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Authors

Mitchell, Ashley
Gutmann-Gonzalez, Abigail
Brindis, Claire D
et al.

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Contraceptive access experiences and perspectives of Mexican-origin youth: a binational qualitative study

Ashley Mitchell,[a] Abigail Gutmann-Gonzalez,[b] Claire D. Brindis,[c] Martha J. Decker [d]

a Graduate Student Researcher, Institute for Global Health Sciences, University of California, San Francisco, CA, USA
b Project Director, Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco, CA, USA
c Distinguished Professor, Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco, CA, USA
d Associate Professor, Department of Epidemiology and Biostatistics, University of California, San Francisco, CA, USA
Correspondence: mara.decker@ucsf.edu

Abstract: *Access to comprehensive contraceptive services for youth is essential to improving sexual and reproductive health. However, youth in many countries still face substantial obstacles to contraceptive access and use. The purpose of this study is to compare the contraceptive access experiences and perspectives of pregnant and parenting Mexican-origin youth in Guanajuato, Mexico, and Fresno County, California. Focus groups and in-depth interviews were conducted in Spanish and English among female youth in Mexico (*n = *49) and California (*n = *25). Participants also completed a brief sociodemographic survey. Using a modified grounded theory approach, qualitative data were coded and thematically analysed based on Penchansky and Thomas's* Theory of Access*, and results were compared by location. Although knowledge of a service provider was high among youth in both locations, access was affected by social, cultural, and institutional dynamics and contraceptive use was mixed. Across locations, participants described obstacles to accessing their preferred method. Participants worried about parental and peer opinions about their use of contraception (*acceptability*), and about perceived side effects including infertility and pain (*adequacy*). Contextual differences included lack of contraceptive choice in Guanajuato (*availability*) and incomplete knowledge about options in Fresno County (*awareness*). The power to request and receive their method of choice (*agency*) emerged as an important dimension that was not part of the original theory. Latina youth living in Mexico and the United States face multiple challenges accessing needed contraceptive options and services. Recognising and reducing these barriers can strengthen the contraceptive care landscape and promote the reproductive health and agency of young people.* DOI: 10.1080/26410397.2023.2216527

Plain language summary: *Although sexually active youth need access to comprehensive sexual and reproductive health services, youth in many countries face substantial barriers to care. This study compares the experiences of pregnant and parenting youth in accessing contraceptive services in Mexico and the United States. We conducted interviews and focus groups with 74 Mexican-origin young women and found that contraceptive use and access was affected by their concerns about parental and peer opinions as well as by provider attitudes. In Mexico, several participants reported being denied their preferred method by their provider. Identifying and addressing barriers to services can improve the quality of care and the reproductive health of young people.*

Keywords: contraception, reproductive health services, youth, hispanic or latino, Mexico, barriers to access

Introduction

Informed choice and access to contraceptive services is a critical component to improving the sexual and reproductive health (SRH) of adolescents and young adults, including the reduction of unintended pregnancies.[1] While meaningful access to SRH care and services are important across the life course, adolescence is a unique period of

development during which individuals are often more vulnerable to undesired health outcomes due to limited knowledge and greater barriers to contraception and related health services.[1] Comparing youth experiences and perspectives surrounding contraceptive access in different settings can identify key enablers and obstacles during this critical period.

Prior research has identified disparities in contraceptive access for youth as well as the importance of youth-friendly SRH services to increase access and use.[2] Obstacles to contraceptive access contribute to persistent differences in pregnancy and childbirth rates among Latina youth globally and within the United States. In Latin America and the Caribbean, the adolescent pregnancy rate is the second highest in the world.[3] In Mexico, nearly 20% of births occur among adolescents.[4] Despite a national policy in Mexico advancing access to all contraceptive options for young people,[5] more than a quarter have reported unmet contraceptive needs and youth are consistently found to have worse access to SRH services than older individuals.[6,7] Although both the United States and Mexican governments have attempted to improve the state of SRH education for adolescents, progress has been mixed, slow, and limited by opposing stakeholders in both countries.[8,9]

In the United States, adolescent pregnancies and births remain highest among Latino groups.[10] While Latinos compose 39% of the total population in California, nearly 75% of adolescent pregnancies occur in the Latino population and about 20% occur with non-native Latina individuals who migrated to the United States.[11,12] A study comparing birth rates of Latinas aged 15–19 living in American border states, however, found that adolescents living in California had lower birth rates than those in other states, likely as a result of increased access to contraception and youth-friendly SRH services.[10] Preventing unintended pregnancy during adolescence remains important as it may result in improved health, educational, and economic outcomes for the affected youth and for future generations.[13,14]

While Latino communities in different locations may embody some cultural similarities and navigate a variety of shared obstacles related to contraceptive access, meaningful differences in broader societal norms, policies, and health care systems shape the experience of young people. For example, research in the United States has highlighted a variety of personal and institutional barriers barring access to SRH care among Latina adolescents.[15,16] Another study with adolescents in California reported that Latina adolescents perceive similar obstacles to accessing SRH services to their non-Latino peers.[17] Aligning with the majority of literature studying migrant populations in the United States, the comparison groups for these studies were native-born non-Hispanic youth rather than non-migrant individuals in the source population, which may be more appropriate.[18] Qualitative research in Mexico revealed that adolescents' ability to access SRH services was hindered by a lack of awareness as well as by provider practices denying youth access.[19] However, research directly comparing these groups in both places is lacking and it is unclear to what extent these barriers persist or are mitigated for Latina migrants compared to their non-migrant peers.

Insufficient knowledge about contraceptive methods and care, including their availability and cost, continues to be an obstacle for young people.[20] A study comparing adolescent perceptions of barriers to accessing SRH services in California concluded that perceived lack of confidentiality, cost, and concerns about test results were among the most common obstacles and that nearly 30% of youth lacked knowledge about clinic services.[17] In both California and Mexico, disparities in contraceptive access between racial and ethnic groups may be driven by social determinants including age, education, relationship status, and economic status.[21,22] Other research has demonstrated that Latina women, and their Black peers, in the United States face worsened SRH access, lower use of the most effective contraceptive methods, and higher rates of unintended pregnancy as a result of gendered racism informed by harmful stereotypes from medical providers.[21] Similarly, a study in Mexico found that indigenous and younger adolescents were less likely to receive quality contraceptive care compared to non-indigenous adolescents and persons over 18 years old, illustrating the intersectional discrimination of age and race.[22]

The purpose of this study was to analyse the contraceptive access experiences and perspectives of pregnant and parenting youth in two different health care and cultural contexts – one in which they are in the dominant culture in Mexico and one in which they are an immigrant group in California. Investigating the nuances surrounding the

contraceptive needs of Mexican-origin youth in both settings is critical to inform context-specific solutions and identify factors associated with the social and health environments of each place.[18] Through this comparison, the findings can be further delineated to identify those which may be more universal to pregnant and parenting youth experiences and perspectives, and which may be more context-specific. Identifying and building awareness about the shared and context-specific enablers and obstacles from the perspective of pregnant and parenting young people may provide the insights needed to advance reproductive agency and access.

Methods

This study is a qualitative analysis of data collected within a broader study of adolescent pregnancy and migration conducted in partnership between the University of California, San Francisco and the Mexican National Institute of Perinatology.[23] Qualitative results from interviews and focus groups with youth were conducted in both locations to identify enablers and obstacles to contraceptive access. Penchansky and Thomas's theory of access was used to assess findings within specific dimensions of access to contraception and SRH services.[24] These dimensions include *Accessibility, Availability, Acceptability, Affordability*, and *Adequacy*. Saurman further refined these dimensions by adding *Awareness* as a dimension and recognised these dimensions as interconnected.[25]

Setting

Respondents were selected from several communities in Fresno County, California, and Guanajuato, Mexico. Guanajuato was selected as a traditional point of origin for migrants to California and Fresno was selected as a primary point of arrival for Mexican immigrants. Both settings are major agricultural regions and reflect a mixture of urban and rural communities. A binational research team with established relationships in both locations recruited youth from public hospitals and clinics in multiple communities in Guanajuato and from community-based organisations in multiple towns within Fresno County.

Participants

Eligible participants were pregnant or parenting females (within 12 months postpartum) aged 14–20 residing in the state of Guanajuato, Mexico, and Fresno County, California. Eligibility criteria also included the ability to speak Spanish or English. Participants in Fresno were limited to youth who migrated from Mexico themselves or had at least one parent that migrated. Youth receiving services from each site were invited to participate, resulting in a convenience sample spanning multiple communities and settings. Recruitment continued until consistent themes began to emerge and the research team agreed that data saturation had been reached.[26]

Data collection

Qualitative data were collected through a strategic combination of focus groups and in-depth interviews, conducted in English or Spanish by a binational team of five trained researchers, between December 2016 and July 2017. Focus groups and interviews occurred in classrooms or meeting rooms. After explaining the study aims and approach, researchers obtained verbal consent from each participant prior to conducting any focus group or interview. There were no participation refusals. Focus groups and interviews explored participant experiences with SRH care and services. Focus groups explored contraceptive availability and information generally, whereas interviews, which were conducted in a more confidential setting, delved into personal experiences with SRH care and access. Participants also completed a brief survey to collect demographic information along with SRH clinic knowledge and contraceptive use.

The study instruments were piloted, modified, and implemented by the binational research team to gather personal experiences and group-generated perspectives. Young people in both contexts were compensated for their time with either a $20 gift certificate or infant supplies, per the recommendation of the relevant local institution. Focus groups had an average of five participants, with a range of 3–22 participants. The greater frequency of adolescent pregnancies in Mexico and fewer eligibility requirements resulted in larger focus groups in Mexico. Focus groups lasted about an hour while interviews were generally less than 30 minutes in length. All focus groups and interviews were audio-recorded and transcribed verbatim.

Table 1. *Dimensions of Access for contraception and sexual and reproductive health (SRH) services.**

Dimension	Definition	Examples
Accessibility	"Accessible" services and resources are near to the intended user	• Contraception is accessible at nearby locations
		• SRH services are accessible within a short distance
Availability	"Available" services and resources are sufficient to meet community demand	• Trained providers are available to competently provide the full range of contraception and other SRH services
		• Health care settings maintain a stock of all contraception and related resources
Acceptability	"Acceptable" services and resources align with the sociocultural norms and practices of the user	• Users perceive contraception options and use to be acceptable for themselves and to their community
		• Users find the available providers to be acceptable to deliver SRH services
Affordability	"Affordable" services and resources suggest reasonable financial cost to the user	• Contraception and SRH services are low- or no-cost (and/or the cost is covered by low- or no-cost health insurance)
Adequacy	"Adequate" services and resources are organised in a way the target population can understand and user-friendly	• Information about available contraception accommodates users' needs and desires
		• SRH clinics maintain relevant hours and user-friendly appointment systems
Awareness	"Awareness" of services and resources is achieved through effective communication and dissemination of relevant information	• Communication about contraception and SRH services builds health literacy among intended users
		• Information about contraception and other SRH services is relevant to its context
Agency	"Agency" entails the ability and personal autonomy to act upon a desire to seek and acquire, or to avoid, services	• Users are able to acquire the SRH services they desire when and how they wish
		• SRH services are free of coercion

*Adapted and expanded from Saurman[25].

Data analysis

All transcripts were coded in the original language using Dedoose software Version 9.0.17.[27] Three researchers coded the focus groups and interviews, and a fourth researcher reviewed the codes for inter-coder consistency. Researchers coded data independently but met weekly to clarify codes and refine the codebook to improve reliability. To ensure coding consistency, a random sub-sample of interviews and focus groups was coded by two separate researchers and inter-coder reliability tests were performed, obtaining an average Cohen's kappa value of 0.88.

This study used a modified form of grounded theory in which a set of preliminary codes were identified *a priori* based on the research's initial

Table 2. Participant demographics by location

	Guanajuato, Mexico		Fresno, California	
	n (49)	%	*n* (25)	%
Age (mean)	17.2		17.6	
Age				
≤16	15	30.6	4	16.0
17 to 18	23	46.9	17	68.0
19 to 20	11	22.5	4	16.0
Currently in school				
No	44	89.8	5	20.0
Yes	5	10.2	20	80.0
Highest level of education				
Elementary	10	20.4	0	0.0
Middle	28	57.1	2	8.0
Some high school	7	14.3	15	60.0
Finished high school	2	4.1	6	24.0
Some college	0	0.0	2	8.0
Missing	2	4.1	0	0.0
Relationship status				
Single	3	6.1	9	36.0
In a relationship but not living with partner	8	16.3	6	24.0
Married or living with male partner	37	75.5	10	40.0
Other	1	2.1	0	0.0
Childbearing status				
Pregnant	22	44.9	3	12.0
Parenting	27	55.1	22	88.0

research questions and the *Theory of Access* and later added emerging codes inductively identified from the data.[28] This approach maintains the essential elements of grounded theory including an iterative and reciprocal data-theory relationship.

Table 1 provides definitions and examples of each dimension as they relate to youth access to contraception. Coded text was exported into Excel spreadsheets and thematically analysed for themes and patterns within and across the various dimensions of access by location. Additional sub-codes were developed based on the themes that emerged during analysis. Qualitative data were analysed by participant location with a focus on identifying enablers and barriers to contraceptive access among young people. Spanish quotes included in this manuscript were translated by a native Spanish-speaking researcher and verified against the original.

Select questions from the demographic survey were analysed to compare participants' characteristics, knowledge of SRH services, and past and/or current use of contraception young by location. Demographic statistics were summarised using Stata Statistical Software: Release 17.[29]

Ethical approval

The Institutional Review Board of the University of California, San Francisco (# 16–20062, 30 November 2016), and the Committee of Investigation of the Secretariat of Health in Guanajuato, Mexico, approved the broader study.

Results

Participant demographics

Eleven focus groups (5 in Fresno; 6 in Guanajuato) and 15 in-depth interviews (5 in Fresno; 10 in Guanajuato) were conducted with 74 pregnant or parenting female youth. Two-thirds of participants resided in the state of Guanajuato, Mexico, and one-third in Fresno County, California (Table 2). Most participants in Guanajuato (90%) reported that they were not currently in school and 76% described their highest level of education as middle school or below, whereas most participants in Fresno (80%) were currently in school and 92% reported their highest level of education as some high school or above. Just over half (55%) of participants in Guanajuato were parenting and the other 45% were pregnant; in Fresno, 88% were parenting and 12% were pregnant.

Participant knowledge and use of contraceptive resources

Young people in Guanajuato were less likely to report knowledge of a SRH health provider in their community—63% compared to 88% in Fresno (Table 3). Both groups reported condoms as the most frequently ever-used contraceptives at 51% and 56%, respectively. Although hormonal methods were the next most common methods ever used in both locations, over half of participants in Fresno (52%) had used them compared to only 14% in Guanajuato. Similarly, almost half (48%) of Fresno participants reported usage of long-acting reversible contraception (LARC) compared to 12% in Guanajuato. Additionally, 29% of participants in Guanajuato said they had never used any method as opposed to 8% in Fresno.

Participant experiences and perspectives

In both locations, several themes emerged within the *acceptability*, *affordability*, and *awareness*, dimensions of access, while comments related to *availability* only emerged among Guanajuato participants and those related to *adequacy* and *accessibility* only emerged among those in Fresno (Table 4). In addition, the concept of individual *agency*, or the power to request and receive their method of choice, emerged as an important dimension. In many instances, these dimensions of access overlapped.

Acceptability

In both locations, participants shared concerns about how the perceptions of others, particularly peers and parents, influenced their contraceptive decisions. Fear of gossip and rumours among their peers shaped participants' willingness to seek contraceptive resources. Focus groups responses in both locations revealed similar concerns:

"If we weren't embarrassed, I think we would have come [to the clinic], because maybe the moment someone else begins to find out that you are seeing someone, you feel ashamed, right? They'll say, 'look, don't stay with that person' and 'this girl already got involved with this guy.'" (Guanajuato Focus Group Participant)

Participants in Fresno similarly shared:

Participant 1: *If they see you going in there and they know they have condoms in there, they'll be like oh, they'll try to be up in your business and stuff. And maybe start a rumor.*

Participant 2: *I think that's why people don't go there. I don't want people to see me. That's what I think …* (Fresno Focus Group Participants)

Participants in Fresno County shared further concerns about the small size of their community and the perception that "*everybody is going to know*" about a clinic visit. In Guanajuato, one person explained that to maintain privacy around accessing SRH services, some youth seek input from a medical professional instead of their peers:

"I think we are all afraid to ask for something … and we think it is better to ask a person at the health center who does not know us than a friend or an acquaintance." (Guanajuato Focus Group Participant)

However, some participants preferred talking with their peers and being concerned that their parents

Table 3. Knowledge and use of contraceptive resources by location

	Guanajuato, Mexico		Fresno, California	
	n (49)	%	*n* (25)	%
Knowledge of a clinic/provider offering youth-friendly SRH services				
No	12	24.5	1	4.0
Yes	31	63.3	22	88.0
Not sure	5	10.2	1	4.0
Missing	1	2.0	1	4.0
Methods of contraception ever used*				
None	14	28.6	2	8.0
Condoms	25	51.0	14	56.0
LARCs (IUD, Implant)	6	12.2	12	48.0
Hormonal methods (Pill, Injectables, Vaginal Ring, Patch)	7	14.3	13	52.0
Non-hormonal methods (Withdrawal, Rhythm method)	2	4.1	8	32.0
Emergency contraceptive	3	6.1	0	0.0
Missing	2	4.1	0	0.0
Methods of contraception currently used**				
None	6	12.2	5	20.0
Condoms	4	8.2	5	20.0
LARCs (IUD, Implant)	9	18.2	11	44.0
Hormonal methods (Pill, Injectables, Vaginal Ring, Patch)	3	6.1	1	4.0
Non-hormonal methods (Withdrawal, Rhythm method)	0	0.0	2	8.0
Emergency contraceptive	0	0.0	0	0.0
Missing	5	10.2	0	0.0

*Participants could select more than one answer.
**Includes only post-partum participants ($n = 27$ from Guanajuato, $n = 22$ from Fresno); Participants could select more than one answer and Guanajuato participants reported no method or 1 single method while 2 Fresno participants reported condom use along with a second method.

would find out if they tried to access services. As one participant in Fresno described:

"Well, they just talk about it because they're scared to tell their parents. And they don't know where to find certain places to go and they're scared that their parents are going to find out if they go to those clinics." (Fresno Interviewee)

The role and influence of parents were mixed. While some mentioned concern about their parents' knowledge and opinions, other

Table 4. Shared and location-specific findings by *Dimensions of Access related to contraception and sexual and reproductive health (SRH) services among youth and young adults**

Guanajuato findings	Shared findings	Fresno findings
Availability • Delays in receiving anything but condoms • Barriers to young people obtaining LARCs before or after first birth *Agency* • Denial of preferred method • Contraceptive coercion by providers	*Acceptability* • General influence of family, friends, or providers • Stigma surrounding parental and/or peer perceptions of youth contraceptive use • Fear of side effects (i.e. pain) related to contraceptive use • Participant desire for pregnancy or prevention *Affordability* • Inadequate access to free, confidential contraception increasing pursuit of higher cost options via pharmacies *Awareness* • Presence or absence of SRH-related community and media outreach • Knowledge or lack of knowledge about contraceptive options • Inconsistent use of short-acting methods (i.e. missing a pill)	*Accessibility* • Unclear presence/ location of school-based SRH resources *Adequacy* • Inadequate contraceptive education • Unclear schedule of health resource trailer at school

*Adapted and expanded from Saurman[25].

participants in both locations described their mothers as having a strong influence in their contraceptive decision-making. For example, when asked about how they chose to use an intrauterine device (IUD), which they reported being happy about, one Fresno participant described:

"*My mom kinda convinced me. Cuz she said that like it was better, cuz the first time I would always worry about taking the pill and then this time, I don't have to like worry about it. It's just there.*" (Fresno Interviewee)

A young person in Guanajuato summarised their perception that mothers should be involved, explaining:

"More than anything else, mothers should be open, 'look, you can use this one or this one, or not this one, and this one is better for you.' So that they [youth] take care of themselves. If you don't talk to them [youth] openly, they will do it anyway." (Guanajuato Interviewee)

There were further nuances in the strength of influence of others on participants' fertility-related decisions. Responses differed by location in this regard in that a couple of participants in Guanajuato specifically chose not to accept contraception advice from their mothers based on their conscious decision to become pregnant. Although not a common issue around acceptability, some participants in both locations also identified concerns about unwanted side effects or pain related to contraceptive use.

Affordability

Although youth in each location acquired contraceptives from different sources, affordability was not perceived as a significant issue in either situation. Participants in both locations described

seeking contraception from their peers or from stores where they presumably needed to pay out-of-pocket as opposed to clinics where some contraceptives were freely available. One Fresno focus group was specifically asked where they or their partners would go to get condoms and, despite availability at the clinic one participant explained, "*just go to the store and buy it.*" In Guanajuato, many participants reported accessing free contraception through their local health centre or hospital, though a few acknowledged that free SRH services were not available in rural settings. Some young people in Guanajuato also reported that pharmacies, convenience stores, and department stores were places youth purchased methods, often out of fear of being seen at an SRH-focused clinic.

Awareness

The most common issues participants mentioned related to awareness were related to SRH education and outreach. In Guanajuato, participants explained that they received contraceptive information, although this did not always translate to use. One participant shared:

"I think it is easy, because nowadays in schools, in communities, in other places there are people from health centers or hospitals who give talks or even give gifts to teenagers, so that if they have sex, they can protect themselves. In any case, there are talks or advertisements on radio, TV, everything … [which] mention all those that are for use after pregnancy, for example, the arm kind, the IUD, the other copper one, and the most known, the ones that teenagers use the most, which are condoms, or pills." (Guanajuato Focus Group Participant)

Another participant agreed and explained that they had witnessed community outreach by nurses and free contraceptive advertising on television.

In contrast, many participants in Fresno reported a more limited awareness of their options prior to pregnancy or visiting a clinic specifically for SRH-related services. As one explained:

"I heard about [contraception] but I only thought there was only one type of birth control. But when I went [to the clinic], I noticed there was like more than one." (Fresno Interviewee)

One participant in Fresno recognised gaps in her own awareness about contraception while seeking pregnancy testing:

" … you can get birth control for free. I didn't know that until I was pregnant already. Once you look up 'where can I get a pregnancy test?', then it pops up you can get birth control here. And it's like no, it's too late for that one, I need the pregnancy test." (Fresno Focus Group Participant)

Finally, awareness and concern among participants of the possibility of pregnancy differed by location. In fact, several participants in Guanajuato described their pregnancies as planned, which was not mentioned in Fresno. Several participants in Fresno instead reflected on their acceptance of the potential for pregnancy as a consequence of sexual activity, although others shared that their peers may not use contraception due to perceived lack of risk. When asked why their peers may not want to use contraception, one participant in Fresno explained, "*they said that they're being careful. That it's not going to happen to them.*"

Availability

Findings within the dimension of availability primarily emerged among participants in Guanajuato. Several explained that condoms are the most common method available to young people followed by pills, patches, and injections. One participant shared that condoms were handed out freely during school-based sex education classes. Several participants, however, detailed obstacles to acquiring their method of choice beyond those most commonly available. For example, one participant noted:

"I wanted the implant, but they told me at the Maternity Hospital that they didn't have any available at the time and asked me if I wanted to get the IUD instead. I said yes because the important thing is to protect myself." (Guanajuato Focus Group Participant)

Many participants in Guanajuato explained that some contraceptive methods were only available under specific circumstances such as being sexually active or immediately following pregnancy and childbirth. In these instances, participants shared stories of providers denying access to desired contraceptive methods. Some participants, for example, shared that LARCs were unavailable to them prior to childbirth despite free

provision of these methods at local health centres. In contrast, young people who had experienced pregnancy and birth often were encouraged to consider LARCs by their provider.

Accessibility

Barriers related to the dimension of accessibility primarily emerged among Fresno youth and also overlapped with awareness. While some participants in Fresno reported no access to a school-based health centre, others mentioned a mobile clinic offering SRH services. However, they had limited knowledge of the mobile clinic's schedule, and none reported utilising it. One participant attempted to recall details about the mobile clinic:

"[The mobile clinic is there] some days, I think it's 3 days a week but it's just there … We don't know about it until a student tells us, another kid tells us. I never, the school never told us … because we do have Sex Ed classes, but they never told us to go to this place … " (Fresno Focus Group Participant)

Adequacy

While most participants in Guanajuato described receiving adequate information about contraceptives and other SRH topics, some participants in Fresno described obstacles to adequate information. Compared to participants in Guanajuato who described their school-based SRH education as fairly comprehensive – including information about contraception such as condoms, pills, and IUDs – those in Fresno outlined a variety of important gaps including a perceived over-emphasis on the menstrual cycle and on sexually transmitted infections, along with a lack of information about contraception and relevant resources. Some participants in Fresno perceived educators or schools to be unwilling to provide contraceptive education. Several focus group participants explained that while they received some SRH education in school, it wasn't comprehensive. When asked whether educators shared information about resources and youth-friendly clinics, one participant reflected:

"I don't think they would ever … they would tell us use a condom, but they wouldn't show us what's a condom and stuff like that. They'd be like, 'oh just use a condom', what's a condom. They don't give too much information, especially in middle school … in middle school they mostly focus on HIV and stuff like that. They just tell us … you know you can get pregnant." (Fresno Focus Group Participant)

Young people in both locations recognised that they had important knowledge gaps and alluded to the benefit of incorporating SRH topics earlier in school.

Agency

Although not one of the initial dimensions of access, an individual's agency, or having the power to request and receive their preferred contraceptive method, emerged as an issue for youth, particularly in Guanajuato. This dimension of access was distinct from availability in that clinics often had the method in stock, yet providers disregarded the young woman's preference. Youth in Fresno did not discuss this concern. Several participants in Guanajuato described being coerced into using a contraceptive method or not receiving their preferred method. One person shared that contraception was required when they were discharged after childbirth "*… you have to leave [the hospital] with a method because they [doctors] make sure that you don't get pregnant again. That's what they require*" (Guanajuato Interviewee).

One participant was denied an implant during their postpartum period and offered an IUD and nothing else. Similarly, another participant reported being coerced into an IUD insertion despite their preference and advocacy for an implant:

"They [providers] made me sign a paper form saying what I was going to use, because they told me that having another baby so soon was going to be very difficult. Also, I told them that I didn't feel strong enough to have another one. They told me you have to sign this paper and indicate what you are going to use to take care of yourself. I had already told them the implant, and they said yes, I signed the form and everything. Here [at the clinic] I told them the same thing and yes, everything was fine, but not even an hour had passed before they told me no and they put the copper IUD in instead. […] they [providers] forced it [IUD] on me. After about three days I lost the IUD, it came out, and now I have nothing." (Guanajuato Focus Group Participant)

When asked why they thought the providers didn't respect their decision to use an implant, this

participant explained, "*because they told me that it was hormonal and they gave me a lot of cons about that device, they told me that the IUD was better, and I told them no, not that one. They told me, but yes, yes that one, so they forced that one on me*."

Other participants in Guanajuato shared that they weren't provided with an explanation for not receiving their chosen method, describing their additional efforts to access contraception elsewhere to make up for the lost opportunity. For example, one voiced preference for a LARC postpartum but was denied one at the hospital, explaining "*they didn't tell me why, they just said no, and I had signed a sheet as well, and they said no, that they couldn't insert it there*." This individual ultimately acquired pills from another health centre.

Another participant reported receiving the Depo shot, but when asked if this was their preferred method, she explained:

"No, before they had told me about a new one that came out, the Mirena, but there at the hospital … they didn't put it in because I was discharged later. First, they asked me if I was the one who was going to get it, I said yes, but then they never came, and I didn't get anything in the end." (Guanajuato Interviewee)

This participant described the additional effort required to make up for the lost opportunity, first seeking an injection at their local health centre and considering finding another provider who would place an IUD "*to better protect myself*." While this participant was aware of the choices and benefits of contraception, and advocated for her preference, she was denied access at specific times and locations.

Discussion

This study explores the multiple, concurrent, and context-specific factors that influence access to contraception and related SRH resources and care for pregnant and parenting Mexican-origin youth in Guanajuato, Mexico, and Fresno, California. Youth in both locations identified barriers and facilitators to contraceptive access across several *Dimensions of Access*. In addition to the original dimensions identified, our findings highlight the importance of personal *agency* in contraceptive access.

In many cases, these dimensions of access overlapped to shape the young people's experiences and ability to access SRH knowledge, care, and resources. For example, lack of *awareness* often was coupled with inadequate services available at the facilities. Unlike in Fresno, youth in Guanajuato perceived their school-based SRH education and resources to be *adequate* and they were aware of the *availability* of no-cost contraceptive options. *Affordability* was not a notable barrier to access in either location with most youth aware of free or low-cost methods. However, many young people in Fresno reported learning about approved contraception methods and about the availability of low- or no-cost resources only after becoming pregnant themselves. Our results affirm prior research which found that comprehensive SRH knowledge, including contraceptive information, is essential to informed health decision-making and that other programming may be needed to reach out-of-school youth, particularly in Mexico.[4,30]

Our findings also underscore that knowledge is insufficient when other dimensions such as *availability* or *accessibility* are limited. For example, although more than half of participants in both locations had reported ever using a condom, participants in Fresno were much more likely than those in Guanajuato to report use of other methods. In contrast, youth in Guanajuato were much more likely to report never having used any contraceptive method and that the pregnancy was intended. This underscores that contraceptive non-use among youth is an imperfect measure of unmet need, as youth for whom pregnancy was planned and desired would have no unmet need for contraception.[31,32] Better understanding the relationship between contraceptive use and other concepts including pregnancy desire, contextual differences in perceptions of access, and societal norms around pregnancy and sexuality is needed. It also highlights the importance of responding to individual needs and motivation.

As found in other research, issues related to *acceptability* included concerns about side effects, stigma, and the influence of peers and family members. In both locations, information and advice from the participants' peers and mothers influenced selecting a specific contraceptive method. This contrasts with recent research suggesting that social norms may be changing at the population level and that many Latina youth do not rely on others to make contraceptive decisions.[33] Other studies have found that Latino parents in Mexico and the United States often are reluctant to talk with their children about

sexual topics and may benefit from culturally-appropriate communication training.[34,35] Addressing misinformation, societal norms, and stigma surrounding contraception among families and peers is likely to increase *acceptability*.

Along with individual obstacles, existing and perceived provider and clinical practices also must be considered to improve *acceptability* and *adequacy*. As in prior research, participants in both locations described a desire for private and non-coercive interactions around contraceptive services.[36] Youth-centred patient-provider relationships involving trust, communication, and shared decision-making have the potential to improve the care experiences and health of Latina youth across contexts.[20,23,37] Providers caring for pregnant and post-partum young people need to avoid negative stereotypes and judgmental attitudes and focus on supporting healthy behaviours and outcomes.[38] In addition, providers should address young people's concerns about contraceptive side effects and support their choices to switch or discontinue contraceptive methods.[20] Notably, several participants in Guanajuato were denied access to their preferred method. While youth in Fresno did not report that barrier in this study, similar obstacles have previously been documented among youth in the United States.[20] Prior research has also identified gaps in provider training as well as provider misconceptions regarding the ability of adolescents to be candidates for LARC methods.[39,40] Offering contraceptive counselling of all methods during prenatal care and providing post-partum options can reduce rapid repeat pregnancies.[38] Although youth in Mexico may have access to multiple over-the-counter contraceptive methods, most methods in the United States require a prescription from a provider. Ensuring *availability* of and *accessibility* to desired contraceptives is a cost-effective and critical component to achieving reproductive *agency*, enabling timely access to preferred methods.

While certain considerations across the dimensions of access were similar in both locations, contextual differences arose, suggesting the need for tailored strategies that recognise the differing experiences and pregnancy intentions of youth. The participants in our study often encompassed intersecting characteristics, including young age, immigration status, and educational level, which affected the power dynamics with the provider and their *agency* in receiving their desired method. Prior research also found that particular barriers to access may be acutely experienced by young persons as a result of their own socioeconomic status, cultural norms, or instances of personal discrimination.[41]

Recommendations

These results illuminate several strategies to improve young people's access to contraceptive services including improving clinical services, providing comprehensive sexual health education, engaging stakeholders, and supporting youth agency and empowerment.

Opportunities remain to substantially improve the clinical care for youth seeking SRH services. These include incorporating training and accountability to ensure non-coercive and patient-centred contraceptive counselling to improve *adequacy* and *acceptability*. Sustained provider education and mentorship should be prioritised alongside changes to clinical protocols to improve provider adherence to clinical recommendations.[42] Strengthening provider practices and young people's *awareness* of their rights and confidentiality is critical to facilitating *accessibility* to often stigmatised SRH services and to promote *affordability* by enhancing confidence in existing free services. Youth-friendly programs and clinics need support to build their capacity and outreach to better serve youth, including offering flexible schedules or more convenient locations to improve *accessibility and availability*.

Merely eliminating obstacles or improving access will remain insufficient to provide contraceptive choice without a deeper and stronger commitment to supporting the development of adolescents' *agency*. The social and political dynamics in each country that shape young people's ability to successfully navigate the health care system must be considered and addressed. In both countries, this includes some political opposition to comprehensive sexual health education and services for adolescents.[8,9] California and the United States also need to better address the lower use and greater barriers to care among migrant youth to ensure timely access to contraceptive and prenatal care.[15,16] This will require collaborative efforts across key stakeholders in the lives of youth including partners and peers, parents and caregivers, school educators and administrators, youth-focused community-based organisations, and providers and others in the

health care delivery systems to truly improve access.

Limitations and strengths

Our study had some limitations. Participant recruitment differed by location as those in Guanajuato were recruited within clinic and hospital settings, while participants in Fresno were recruited primarily within community-based organisations. Because of this, populations in each setting varied by pregnancy status, resulting in a greater focus on post-partum experiences among the Guanajuato participants. Additionally, Fresno recruitment included the additional eligibility criteria of recent migration, restricting potential participants and possible willingness to participate related to stigmatisation of immigration status. Consequently, the focus groups in Guanajuato had more participants due to greater ease of recruitment. However, the researchers conducting the focus groups in both locations followed the same protocol and questions and did not note a substantial shift in the dynamics within the groups. In addition, the experiences and views of the pregnant and parenting participants may not be reflective of other young people in these locations.

Despite these limitations, similar themes emerged across the locations. These data points allow for an increased understanding of personal and social enablers and obstacles documented in each location and the utility of using the *Dimensions of Access*[25] to identify key themes. Overall, findings revealed important considerations for youth that can inform future efforts to improve contraceptive access. Considered holistically, findings from the surveys, interviews, and focus groups offer insights into who and what may influence contraceptive decision-making among Latina youth in distinct cultural settings and health systems.

Conclusion

A youth-centred and context-specific approach to understanding and addressing the multiple dimensions that constitute contraceptive access is crucial to improving SRH outcomes and equity. This study confirms that providing non-judgmental and accurate information, improving clinical services, and supporting youth empowerment, are essential for informed choice among expectant and parenting young people, and ultimately affect their health and wellbeing. Collectively, strengthening all *Dimensions of Access* will improve the contraceptive care landscape and support young people's sexual and reproductive goals.

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ORCID

Martha J. Decker http://orcid.org/0000-0002-9927-7303

References

1. UNFPA. Universal access to reproductive health: progress and challenges; [cited 2016 Jan]. Available from: https://www.sdgfund.org/universal-access-reproductive-health-progress-and-challenges.
2. Mazur A, Brindis CD, Decker MJ. Assessing youth-friendly sexual and reproductive health services: a systematic review. BMC Health Serv Res. 2018;18(1):216. doi:10.1186/s12913-018-2982-4.
3. Pan American Health Organization, United Nations Population Fund, and United Nations Children's Fund. Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean; 2017. ISBN: 978-92-75-11976-1.
4. Flores-Valencia ME, Nava-Chapa G, Arenas-Monreal L. [Adolescent pregnancy in Mexico: a public health issue]. Rev Salud Publica Bogota Colomb. 2017;19(3):374–378. doi:10.15446/rsap.v19n3.43903.

5. Küng SA, Saavedra-Avendano B, Vélez EA, et al. Factors associated with support for adolescent access to contraception among Mexican Catholic parents. J Relig Health. 2021;60(3):1600–1612. doi:10.1007/s10943-021-01186-w.
6. Villalobos A, Allen-Leigh B, Salazar-Alberto J, et al. Quality of reproductive healthcare for adolescents: a nationally representative survey of providers in Mexico. PLOS ONE. 2017;12(3):e0173342. doi:10.1371/journal.pone.0173342.
7. Juarez F, Gayet C, Mejia-Pailles G. Factors associated with unmet need for contraception in Mexico: evidence from the National Survey of Demographic Dynamics 2014. BMC Public Health. 2018;18(1):546. doi:10.1186/s12889-018-5439-0.
8. The SIECUS State Profiles. The State of Sex Ed. SIECUS; 2019/2020 [cited 2023 Apr 6]. Available from: https://siecus.org/state-profiles-2019-2020/.
9. Chandra-Mouli V, Gómez Garbero L, Plesons M, et al. Evolution and resistance to sexuality education in Mexico. Glob Health Sci Pract. 2018;6(1):137–149. doi:10.9745/GHSP-D-17-00284.
10. McDonald J, Mojarro O, Sutton P, et al. Adolescent births in the border region: a descriptive analysis based on US Hispanic and Mexican birth certificates. Matern Child Health J. 2015;19(1):128–135. doi:10.1007/s10995-014-1503-2.
11. California Department of Public Health. Adolescent sexual and reproductive health, Fresno County. 2016;2016:2.
12. Pew Research Center. Demographic and Economic Profiles of Hispanics by State and County; 2014 [cited 2022 Apr 12]. Available from: https://www.pewresearch.org/hispanic/states/.
13. Chabot MJ, Kwan K, Guenzburger GV, et al. Adolescent Births in California, 2000–2018. California Department of Public Health Center for Family Health Maternal, Child and Adolescent Health Division, Sacramento, CA; June 2021, p. 28.
14. Guttmacher Institute. Investing in adolescents' sexual and reproductive health in low- and middle-income countries. Fact Sheet; July 9, 2020 [cited 2022 Dec 10]. Available from: https://www.guttmacher.org/fact-sheet/adding-it-up-investing-in-sexual-reproductive-health-adolescents.
15. Torres R. Access barriers to prenatal care in emerging adult Latinas. Hisp Health Care Int Off J Natl Assoc Hisp Nurses. 2016;14(1):10–16. doi:10.1177/1540415316631504.
16. Martinez-Donate AP, Ejebe I, Zhang X, et al. Access to health care among Mexican migrants and immigrants: a comparison across migration phases. J Health Care Poor Underserved. 2017;28(4):1314–1326. doi:10.1353/hpu.2017.0116.
17. Decker MJ, Atyam TV, Zárate CG, et al. Adolescents' perceived barriers to accessing sexual and reproductive health services in California: a cross-sectional survey. BMC Health Serv Res. 2021;21(1):1263. doi:10.1186/s12913-021-07278-3.
18. Schenker MB, Castaneda X, Rodriguez-Lainz A. Migration and health: a research methods handbook. Oakland: University of California Press; 2014.
19. Gómez-Inclán S, Durán-Arenas L, Gómez-Inclán S, et al. El acceso a métodos anticonceptivos en adolescentes de la Ciudad de México. Salud Pública México. 2017;59(3):236–247. doi:10.21149/7891.
20. Brittain AW, Loyola Briceno AC, Pazol K, et al. Youth-friendly family planning services for young people: a systematic review update. Am J Prev Med. 2018;55(5):725–735. doi:10.1016/j.amepre.2018.06.010.
21. Dehlendorf C, Park SY, Emeremni CA, et al. Racial/ethnic disparities in contraceptive use: variation by age and women's reproductive experiences. Am J Obstet Gynecol. 2014;210(6):526.e1–526.e9. doi:10.1016/j.ajog.2014.01.037.
22. de Castro F, Barrientos-Gutierrez T, Braverman-Bronstein A, et al. Adolescent access to information on contraceptives: a mystery client study in Mexico. J Adolesc Health. 2018;62(3):265–272. doi:10.1016/j.jadohealth.2017.08.001.
23. Decker MJ, Pineda N, Gutmann-Gonzalez A, et al. Youth-centered maternity care: a binational qualitative comparison of the experiences and perspectives of Latina adolescents and healthcare providers. BMC Pregnancy Childbirth. 2021;21(1):349. doi:10.1186/s12884-021-03831-4.
24. Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. Med Care. 1981;19(2):127–140. doi:10.1097/00005650-198102000-00001.
25. Saurman E. Improving access: modifying Penchansky and Thomas's theory of access. J Health Serv Res Policy. 2016;21(1):36–39. doi:10.1177/1355819615600001.
26. Maxwell JA. Qualitative research design: an interactive approach; 2023 [cited 2023 Apr 9]. Available from: https://us.sagepub.com/en-us/nam/qualitative-research-design/book234502.
27. Dedoose. Version 8.0.35. Web application for managing, analyzing, and presenting qualitative and mixed method research data. Los Angeles: SocioCultural Research Consultants, LLC; Published online 2018.
28. Dey I. Grounding grounded theory: guidelines for qualitative inquiry; 1999 [cited 2023 Apr 9]. Available from: https://www.abebooks.com/first-edition/Grounding-Grounded-Theory-Guidelines-Qualitative-Inquiry/14136120113/bd.
29. StataCorp. Stata Statistical Software; Published online 2021.
30. ACOG. Comprehensive sexuality education [cited 2022 Apr 13]. Available from: https://www.acog.org/en/clinical/

clinical-guidance/committee-opinion/articles/2016/11/comprehensive-sexuality-education.
31. Estrada F, Suárez-López L, Hubert C, et al. Factors associated with pregnancy desire among adolescent women in five Latin American countries: a multilevel analysis. BJOG Int J Obstet Gynaecol. 2018;125(10):1330–1336. doi:10.1111/1471-0528.15313.
32. Rocca CH, Harper CC, Raine-Bennett TR. Young women's perceptions of the benefits of childbearing: associations with contraceptive use and pregnancy. Perspect Sex Reprod Health. 2013;45(1):23–31. doi:10.1363/4502313.
33. Carvajal DN, Zambrana RE. Challenging stereotypes: a counter-narrative of the contraceptive experiences of low-income Latinas. Health Equity. 2020;4(1):10–16. doi:10.1089/heq.2019.0107.
34. Campero L, Walker D, Rouvier M, et al. First steps toward successful communication about sexual health between adolescents and parents in Mexico. Qual Health Res. 2010;20(8):1142–1154. doi:10.1177/1049732310369915.
35. Guilamo-Ramos V, Dittus P, Jaccard J, et al. The content and process of mother-adolescent communication about sex in Latino families. Soc Work Res. 2006;30(3):169–181. doi:10.1093/swr/30.3.169.
36. Fuentes L, Ingerick M, Jones R, et al. Adolescents' and young adults' reports of barriers to confidential health care and receipt of contraceptive services. J Adolesc Health. 2018;62(1):36–43. doi:10.1016/j.jadohealth.2017.10.011.
37. Carvajal D, Gioia D, Mudafort E, et al. How can primary care physicians best support contraceptive decision making? A qualitative study exploring the perspectives of Baltimore Latinas. Womens Health Issues. 2016;27:158–166. doi:10.1016/j.whi.2016.09.015.
38. Powers ME, Takagishi J, Committee on Adolescence, et al. Care of adolescent parents and their children. Pediatrics. 2021;147(5):e2021050919. doi:10.1542/peds.2021-050919.
39. Kumar N, Brown JD. Access barriers to long-acting reversible contraceptives for adolescents. J Adolesc Health. 2016;59(3):248–253. doi:10.1016/j.jadohealth.2016.03.039.
40. Badal B, Hwang LY, Pollack L, et al. Availability of and interest in long-acting reversible contraception (LARC) and their effect on LARC utilization among Latina adolescents. J Womens Health Care Manag. 2021. doi:10.47275/2692-0948-123.
41. Wallander JL, Fradkin C, Elliott MN, et al. Racial/ethnic disparities in health-related quality of life and health status across pre-, early-, and mid-adolescence: a prospective cohort study. Qual Life Res. 2019;28(7):1761–1771. doi:10.1007/s11136-019-02157-1.
42. Cabana MD, Rand CS, Powe NR, et al. Why don't physicians follow clinical practice guidelines? A framework for improvement. JAMA. 1999;282(15):1458–1465. doi:10.1001/jama.282.15.1458.

Résumé

L'accès des jeunes à des services contraceptifs complets est essentiel pour améliorer la santé sexuelle et reproductive. Néanmoins, dans beaucoup de pays, les jeunes font encore face à des obstacles considérables à l'accès et l'utilisation de la contraception. L'objet de cette étude est de comparer l'expérience de l'accès à la contraception et les perspectives de jeunes femmes d'origine mexicaine enceintes et mères à Guanajuato, Mexique, et dans le comté de Fresno, Californie. Des entretiens approfondis et par groupes d'intérêt ont été menés en espagnol et en anglais avec des jeunes femmes au Mexique (n = 49) et en Californie (n = 25). Les participantes ont aussi complété une brève enquête sociodémographique. À l'aide d'une approche de théorie ancrée modifiée, des données qualitatives ont été codées et analysées thématiquement sur la base de la théorie sur l'accès de Penchansky et Thomas, puis les résultats ont été comparés par lieu géographique. Même si la connaissance d'un prestataire de service était élevée parmi les jeunes dans les deux lieux, l'accès était influencé par la dynamique sociale, culturelle

Resumen

El acceso a servicios integrales de anticoncepción para jóvenes es esencial para mejorar la salud sexual y reproductiva. Sin embargo, en muchos países la juventud aún enfrenta considerables obstáculos para obtener y utilizar métodos anticonceptivos. El propósito de este estudio es comparar las experiencias y perspectivas de jóvenes embarazadas o con hijos, de origen mexicano en Guanajuato, México, y en el condado de Fresno en California. Se realizaron grupos focales y entrevistas a profundidad en español y en inglés entre mujeres jóvenes en México (n = 49) y en California (n = 25). Además, las participantes contestaron una corta encuesta sociodemográfica. Aplicando un enfoque modificado de teoría fundamentada, se codificaron y analizaron temáticamente datos cualitativos, según la *Teoría de Acceso de* Penchansky y Thomas, y se compararon los resultados por lugar. Aunque en ambos lugares las jóvenes estaban bien informadas sobre un prestador de servicios, su acceso era afectado por dinámicas sociales, culturales e

et institutionnelle et l'utilisation de contraceptifs était disparate. Dans les deux sites, les participantes ont décrit les obstacles pour avoir accès à leur méthode préférée. Elles s'inquiétaient de l'opinion de leurs parents et de leurs pairs sur l'utilisation de la contraception (acceptabilité) et sur les effets secondaire perçus, notamment l'infertilité et la douleur (adéquation). Les différences contextuelles comprenaient le manque de choix contraceptif à Guanajuato (disponibilité) et des connaissances incomplètes sur les options dans le comté de Fresno (sensibilisation). La possibilité de demander et de recevoir leur méthode de choix (pouvoir) est apparue comme une dimension importante qui ne faisait pas partie de la théorie initiale. Les jeunes Latino-Américaines vivant au Mexique et aux États-Unis font face à de multiples obstacles pour avoir accès aux options et services contraceptifs dont elles ont besoin. En prenant conscience de ces obstacles et en les réduisant, il est possible de renforcer l'offre de soins contraceptifs et de promouvoir la santé et le pouvoir des jeunes en matière de procréation.

institucionales y el uso de anticonceptivos variaba. En ambos lugares, las participantes describieron los obstáculos para obtener su método preferido. Ellas se preocupaban por las opiniones de sus padres y pares sobre su uso de anticonceptivos (*aceptabilidad),* y por los efectos secundarios percibidos, tales como infertilidad y dolor (*idoneidad*). Ejemplos de diferencias contextuales eran la falta de opciones anticonceptivas en Guanajuato (*disponibilidad*) y el conocimiento incompleto de las opciones en el condado de Fresno (*conciencia*). El poder para solicitar y recibir su método de elección (*agencia*) surgió como una dimensión importante que no formaba parte de la teoría inicial. Las jóvenes latinas que viven en México y en Estados Unidos enfrentan múltiples retos para obtener las opciones y los servicios de anticoncepción que necesitan. Al reconocer y reducir estas barreras, se puede reforzar el ámbito de servicios de anticoncepción y promover la salud reproductiva y la agencia de las personas jóvenes.