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Perspectives on patient-centered family planning care from incarcerated girls: a qualitative study

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Abstract

Study objective: We applied a patient-centered care (PCC) framework to explore incarcerated girls' experiences of and preferences for family planning (FP) care.

Design: We conducted qualitative semi-structured interviews with incarcerated girls to explore domains of PCC: access to care, patient preferences, information & education, emotional support, family & friends, physical comfort, coordination of care, and continuity and transition.

Setting: A juvenile detention center (JDC) in an urban California county.

Participants: Girls incarcerated during the study period.

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Initial findings presented at the Fellowship in Family Planning Annual Meeting on May 6, 2017, in San Diego, CA.

Interventions and Main Outcome Measures: Transcripts were analyzed using directed content analysis to identify themes related to PCC and additional overarching themes.

Results: Twenty-two participants completed interviews. Overarching themes of stigma and autonomy emerged as influential in girls' experiences and preferences for FP care. Participants described stigma related to incarceration, sexual activity, and lack of contraception use. Participants' desire for autonomy contributed to concerns around FP care. Despite this, the vast majority desired access to FP care while incarcerated. Many valued relationships they had with JDC providers, reporting more trust and familiarity with JDC providers than those in the community. Constraints of incarceration decreased availability of emotional supports and decreased involvement of family in health-related decision-making, which both worsened girls' experiences with FP care and enhanced their sense of autonomy. Difficulties with care coordination and transitions between the JDC and community often resulted in fragmented care.

Conclusions: Providing patient-centered FP care in JDCs is desirable but complex, and requires prioritizing patient preferences while recognizing the strengths and limitations of providing FP care within JDCs.

Keywords

Juvenile justice; reproductive health; family planning

Introduction

Approximately 15% of incarcerated youth aged 10 to 20 are female.[1] While proportions of youth involved with the criminal legal system have been decreasing, the decrease has been larger for males than females.[2] While research involving incarcerated girls is sparse, evidence suggests that compared to their non-incarcerated peers, they are more likely to have mental health and substance use disorders; to have experienced trauma, abuse and family dysfunction; and to come from families with a history of incarceration.[3-5] Incarcerated girls are also more likely to have a history of sexually transmitted infections (STIs) or pregnancy than their non-incarcerated peers.[6]

Indiviuals who are incarcerated have a right to healthcare,[7] however the details of accessing care, the quality of care and services available vary by facility. Professional societies, such as the American Academy of Pediatrics, the Society for Adolescent Medicine, and the American College of Obstetricians and Gynecologists, recommend that comprehensive reproductive healthcare be available to all incarcerated girls;[8-10] however, limited evidence from surveys of correctional facilities suggests that this is not common practice.[9,11,12] Although the National Commission of Correctional Health Care sets standards for family planning (FP) services within juvenile detention facilities,[13] compliance with these standards is voluntary; one survey found less than two percent of juvenile residential facilities have documented compliance.[14]

Patient-centered care (PCC)—defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions"[15]—was described in a 2001 Institute of Medicine report as an essential

component of quality care.[15,16] PCC has been used in a variety of patient populations to move from disease-centered approaches to one that centers patients' preferences, needs and values.[17-20] Incarceration can interfere with patient-centeredness by imposing structural barriers, including limitations on the type of care and providers available, and affecting how care is accessed. Therefore, a focus on PCC is crucial in this context as a means to ensure that incarcerated girls receive quality care that is consistent with their values, and to improve the reproductive healthcare experiences of incarcerated girls. A qualitative study of incarcerated girls explored barriers to accessing reproductive healthcare and complying with recommendations, describing factors related to individual motivations,[21] however little is known about their preferences for reproductive healthcare. The objective of this study was to use a framework of PCC to describe the experiences and preferences of incarcerated girls with receiving FP care within a juvenile detention center (JDC).

Materials and Methods

We conducted qualitative interviews with girls incarcerated in a JDC in an urban California county from September 2016 to March 2017. On-site medical services administered by the county health department were available in the JDC, including routine care, such as well-child care and immunizations, and low-acuity urgent care. Combined hormonal contraceptives and injectable contraceptives were available onsite, with intrauterine devices and contraceptive implants available with transfer to an outside clinic.

All girls aged 13-18 who spoke English were eligible. Facility staff identified eligible participants who were incarcerated during the study. Potentially eligible participants were then brought to the clinic within the JDC, where they were offered participation in the study. If potential participants were interested, study staff explained the study and obtained informed verbal consent. The voluntary nature of the study was emphasized, as well as its independence from youths' standing with the JDC. Written consent was not obtained to limit collecting identifying information, and parental consent was waived as this study pertained to reproductive healthcare. The study protocol was approved by the University of California, San Francisco Committee for Human Research. Permissions were granted from the county Juvenile Court and Probation Department.

Interviews covered two general topics: 1) past experiences with FP; and 2) preferences for FP services while incarcerated, with specific questions centered around domains of PCC. Interview guides were piloted with non-incarcerated youth, and modified based on youth feedback. Individual interviews were conducted in person in private rooms at the clinic in the JDC. Interviews lasted 20-45 minutes. Participants were compensated for their time with a $40 gift card that was held with their belongings and received upon release.

Interviews were recorded on a secure device and transcribed by a professional transcription service with identifying content redacted. Transcripts were coded using NVivo 11 software (QSR International, Victoria, Australia). Coding was conducted by AT and RB, with guidance from the research team. We began with line-by-line open coding of the first interview to identify emergent themes and used directed content analysis to map these themes onto each of the eight PCC domains.[23] AT and RB applied these codes to the first

three interviews and agreed upon a codebook. The remaining interviews were divided for independent coding. Discrepancies or difficulties with coding were resolved by discussion between AT, RB, and CD. Recruitment continued until we reached theoretical sufficiency surrounding the relevant domains of PCC.

Results

Participant characteristics

Twenty-two incarcerated girls participated in the study, with ages ranging from 13-18 years. The average age was 16.4 years (Table 1). The majority (59%) of participants self-identified as Hispanic, 23% identified as mixed race, 9% as black, and 9% as Asian. Most (82%) had been detained in a JDC at least once prior to their current detention. Nearly 30% had a history of foster care. The vast majority (91%) identified as having ever been sexually active. All but two had also used some form of contraception in the past, and the most common form used was condoms. Eight (37%) were using contraception at the time of the interview. Nearly one-third had been pregnant before, but only one had been pregnant during a prior episode of incarceration.

Overarching Themes

We used a PCC framework that describes eight domains: patient preferences, emotional support, physical comfort, family and friends, information and education, continuity and transition, access to care and coordination of care.[24] During analysis, two overarching themes emerged that provided context for provision of care in an incarcerated population: stigma and autonomy. We will first describe the overaching themes and then the PCC domains (Table 2).

Overarching themes

Stigma.—Many girls described feeling stigmatized by healthcare providers both inside and outside of the JDC, which had broad impacts on their feelings about and experiences with family planning care. One source of stigma was related to incarceration. Girls conveyed that stigma surrounding incarceration was more frequently an issue with providers outside the JDC, although they sometimes felt stigma from JDC staff (Table 2, Quote 1). A few youth specifically stated they did not want their JDC health records released to community providers to avoid disclosing their incarceration.

An additional source of stigma was sexual activity. For those who were sexually active, many felt stigmatized by the medical staff because of their sexual activity (Table 2, Quote 2). Most described feeling judged by providers for not using contraception, and some felt providers were pressuring them to initiate contraception (Table 2, Quote 3). This stigma limited some girls' trust in providers and their willingness to discuss FP.

Autonomy.—Autonomy also emerged as a theme across all the PCC domains. Nearly all participants described circumstances of incarceration - which limit autonomy - that led to tension around the receipt of reproductive healthcare. One participant described a reluctance to start contraception while incarcerated because it would add to the things she could not

control (Table 2, Quote 4). Others indicated that incarceration provided an opportunity for new autonomy and self-reliance, as for some this was the first healthcare experience independent from family or friends. Some saw extra time for contemplation coupled with increased health education around contraception as a situation that allowed girls to take more control of their lives (Table 2, Quote 5).

Patient-Centered Care

Participants' *experiences* and *preferences* for FP care were related to the eight domains of PCC, all of which were influenced by the overaching themes of stigma and autonomy, as reflected by desires to reduce stigma or increase autonomy when discussing preferences around each domain.

PCC: access to care.—Many respondents described experiencing barriers when accessing care, both before and during incarceration. Barriers in accessing care while not incarcerated most often related to parental or guardian involvement: for some, this meant relying on parents' availability; for others, this meant avoiding certain types of care (e.g. sexual healthcare) if their parents would find out (Table 2, quote 6). Lack of insurance was also cited by some as a barrier to care in the community, which was not an issue once incarcerated (Table 2, quote 7). Girls stated that at this JDC they had access to combined hormonal contraception and injectables, but other forms of contraception required transport to an off-site clinic. For some, this was viewed as and barrier, for example, if their sentence was short and scheduling was not within the timeframe of their incarceration (Table 2, quote 8).

With regards to preferences around accessing care, nearly all participants desired access to contraception while incarcerated. Girls were divided on whether they preferred to get this care at the JDC or be sent to an outside clinic. Some valued the technical expertise of outside clinics, particularly with procedures such as intrauterine device placement, and some simply wanted a chance to leave the JDC. Others felt more comfortable at the JDC clinic or were concerned about stigma from being in shackles in the community. (Table 2, quotes 8-10)

PCC: patient preferences.—While patient preferences are interrelated to all PCC domains, this domain focuses on the importance of attending to patient values and preferences. For both general healthcare and FP care, most participants expressed having strong preferences for providers they could trust and for confidential care. All had a hard time articulating exactly what made them trust a person or clinic, although two factors that contributed to trust were continuity and familiarity. Many participants had come to know and trust providers within the JDC, sometimes more so than clinicians in the community.

As a pathway to trust, a common theme was the preference of girls for providers with similar backgrounds to themselves or empathetic providers, as this made them more confident that they would be understood (Table 2, Quote 11). One girl said that speaking Spanish with a staff member helped her feel more at ease to discuss personal issues (Table 2, quote 12). Others related how JDC providers understood their incarceration better than outside providers. Only a few mistrusted the JDC providers, either inherently or because of a prior bad experience. Those who were not interested in starting contraception while

incarcerated cited concerns about trust and autonomy as factors limiting acceptability of receiving contraceptive care while incarcerated.

Concerns about confidentiality also influenced decisions about seeking care. Since most participants were minors, parent/guardian involvement in their medical care was often a source of frustration, even in the case of reproductive healthcare. Some described instances when their confidentiality was compromised, while others avoided care due to concerns for confidentiality (Table 2, quote 13). During incarceration, some described how the physical separation from their guardians meant greater confidence in confidentiality and increased interest in seeking FP services.

PCC: information & education.—Most participants reported having discussed FP care with JDC clinic staff at some point during their incarceration. There were a range of experiences with receiving contraceptive education from JDC staff. Those who had positive experiences emphasized the importance of clear and honest communication. For others, being repeatedly questioned about using contraception made youth feel disrespected or pressured, which ultimately lead to distrust of the JDC clinician's information. One reported that during a previous instance of incarceration, she started a contraceptive method not because she wanted to, but because she got tired of being lectured about it at each clinic visit (Table 2, quote 14); she ultimately discontinued the method after release from the JDC.

Regardless of their previous experiences or personal interest in contraception while incarcerated, nearly all participants felt it was important for providers to discuss FP with every incarcerated girl (Table 2, quote 15). Further, they felt strongly that girls need this education whether or not they were sexually active. They favored education in the JDC as they felt available to listen and believed it would prepare them to obtain contraception in the future. Many also perceived that, in contrast to busy community providers, JDC providers were trustworthy and had ample time to answer questions.

PCC: family & friends/emotional support.—The domains of emotional support, and family and friends were highly interrelated for the participants and are presented together here. Nearly all described previously having family members closely involved in their healthcare. their most frequently cited source for support, counsel, or company to medical appointments were female family members. Most viewed this positively, however in one extreme example, a participant described her mother pressuring her into getting an abortion that she was not sure she wanted (Table 2, quote 16). The desired role of family members in reproductive healthcare varied. While some valued family support for both decision-making and logistics, many described wanting to keep their reproductive healthcare hidden from their families (Table 2, quote 17).

Fewer participants relied on friends for support, although some described going with friends to FP clinics, either for their own or for their friends' care. Sexual partners were rarely mentioned as sources of support in obtaining FP care, either because they did not have an identified partner or did not want their partners involved. The few who said they were partnered all expressed an interest in discussing FP care with their partner as it could affect both parties.

While incarcerated, access to usual support was limited, as only immediate family or court-approved visitors were allowed to communicate with the girls on certain days of the week. This disruption caused variable preferences towards surrogate support systems. Many of the girls cited both housing unit and clinic staff as potential sources of emotional support, as they felt they could talk with them and discuss health-related decisions. Participants cited staff's availability, knowledge of their current incarceration, and for some, comfort and familiarity, as reasons for turning to the staff for support. However some were wary of turning to staff for support and preferred waiting to make decisions until they could access trusted family members or friends. Few preferred to make decisions completely without support.

PCC: physical comfort.—Aside from concerns discussed in *access to care* about being shackled in the community, most did not have significant experiences or concerns related to physical comfort in the context of FP care. All felt comfortable in the clinic and only had minor aesthetic critcisms, such as paint color or empty wall space (Table 2, quote 18). One concern for a few participants was limited or lack of timely access to pain medications for common issues such as headaches or menstrual cramps. Of the positive experiences, one girl felt more comfortable with JDC clinicians and appreciated that they did not perform unnecessary physical exams, contrasting what she experienced in the community (Table 2, quote 19).

PCC: coordination of care.—*Coordination of care* helps reduce feelings of vulnerability as patients navigate complex systems. Few participants required significant care coordination across specialists, and none described needing specialty FP care. The few who required coordinating care between outside specialists described difficulties in scheduling or keeping outside appointments, as well as occasional delays or disruptions in chronic medications. To improve coordination and reduce disruptions, some participants preferred structured communication, for example formal family meetings (Table 2, quote 20).

PCC: continuity & transition.—This final domain of PCC traditionally focuses on transitions around hospital discharge. Our discussions focused on transitions between JDC and community providers.

Most participants had some prior experience with transitions into and out of the JDC because of prior episodes of incarceration. Many reported good continuity within the JDC because they saw the same clinic staff repeatedly. One girl, a self-described "regular," expressed valuing this continuity in the JDC (Table 2, quote 21). The continuity with JDC providers improved trust and decreased feeling judged or disrespected.

Transitioning care from the JDC to community was disruptive to continuity. Several girls described stopping contraceptive pills or other medications that they had started while incarcerated as a result of the transition to community FP providers (Table 2, quote 22). Despite this, participants had mixed views about how their care from JDC should be communicated to outside clinics. Most preferred that either their parents/guardians or the clinics themselves would take care of transferring records without the girls' involvement. With concerns about stigma and privacy, a few wanted to be in charge of their own medical

records and to be in control of sharing information. Some were worried about being judged because of their history of incarceration; one specifically did not want her doctors on the outside to know anything about her incarceration.

Conclusions

Our findings from this in-depth qualitative study show that there are opportunities to meet adolescent girls' needs for patient-centered contraceptive care within JDCs, but that doing so requires careful attention to the impact of the carceral environment on the experience of care. The overarching themes of stigma and autonomy that emerged across PCC domains are understandably important in the setting of incarceration, where institutional structure limits autonomy and social stigma can lead to feelings of judgement towards incarcerated girls for a number of reasons. In the context of FP services, providers must also confront a history of coercive care enacted by judicial institutions. Sensitivity to and awareness of these issues as they relate to patients' senses of security and trust is of utmost importance. However, despite these concerns, our interviews also reveal that incarcerated girls overwhelmingly favor having conversations about reproductive healthcare and access to FP services in the JDC. JDC providers should leverage the strengths of their clinics (e.g. continuity with patients; patient time, availability, and willingness to learn) to provide non-judgemental FP counseling and care.

One domain of PCC that many participants reported finding especially challenging in the JDC was that of having adequate *emotional support*. JDC staff and clinicians should recognize that incarcerated girls may feel isolated from their usual support systems and may welcome emotional support when facing healthcare decisions, including those related to FP. Additionally, removing unnecessary impediments to accessing supportive family or friends in the community when faced with FP-related decisions while incarcerated may help girls make personalized decisions about their FP care and better plan for decisions that can be sustained after release.

Another important strength of JDCs was continuity of care. Several participants had been incarcerated multiple times, creating the unintended consequence of continuity of care with JDC providers. Continuity facilitated familiarity and trust with JDC providers for many girls, a population often lacking in reliable social supports in the community. However, it is also essential to recognize the non-optimal etiology of this continuity being borne out theof the conditions and restrictions of incarceration. Further, given the time-limited nature of incarceration, there is the potential fracture in care from sudden transitions back into the community. Pre-release planning should address this by strengthening communication with community providers and allowing girls the opportunity to guide their transitions of care.

Our findings echo a similar study of incarcerated adult women, who likewise expressed that contraception should be available in jail, and also had concerns about the quality of care in jail, safety and stigma surrounding contraception, and difficulties with follow-up care on the outside.[26] Other studies have found providing FP care for incarcerated adult women to be both feasible and acceptable.[27-29] Our results support providing FP education and services to

girls in custody, and may help girls and clinicians navigate barriers found in previous research[21] or help clinics guide interventions around FP.[30]

This study was limited to one juvenile facility in California, where all forms of contraception were available within the facility or by referral, and where confidential FP care is accessible in the community. Access to FP care in the community has important implications for the continuation of methods started in the JDC as well as the removal of implants or IUDs placed in the JDC, and must not be overlooked. Although this may limit the generalizabiliy of our study, the fact that we found similar results to an analogous study of incarcerated adult women may speak to some unifying themes when addressing reproductive healthcare of marginalized girls and women in the criminal legal system. Additionally, interviews were conducted within the JDC and participants may have felt pressure from social desirability to speak favorably about JDC staff and systems. Separation of the study and the JDC and confidentiality were emphasized during informed consent however it is possible that participants felt pressured to remain positive.

Providing reproductive healthcare to incarcerated girls is important, but complex. Recognizing the centrality of our overarching themes of stigma and autonomy while adhering to principles of PCC can help navigate the tension between ensuring access and education, without alienating patients or compromising autonomy. Through the delivery of high-quality, patient-centered FP services responsive to the carceral environment, providers can positively contribute to the well-being of individual girls and promote reproductive justice for incarcerated girls.

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Table 1.

Demographic characteristics of study participants, N=22

Demographic	n (%)
Age	
13	1 (5)
14	0 (0)
15	3 (14)
16	6 (27)
17	10 (45)
18	2 (9)
Race/ethnicity	
Asian	2 (9)
Black	2 (9)
Hispanic	13 (59)
Mixed	5 (23)
Religion	
Catholic	8 (36)
Christian	9 (41)
None	5 (23)
Prior stay in a juvenile detention center	
Yes	18 (82)
History of sexual activity	
Yes	20 (91)
Previous birth control	
None	2 (9)
Condoms only	8 (36)
Pill/patch/ring	1 (5)
DMPA	3 (14)
Implant	1 (5)
Multiple	7 (32)
Current birth control	
None	14 (64)
Oral contraceptive pills	1 (5)
Implant	6 (27)
Intrauterine device	1 (5)
Previous pregnancy	
Yes	7 (32)
Sexual preference	
Males	19 (86)
Females	1 (5)
Both	2 (9)

DMPA = depo medroxyprogesterone acetate.

Table 2.

Overarching themes and patient-centered care: domain descriptions and illustrative quotes.

Domain	Quote	Participant
Overaching Themes		
Stigma Related to incarceration, sexual activity, and not using contraception.	Quote 1: *"Maybe that's because they're more professional because it's the outs. Like just you're going to see your doctor. They just think you're any normal person versus in here you're in here for whatever reason, but you're kind of looked at as more irresponsible"*	Girl 015
	Quote 2: *"[The facility staff's] cooler… like if you're pregnant or if you're having sex, they don't really care… they're more like your friend… they don't like judge you or anything. But medical [staff]… whenever they try to educate us about sex and birth control, they always get back to the point of 'don't have sex.' They try to make [it] sound like sex is bad. Like you shouldn't have sex. So like I don't like that… it just feels like a little more judgmental…I feel like they think that we're having sex because we don't know about all the things that could happen, and like we do. And I feel like they try to tell us all the things that can happen, but make it sound worse, so that we don't have sex. Because I guess they think that because we're here, that we're irresponsible in a way for like a child, and we don't care if we get pregnant or not."*	Girl 015
	Quote 3: *"The lady was like forcing me - not forcing me, but she was just like trying to persuade me into getting another form of birth control. And I was like telling her like, no, I'm fine. I have to go do something right now, so I don't really have time to deal with all of that right now. Maybe I'll come back some other time, or I'll just use condoms or something. And she was like, are you sure? Because you're very young, and you need to take care of yourself. Yeah. I mean, I know that… I know that I need to take care of myself."*	Girl 018
Autonomy Related to reproductive health care and circumstances of incarceration.	Quote 4: *"It made it seem like they really wanted to put me on birth control here… they asked me a bunch of questions, and I answered about like sex and stuff like that… afterwards they're like trying to get me to start on birth control. And I obviously said, no, because I would rather do that not here – because I'm in here, I kind of just don't want more things that I feel like I have no control over."*	Girl 015
	Quote 5: *"I feel more not grown, but I feel more, like, responsible if I have - like, if I'm over here taking care of my own self and the health and all that"*	Girl 007
Patient Centered Care		
	Quote 6: *"Like all the teenagers, they always go [to Planned Parenthood] because it's confidential, and you can get like birth control without like a parent. You can just go by yourself. And a lot of people, like the parents don't want - like for me, my case, they don't want me having sex. And so then like that makes me comfortable that there's someplace like that I can go to for anything and for little or like no cost. [Interviewer:]* And how did you guys decide that you were going to go to Planned Parenthood? [Respondent:] When we heard about it, that you didn't need a parent.	Girl 015
	Quote 7: *"Grandma would be like, yeah, give her the shot, whatever she needs. Let her get it in [JDC] because her [Medicaid is] up and down. Here it's free, so might as well get what I need here."*	Girl 007
Access to Care Importance of patients' understanding of how to access care when it is needed.	Quote 8: *"I think it'd give girls easier access to birth control if they just did [Implant insertions] here, yeah, instead of making an appointment from a couple [weeks]- like let's say you're not here for those couple weeks. Yeah, I think that'll make it more accessible to other girls, and it's three years.*	Girl 011
	Quote 9: *"[Where would you want to receive care while in JDC?] Maybe Planned Parenthood so I could just get out of the sys - like leave, like, the system real quick just for 20 minutes, then come back. But then I would have to be in shackles. But I'd probably go to Planned Parenthood, though, because that's an actual place that's known for things like that, and this is more like of the juvenile hall, so, yeah, I kind of trust Planned Parenthood better"*	Girl 009
	Quote 10*: "Yeah, maybe just do [implant placements] here, but whatever. I got out. I was in here for like two months, and I wanted to go get fresh air, eat some chips. That's it. But I was like handcuffed the whole time. My ankles hurt and like my wrists, like friggin' chains everywhere. Yeah, it's not comfortable. But, yeah, maybe if they were able to do it here, that would be easier, I think, yeah."*	Girl 016
Patient Preferences Values and preferences, focusing on familiarity with providers, confidential care, and trusted providers.	Quote 11: *" if you haven't worked with juveniles who have been incarcerated, then you really won't know where they're coming from half the time. Or if they're throwing attitude at you, you're - you might just take it the wrong way; like, you don't know their story. Or you don't know if they had a bad phone call or a bad court day…like, if they've came from a troubled background, then I automatically want to hire them because they just understand the person… Like, some COs here, they don't get it because they've lived a little lavish little life or little stuff like that, and they really haven't been through anything."*	Girl 009

Domain	Quote	Participant
Information & Education Importance of honest information, communication and patient education.	Quote 12: *"But if I'm in a crisis, yeah, there's somebody I could talk to over there for sure. There has been a couple upsetting moments where I was able to talk to them…I think some people just feel comfortable with people of their own like culture and stuff. Like with [Staff Member Name], like I feel comfortable because I can talk Spanish to her pretty much, just that little simple fact that I could speak to her in Spanish."*	Girl 016
	Quote 13: *"Yeah, my parents take me to the doctor, you know, so it's, like, no confidentiality whatsoever, so…I actually liked going to the doctor [inside the facility]; like, I - that was not my regular doctor, so it was kind of foreign to me. I didn't - so, I had to fill out a lot of paperwork first, and they're, like, do you want this to be confidential or do you want us to call your parents? And I was, like, no, confidential is best. And since, you know, it actually is good, though. It's beneficial to me.*	Girl 007
	Quote 14: *"They wanted me to get on birth control, and it's like - it was more like, you need to get on birth control, and it's for your benefit. So I was like - I kept hearing it and hearing it and hearing it. So I was like, all right, go ahead, whatever. Give me birth control…I guess maybe first of all [I think they should talk to girls about birth control], just how does that make you feel when somebody's trying to convince you to do something like that?… I have my own mind. I can say yes or no. But it was just like, just do it, you know what I mean, just to get them off my back. Yeah, I hate it. It irritated me. It did irritate me a lot, but…they won. They won."*	Girl 011
	Quote 15: "*it's something that has to be considered. Every girl could like think the majority is like having sex. Yeah, so it's [good] to be protected… because [for girls who haven't started having sex yet] the time will come around, and they should know that there's resources out here for them that are free."*	Girl 016
Emotional Support Family & Friends Roles of family and friends in health care decisions, and the need for emotional support.	Quote 16: *"I feel like it was really just like my mom, she set everything up for me. Like, I felt like… everything, like, was just, like, for her; like, she, like, wanted me to get the abortion, she wanted me to, like, get birth control…so I wouldn't get pregnant anymore…I felt like she was only thinking about herself and how I was going to make the family look, and she didn't really stop to think like - like my daughter having a baby, like, this young, is this really going to help her stop getting into what she's, like, doing?… I'm not saying, like, it's right for me to have a baby so young, but I mean, if it came down to, like, oh, I'm already pregnant, I didn't, you know, I feel like you should just, like, keep it. And especially, like, I just felt like I could have stopped doing what I'm doing because, one, I can't do drugs. That's what I was doing. I was doing - smoking and drinking. I can't do that if I'm pregnant. If I'm saying I want to keep the kid, you know, I'm not going to do those things. And I feel like it would - it would keep me out of trouble"*	Girl 010
	Quote 17: *"Because what if I have like an STD or something? Say like an infection in my stomach or something, like I think they have the right to know. Well, an STD, I'd be kind of like ashamed. Like I'd be afraid of telling my parents. They'd be mad, so, yeah, I would rather keep that to myself."*	Girl 013
	Quote 18: *"[If I could redesign the clinic what I would do] first is, the room wouldnt' be all white, because it's very depressing and sad. And when you're sitting in your cell, you see all white already."*	Girl 005
Physical Comfort Impact on the patient experience.	Quote 19: *"And at the doctors outside of here, I don't have a personal relationship with them… and they are more physical with me… they're more, like, touchy feel because, you know, like… they touch my stomach, they have to, like…physical exams?… so it's kind of more weird, kind of awkward… Yeah. And here they're not really that touchy and stuff, only if they need to.. and I'm comfortable with it because I know- I know who they are."*	Girl 007
Coordination of care To reduce feelings of vulnerability when navigating complex health systems	Quote 20: *"I'd also try to get more in contact with the family, have sit-down meetings…Like, maybe have more sit-downs with the family instead of calls and calls and calls. Because, I mean, a lot of parents do be stressing that their kids are locked up up there….Because there's boys up there who… their parents don't really know everything. I mean, the phone is different; you know? Like a good sit-down with the medical person, so the family is also comfortable with who's seeing their son or their daughter, just things like that."*	Girl 009
Continuity & Transition Continuity with health care providers and transitions between the JDC and community.	Quote 21: *"I'm a regular, so guess they know me already. I all have, like, a personal base relationship with them, too, so I'm cool with all of them at some [level]; you know? That's what I really like. And at the doctors outside of here, I don't have a personal relationship with them like that; like, it's just my doctor, I say hi, bye, and don't even have a word… So, it's kind of more weird, kind of awkward."*	Girl 007
	Quote 22: *"I could go to clinics next to my house, or like they're supposed to give you somebody on the outs from like the lady that gives us the meds. She's supposed to give us somebody who will continue to give us the same meds and like offer the same things they offer in here… I usually just always stop taking my meds…*	Girl 021