Published in final edited form as:

Contraception. 2020 January ; 101(1): 21–25. doi:10.1016/j.contraception.2019.09.007.

Patient perceptions of immediate postpartum long-acting reversible contraception: A qualitative study[☆]

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Abstract

Objectives: The objective of this study was to explore perceptions and experiences of immediate postpartum long-acting reversible contraception (LARC) counseling and decision-making, with a focus on reproductive autonomy. We aimed to assess the potential for reproductive coercion.

Study design: This was a qualitative study using semi-structured interviews with Spanish and English speaking women who received an intrauterine device or contraceptive subdermal implant immediately postpartum. They were recruited before discharge from two hospitals in Baltimore, MD. We analyzed interviews using directed content analysis.

Results: We interviewed a diverse group of 17 women. Participants praised the convenience of LARC and the ease of immediate postpartum placement. Some women reported feeling pushed by providers during counseling and were critical of their experiences. Women expressed a desire for comprehensive, objective information early and often during antepartum contraceptive counseling, and some valued counseling from multiple providers. They wanted autonomy in their contraceptive decision-making and described making internally motivated decisions based on their life goals and individual priorities.

Conclusions: Some women felt pressured to choose immediate postpartum LARC, while others expressed enthusiasm for immediate postpartum LARC. Our data suggest that providers should start contraceptive counseling early in prenatal care and readdress it at multiple visits. Patients may benefit from speaking with multiple providers.

Implications: Our study supports immediate postpartum LARC as a favorable contraceptive option for some women when discussed during prenatal care. Providers should take care to avoid coercion during counseling and focus on delivering comprehensive, objective information about all contraceptive methods, including side effects and removal options.

Keywords

Long-acting reversible contraception; LARC; Immediate postpartum LARC; Patient-centered outcomes; Qualitative research; Contraceptive counseling

[☆] Declarations of interest: None.

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1. Introduction

As highly effective and safe methods of preventing pregnancy, long-acting reversible contraception (LARC) should be widely accessible. An increasingly popular means to achieve this is immediate postpartum LARC provision, meaning placement of a subdermal contraceptive implant or intrauterine device after delivery and before hospital discharge. The immediate postpartum period is an optimal moment to initiate LARC for many women, given a higher likelihood of insurance coverage, existing interaction with the healthcare system, and increased motivation to use contraception [1]. However, this can also be an especially vulnerable time for women as they are typically exhausted and have just experienced childbirth; these factors likely influence their outlook on contraception and the consent process. Furthermore, LARC methods are provider-controlled, so once placed, a woman may have diminished reproductive autonomy if she is subsequently unable to access removal due to lapsed insurance, lack of interaction with the healthcare system, or provider resistance or refusal to discontinue the method [2,3] Table 1.

In the United States, there is a disturbing history of implementing fertility control measures including forced sterilizations and the use of contraception, including LARC, as a tool for economic and social engineering targeted at limiting the childbearing of women of color and people with disabilities [4–7]. In addition to legacies of conscious eugenics-based policies, subconscious or implicit provider bias has also contributed to inequity in reproductive health. For example, there is evidence that providers recommend LARC preferentially to poor women and women of color [8]. Immediate postpartum LARC placement is more common for women with non-private insurance, who are disproportionately poor, Black and/or Latina [9]. When counseling pregnant women about immediate postpartum LARC, clinicians may provide differential counseling based on their conscious and unconscious assessments of whether a patient will return for a postpartum visit, lose her insurance, or have a rapid repeat pregnancy. These judgments are intrinsically laden with bias and unjust assumptions.

In order to deliver just and equitable healthcare, providers should consider the tenets and historical context of reproductive justice during contraception counseling; such an approach can help to address the ways that public policies have negatively impacted the reproductive autonomy of many marginalized groups. Reproductive justice is an intersectional framework that emerged from Black women and centers on the experiences of women of color and other marginalized groups; it emphasizes as human rights: 1) the right *not* to have a child; 2) the right to *have* a child; and 3) the right to *parent* children in safe and healthy environments [10]. These core principles of reproductive justice are rooted in an awareness and understanding of past and current reproductive injustices committed against women of color and other marginalized groups in the U.S. We must thus understand an individual's experience and perceived autonomy in reproductive decision-making as shaped by these broader social and structural forces.

Considering reproductive justice as a framework for contraceptive counseling and provision, it imperative then both to increase access to LARC for women with limited access to contraception, while also understanding the reality that many of these same women are also

at risk for undue pressure to use LARC and may have limited access to removal. This is relevant for immigrant women in the U.S., particularly undocumented immigrants, who may have additional challenges when navigating the healthcare system due to language barriers, lack of insurance, and fear of deportation [11,12]. It is therefore important to hear women's perspectives on their decisions about and receipt of immediate postpartum LARC, to better understand whether and how contraceptive autonomy was experienced. We conducted a qualitative study of a racially, ethnically, and socioeconomically diverse group of women in Baltimore, MD who received immediate postpartum LARC to characterize the patient perception of the peripartum contraceptive counseling experience, specifically with regard to autonomy, and to better guide this expanding practice in a patient-centered fashion.

2. Materials and methods

2.1. Study setting and participants

We collected interview data as part of a mixed methods study on patient perceptions regarding immediate postpartum LARC placement. For the parent study, we recruited a facility-based, non-probability convenience sample of Spanish- and English-speaking adult postpartum women from Johns Hopkins Bayview Medical Center and Johns Hopkins Hospital. These hospitals serve a diverse population of women, including a large population of undocumented Latina immigrants and women with substance use disorders. Immediate postpartum LARC provision became routine practice at our institution in 2010 and is popular among patients and providers [13]. Our team enrolled postpartum women after they had decided on a contraceptive method (or no method) but before hospital discharge. Recruitment occurred from September 2015 to May 2016. The study was approved by the Johns Hopkins School of Medicine Institutional Review Board.

A total of 301 women participated in the parent study. The quantitative portion aimed to develop instruments to measure autonomy in contraceptive decision-making and analyze perceived autonomy in this population. We then invited select women who received immediate postpartum LARC to participate in a semi-structured interview between 4 and 12 weeks postpartum at the time of a follow-up survey for the parent study. We selected a purposive maximum variation sample from the larger study population to ensure variety across race, ethnicity and socioeconomic status with greater sampling of immigrant women and women who made their decision during labor given potentially increased vulnerability. We invited 33 women to interview and 17 women agreed to participate. We conducted 11 interviews in English and six in Spanish from November 2015 to August 2016. The interview sample size was based on the goal of thematic saturation. Interviews were largely conducted in person and occasionally ($n = 2$) over the phone if an in-person meeting was not possible.

2.2. Data collection

Three research team members trained in qualitative research conducted semi-structured interviews with participants. We developed the interview guide using self-determination theory to explore the various influences on women's contraceptive decisions. Self-determination theory addresses how different types of motivation influence decision-making

behavior. It links autonomous or internal motivation to better health outcomes than controlled or external motivation [14]. Interview questions investigated women's experiences with contraceptive counseling during pregnancy and during admission for delivery and asked about factors that influenced their decisions, including perceived autonomy. We asked women about their approach to decision-making and their reasons for specific method choice. We also asked them to evaluate their interactions with health care providers. For example, we asked what was important to participants in making their decision to receive immediate postpartum LARC and what they felt was important to their providers. They were asked to reflect on both positive and negative aspects of their experiences and compare them to other contraceptive decisions during their reproductive life course. Interview length ranged from 16 to 46 minutes with a mean of 26.5 min. Women received a \$20 gift card for participation in the interview. All interviews were digitally recorded then transcribed verbatim from English or Spanish.

2.3. Data analysis

Analysis was performed using directed content analysis [15]. We analyzed the interviews in the context of the above theories and let the data drive our final codes and themes. The three authors, all trained in qualitative research methods and analysis, independently reviewed the interview transcripts to identify and code common themes and draft memos. Two authors are bilingual (one is a native speaker) and reviewed the Spanish transcripts, discussing key findings and themes with each other and the third author. Through iterative reflection and discussion, we developed a shared codebook. After applying codes to the transcripts, we summarized key themes; we then identified representative quotes corresponding to these themes and explored differences across women of different races, ethnicities and socioeconomic status. The authors translated Spanish quotes to English. Atlas.ti 1.0.22 was used for analysis.

3. Results

3.1. Baseline characteristics

The table outlines demographic characteristics of the 17 participants. Age ranged from 18 to 39 with a mean of 28-years-old. Almost half ($n = 8$) of patients identified as Latina whereas about a quarter ($n = 4$) identified as white, non-Latina and Black, non-Latina respectively. Forty-one percent of participants were immigrants. Approximately three quarters of participants ($n = 13$) reported having difficulty with basic costs of living. We present four key themes that emerged from the data, discussed below with corresponding participant quotes. All participant names are pseudonyms.

3.2. Themes

3.2.1. Women praised the convenience of LARC and the ease of immediate postpartum placement.—Several women referenced prior failures on non-LARC methods or their own difficulty in remembering to take pills or come in for injections. Women recognized these challenges could be exacerbated postpartum and appreciated that LARC methods helped avoid these problems. Elena, an 18-year-old primiparous Latina woman remarked, “In my mind...with the baby, it really feels more difficult to remember.”

Regarding timing, Latesha, a 32-year-old, black, non-Latina woman with difficulty with basic costs of living praised “just not having to come in for a separate visit to get it done... just have it done all at once.” Women recognized that there were certain disadvantages to having something placed immediately postpartum, such as confusion regarding etiology of side effects. Dunia, a 26-year-old Latina woman with the implant noted, “I get a lot of headaches. But right now I think it’s from lack of sleep.” Susan, a white, non-Latina woman with an IUD noted, “I was having an issue with the spotting and my mood...but it’s hard to...it’s so close to after having the baby. I don’t know if it’s post-baby things that I’m going through.” They considered that their symptoms could be attributed to their postpartum state and were patient with them.

3.2.2. Women wanted comprehensive, objective information early and often during antepartum contraceptive counseling—Participants reported wanting to hear about all options and side effects. They requested both verbal and written information in their own language and the opportunity to ask questions. Anna, a 19-year-old, American Indian woman who received an implant advised her providers, “Just don’t get irritable when we’re asking 50 million questions. We’re just trying to make sure.” Women emphasized the importance of information regarding the insertion process as well as access to device removal. Danielle, a Black, non-Latina woman complained of a negative implant insertion experience during which the provider did not address her or explain the process. She advised providers, “Talk to me. Guide me through it.” Women mentioned information about removal as critical in making the decision to receive immediate postpartum LARC. Anna recalled, “They made sure I knew if I changed my mind, of course, they can take it out, and we’ll think of other options.” Sarah, a white, non-Latina, college-educated woman explained she decided to receive an immediate postpartum IUD “because you can get it out at any time. It’s easy to take out. Easy to put in; easy to take out.”

Women acknowledged that provider bias exists and expressed a strong desire for objective information. Charlotte, a 35-year-old, white, college-educated woman recommended “just making sure you explain all the options even if you... don’t maybe think they’re the best.” Given the academic hospital setting, women frequently saw multiple providers over the course of their pregnancy. Many brought this up as an advantage as it allowed them to hear different viewpoints to help counteract bias. Courtney, a 32-year-old white, non-Latina woman with a substance use disorder remarked, “[Providers] will have in their head what they feel like works best. And that’s what they’ll tend to encourage. You know, so it’s nice to talk to different people that maybe champion different products, you know?” She went on to recall, “I would have different conversations with different people, and I think that was helpful too. To kind of get different perspectives. And then different people would add different things.” During labor, she made the decision to receive an implant, factoring in the information she had received from multiple providers during her prenatal care.

Most women reported discussing contraception at one of their first prenatal visits and revisiting it at almost every subsequent visit, and this was acceptable to them. Several mentioned they were already thinking about it themselves and welcomed the information and the time to digest it. In terms of when to start the conversation, Sarah said, “I think the earlier, the better. Some women need more time...to reflect on it than others. So, I think

bringing birth control [contraception] up early in the pregnancy is a good idea.” She related her own desire for this to the unintended nature of her pregnancy. In terms of frequency of counseling, Elena explained, “At some appointments I would bring it up...and then at some other appointments, they would just bring it up. But, I mean, I didn’t get offended by that. I would like to know more about birth control [contraceptive methods].” Several of the women interviewed did not actually decide until the third trimester, labor, or immediately postpartum. In most cases this was not because of a delay in counseling or lack of prenatal care. Elena’s explanation is exemplary: “Like before I was pregnant and in the beginning of my pregnancy – I didn’t have all the information about all the birth control [contraceptive] methods. And by eight months, I had all the options.”

3.2.3. Women wanted autonomy in their contraceptive decision-making and made internally motivated decisions—Women saw contraceptive choice as a personal decision within the context of their life circumstances. While they often appreciated others’ opinions and outside information, they very much did not want to feel pressured into choosing certain methods. Although many women cited external sources-- such as providers, family, friends, or the Internet-- that influenced their decisions, those who expressed positive views of the experience ultimately claimed internal factors as pivotal. They saw information from others as complementary and appreciated partnering with providers.

Women mentioned several internal priorities that motivated their postpartum contraceptive decisions. However, their priorities were shaped in the context of larger forces such as poverty, housing, and relationship status. Most commonly they spoke of their feeling of responsibility to other children, importance of their own health and education, and wanting a more stable relationship with a partner. Courtney explained that she decided on immediate postpartum LARC, “To make sure that I can provide for my child in a way that I see fit. Emotional factors – to make sure that I am in a good place in my own life and to make sure that I am in a stable, healthy relationship.” Latina immigrant women frequently cited financial concerns as paramount, including instability and the need to provide for children in their home country. Rosa, a 23-year-old immigrant with difficulty with basic living expenses described, “I can’t work with more children.... I’m a single mother. I live with people who support me but who at any moment can say that they are no longer going to continue to support me, and I will have to find a place to live.”

Women appreciated and praised provider counseling most highly when it supported a woman’s individual needs and desires. Clara, a 34-year-old, Latina immigrant woman commented, “The providers were good because they told me that it was my decision what I wanted to put in me or choose, and that they would respect my decision.” Danielle, the 23-year-old, Black woman quoted above remarked, “They were actually caring. It wasn’t like they were pushing me, like, ‘Oh you shouldn’t have kids, and you need birth control [contraception].’ It wasn’t nothing like that. So, they were really caring and basically trying to look out for me, since I was young when I had my first daughter.”

3.2.4. Women who reported feeling pushed during counseling were critical of their experiences—Women criticized providers when they viewed them as coercive or not interested in listening to their personal needs and desires. Susan, a 39-year-old, white,

non-Latina socioeconomically disadvantaged woman who decided on an IUD during labor complained, “They don’t talk to you. They just pretty much say, ‘What are you going to do about it? What are you going to do about preventing this from happening again’...in the middle of contractions.” She felt like judgements were being made about her reproductive desires without a conversation, and she resented the timing of the counseling. Many women used the word “pushy” to negatively portray providers. Charlotte, the white, non-Latina, college educated woman who received an IUD remarked, “They were kind of pushing for the birth control in [the delivery room] before I even delivered.” She further explained how she felt like providers minimized side effects to talk her into getting a specific method, tying together the themes of wanting comprehensive information and wanting autonomy: “I feel like the doctor...I feel like it’s pushed...certain things are pushed, you know. And then the negative...they don’t tell you the positives and the negatives, so maybe they can offer the information: okay, this is great because of A, B, and C, but there is a small chance of D happening...I just heard the positive things or the pushing part – the Mirena, Mirena, Mirena, Mirena.” Women did not appreciate providers pressuring them into getting contraception or assuming they did not want more children. Some women expressed suspicion that there were larger policies to control their fertility. For example, Charlotte said, “I was wondering if it had something to do with my health insurance too. Because it’s state health insurance...so, I thought that might have something to do with it...some type of control on how many kids.” Charlotte’s speculation about a state institution trying to regulate her family size is historically relevant, whether or not she was aware of such history.

4. Discussion

Some women criticized their providers or their experience with immediate postpartum LARC counseling. They cited feeling pressure to choose immediate postpartum LARC and expressed feeling their providers ignored their preferences during a vulnerable time. However, overall the women we interviewed were enthusiastic about postpartum LARC and praised the convenience of the methods themselves and immediate postpartum placement. Previous studies have demonstrated that Black and Latina women feel more pressure from their providers to use contraception and more often report negative experiences, including postpartum [16–18]; a study of postpartum Medicaid patients similarly demonstrated that they felt undue and negative pressure to choose immediate postpartum LARC [19]. Therefore, the positive nature of most accounts in our study was noteworthy.

Women’s preferences for comprehensive, objective information and autonomy were similar to what has been demonstrated in studies outside of the perinatal context [20,21]. Our data aligns with a growing body of literature supporting shared decision making as a patient-centered approach to contraceptive counseling [22,23]. Women cited satisfaction with counseling when they felt listened to and when it met their individual needs, not when they felt providers were biased or pressuring them to select a specific method.

Unique to the perinatal context, we found that women were happy to receive counseling early and often, and some expressed that hearing from multiple providers was beneficial to offset bias. This contrasts with another study that showed that women felt annoyed and pressured by recurrent inquiries about contraception [24]. Perhaps this difference is due to

the unique context of prenatal care, which includes multiple visits that can build on one another, or the fact that not all conversations cited by study participants were provider-initiated. A similar qualitative study by Mann et al. on immediate postpartum LARC experiences among Medicaid recipients in South Carolina found predominantly negative experiences, with patients' concerns focusing on intrapartum counseling and difficulty accessing removal [19]. Relatedly, in our study, discussions and decisions regarding immediate postpartum LARC during labor were satisfactory for women who reported prior discussions with providers and adequate information in the prenatal context but unsatisfactory for women who felt pressured or judged at this vulnerable time. As with the Mann study, several women in our study expressed that ease of removal was important in helping them to make the decision for immediate postpartum LARC. This is especially relevant given other studies that show evidence of provider resistance to LARC removal, which may deter women from these methods in the long-run [2,3,18].

The four themes emerging from this study-- convenience of access to immediate postpartum contraception, desiring comprehensive objective information, exercising autonomy in decision-making, and negative reactions to feeling pressure to choose immediate postpartum-- all resonate with the core principles of reproductive justice. By acknowledging the importance of access to immediate postpartum LARC *as well as* of the need for comprehensive, objective contraceptive counseling, participants made it clear that access alone is not enough; they asserted their reproductive autonomy in part through this dual emphasis. Access to LARC must be accompanied by just care that promotes people's human right to determine if, when, and how to parent.

There are potential limitations to our study. Women may have been more likely to decline an interview if they were unhappy with their method or counseling experience. Furthermore, women may have felt uncomfortable criticizing providers or practices in an interview with people who were affiliated with the medical institution in question. Therefore, our data may be skewed to show higher satisfaction. Only one woman interviewed had a substance-use disorder, and only four identified as Black. Therefore, the unique experiences and opinions of these groups may not be adequately represented by our data. Two of the interviewers were white, non-Latina and one was Latina. Mismatches in interviewer-interviewee race, ethnicity, or SES may have limited the richness of our data. Additionally, this study did not include women who chose not to receive immediate postpartum LARC so we were unable to compare those perspectives.

Our findings show that participants' perspectives on counseling for immediate postpartum LARC are overall like other contexts. They suggest that providers should consider starting contraceptive counseling early in prenatal care and readdress it at multiple visits. Patients may benefit from speaking with multiple providers. Providers should strongly consider counseling using a lens of reproductive justice that recognizes historical and current reproductive inequities, especially for poor women and women of color, and that focuses on delivering comprehensive, supportive, and objective information about all contraceptive methods, including side effects and availability of removal.

Funding:

This study was provided by the Society of Family Planning Research Fund.

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Table 1

Characteristics of immediate postpartum LARC recipients who participated in interviews.

Demographics		n(%)
Age, mean (range)		27.9 (18–39)
Race/ethnicity		
	White, non-Latina	4 (24)
	Black, non-Latina	4 (24)
	Latina	8 (47)
	Other	1 (6)
Primary language		
	English	11 (65)
	Spanish	6 (35)
Birth country		
	United States	10 (59)
	Other	7 (41)
Parity		
	Primiparous	3 (18)
	Multiparous	14 (82)
Education		
	Some primary school	4 (24)
	Some high school	5 (29)
	High school graduate	3 (18)
	Some college	3 (18)
	College graduate	2 (12)
Difficulty with basic costs		
	Yes	13 (76)
	No	4 (24)
LARC device		
	Implant	12 (71)
	IUD	5 (29)
When contraceptive decision was made		
	First trimester	4 (24)
	Second trimester	2 (12)
	Third trimester	5 (29)
	During labor	6 (35)