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**Original Research Article in *Critical Public Health* – Author Version**

**“It Would Have Control Over Me Instead of Me Having Control”:  
Intrauterine Devices and the Meaning of Reproductive Freedom**

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## **Abstract**

In the past decade enthusiasm for intrauterine devices (IUDs) has rapidly grown in the United States. Messages from healthcare providers, pharmaceutical advertisements, and public health campaigns extol the freedom that women can experience by using a long-term, internal, highly effective contraceptive method. Little research has investigated how young women conceptualize IUDs in terms of freedom and control. We conducted a thematic analysis of in-depth, individual interviews with 37 young Black and Latina women and explored their perspectives on IUDs as promoting and constraining freedom. Participants with favorable views of the IUD (n=13) appreciated that it would allow them to live their day-to-day lives “normally” without thinking about contraception and with minimal side effects. Four current IUD users found the method empowering because they could pursue their goals without fear of unintended pregnancy. In contrast, nearly two-thirds of participants (n=24) had predominantly negative views and focused on temporal and physical features of IUD use. They expressed concern that IUDs would impinge on their personal agency by restricting their bodily autonomy since they would not be able to discontinue use without a healthcare provider; found the idea of a contraceptive method inside their body for years unsettling; and/or desired flexibility over their pregnancy plans. These results highlight a contradiction between IUD promotion discourses and some women’s views about both the method and their approaches to pregnancy. Discursive and clinical practices that encourage the use of long-acting contraceptive methods like IUDs over other methods may unintentionally infringe upon reproductive autonomy.

## **Keywords**

Intrauterine devices (IUDs); contraception; reproductive health; young women; United States

## Introduction

Contraception has been heralded as a great success of the 20<sup>th</sup> century, with the birth control pill even named as one of “seven wonders of the world” by *The Economist* (Centers for Disease Control and Prevention, 1999; Modern wonders: The age of the thing, 1993). For millions of women, contraception has offered increased control over their fertility, the option of non-procreative sexual activity, and access to educational and economic opportunities (May, 2010). Indeed, in a national survey, 60% of U.S. family planning patients reported having greater control over their life as a very important reason for using contraception (Frost and Lindberg, 2013). While contraception has been a liberating force since the introduction of the first birth control pill in 1960, it has also been used to perpetuate stratified reproduction—the systematic devaluation and regulation of the fertility of marginalized populations by those in positions of power (Harris and Wolfe, 2014; Colen, 1995). Women not seen as “fit” reproducers (e.g., women of color, poor women) have been sterilized without their consent, as recently as 2013 in California prisons (Johnson, 2013; Stern, 2005). Furthermore, contraception has been used in proposals to incentivize smaller family size among low-income women receiving government benefits. For example, in 2015 Arkansas legislators introduced a bill that would offer a one-time incentive of \$2,500 for intrauterine device (IUD) placement to unmarried mothers receiving Medicaid (Hammer, 2015). The contraception paradox—that contraception can be both a source of empowerment and agency for women who wish to control their fertility and a source of oppression for women deemed socially undesirable reproducers—signals that contraceptive use in the contemporary U.S. continues to be a complex issue, rife with contradictions.

No contraceptive method better embodies this paradox than the IUD (Takeshita, 2012). The IUD is a highly effective, long-acting method of contraception, placed internally in a user’s uterus by a healthcare provider. Five IUDs are currently available in the U.S., with periods of use from three to ten years approved by the U.S. Food and Drug Administration (FDA). IUD use was virtually non-existent in the U.S. for decades after the fallout from the Dalkon Shield, an IUD used in the 1970s that caused infections, infertility, and, in some cases, death (Tone, 2001; Mosher and Jones, 2010). Since 2002 IUD use has grown fivefold, with 11.6% of contraceptive women using IUDs in 2011-13 (Kavanaugh, Jerman, and Finer, 2015). More broadly, methods of long-acting, reversible contraception (LARC), including IUDs and contraceptive implants, have been increasingly embraced and promoted by healthcare providers as a first-line contraceptive

option for all women, including adolescent and nulliparous women (American College of Obstetricians and Gynecologists, 2009; Ott, Sucato, and Committee on Adolescence, 2014; American College of Obstetricians and Gynecologists, 2012). Under the Affordable Care Act's contraceptive coverage mandate, LARC methods are available without co-payment, removing cost barriers for many women (Health Resources and Services Administration, n.d.). Taken together, these data indicate that the acceptability and accessibility of LARC methods is growing in the U.S.

At the same time, researchers and advocates have expressed concern that the enthusiastic promotion of LARC use may paradoxically undermine reproductive autonomy (Gomez, Fuentes, and Allina, 2014; Gubrium et al., 2016; Sister Song Women of Color Reproductive Justice Collective and National Women's Health Network, 2016). This is of particular concern, since the populations experiencing the highest rates of unintended pregnancy—and thus frequently the targets of interventions to increase contraceptive use—are ostensibly the same ones whose fertility has been historically devalued: women of color, poor women, and, more recently, young women (Finer and Zolna, 2016; Harris and Wolfe, 2014; Sisson, 2012). A growing body of research highlights important individual, interpersonal, provider, and structural influences on contraceptive decision-making. Findings from several studies indicate that key aspects of LARC use may be misaligned with women's key contraceptive preferences, such as long-term placement of a foreign object in one's body or the need to visit a healthcare provider to start and stop use (Hall et al., 2016; Gomez and Clark, 2014; Gomez et al., 2015; Asker et al., 2006; Lessard et al., 2012). Notably, a recent study found that Black and Latina women were more likely than white women to prefer a contraceptive method they could (1) discontinue independent of a healthcare provider; and (2) decide whether and when to use (Jackson et al., 2016). Other research has explicated bias in healthcare provider recommendations for IUD use, finding that providers are more likely to recommend IUD use to low-income Black and Latina women than to low-income white women (Dehlendorf et al., 2010).

In this paper we present an analysis of young Black and Latina women's perspectives on IUDs and put our findings in conversation with the contraception paradox. Our objective is to illustrate the complex processes underscoring decision-making about IUDs and to illuminate ways healthcare providers and public health researchers might more effectively reconcile efforts to increase contraceptive use with respect for reproductive autonomy.

## Methods

Data for this analysis were drawn from a qualitative study of contraceptive decision-making conducted in 2013. Study eligibility criteria included: being between the ages of 18 and 24; identifying as Black, African-American, Latina, or Hispanic; having had vaginal sex in the last three months; and not being pregnant or trying to become pregnant. To recruit participants, we distributed flyers and business cards at various community colleges and agencies and posted ads on Craigslist. Participants (n=38) received an incentive of \$30. The Institutional Review Board of San Francisco State University approved the study protocol.

After providing informed consent, each participant completed a brief survey, assessing sociodemographic characteristics, contraceptive use, and pregnancy intentions. In-depth interviews were conducted using a semi-structured interview guide, which explored participants' contraceptive histories and decision-making processes, pregnancy plans, and cultural and familial values about sexuality and childbearing. During the interview, participants were asked about their opinions about long-term methods of contraception more generally, as well as a series of questions about IUDs. Interviewers asked participants if they had heard of IUDs, and if they had, what they knew about this method, liked and disliked about it, and whether they might use it in the future. After eliciting participants' baseline knowledge of and attitudes toward IUDs, interviewers provided additional information about IUDs and shared models of three FDA-approved IUDs: Paragard, a copper IUD approved for ten years of use; and Mirena and Skyla, hormonal IUDs approved for five and three years of use, respectively. Educational information provided by interviewers included the mechanism, logistics and length of use; descriptions of insertion and removal procedures; and common side effects. Additionally, interviewers answered any questions the participants posed. After the provision of this additional information, interviewers probed for participants' reactions to physically seeing the devices and the new information, and asked if their views on IUDs and expectations about future use had changed. Two authors (AMG and VT) conducted the majority (80%) of the interviews. The mean interview length was 81 minutes (range 46-118 minutes).

Interviews were professionally transcribed verbatim. Research staff verified the accuracy of transcripts by simultaneously listening to interview recordings and reviewing transcripts, which also provided an opportunity for immersion into the data to support the analytic process.

An initial codebook was generated. Deductive codes were derived from the interview guide, while inductive codes were developed through the iterative process of initial interviewer observations, field notes, and in-depth transcript reviews. Five transcripts were initially coded, followed by a revision to the codebook to collapse redundant codes, clarify code definitions and application conventions, and generate additional codes. The first author and a research assistant coded all transcripts using Dedoose, a web-based qualitative analysis tool.

For this analysis, coded data capturing participants' descriptions of what they liked and disliked about IUDs were initially examined. Because educational information about IUDs was provided during the course of the interview, we focus on participants' final views on whether they would use an IUD and favorable and unfavorable characteristics of the method. Across the sample, coded data revealed frequent references to notions of freedom, agency, and control in attitudes toward, expectations about, and experiences of IUD use. A cross-case analytic approach was employed to investigate patterns and establish themes (Miles, Huberman, and Saldaña, 2014). Full transcripts were iteratively reviewed to locate participants' views about IUDs within the context of broader narratives around contraceptive decision-making, informing the establishment and deepening of themes. This analysis includes data from 37 participants. One participant who had never heard of IUDs prior to the interview and had not formulated an opinion about the method was excluded from the analysis. Nineteen participants identified as Black or African-American, 19 identified as Latina or Hispanic, and eight with more than one racial or ethnic group (Table 1). The majority (n=22) had attended college but not graduated, with only seven participants having attained a bachelor's degree. Eleven participants were mothers. The most common current contraceptive methods included condoms (n=14) and oral contraceptives (n=10), with eight participants reporting current use of a LARC method.

## **Results**

The interviews revealed substantive complexity and diversity regarding participants' views about IUDs, with a significant majority (n=24) exhibiting ultimately unfavorable views. Among these participants, there was an overarching concern about IUDs impinging on personal agency, with a focus on perceptions of the method's inflexibility and invasiveness. The remaining 13 participants with largely favorable views expressed appreciation that the IUD would allow them to live their day-to-day lives "normally" without having to think about

contraception and with fewer perceived side effects than alternative methods. Among the five current IUD users, four described favorable views. Participants' views illustrate the persistence of the contraception paradox; for some the IUD was regarded as enhancing reproductive freedom, while for others the lack of user control over the method meant they perceived the IUD as restricting their reproductive autonomy.

*Enhancing agency: The IUD as a symbol of freedom*

Overall, 13 participants perceived the IUD favorably, including four current IUD users. Among the non-users (n=9), IUDs were generally described positively, though many still expressed discomfort with the idea of internal contraception. For many university students and graduates in particular, the duration of IUD use aligned well with educational and career goals. Highly educated participants frequently regarded the IUD as allowing them the freedom to work towards their life objectives without regularly thinking about pregnancy prevention. For example, 22-year-old Maya had recently finished college, did not intend to have children, was using oral contraceptives, and had scheduled IUD insertion. She said,

That's a full solid ten years of my life, like I can grow and develop as a person...I just feel it's a great protection of my investment that I've put in myself, in my education. Not that kids are bad, it's just, right now in my life, in the next ten years of my life, there's not an actual place for them.

Although Maya had made several appointments for both implant and IUD insertion in the past, she cancelled them owing to fears of infection and device migration, and, unsure of where she would be living in the future, concerns about removal. While she lamented the lack of contraceptive options with fewer side effects, she had only recently become sexually active and felt a mounting pressure to avoid pregnancy, particularly since several of her partners had expressed the desire to have children with her. As a whole, Maya's narrative revealed conceptions of IUDs as both promoting and restricting freedom. Over time, her cost-benefit analysis had evolved such that her discomfort with internal contraception had lessened and was eclipsed by her current feeling that a long-term method would offer her the freedom to achieve her educational goals while engaging in pleasurable sex with a secure pregnancy prevention approach.

In addition to long-term effectiveness, most participants appreciated the IUD's convenience, even if they didn't want to use it themselves. Among the group viewing the IUD



positively, its internal placement alleviated the stress of having to regularly think about or see a healthcare provider for contraception. Tina, a 19-year-old college student, noted she might be interested in IUD use because it would allow her the freedom to live her daily life without having to arrange her routine around her method for it to remain effective, as is the case with her current method (oral contraceptives).

If I don't have it with me for whatever reason, then I get home, and I'm so tired, and I just pass out without even remembering, and the next morning, I'm like, oh crap, I didn't take my birth control... So I mean, this [the IUD] is way more convenient, and it'll just sit there.

A few women with favorable views of the IUD were excited by (potential) reduced side effects compared to other methods. Elizabeth, a 21-year-old hormonal IUD user, shared that the IUD assisted her in living a "normal life." She said, "It hasn't affected my skin, so my hormones are in balance. I mean, I live a normal life." Elizabeth also noted that she used condoms with her casual partners "because it's protocol," expecting she would rely on the IUD as her sole method only in a committed relationship. She said:

When I finally get that opportunity to be in a relationship where like, okay, you know we're good now, I know you're not a complete freak. I'm like, we might not be able to use condoms anymore, let's do it because I'm on the five-year-plan.

In this way, she expressed how the IUD offered her flexibility, fitting in with her present circumstances and potential future experiences, such as entering a relationship where she deemed condoms unnecessary.

Despite apprehension before insertion, the current IUD users with favorable views (n=4) believed the method had enhanced their lives, allowing them freedom to work towards their goals without worrying about pregnancy. Natalie, a 24-year-old mother and community college student who aspired to eventually earn her PhD, had a complex life: she grew up poor, was a young mother, and was physically and emotionally abused by her son's father. For years, Natalie was deterred by fear of insertion and all the "bad things" she'd heard about the IUD: "That's not worth it, just to have sex, to get fat, no way." Her hesitation reflected a deep desire to remain in control of her body. Others may regard these side effects as minor, but for women who are multiply marginalized (i.e., poor, Latina, a victim of abuse, and a young, single mother), incurring additional stressors is especially undesirable. Ultimately, Natalie chose the non-hormonal, copper IUD because it allowed her freedom in the form of the ability to alter her

body's functioning in ways she deemed critical without the undesirable side effects she associated with hormonal methods.

*Limiting reproductive autonomy: The IUD in conflict with freedom*

Most of the women interviewed (n=24) largely viewed the IUD unfavorably, including one current and one former IUD user. Most mothers in the sample (n=7) fell into this group. Though many women mentioned the convenience of a method that did not require regular maintenance, this benefit was outweighed by concerns about invasiveness and inflexibility. The fear of having a device implanted in the body was intertwined with the ways women conceptualized their bodily autonomy. Since IUDs typically require medical intervention to discontinue use, many participants felt they would lose some bodily control. For example, Elisa, a 24-year-old graduate student, felt the internal nature of IUDs would reduce her ability to choose when to become pregnant, compared to a method she could discontinue at will, stating, "I feel like it would have control over me instead of me having control." In this way, some felt the long-acting, internal nature of IUDs actually undermined, rather than enhanced, their reproductive autonomy. Elisa added:

I think if I was going to do it, I would have already done it when I was younger...I eventually want to have kids, within like five to six years, I don't want to have something that's gonna last for half of that [time] to prevent me from getting pregnant.

Like other participants, Elisa wanted to delay pregnancy for at least a few years but felt that she wanted to become pregnant "soon"; because she conceived of IUDs as inflexible, they felt incompatible with her pregnancy intentions.

Additionally, concerns about the internal aspect of IUDs extended to the insertion and removal processes for a few women. For 21-year-old Olivia, who wanted to avoid pregnancy until her late 20s, severe discomfort with insertion dissuaded her from IUD use. Olivia described actively avoiding pregnancy by trying to abstain from sex; however, her boyfriend wanted to have a child, and she feared becoming "trapped." When prompted further, Olivia shared that if the insertion procedure were not so invasive, she would likely be interested in an IUD, noting, "It's the getting it that's scary." Likewise, Denise, a 23-year-old copper IUD user, was ambivalent about continued use. Despite having previously become pregnant while using a copper IUD, she was satisfied with the method and appreciated not having to worry about

“accidents or slip-ups.” As time passed, she grew nervous about difficulties with removal after long-term use:

I don't like the fact that it's inside of me, cuz it just scares me that it's been there for four years now. So I'm just trying to think, like okay, how are they gonna get it out now? I mean, I know they say they can just pull it out, but it's been in there for four years now, so is it gonna be that easy, or am I gonna go have to go through some type of surgery to get it removed?

Denise referenced recently seeing commercials advertising lawsuits for women experiencing complications from hormonal IUDs, as well as an aunt whose cervical cancer she attributed to hormonal IUD use. While these influences did not make her doubt the functionality of her copper IUD, they fueled her anxiety about removal and difficulties becoming pregnant in the future. Moreover, until recently, Denise was uninsured. Now that she had health insurance again, she felt she had the freedom to decide about removal.

In contrast to participants with favorable views, many who regarded the IUD negatively were preoccupied with certain temporal features of IUD use. This took a variety of forms. Some referred to the different IUDs as “five-year methods” or “the ten-year plan,” appearing to suggest that the maximum length of use equaled how long they would be expected to use the method. As such, the IUD was seen as inappropriate owing to the presumed time commitment. India, a 22-year-old-university student, illustrated this perspective because she thought that an IUD would only be a good fit for her if she were in a long-term relationship. At the time of the interview, she was in a new relationship and using the Nuvaring. She said,

I don't know what could happen between us...I keep going back to that freedom. I'd rather have the freedom to stop it at any time than rather just keep it, like the implant or the IUD for a long period of time even knowing that I'm not going to be with anybody.

Although proponents frequently emphasize the long-term freedom from pregnancy offered by IUDs, India felt the duration of use would impede her freedom because she would have less autonomy over when she could discontinue use compared with the Nuvaring, which she could remove at will without seeing a healthcare provider. Even when interviewers explained that IUD use could be discontinued at any time before reaching the maximum length of use, participants still conceived of the IUD as fundamentally inflexible. Such interpretations highlight how the concept of reproductive freedom is relative to the individual's context. For India, relational

context was a salient influence on contraceptive decision-making; in the absence of long-term commitment and trust, she saw the IUD as constraining her bodily autonomy.

Another theme at the intersection of temporality and agency involved implicitly questioning the presumed universal desirability of pregnancy planning. For example, 20-year-old Nia explained her decision to discontinue IUD use:

Like, I don't even really care if I was to get pregnant. I feel like if it happens, it happens. I'm of age now...and I feel I'm able to take care of myself now. So if it happens, it happens; if it doesn't, it doesn't, and I don't want to stop Mother Nature is how I felt about the IUD.

While Nia was not actively trying to become pregnant, she was open to the possibility in part because she regarded herself as ready to become a parent and did not want to interfere with “Mother Nature.” Her perspective diverged from the normative ideal that all pregnancies should be planned and illuminated a form of reproductive agency that is largely invisible in public health research and practice because it challenges the binary assumption that pregnancies are either planned or unplanned, intended or unintended, or wanted or unwanted.

Moreover, a few participants questioned if IUD use was appropriate for women with limited control over their lives owing to the precarity of their marginalized communities. For example, Regina, a 24-year-old medical student, described IUDs as being “unreasonable” and “unrealistic” for women in low-income, Black communities. She elaborated,

To plan for five years down the line when...most Black folks in this country are dealing with things day-to-day or week-to-week. That's just the reality of the situation for most Black communities in this country. So to make them, to make folks have to plan that far in advance, it doesn't seem reasonable to me because that doesn't happen in any other aspect of their life.

For Regina, IUDs seemed more suitable for more privileged women, like herself, who had educational and economic opportunities that rendered a long-term approach to planning pregnancy logical. In contrast, she regarded IUD use as potentially undesirable for women without such opportunity structures, explaining that in her Black community, “Most of us don't know where we're gonna be at.” Although the promotion of IUD use frequently focuses on how a long-term method may be advantageous to those who wish to achieve specific educational, occupational, and/or relationship goals before having children, Regina's comments highlighted how uncertainty about one's future is enough reason to *not* use the IUD. Some approaches to the promotion of IUD use can thus reinforce narrow definitions of life planning. Regina asserted

agency by rejecting the idea that pregnancy planning is universally desirable and appropriate. As a number of skeptical participants noted, IUDs work well for women who have certain types of “plans” and the resources to implement them; in the absence of such conditions, the IUD may be seen as restricting rather than creating reproductive freedom.

## **Discussion**

This qualitative analysis revealed two distinct ways that young Black and Latina women made sense of IUDs in the context of their own reproductive autonomy. The capacity to exercise agency with respect to contraceptive method choice was a key consideration, with most expressing the strong desire for flexibility. Although the emphasis on freedom was consistent among participants, the definitions varied. Owing to high efficacy and duration of use, some women perceived the IUD as allowing them the freedom to plan their lives in the near and distant future. For others, the IUD seemed like a hindrance, inhibiting their freedom to choose when they want to become pregnant or to discontinue contraceptive use at will. For already skeptical participants, not being able to see, insert, or remove the IUD themselves made them feel as though the method and/or provider had more control over their reproductive choices than they did.

Despite the large body of interdisciplinary and social science literature elucidating the myriad ways women have sought to manage their fertility and how different groups have been subject to distinct forms of reproductive control, much public health research on unintended pregnancy prevention is driven by an economic model of rational choice (Takeshita, 2012; Martin, 1990; Littlejohn, 2013; Luker, 1978, 1999; López, 2008). This model narrowly defines a match between contraceptive use and pregnancy plans as “rational” and neglects key dimensions of social life, including emotions, relationships, and opportunity structures (Johnson-Hanks et al., 2011). Contraceptive choices not aligned with clear pregnancy plans may be designated as irrational, despite the logical reasoning that women describe in making these choices (Luker, 1978; Geronimus, 2003; Sawhill, 2014). This has resulted in research, interventions, policies, and programs that do not attend to the fraught legacy of contraception in the U.S. and the complexity of reproductive decision-making. At the same time, these models may be applicable to some individuals and reflect differential values about, opportunities for, and approaches to

family planning between more advantaged individuals, including healthcare providers, and those considered at “high-risk” of unintended pregnancy (Stevens, 2015; Mann, 2013).

Our findings highlight a disconnect between the now-dominant discourse promoting the IUD as a symbol of reproductive freedom, flexibility, and agency and some women’s negative appraisals. This disconnect reflects the limitations of the theoretical underpinnings and conventional wisdom informing the prevailing approach to family planning. While some women may privilege the near-term consequences of contraceptive use (e.g., side effects) over longer-term pregnancy prevention goals, others may simply not prioritize or formulate such goals in the first place because of their openness about pregnancy timelines, or other approaches that challenge the traditional pregnancy planning paradigm (Luker, 1978; Borrero et al., 2015; Aiken et al., 2016). For example, as Geronimus (2003) has argued, differential norms around pregnancy intentions and childbearing timing in the U.S. may reflect adaptive strategies in the context of structural inequality and social immobility. A continued emphasis on reduction of unintended pregnancy rates through LARC promotion neglects salient social determinants of health, which indelibly inform the creation of pregnancy intentions (Gubrium et al., 2016). Further, while LARC can offer many women the freedom they desire during young adulthood, such conceptualizations are contingent on the social and structural context of their lives. To promote reproductive health equity, it is essential that public health professionals prioritize improving the social conditions that impact health and well-being, as well as continue to work to ensure that the full spectrum of reproductive care, including access to all contraceptive methods and related services, is accessible and affordable (Gubrium et al., 2016; Gomez, Fuentes, and Allina, 2014).

Perceived issues around removal inhibited the freedom that participants expected from or experienced with IUD use. While the long-acting and “forgettable” nature of LARC has been extolled by healthcare providers and researchers, there has not been a commensurate focus on reversibility in the literature or in programmatic efforts. Studies examining contraceptive preferences indicate the logistics of LARC removal can be a deterrent to use and that women value personal control over contraceptive discontinuation (White et al., 2013; Jackson et al., 2016; Gomez et al., 2015; Gomez and Clark, 2014). Perceptions that IUD removal is difficult may mirror general experiences with healthcare as cumbersome, as well as reflect medical distrust and experiences of racial discrimination in healthcare settings, including family planning settings (Arnett et al., 2016; Thorburn and Bogart, 2005). Further, if providers feel that removal

is occurring “too soon,” women may face resistance in actualizing their desired removal, even with excellent healthcare access (Stevens, 2015; Amico et al., 2016). Lastly, while most participants did not mention their health insurance status in relation to their views on IUDs, the fact that five participants were uninsured at the time of the interview raises questions about how lack of health insurance coverage may impact women’s willingness to get an IUD and ability to get an IUD removed when desired. This is particularly important given current threats to the repeal of the Affordable Care Act and/or its contraceptive coverage mandate, and recent reports of increases in IUD uptake that may be driven by fear of loss of contraceptive and/or insurance coverage (Sonfield, 2017; Rice, 2017).

Strengths of this analysis include leveraging holistic, qualitative contraceptive histories to understand complex decision-making processes. As with other small, purposively derived sample sizes, our findings are not generalizable; future studies should recruit a larger sample of participants from a wider range of racial and ethnic groups, ages, socioeconomic statuses, and geographies. Additionally, IUD use in the U.S. has increased since these data were collected in 2013 (Kavanaugh, Jerman, and Finer, 2015). Women’s familiarity with IUDs has likely grown as well, including insights imparted by friends, family members, and others, presumably informing acceptability of IUDs. At the same time, these results are grounded in the longstanding scholarship on contraception’s paradoxes, which holds relevance across methods and time (Takeshita, 2012; Luker, 1978; López, 2008).

These results underscore the importance of universal and seamless access to the full range of contraceptive methods and services, and highly trained healthcare providers to support women in selecting, using, and discontinuing methods that best suit their needs, preferences, and plans. Family planning programs and clinical approaches relying on rational choice models or centering single method characteristics such as method effectiveness neglect social influences on contraceptive decision-making, non-medical aspects of contraceptive use, and the risk-benefit calculus in which women engage while considering the potential and expected experience of contraceptive use versus longer-term goals of pregnancy prevention (Littlejohn, 2013; Luker, 1978; Downey et al., In Press). In clinical practice recent efforts have focused on advancing a shared decision-making approach to patient-centered contraceptive counseling, recognizing healthcare providers as medical experts and patients as experts on their lives, preferences and needs (Dehlendorf et al., 2016). Such considerations can also be incorporated into public health

programs, which serve the important purpose of removing barriers to IUD access but must also promote reproductive autonomy and health equity by attending to the social determinants of health that underscore and constrain contraceptive and reproductive decision-making (Roberts and Kaplan, 2016).

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**Table 1. Demographic Characteristics**

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Characteristic	N
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Race/ethnicity <sup>1</sup>	
Latina	19
Black	19
Multiracial	8
Relationship status	
Cohabiting or married	5
In a serious relationship	17
In a casual relationship	14
Single	1
Educational attainment	
High school or less	7
Some college or associate degree	22
Bachelor's degree	7
Other	1
Health insurance status <sup>2</sup>	
Uninsured	5
Publicly insured	12
Privately insured	19
Employed	28
Has children	11
Current contraceptive use <sup>3</sup>	
Condoms	14
Oral contraceptives	10
Withdrawal	5
Intrauterine device	5
Implant	3
Contraceptive ring or patch	2
Vasectomy	1
No method	2

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*Notes:* n=37. (1) Participants could select more than one racial or ethnic identity. (2) One participant was missing health insurance information. (3) Some participants reported currently using multiple methods.

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