Perceptions of Coercion, Discrimination and Other Negative Experiences in Postpartum Contraceptive Counseling for Low-income Minority Women

Lynn M. Yee, MD, MPH
Melissa A. Simon, MD, MPH

Abstract: **Background**. Using in-depth qualitative methods, we investigated negative contraception counseling experiences, including those felt to be coercive or discriminatory, in a population of postpartum urban minority women. **Methods**. Brief surveys and semi-structured interviews were conducted with 30 consenting postpartum women who had received care at a Medicaid-funded obstetrics clinic. In-person one-on-one interviews were then reviewed for themes using an iterative process of qualitative analysis. **Results**. In this sample of African American (63%) and Hispanic (37%) women (median age 26), 73% had unplanned pregnancies. Features of negative counseling experiences included having insufficient, non-physician-directed and impersonal counseling. Most women had experienced episodes of poor communication with providers; 10 described feeling coerced or perceiving racially-based discrimination in counseling. **Conclusions**. Negative experiences with contraceptive counseling may affect contraception utilization. Contraceptive education should respect each individual's autonomy, culture, and values.

Key words: Contraception, discrimination, contraception counseling, shared decision-making.

In the United States, as many as 49% of pregnancies are unintended.[1–3] Consistent use of contraception can significantly reduce the likelihood of unintended pregnancy, yet many women experience gaps in contraceptive use even during times in which they are sexually active.[4] Understanding reasons for contraceptive non-use and facilitating women's knowledge and use of family planning methods is critical to improving comprehensive women's health care.

Planning for postpartum contraception is particularly important for pregnant women at risk of repeat unintended pregnancy; there are data to suggest that antepartum contraception counseling is effective at increasing postpartum contraception uptake.[5–6] Counseling, however, takes place in the context of other complex factors that influence contraceptive use and decision-making, including social inequality and

LYNN YEE is in the Department of Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco, and MELISSA SIMON is in the Department of Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine. *Dr. Simon was supported by an NIH K12 WRHR (HD050121-04) award during the time this study was performed.* *Please address correspondence to Melissa Simon, MD, MPH, Department of Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine, 680 North Lakeshore Drive, Suite 1015, Chicago, IL 60611; (312) 695-2653; m-simon2@northwestern.edu.*

© Meharry Medical College

health disparities. Low-income, minority women are at greatest risk of unintended pregnancy. Factors underlying contraceptive nonuse or gaps in use for those at risk of unintended pregnancy include having less than a college education; being Black; being older; having infrequent sexual intercourse; not being in a current relationship; being dissatisfied with a contraceptive method; and believing that health care providers were unavailable for questions.[4]

Provider-dependent contributors to disparities in contraceptive use, such as the quality of counseling for underserved women, are of particular interest. A negative or poorly communicated counseling interaction, including experiences in which an unwanted contraceptive method was prescribed without provision of other options, may contribute to unintended pregnancies.[7] Second, although providers have been reluctant to say that counseling is sometimes affected by race, it sometimes is. For example, providers may have biases motivated by race or economic status when making their recommendations for intrauterine contraception (IUC).[8] An 1988 paper reported that physicians were more willing to sterilize African American than White women.[9] In a study of Los Angeles homeless women, of whom a majority were African American or Latina, a common barrier to seeking reproductive health care services included feeling stigmatized or disrespected by providers.[10] Finally, several studies indicate that Latina and African American women are more likely than non-minority women to report feeling they were encouraged by health care providers to use contraception, be sterilized, and limit family size.[11–13] Overall, provider bias and communication practices may play an important role in how patients receive and interpret reproductive health care services.

Minority women's interpretation of contraception counseling may be influenced by awareness of historical injustices. Historically, African American women and Latinas were disproportionately subject to forced sterilization and undesired contraception as a way to control the fertility of poor and minority women in the United States.[14–15] The United States has a long history of discriminatory behaviors related to reproduction, beginning in the ignominious period of African slavery. In the 20th century, sterilization of poor, criminal, mentally ill, and minority women, using techniques such as uninformed consent or court-ordered surgery, was sponsored by the government as recently as the 1970s; at the peak of the eugenics movement in the 1930s, a majority of states had laws permitting involuntary sterilization, leading to the sterilization of over 60,000 persons during this period.[14,16–21] Controversially, the contraceptive Norplant® (Wyeth, Madison, NJ) was promoted in African American communities in the 1980s and 1990s, and was often linked to receipt of public benefits.[16–17] Although Norplant® is no longer in use in the United States, this very recent history has affected perceptions of modern contraceptive methods in some communities, including among African American women. This history may lead some minority women to perceive negatively any recommendation for a contraceptive method, even if highly effective and reversible.[22] Studies in the 1970s documented such beliefs two generations ago, yet guarded attitudes toward contraception still exist in some communities.[23] Indeed, Thorburn and Bogart have described a "conspiracy belief" in some communities of African American women, reporting concerns about genocide and contraception safety; women strongly holding these beliefs were less likely to use highly effective contraceptive methods, suggesting these concerns to be a significant barrier to pregnancy prevention.[17,22,24]

Central to the issues of inequality and health disparities are the patient-provider interaction and its role in patient decision-making. Patient-centered care, in which patients understand and participate in their own care and their needs are addressed *via* good patient-provider communication, is considered a key component of high-quality health care.[25] The 2009 *National Healthcare Disparities Report* reported that minority and low-income Americans were more likely to experience poor patient-provider communication than non-minorities or those with higher incomes.[26] Further, over the past several decades, the shift to patient-centered care and its emphasis on quality patient-provider communication have involved recognition of the value of shared decision-making, in which provider and patient come to a mutually agreeable decision that reflects patient preferences as well as medical recommendations.[27] Decision-making may take place with varying degrees of patient autonomy. Regarding contraception, Dehlendorf et al. found that women seeking contraceptive care desire more autonomy in their contraception decisions than in decisions about general health care issues; not only did women prefer autonomous contraceptive decision-making, but those expressing that preference also reported higher levels of satisfaction with their chosen contraceptive method.[28] In this study, there was no difference in preference for autonomy based on race/ethnicity or other demographic characteristics.[28] There is further literature to suggest that women place value on having personalized, caring, and nonjudgmental contraceptive counseling that respects individual decision-making autonomy.[29] It appears that not only does the quality of patient-provider communication, such as the degree of respect and personal attention expressed, matter to patients, but that specifically having autonomy in the contraceptive decision-making process is also an important feature of contraceptive counseling. This issue of respecting patient preferences is likely to be particularly salient for poor, minority populations where patients have reported poorer patient-provider communication experiences.[26]

With this background, we seek to understand better women's perspectives regarding negative experiences with postpartum contraception counseling. Although there are data to support the efficacy of high-quality contraception counseling, we know little about women's perceptions of negative counseling experiences, particularly in the most underserved communities. We expect that attitudes toward negative contraception counseling experiences affect the individual contraceptive decision-making process, yet no studies have explored this link. Thus, the purpose of this exploratory study using brief surveys and semi-structured interviews was to apply a qualitative methodology to understand perspectives on negative contraceptive counseling experiences, including experiences in which there was perceived coercion, in a specific population of low-income, urban, minority women.

Methods

Women in the hospital after giving birth were recruited from a large academic medical center in Chicago. All English-speaking women 18 years old or older who had attended the women's outpatient ambulatory care clinic for antenatal care and who delivered *via* normal term birth at this hospital were eligible for participation. This clinic serves a group of low-income women who receive public aid assistance and are cared for by

the residents in the Department of Obstetrics and Gynecology at this medical center. In this clinic, more than 90% of women are English-speaking and 18 years old or older, so the inclusion criteria included a majority of women receiving care. Patients were primiparous or multiparous.

Using a cross-sectional study design, recruitment was conducted as a non-probability convenience sample of the women who attended this clinic, were inpatients in the hospital, and who fit the inclusion criteria. Women were approached by the study team during their hospital stay, and participants received a $10 gift certificate to a local grocery store upon completion.

Between December 2007 and February 2008, 39 patients were approached. Nine women (23%) declined participation; reasons included feeling ill, having too many guests, not liking surveys, or no interest. Ultimately 30 women participated in the study. Sample size was determined based on the goal of saturation in qualitative research, in which the data collected capture the range of experiences and variation in responses in a population.[30] Each interview was transcribed immediately after it was conducted. Groups of three to five interviews were reviewed as the study progressed to iteratively code common themes and to examine if saturation of themes had been achieved. Upon collection of data from 30 interviews, all members of the study team agreed that data saturation was achieved. All participants provided written informed consent. This study was approved by the Institutional Review Board of Northwestern University.

Two methods of data collection were used. First, to identify demographic and obstetric data and quantitatively to assess contraceptive use history, women completed a short survey. The survey consisted of eight demographic items, regarding age, parity, education, ethnicity and relationship status, as well as six items about contraceptive use history. Women then participated in a semi-structured, face-to-face, interview using scripted questions with follow-up probes. A single member of the study team with prior interviewing experience conducted all interviews; this interviewer was trained to perform non-directive interviews using a structured guide with open-ended prompts. Interviews lasted approximately 30 to 45 minutes. Women were asked about their obstetric and contraceptive use history, attitudes towards contraceptive methods, and their perceptions of contraceptive counseling experiences during their current pregnancy or in prior clinical interactions.

Non-directive prompts exploring negative experiences were used to examine the breadth of contraceptive counseling experiences in this population. Specifically, women were not directly asked about coercion and discrimination; these issues were raised spontaneously by participants in the course of discussing negative experiences with counseling. For example, participants were asked to describe prior episodes of contraceptive counseling, including if she had any experiences that she would consider negative; if she described a dissatisfactory experience, the interviewer would probe with statements such as, “Tell me more about that counseling experience” and “What made it a negative experience for you?” The interviewer would ask women to describe specific examples if possible. Interviews were conducted privately in patient rooms, and participants were encouraged to voice their opinions freely. Participants were informed that there were no correct or incorrect answers; answers would not affect their medical care; and that they were free not to answer any questions. In order to prevent women

from selecting answers based on what they perceived to be the social desirability of their responses, women were informed that the interviewer would maintain confidentiality of all answers, and that their providers would not receive information about the results of the interview.

Interviews were recorded using a digital audio recorder. Sessions were transcribed *verbatim* by the investigative team immediately after interview completion. Informal analysis of themes from early interview transcripts informed later data collection; we performed an iterative process of interviewing and reviewing the interview responses until saturation.[27] Early review of interview responses allowed for clarification of themes during later interviews. Responses to survey questions were analyzed using simple descriptive statistics using SPSS (Chicago, IL) software. Qualitative data analysis, including coding, data management, and text retrieval, were conducted using NVivo software, a qualitative data analysis software program (QSR International, Cambridge, MA). Formal data coding was conducted by both investigators to organize the data by themes using a version of the grounded theory approach to qualitative research; themes were not pre-developed, but rather emerged during the exploration of interview data, using techniques similar to those described by Ulin et al.[30–31] NVivo software was utilized to organize coded data electronically. Coded transcripts were reviewed and assessed for inter-reviewer agreement; discussion between investigators was utilized to resolve inconsistencies of interpretation. Emergent themes were then identified using illustrative quotations and descriptive statistics.[30–31]

Results

Demographic data. Thirty women were interviewed during the immediate postpartum period. Median age was 26 (range 19–35). All patients were women of minority ethnic backgrounds who received public assistance for medical care. Table 1 describes population demographic characteristics. Mean and median gravidity among participants were 3.07 and 2.0, respectively. Mean and median parity were 2.17 and 2.0, respectively. Nine (30%) had experienced one or more elective abortions. Twenty-three women (76.7%) did not use contraception at the time of conception, and 22 (73.3%) reported that this pregnancy was unplanned. Thirty (100%) desired postpartum contraception. Twenty women (66.6%) reported family and/or partner support of postpartum contraception use.

Qualitative results. Women in this study discussed positive contraception counseling experiences, which have been reported elsewhere,[32] and features of contraceptive counseling they perceived to be negative. In analyzing interviews regarding negative counseling experiences, three major themes emerged. First, women described what happened during negative counseling experiences, including feeling ignored or receiving impersonal counseling. Second, women described the undertones of coercion they sometimes perceived in contraceptive counseling, particularly when their method choice differed from the provider's recommendation. Third, a minority of women described feelings of racial discrimination taking place in their contraceptive counseling experiences. These three themes will be discussed separately below.

Negative counseling experiences. Sixteen women reported negative experiences

Table 1.

DESCRIPTIVE CHARACTERISTICS FOR STUDY PARTICIPANTS (N=30)

Characteristic	N	%
Race or ethnicity		
Hispanic	11	36.7
African American	19	63.3
Marital status		
Married	5	16.7
Member of unmarried couple	10	33.3
Single	14	46.7
Divorced or separated	1	3.3
Education		
Less than high school	4	13.3
High school graduate	6	20.0
Some college or technical school	13	43.3
College graduate	7	23.3

with prior counseling interactions. These negative experiences primarily occurred in counseling interactions prior to the current pregnancy, and were often associated with failure to utilize an effective contraceptive method following the counseling session. Providers' communication skills in delivering the counseling were often the hallmarks of a negative interaction. Features of poor counseling interactions included receiving impersonal counseling, feeling that physicians were uncaring, not having all questions answered, receiving incomplete information, receiving overbearing or "pushy" counseling, having to initiate counseling sessions, or not receiving written information or pictures. Box 1 illustrates perceptions of reasons for "bad" counseling.

"Just drop it already": Avoiding coercion and trying to be heard. In this population, there was a fine distinction between being "pretty firm" in recommending birth control, considered a positive counseling attribute, and being coercive or overbearing in counseling. Overbearing counseling interactions took place primarily for two types of participants: women seeking sterilization who felt they had to fight for their postpartum tubal ligation (PPTL) and women who felt they were being coerced into utilizing a particular contraceptive method. Eight women described experiences in which they felt their physician was being overbearing, coercive, or restrictive in their counseling. One 26-year-old woman, a diabetic patient who had two complicated prior pregnancies and strongly desired sterilization, felt she was being forced to consider an IUC:

> They wanted to go with the IUD [Copper Intrauterine Device]. Yeah. That's the one they kept bringing up over and over again. I was like, it's definitely a no-no. It's something I don't even want to think about, it's not even crossing my mind! You know

Box 1.

COMMUNICATION STYLES AND PRACTICES REPORTED IN NEGATIVE COUNSELING EXPERIENCES

Insufficient counseling	Enough counseling . . . I don't think so . . . [S]ome doctors, they like a certain thing and that's what they're gonna try to get you to like too. You know, like, 'oh I like this Depo shot . . . you know, it's better for you.' Well, that's your opinion, but give me my options, and let me choose. (24 year-old, mother of 3)
	Well, going over . . . they didn't really go over different kinds of birth control, they probably didn't have something, didn't know. I don't know. They just told me about the pill . . . (21 year-old, mother of 2)
	"They said that . . . have I thought about birth control, or am I using some form of birth control. I told them I was using condoms, and that was it." (25 year-old, mother of 1)
Impersonal counseling	"I start to say something and they're like, 'oh yeah yeah, okay.' That I hate . . . listen to what . . . because my situation is not exactly the same as everybody else's, and that's what I think a lot of doctors get into. "Yeah, okay, I know what you're saying, I know what you're saying." Actually, NO, you don't know what I'm saying until I actually finish what I'm saying. And I think here they really let you talk, get everything out, they hear it, they take it in, and THEN they talk to you about what your options are. And what they think would be best for you, independently, not just lumping you into a group of people." (28 year-old, mother of 4)
	"No, there were really no options where I was going. For lack of a better word, it was just like a factory—you go in, this is what we have, this is what you get. And if you don't like it, oh well. You know, this is what we have. . . . It wasn't even an individual basis, it was just whatever was there." (28 year-old, mother of 4)

(Continued on p. 1394)

what I mean? I mean, they said "It's good, and you know like 90% of the women, they love it," and you know . . . I was like, "100% of me says NO!" I was like I really don't want it, you guys need to just drop it already . . .

She felt this situation would have been better if her physicians had been more understanding:

Put themselves in my shoes. And just kind of think, okay, what she went through, we can understand why. I mean, that's fine they want to give their opinion and what

Box 1. ***(continued)***

Physician did not initiate counseling	"[I]t's never usually initiated. It was never initiated. It was more me asking about it, you know, especially after pregnancies." (29 year-old, mother of 4) "No it was never a question, it was never asked. Just, pretty much just what are you, do you have any plans for contraception afterwards? And I just said the pill, and that was it. There was never any other options . . . I've had to ask." (28 year-old, mother of 1) "[T]hey didn't take the time to sit down and say okay, you know these are the different types of birth control, you know I don't know if anybody has told you or anything . . . I think they could have done a better job." (20 year-old, mother of 2)
Not listening to the patient's opinions	[After choosing post-partum tubal ligation] "They were like, 'oh well we're not gonna stop [counseling on other methods]' and which, that kinda made me angry for some reason. For the most part, I was like, you know—it's up to me! It's like, this is what I want, this is what I'm comfortable with, and I'm like 100% sure. And they were like, 'we'll let you think about it.' And they kept giving me days, and weeks, and I'm like DUDE, you know! I'm like telling you this for months! This is what I want to do! From the very beginning when I got pregnant, I was like, after this kid, that's it! I was like, cut them off! I don't want anymore. They were like very, very persistent about it . . ." (26 year-old, mother of 2) [Wanted non-hormonal methods] "They basically, it felt like they didn't listen to me all the way up until my very last appointment! All of them, it was like they kept on suggesting, and it seemed like the very last 9—10 months almost by this point—and then they seemed to finally listen to me and said something like, 'okay, we noticed that you seem to not be gearing towards hormonal birth control.' I was just like, I didn't have any idea that they heard me before. But um . . . so, they would always still suggest other hormonal stuff like the IUD thingy and stuff like that." (35 year-old, mother of 1)

they think, but they kinda just forced something on me that I don't want to do. I felt like that's what they were trying to do.

Some women choosing hormonal methods described only a mildly overbearing tone to counseling; they described physicians who felt strongly about a method type and may have even tried "to get you to like [it] too." These patients were not necessarily

offended by the counseling, but disliked the narrow perspective they received. Others were "fed up" with having to convince physicians at every visit that they did or did not want a method, such as the same 26-year-old diabetic woman:

> They just kept being persistent about it. . . . And I was like, this is what I want to get, you know? On the same thing, all over again. It's like they constantly want to get like every single woman on the IUD. . . . And every visit they kept asking the same questions, and I kept telling them what I wanted to do, but they kept addressing the IUD.

Another woman, a 21-year-old with two pregnancies and one baby, described feeling undecided about her contraceptive plans until after labor, and her frustration at feeling forced to make a decision:

> I feel like, that I don't think it should be pressured so much during, because it's like, you're pregnant, you trying to concentrate on the current pregnancy, and all you have is doctors trying to tell you about preventing the next one. Like who's to say that you want to do that! And I know it varies, but it's like, "Oh, you having one, let's bombard you with information about preventing the next one." Like, why should a system be made to do that? . . . I don't think it should be forced, or you know . . . I don't think it should be forced.

Some women highlighted struggles to convince physicians of their desire for sterilization. For those women who strongly desired postpartum tubal ligation (PPTL) but felt their physicians failed to appreciate their choice, there was frustration at engaging in counseling sessions in which they were not being heard. A 31-year-old with eight pregnancies and five children described a situation in which she wanted a PPTL at age 19 after her first two children; both times, she described being told "no" due to her age, and since then she has had three more children:

> I stood, I tried for the tubal and they said no, because I only had two babies [at age 19] . . . Because it was too hard already with two babies, and they were right after another. . . . They said I only had two kids, I was too young. They don't understand.

A 26-year-old with a complicated first pregnancy felt similarly about having to prove her seriousness to her physicians:

> [T]hey kinda don't want you to get your tubes cut. That's what I had done now. I had my tubes cut, I was like I'm definitely done. Which they like, 80% of the time were trying to convince me not to get it, because they think that I was young, I might change my mind in a few years from now, and you know . . . I was actually thinking, well really what made me get that, make that decision was my first pregnancy. It was horrible.

Another woman, a 27-year-old with five pregnancies and two children, was told the same thing by her previous physician, whom she reported saying, "I was too young and didn't know." She later reported having to repeatedly "convince" multiple clinic physicians that she truly wanted a PPTL after this pregnancy:

> This one, they didn't want me . . . they wanted me to wait and see first. See how everything went and you know, she was like, "Are you sure you want to go through with the tubes tied, you're young." I'm sorry, I'm 27, about to be 28. "You're only 27, you only got two, you don't want to have any regrets." And I'm like, I don't have none. I say I went through five kids, I don't have none. I got one [child] before and I got this one now, and I'm good.

"I started getting suspicious!" Perceived discrimination. Two women described an element of coercion that they felt was influenced by racism or the government. A 35-year-old African American woman with three pregnancies and one child, who refused hormonal contraception, felt that instead of listening to patients, physicians were single-minded in their desire to have her use contraception:

> It [counseling] seemed obsessive to me! Honestly, they constantly asked about it every single time I came in. . . . It was like, are you trying to stop me that bad, from having a kid? But they were constantly asking until I started getting suspicious, honestly! . . . I was suspicious of them trying to stop . . . well because I had that Medicaid, I assumed that maybe, you know, if you can't afford health care, they're trying to make sure you not just spending on everybody's dime. . . . Instead it's like, it seemed you were kinda ignored for what they feel was best or most effective. . . . Or possibly, you know, whatever it is that you get for making sure people use birth control! If there's something, if the doctors get something, I don't know, it started looking like, that's something I was suspicious of, you know?

This woman, who surmised that physicians may have been receiving "kickbacks" for getting Medicaid patients to take contraception and admitted that she considered "the race thing" as a reason for her physician's attitudes, was not alone in her suspicions. A 34-year-old primiparous African American woman who had researched Norplant® while a college student was also very suspicious of long-term contraception:

> I guess I've always had the same anti-, they're trying to kill the Black race, don't inject anything into the body. . . . I guess the general consensus [in college] was that there was not enough testing, and that it was being highly used in urban and lower socioeconomic communities. And, you know, that always, you know . . . red flag! Red flag for African Americans, it's why are they pumping this on us?

These experiences hearing about Norplant® contributed to this patient's distrust of other long-acting methods, including depot medroxyprogesterone acetate (DepoProvera, or DMPA) and IUCs. This patient felt her experiences in this pregnancy, where she was being convinced to use an IUC, echoed her community's perspectives on Norplant®. She described feeling pressured and surprised that she had to talk about postpartum contraception so regularly; her experiences were "off-putting," particularly when she felt the IUC was the only method the doctors were recommending for her.

Discussion

This study explores negative contraceptive counseling experiences in a population of young, African American women and Latinas in the immediate postpartum period, a majority of whom experienced an unintended pregnancy. We have gathered a rich and compelling collection of perspectives that shed light on a rarely discussed concern regarding contraceptive counseling. In this underserved community, contraception decisions are surely influenced by a number of factors not explored in our study. However, it is equally true that our data point to the importance of listening to women and providing balanced, non-judgmental, patient-centered counseling that involves the woman in a shared decision-making process.

Women in this study expressed strong feelings about the communication that took place in a negative counseling experience. Receiving impersonal, hurried, incomplete, or uncaring counseling turned some of these women away from using recommended effective contraception methods. This complements our prior work exploring traits of positive counseling experiences, which were felt to include having frequent sessions of provider-initiated counseling inclusive of all appropriate methods and personalized to individual needs.[32] In addition, our data provide new insight into the ways in which perceptions of discrimination and coercion can significantly affect contraceptive decisions. Coercion of racial and ethnic minority group women in contraception counseling is a theme with historic and modern interest; in this small study, some women endorsed conspiracy beliefs and concerns about racially-motivated contraceptive counseling. Others expressed more individualized concerns that their autonomy in choice of contraceptive method was being restricted by physicians who failed to appreciate their individual family planning desires.

Well-intentioned, directive contraceptive counseling is not necessarily perceived as such by the person to whom it is directed. In particular, certain communication styles, such as having a provider who fails to listen, to ask open-ended questions, or to provide information on a level to which the patient can relate, as well as lack of personal connection with the patient, impersonalized care, and lack of provider-initiated contraceptive counseling can set a negative tone for the counseling session. The communication strategies used in postpartum contraceptive counseling may affect subsequent reproductive behavior. More strikingly, patients can perceive directive counseling, such as encouragement to use a long-acting method, as discriminatory or even coercive. An emphasis on informed choice, even when providers do not agree with patient choices, should be central to shared decision-making and the counseling process, particularly since women tend to feel strongly about autonomous contraceptive decision-making.[28]

This study has a number of limitations. First, our participants were primarily Latinas or African American women in a limited geographic area, and thus the findings cannot be generalized. Second, the small sample size makes our quantitative data weak. In addition, this study is cross-sectional in design, precluding the assessment of long-term outcomes or causality. Specifically, although we can surmise that a negative counseling experience may lead to lower uptake of a recommended contraceptive method, we cannot determine from these data whether this ultimately has an effect on repeat unintended pregnancy rates. We also cannot assess regret and the role of regret on

recall bias using this study design. In addition, the finding that many of the women reporting negative counseling experiences had experienced unplanned pregnancies is a potential source of recall bias. Further, although some women discussed their medical problems in the course of interviews, we did not specifically investigate the women's underlying medical histories; it is possible that these medical histories affected provider counseling and the patient perspectives on the counseling they received.

In addition, our study is observational, and no comparison group was interviewed. Although our study sample has a profile resembling that of many urban, low-income women seeking care at public aid-funded clinics, findings drawn from this single hospital with a discrete group of resident physician providers and faculty physician mentors may not be generalizable to different clinical settings. Additionally, as there is no comparison group in this study, we cannot determine if these issues are unique to a minority, low-income population. It is possible that poor communication between patients and providers also occurs with a broader patient population, including high-income and non-minority women undergoing counseling about postpartum contraception, but this too remains unknown. Lastly, although interviews were conducted in private in patient rooms, the possibility remains that women were withholding information about prior negative experiences, and it is possible that our study underestimates the incidence or effects of negative experiences in this population. This study is dependent on self-report, and perceived discrimination is a sensitive topic that may not be fully disclosed by all women despite interviewers' efforts to ensure confidentiality. However, we consider these limitations to be acceptable as our qualitative data reached thematic saturation and one purpose of qualitative work is to generate a framework for deeper discussion in an understudied area.

Using these data, recommendations for providers include utilizing a shared decision-making approach that respects patient autonomy when providing contraceptive counseling. We would suggest that providers use direct questions to ask patients their decision-making preferences and then use these preferences to provide respectful, inclusive counseling. Providers should make an attempt to listen fully to patients and provide counseling on all available options for contraception, as well as to ensure that women feel all questions are answered. However, we also suggest that future work is needed to investigate further the relationship between patient-provider communication, patient preferences, and health outcomes regarding contraception. Specifically, future work may apply greater quantitative study to a similar population in order to understand more fully the degree to which women in underserved communities perceive these negative tones in counseling and the effect this has on long-term outcomes, such as repeat unintended pregnancy. We hope that future work will also investigate the impact of medical history on the contraceptive counseling experience. Additionally, future investigations should include actual interactions with providers, such as observations of patient-provider interactions or post-counseling interviews and surveys with both patients and providers, in order to investigate patient-provider communication about postpartum contraception. We hope to understand better how to overcome the barriers to uptake of effective contraceptive methods that arise when patients dislike their counseling experiences. The findings that emerged in this hypothesis-generating study can ultimately be used to improve the quality of contraceptive counseling and

care for women in similar underserved communities. Further, future work should focus on building acceptable messaging around specific contraceptive methods for these populations.

Our data suggest that in this population, negative experiences with a provider offering contraceptive education may affect contraceptive utilization and patient-provider relationships. These findings should be studied in greater depth in a broader quantitative study. Insightful postpartum contraceptive education should be personalized, inclusive, non-judgmental, and supportive of a shared decision-making process that respects each individual's autonomy, culture, and values.

Notes

1. Jones RK, Zolna MR, Henshaw SK, et al. Abortion in the United States: incidence and access to services, 2005. Perspect Sex Reprod Health. 2008 Mar;40(1):6–16.
2. Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. Perspect Sex Reprod Health. 2006 Jun;38(2):90–6.
3. Henshaw SK. Unintended pregnancy in the United States. Fam Plann Perspect. 1998 Jan–Feb;30(1):24–9, 46.
4. Frost JJ, Singh S, Finer LB. Factors associated with contraceptive use and nonuse, United States, 2004. Perspect Sex Reprod Health. 2007 Jun;39(2):90–9.
5. Glasier AF, Logan J, McGlew TJ. Who gives advice about postpartum contraception? Contraception. 1996 Apr;53(4):217–20.
6. Gilliam M, Knight S, McCarthy M Jr. Success with oral contraceptives: a pilot study. Contraception. 2004 May;69(5):413–8.
7. Isaacs JN, Creinin MD. Miscommunication between health care providers and patients may result in unplanned pregnancies. Contraception. 2003 Nov;68(5):373–6.
8. Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for intrauterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. Am J Obstet Gynecol. 2010 Oct;203(4):319.e1–8.
9. Harrison DD, Cooke CW. An elucidation of factors influencing physicians' willingness to perform elective female sterilization. Obstet Gynecol. 1988 Oct;72(4):565–70.
10. Gelberg L, Browner CH, Lejano E, et al. Access to women's health care: a qualitative study of barriers perceived by homeless women. Women Health. 2004;40(2):87–100.
11. Borrero S, Schwarz EB, Creinin M, et al. The impact of race and ethnicity on receipt of family planning services in the United States. J Women's Health (Larchmt). 2009 Jan–Feb;18(1):91–6.
12. Downing RA, LaVeist TA, Bullock HE. Intersections of ethnicity and social class in provider advice regarding reproductive health. Am J Public Health. 2007 Oct;97(10): 1803–7.
13. Becker D, Tsui AO. Reproductive health service preferences and perceptions of quality among low-income women: racial, ethnic and language group differences. Perspect Sex Reprod Health. 2008 Dec;40(4):202–11.
14. Stern AM. Sterilized in the name of public health: race, immigration, and reproductive control in modern California. Am J Public Health. 2005 Jul;95(7):1128–38.
15. Critchlow DT. Birth control, population control, and family planning: an overview. J Policy Hist. 1995;7(1):1–21.
16. Dawson G. Book review of "Killing the Black body, race, reproduction and the meanings of liberty," by Dorothy Roberts. J Natl Med Assoc. 1998 Mar;90(3):185–6.

17. Bird ST, Bogart LM. Conspiracy beliefs about HIV/AIDS and birth control among African Americans: implications for the prevention of HIV, other STIs, and unintended pregnancy. J Soc Issues. 2005 Mar;61(1):109–26.
18. Reilly PR. The surgical solution: a history of involuntary sterilization in the United States. Baltimore, MD: Johns Hopkins University Press, 1991.
19. Shapiro TM, Fisher W, Diana A. Family planning and female sterilization in the United States. Soc Sci Med. 1983;17(23):1847–55.
20. Smith KA. Conceivable sterilization: a constitutional analysis of a Norplant/Depo-Provera welfare condition. Indiana Law J. 2002 Spring;77(2):389–418.
21. Silver MG. Eugenics and compulsory sterilization laws: providing redress for victims of a shameful era in United States history. George Washington Law Rev. 2004 Apr; 72(4):862–92.
22. Thorburn S, Bogart LM. Conspiracy beliefs about birth control: barriers to pregnancy prevention among African Americans of reproductive age. Health Educ Behav. 2005 Aug;32(4):474–87.
23. Turner C, Darity WA. Fears of genocide among Black Americans as related to age, sex and region. Am J Public Health. 1973 Dec;63(12):1029–34.
24. Bogart LM, Thorburn S. Relationship of African Americans' sociodemographic characteristics to belief in conspiracies about HIV/AIDS and birth control. J Natl Med Assoc. 2006 Jul;98(7):1144–50.
25. Institute of Medicine/Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press, 2001 Mar. Available at: http://www.nap.edu/html/quality_chasm/reportbrief.pdf.
26. Agency for Healthcare Research and Quality. 2009: National healthcare disparities report (ARHQ Publication Number 10-0004). Rockvillle, MD: Agency for Healthcare Research and Quality, 2010. Available at: http://www.ahrq.gov/qual/nhdr09/nhdr09.pdf.
27. Makoul G, Clayman ML. An integrative model of shared decision making in medical encounters. Patient Educ Couns. 2006 Mar;60(3):301–12.
28. Dehlendorf C, Diedrich J, Drey E, et al. Preferences for decision-making about contraception and general health care among reproductive age women at an abortion clinic. Patient Educ Couns. 2010 Dec;81(3):343–8.
29. Becker D, Klassen AC, Koenig MA, et al. Women's perspectives on family planning service quality: an exploration of differences by race, ethnicity and language. Perspect Sex Reprod Health. 2009 Sep;41(3):158–65.
30. Ulin PR, Robinson ET, Tolley EE. Qualitative methods in public health: a field guide for applied research. San Francisco, CA: Jossey-Bass, 2004.
31. Creswell JW. Qualitative inquiry and research design: choosing among five approaches. Thousand Oaks, CA: Sage Publications, 2007.
32. Yee L, Simon M. Urban minority women's perceptions of and preferences for postpartum contraceptive counseling. J Midwifery Women's Health. 2011 Jan–Feb;56(1):54–60.