learning about STIs and knowing that most of them are treatable.” Three participants talked about how all options for contraception were offered, and that “we learned about not just external, but also internal condoms, and dental dams.”

In addition to inclusivity and comprehensive education, the ICAH participants emphasized the importance of using different teaching modalities. They especially appreciated being given opportunities to practice the skills they had learned in the curriculum such as practicing how to talk to their provider or partners. Participants also enjoyed active learning and demonstrations. For example, in addition to being given information on dental dams, one participant noted that they also learned how to make them. Overall, they appreciated that they were able to retain what they felt was important and necessary for their own health.

The ICAH participants noted plenty of positive experiences with the sexual education curriculum they were offered through the program, but participants of the other focus groups shed light on a number of topics that they felt were inadequately covered through their school-based sexual health education. Participants from both the BYC and Mujeres Latinas en Acción focus groups mentioned that pleasure was often excluded in the conversation. One participant wished that pleasure was actually taught because he “had to learn about it on YouTube.” Another participant stated that at first, she did not know what an orgasm was. Participants in the BYC focus group also had concerns about the lack of thorough education and resources. One
participant shared that “all that was shown in classes were bumps on genitalia, [which] for young teens to learn about the messed up sexual stuff was bad.” Others also shared this sentiment and wished that sexual education was taught “more thoroughly and realistically, other than just biology,” to include conversations about contraception, and resources for those who were already having sex.

Finally, many participants in the Mujeres Latinas en Acción focus groups were particularly interested in initiating conversations with their children about sexual and reproductive health. Several women shared that their mothers or other family members had been unwilling to speak to them about sexual and reproductive health. For example, one woman shared, “I found a condom and when I asked my mom what it was, she slapped me.” Another woman said that despite having multiple sisters, when she first started menstruating, she “still did not know about it [periods]…and thought she had cut herself.” Despite the fact that some participants had not had conversations with their family, they felt that sexual health was an important topic to discuss. However, they did not know when and how to initiate the conversation. Parents were also particularly concerned about creating a balance between necessary information and what would be considered too much. One mother stated that “you don’t need to talk about specifics…but you should talk to them and teach them about what is good,” and another stated “they should get the basic information and not to an extreme.” Many mothers mentioned the importance of age-appropriate and accurate information over the course of the lifetime. For example, one mother stated that when talking to her children she calls their body parts by their names and explains inappropriate touching. Participants agreed that trust and good communication were necessary in order to educate their children.
**Contraceptive Experience**

Three of the four focus groups (N=46) answered a poll during the discussion about their contraceptive method use which was facilitated by a contraception methods chart. The most commonly tried methods were external condoms (43.48 %), withdrawal (41.30 %), and fertility awareness (41.30 %). Almost a third of the participants had also tried the copper IUD, pill, and EC. No participants reported having tried the diaphragm. Additionally, at least one participant had not heard of the following methods: shot, ring, patch, mini-pill, diaphragm, and spermicide. Figure 1 shows contraception use by method according to each focus group that was polled. In relation to contraception use, participants also acknowledged other medical reasons other than pregnancy prevention to use contraception, such as to regulate the menstrual cycle.

Several participants noted trying different methods before picking one. They shared that their preferred method was effective and also “worked well with my body.” In describing their contraceptive history, many participants had experienced side effects. Reported side effects included infection, irregular periods, hemorrhage, changes in mood, bloating, and vomiting. As such, participants were often concerned with both short and long-term side effects. Two participants from the ICAH and BYC focus groups were also concerned about forced sterilization. The participant from BYC stated that they were uncomfortable with certain contraceptive methods because “anything that is put in my body is a form of sterilization,” and the participant from ICAH reported they were uncomfortable with the copper IUD after hearing stories about women in the south being given it to prevent pregnancy.

A number of barriers to access to preferred methods of contraception emerged in the discussion. Several participants mentioned that only a limited number of options are offered during contraceptive counseling. For example, one participant shared that she was only offered
LARC after she had given birth, and several participants agreed that they usually only receive information about two methods during a visit. Furthermore, experiences in which providers “pushed” certain methods served as a barrier. Three participants in the BYC focus group shared that they did not like it when providers pushed methods because they felt that their decision was not being respected, or that there was a hidden agenda. Finally, participants also listed lack of insurance or cost as dictating their options. One participant shared the role that their insurance status played in their experience with LARC: “It [Nexplanon] made me bleed the entire time I had it for 2 years. I was homeless at the time and did not have insurance and did not have a way to remove it. I thought about cutting it out myself.” Experiences such as these show the need to consider removal of LARC as a component of contraception access, as well.

On the other hand, participants shared what they felt would facilitate their access to a preferred method of contraception. Facilitators included being provided information on all methods of contraception, such as a list of different methods; being treated with respect by providers; and having providers use understandable language when providing information.

Discussion

Although there is a substantive body of literature regarding contraceptive access and experience related to identities such as race, age, income, etc. less is known about those of the immigrant or LGBTQIA communities. We conducted focus groups at three community organizations, Mujeres Latinas en Acción, ICAH, and BYC, in order to bridge the gaps in the literature and inform recommendations and an action plan. The results centered around four major themes which included sexual and reproductive health, sexual health education, physician experience, and contraception experience. Participants were eager to share their experiences learning about sexual and reproductive health and it was apparent that their primary sources of
information were the social circle consisting of family and friends and school-based sexual health education, the latter of which was often inadequate. The literature supports the important role that family and friends play in initiating conversations and providing information for sexual and reproductive health. Despite the fact that the social circle was commonly cited as a source of information in our focus groups, many participants acknowledged that at a young age, they did not have conversations with their family members about sexual and reproductive health or were even denied conversations on the topic. Experiences such as these perpetuated feelings of stigma and posed a great challenge for learning about sexual and reproductive health from family members, even into adulthood. As a result, many mothers knew the importance of having lifelong conversations with their children but were unsure of how to approach the conversation. This highlights the need for adult sexual health education that provides parents with the skills necessary to have conversations with their children and which addresses internalized stigma.

Focus group participants also expressed a number of inadequacies in their school-based SRHE. As such, many expressed a desire for more comprehensive education. The literature also supports the implementation of comprehensive SRHE. In fact, a literature review exploring abstinence-only sexual education for adolescents stated that the curricula were found to have scientifically inaccurate information with little evidence of efficacy. Additionally, because abstinence-only education programs withhold potentially life-saving information on HIV and other STIs, they are considered a human rights violation. On the other hand, comprehensive sexuality education programs are more effective in delaying initial sexual intercourse and reducing sexual risk behaviors. Focus group participants revealed the need for and recommended SRHE that is age-appropriate, medically-accurate, inclusive, and covers STI prevention, provides information on all methods of contraception, discusses pleasure, and
includes intersex anatomies. Furthermore, people who had received sexual education from programs at ICAH also emphasized the value of education that is taught in different modalities. They appreciated having the opportunity to discuss material they read, practice skills, and engage in creative activities to foster their learning. In this way, SRHE that is taught in different modalities would allow students to be more engaged in the curriculum and better retain information that they find useful.

Additionally, a significant number of participants shared stories of sexual abuse and the long-lasting impact of the abuse. They also mentioned the stigma that they faced as a result. Therefore, it is incredibly important that education is trauma-informed and de-stigmatizing.

In terms of physician and contraception experience, the participant responses and recommendations support a number of best practices that have been previously endorsed. In the case of physician experience, participants revealed the impact that confidentiality, distrust, and language have on the patient-physician interaction. Previous studies have shown the impact that mandated parental consent for reproductive health services would have on health-seeking behaviors of young people, which include delayed health-seeking, reduced service utilization, and reliance on less effective contraceptive methods, all despite remaining sexually active.9,26 Therefore, in order to prevent adverse health outcomes that could result due to changes in health-seeking behaviors, confidentiality of young people should be respected. Our focus group responses also support this recommendation; participants indicated the negative effect that breaches of confidentiality had on their relationship with their physicians, and how it reduced their likelihood of returning for service.

Participants also discussed feelings of distrust for their providers and provided recommendations for improving patient-physician interactions such as treating people with
respect, avoiding “pushing” contraception methods, and explaining things in an understandable language. The latter of these recommendations is similar to a strategy given by providers for improving patient-physician interactions in one study which was to improve communication by accepting language and customs of young people and speaking to youth in their own language. This strategy would also be very useful in improving patient-physician relationships for gender-expansive folks as many of our focus group participants who were gender expansive expressed the need for more inclusive and accurate language both in conversation and on intake forms.

In terms of contraceptive experience, many participants noted having tried different methods before finding one that worked well for them. In the process of trying different methods, many women either experienced or were concerned about side effects and some were concerned about forced sterilization. Participants also reported a number of different barriers to accessing their preferred method of contraception including providers “pushing” a certain method, insurance/cost, and being offered a limited number of options. On the other hand, recommendations to improving access to preferred methods included having information about many options and being treated with respect. One recommendation that is cited in the literature that would incorporate these recommendations and address the barriers to access would be to utilize the reproductive justice framework to help people make informed choices about which contraception option is best for them, including LARC.

As of late, methods of contraceptive counseling are often tiered by effectiveness and therefore push LARC as a first-line contraception method to prevent unintended pregnancy. However, framing LARC as a solution to unintended pregnancy ignores how social determinants impact unintended pregnancy; economic inequality, stigma, lack of universal health care all contribute more to unintended pregnancy rates than LARC non-use. The first-line argument
also minimizes options by presenting LARC as the best option for all and promotes assumptions about whose reproduction is valued, which perpetuates racial and class biases. A reproductive justice approach to LARC that places equal value to all lives should be adopted instead. Family planning and training should be developed with a woman-centered framework, LARC promotion should expand, not restrict, contraceptive options for all women, and policy barriers to LARC insertion and removal should be eliminated in order to improve the delivery of LARC services and support reproductive autonomy and health.

There are a few limitations to this study. When conducting focus groups, it is recommended that for each differing characteristic, at least two focus groups should be completed. This method allows the research team to better understand if they have reached saturation with their themes, and if themes can be representative of the perceptions of the populations participating in the focus group discussions. However, we only had one focus group entirely made up of participants who self-identified as gender-expansive people. Despite this, we can be fairly certain that the themes which emerged from this discussion are comprehensive. This is because all of the participants were comfortable and actively engaged in the conversation. Although there was consensus on a number of topics discussed, participants did not appear hesitant to share differing opinions and experiences.

Another limitation was that the focus groups were not audio recorded. In speaking with community organization leaders, it was recommended that we do not audio record as participants may have privacy concerns. We wanted to respect their concerns and do our best to mitigate them, so that the focus group experience was comfortable, and the discussion was authentic. As such, findings are based on an analysis of notes that captured as many quotes and ideas as
possible. However, there is a possibility that some ideas may not have been captured, and in turn, some themes may not be reflected here.

One final limitation was in the analysis of the demographics questionnaire. The questionnaire was administered using different methods and many questions were open-ended. This resulted in different interpretations of questions asking about gender or race and ethnicity. Therefore, some presumptions were made about participants’ identities during analysis. For example, answers such as “Hispanic,” “Mexican,” or “Latino” were all grouped as “Latinx.” In terms of gender, participants who did not explicitly identify as “gender-expansive,” “transgender,” or “cismale,” were presumed to be ciswomen. Overall, the data reflected is as accurate as possible and any presumptions made are indicated.

Conclusion

The findings from these focus groups contribute to the body of knowledge describing contraceptive access in the United States, particularly for marginalized populations including the gender-expansive, low-income, and immigrant communities. For the Contraceptive Justice Project, this insight will be used to create a multi-dimensional action plan and inform strategies to reduce barriers that people face in obtaining their preferred method of contraception in Illinois. On a grander scale, this project and its findings highlight the importance of stakeholder collaboration, community engagement, and even a social justice framework, in addressing health disparities. Hopefully, the methods and/or findings from this project can aid public health professionals in creating just strategies for improving reproductive and sexual health, as well as, the overall health of communities.
References


### Table 1: Analysis of Qualitative Data

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category/Sub-Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reproductive and Sexual Health</td>
<td>Knowledge/Sources of Knowledge Family</td>
<td>“Really didn’t know what it [periods] was with the exception that my father once told me women bleed” (4,2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“My friends were “promiscuous” and that is how we kind of learned what was happening” (2,2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I learned once I gave birth” (4,2)</td>
</tr>
<tr>
<td></td>
<td>Stigma</td>
<td>“I have always felt shame due to that [forced to have sex]” (4,2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“they had to cover up their boobs because they couldn’t show them” (1,4)</td>
</tr>
<tr>
<td></td>
<td>Trauma</td>
<td>“I remember being 13 years old and I was offered alcohol the next day I woke up with a man.” (4,1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“This [abuse] happens to so many women…but no one talks about this (1, 6)”</td>
</tr>
<tr>
<td>2. Sexual and Reproductive Health Education (SRHE)</td>
<td>Positive Experience Inclusivity</td>
<td>“the inclusion of other identities and medical histories” (3,2,5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“like that it includes a conversation about pleasure” (3,2,3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“They provide all options” (3,2,3)</td>
</tr>
<tr>
<td></td>
<td>Familial Conversations Initiating Conversations</td>
<td>“teach your children if they don’t like to be touched a certain way or you don’t want to hug your aunt or uncle tell them that is okay” (1,6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>her mom did not say anything or tell her anything about it [sex] (1,2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“your son should be able to come to you before if he’s thinking about having sex” (1, 5)</td>
</tr>
<tr>
<td>3. Physician Experience</td>
<td>Factors Affecting Patient-Physician Relationships Distrust</td>
<td>“There is no concern about when asking these questions [about sexual health]” (3,3,5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“[Use] questions such as ‘are you having sex with someone with a vagina, sex with someone with a penis, etc.?’” (3,6,5)</td>
</tr>
<tr>
<td>4. Contraceptive Experience</td>
<td>Contraceptive History Side Effects</td>
<td>“I used the shot, so either I would not get my period for months or I would have it for a complete month.” (4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I experienced a severe hemorrhage and head-aches [with copper IUD].” (4)</td>
</tr>
<tr>
<td></td>
<td>Barriers to Access to Preferred Method Limited Options Offered “Pushing Methods”</td>
<td>“They get info on about 2 [contraception methods]” (1,3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“They [providers at hospital] were pushing contraception on me…I thought there was a hidden agenda” (2,3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Already taking the shot and another doctor was pushing IUD on her…because it was “personally better for her” (2,3)</td>
</tr>
<tr>
<td></td>
<td>Recommendations to Improve Experience Improve patient-physician relationship</td>
<td>“Stop using big ol’ words, break it down” (2,4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Treat people with respect, not like they are below you” (2,4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“De-gendering questions around that [question of who you’re having sex with]” (3,6,3)</td>
</tr>
</tbody>
</table>
Table 2: Participant Characteristics

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total N</strong> = 57</td>
<td></td>
</tr>
<tr>
<td><strong>Mean Age</strong></td>
<td>35</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Presumed ciswomen</td>
<td>79%</td>
</tr>
<tr>
<td>Cismale</td>
<td>4%</td>
</tr>
<tr>
<td>Transgender</td>
<td>4%</td>
</tr>
<tr>
<td>Gender-expansive</td>
<td>12%</td>
</tr>
<tr>
<td>Unsure</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Latinx**</td>
<td>51%</td>
</tr>
<tr>
<td>Black</td>
<td>16%</td>
</tr>
<tr>
<td>white</td>
<td>21%</td>
</tr>
<tr>
<td>Native American</td>
<td>2%</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
<tr>
<td>No Answer</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Primary Language</strong></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>32%</td>
</tr>
<tr>
<td>Spanish</td>
<td>63%</td>
</tr>
<tr>
<td>English/Spanish</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
</tr>
<tr>
<td>Above $30K</td>
<td>4%</td>
</tr>
<tr>
<td>$15K-$30K</td>
<td>18%</td>
</tr>
<tr>
<td>Below $15K</td>
<td>74%</td>
</tr>
<tr>
<td>No Answer</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Insurance Status</strong></td>
<td></td>
</tr>
<tr>
<td>Insured</td>
<td>40%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>56%</td>
</tr>
<tr>
<td>Not Sure</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Immigration Status</strong></td>
<td></td>
</tr>
<tr>
<td>Immigrant</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
</tr>
<tr>
<td>At least one child</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
</tr>
<tr>
<td>Chicago</td>
<td>86%</td>
</tr>
<tr>
<td>Illinois Suburb</td>
<td>5%</td>
</tr>
<tr>
<td>Out-of-state</td>
<td>2%</td>
</tr>
<tr>
<td>Homeless</td>
<td>2%</td>
</tr>
</tbody>
</table>

*Across four focus groups

**Includes participants who self-identified as “Mexican,” “Hispanic,” or “Latino.”
Figure 1: Contraceptive Use by Method According to Polled Focus Groups
Appendix 1: Focus Group Protocol

Focus Group Guide & Questions

Patient/Client Perspective on Contraception

Materials:
- Recorder: To record focus group conversations.
- Flip Chart/Dry Erase Board: To take notes for the group’s viewing
- Contraceptive Options Chart (from Reproductive Health Access Project): Before beginning, review the different types of contraceptives so that consumers can share their knowledge, or lack thereof, of each one.
- Definition list: Provide participants with a handout of definitions and post around room on easel paper, of possible, to ensure focus group participants and facilitators are using the same language.

1. Contraception -
   a. Sterilization -
      i. Tubal ligation -
      ii. Vasectomy -
   b. Hormonal -
      i. Long-Acting Reversible Contraceptives (LARC) -
         1. Implant -
         2. Hormone IUD -
         3. Copper IUD (non-hormonal LARC) -
         4. Shot -
      ii. Ring -
      iii. Patch -
      iv. Pill -
      v. Mini-pill -
   c. Barrier -
      i. External condom (aka male condom) -
      ii. Internal condom (aka female condom or FC2) -
      iii. Diaphragm -
   d. Spermicide -
   e. Withdrawal (aka pulling out) -
   f. Fertility awareness (rhythm method) -
   g. Emergency contraception -

2. Contraceptive Options Counseling -
3. Sex Education -
4. Family Planning Education -
5. Legal Health Care Rights -

Disclaimer: We are going to be talking about sensitive issues such as contraception, family planning, sex education, etc. We would like you to stay and participate to get your input but you are welcome to leave or not participate if you so choose.
1. What has your experience been learning about sex?
   a. Where did you first learn about sex? Was it in sex ed?
   b. From whom did you learn about sex?
      i. Did they bring it up, or did you?
      ii. Which contraceptive options did they discuss with you?
      iii. Did they recommend any particular contraceptive option to you?
      iv. Did they take the time to answer all of your questions?
      v. Did they make you feel comfortable in this conversation?
         1. What made you feel comfortable? What made you feel uncomfortable?
   c. What did you think about the information that you received? Did it shape the choices that you made about your reproductive health?

2. What has been your experience learning about family planning and how to prevent an unintended pregnancy?
   a. Where did you first learn about family planning and how to prevent an unintended pregnancy?
   b. From whom did you learn about family planning and how to prevent an unintended pregnancy?
      i. Did they bring it up, or did you?
      ii. Which contraceptive options did they discuss with you?
      iii. Did they recommend any particular contraceptive option to you?
      iv. Did they take the time to answer all of your questions?
      v. Did they make you feel comfortable in this conversation?
         1. What made you feel comfortable? What made you feel uncomfortable?
   c. What did you think of the information that you received? How did it shape your thoughts on family planning?

3. What has been your experience learning about or trying contraceptive options?
   a. Where did you learn about contraceptive options?
   b. From whom did you learn about contraceptive options?
      i. Did they bring it up, or did you?
      ii. Which contraceptive options did they discuss with you?
      iii. Did they recommend any particular contraceptive option to you?
      iv. Did they take the time to answer all of your questions?
      v. Did they make you feel comfortable in this conversation?
         1. What made you feel comfortable? What made you feel uncomfortable?
   c. What do you think about the information that you received? How did it shape your thoughts on contraceptives in general?
   d. Have you ever used or are you currently using any form of contraceptive?
      i. What type(s) have you used or are you currently using?
      ii. Are you using it to prevent unintended pregnancies or for other reasons?
      iii. What are the pros and cons for the type you are using or have used in the past?
      iv. How did you choose the types that you are using or have used in the past?
v. If you have health insurance does it cover the cost for the type you are currently using?

e. If you’ve never used a contraceptive, is there a reason you have never used a contraceptive?

f. What are your thoughts on contraceptives in general?

4. What are your thoughts on LARC?

   a. Besides today, have you ever heard of LARC in general or the specific kinds of LARC we named? What did you think about them?

   b. What do you family and friends think about LARC? How do people in the community say about/think about LARC? How does this compare with what you’ve heard healthcare providers say about LARC? Whose opinion do you trust when it comes to information about LARC? Do you have any questions about LARC?

   c. If you had never learned about LARC before today, what do you wish you had know about it? Moving forward, would you be interested to learn more about LARC?

5. Do you know what your legal health care rights are?

   a. Do you feel comfortable getting the health care you need?

   b. Are you worried about anything related to your health care?

6. Is there anything else you want to share that we didn’t ask about?
### Appendix 2: Contraceptive Methods Chart from Reproductive Health Access Project (English)

#### Your Birth Control Choices

<table>
<thead>
<tr>
<th>Method</th>
<th>How Well it Works</th>
<th>How to Use</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>&gt;99%</td>
<td>Prevents pregnancy up to 5 years</td>
<td>May cause spotting</td>
<td></td>
</tr>
<tr>
<td>Hormone IUD</td>
<td>&gt;99%</td>
<td>Prevents pregnancy up to 3 or 7 years depending on which IUD you choose</td>
<td>May cause spotting</td>
<td></td>
</tr>
<tr>
<td>Copper IUD</td>
<td>&gt;99%</td>
<td>Prevents pregnancy up to 12 years</td>
<td>May cause more cramps and bleeding</td>
<td></td>
</tr>
<tr>
<td>Shot</td>
<td>94%</td>
<td>Get a shot every 3 months</td>
<td>May cause spotting and weight gain</td>
<td></td>
</tr>
<tr>
<td>Ring</td>
<td>91%</td>
<td>Put the small ring into your vagina</td>
<td>Can increase vaginal moisture</td>
<td></td>
</tr>
<tr>
<td>Patch</td>
<td>91%</td>
<td>Put a new patch on your skin once a week for three weeks</td>
<td>Can irritate skin under the patch</td>
<td></td>
</tr>
<tr>
<td>Pill</td>
<td>91%</td>
<td>Take one pill each day</td>
<td>Can make periods more regular and less painful</td>
<td></td>
</tr>
<tr>
<td>Sterilization: Vasectomy</td>
<td>&gt;99%</td>
<td>A health care provider blocks or cuts the tubes that carry sperm from your testicles</td>
<td>You may feel minor pain, but it is temporary</td>
<td></td>
</tr>
</tbody>
</table>

#### How to Use

- **Use a new condom each time you have sex.**
- **Use the diaphragm each time you have sex.**
- **Use the contraceptive each time you have sex.**
- **Take pills as soon as possible after unprotected sex.**

#### Pros

- **Protects against HIV and other sexually transmitted infections (STIs).**
- **Can be used with other methods to protect against HIV and other STIs.**
- **Can be reused for several years.**
- **Cannot cause sexual transmission.**
- **Does not cause bleeding.**
- **Can be used with other methods to protect against HIV and other STIs.**

#### Cons

- **Can decrease sensation for some.**
- **Can reduce loss of sensation.**
- **Can break or slip off.**
- **Can cause pain or discomfort.**
- **Can cause irritation.**
- **Can cause inflammation.**
- **Can cause bleeding.**
Appendix 3: Schematic of Categorical System

SRHE
- Positive Experience
  - Inclusive
  - Comprehensive
  - Multiple Modalities
- School-Based Sexual Health Education
- Familial Conversation
  - Inadequate Information
  - Initiating Conversation

Physician Experience
- Factors Affecting Patient-Physician Relationship
  - Confidentiality
  - Language
  - Distrust
- Transparent Competencies

Contraceptive Experience
- Barriers to access to Preferred method
  - Limited Methods Offered
  - Insurance/Cost
  - "Pushing Methods"
- Contraceptive History
- Other Medical Uses
  - Side Effects
  - Preferred Method
  - Provide All Options
- Recommendations to Improve Experience
  - Improve Patient-Physician Relationship
  - Improve SRHE

Sexual and Reproductive Health
- Trauma
- Knowledge
- Stigma
  - Questions
  - Sources of Information
  - Misconceptions
  - Family
  - Friends
  - Physician
  - Media/Tech
  - Experience
  - Observation
  - School-based Sexual Health Education

Key:
- Purple: Major Theme
- Blue: Category
- Teal: Sub-category