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More Than a Destination: Contraceptive Decision-making as a Journey

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Abstract

Background

Contraceptive use is widely recognized as a means of reducing adverse health-related outcomes. However, dominant paradigms of contraceptive counseling may rely on a narrow definition of “evidence” (i.e., scientifically accurate but exclusive of individual women’s experiences). Given increased enthusiasm for long-acting, reversible contraceptive methods, such paradigms may reinforce counseling that over-privileges effectiveness, particularly for groups considered at high-risk of unintended pregnancy. This study investigates where and how women’s experiences fit into the definition of evidence these counseling protocols utilize.

Methods

Using a qualitative approach, this analysis draws on semi-structured interviews with 38 young (ages 18-24) Black and Latina women. We employ a qualitative content analysis approach, with coding categories derived directly from the textual data.

Findings

Our analysis suggests that contraceptive decision-making is an iterative, relational, reflective journey. Throughout contraceptive histories, participants described experiences evolving to create a foundation from which decision-making power was drawn. The same contraceptive-related decisions were repeatedly revisited, with knowledge accrued along the way. The cumulative experience of using, assigning meanings to, and developing

values around contraception meant that young women experienced contraceptive decision-making as a dynamic process.

Implications for Practice

This journey creates a rich body of evidence that informs contraceptive decision-making. In order to provide appropriate, acceptable, patient-centered family planning care, providers must engage with evidence grounded in women's expertise on their contraceptive use in addition to medically accurate data on method effectiveness, side effects and contraindications.

Introduction

Contraceptive use is a widely accepted means of reducing adverse health-related outcomes, from teen and unintended pregnancy to sexually transmitted infections (Dworsky & Courtney, 2010; Harper et al., 2013; Secura et al., 2014; Stevens-Simon & McAnarney, 2014). Dominant paradigms of contraceptive counseling promote an evidence-based approach (Harper et al., 2013) and development of “treatment” plans that anticipate behaviors and risks (Files et al., 2011). Contraceptive counseling aimed at increasing use of long-acting reversible contraception (LARC) is described as evidence-based, owing to its use of medically accurate data regarding contraception (Secura, Allsworth, Madden, Mullersman, & Peipert, 2010). LARCs, including intrauterine devices (IUDs) and implants, are highly effective at preventing pregnancy and a popular method among healthcare providers themselves (Stern et al., 2015). The most recent data show that 8.5% of contracepting U.S. women use LARC methods, with the highest rates of use among women aged 25–29 (11.4%) compared with women aged 15–19 (4.5%), aged 20–24 (8.3%), and aged 30–34 (10.3%) (Kavanaugh, Jerman, & Finer, 2015). Among all contracepting women ages 15–44, Latina women use LARCs at a rate of 8.5%, compared with 8.3% for White women and 9.2% for Black women (Kavanaugh, Jerman, & Finer, 2015). Scholars note that overall, LARC usage has increased in the last decade due to the reduction of barriers such as cost, patient unfamiliarity, provider unfamiliarity, and insurance restrictions (Bearak, Finer, Jerman, & Kavanaugh, 2016; Harper et al., 2012; ACOG, 2009). With nearly half (45%) of pregnancies in the United States classified as unintended, LARC promotion in particular is presented as a key solution to this issue and its related costs (Finer & Zolna, 2016). Unintended pregnancy rates are

disproportionately high among young, black, Latina and poor women (Finer & Zolna, 2016). These populations are deemed at “high-risk” for unintended pregnancy and targeted for LARC promotion (Secura et al., 2010). However, when epidemiological data and method effectiveness are the primary evidence, many women’s needs are neglected, resulting in a “one-size-fits-all technological solution” to an issue that is highly personal, contextual, and evolves over time (Foster, 2016). Contraceptive decision-making in particular is often portrayed as only a “woman’s” issue, without acknowledging the role and positionality of male partners (Dehlendorf, 2013). As Cookson (2005) observes, scientific research is just one factor – alongside experience, anecdote, opinion, and political, economic, legal, or ethical constraints – that impacts healthcare decisions.

A rich body of literature around evidence-based medicine highlights the tension between scientific data and patient experiences, raising questions about *whose* evidence is centered and *how* it is valued (Sim, 2016; Greenhalgh, Howick, & Maskrey, 2014; Timmersman & Berg, 2010). As illustrated in Martin’s (2001) classic text *The Woman in the Body*, women express “scientific” knowledge in one reproductive health domain and “personal” knowledge in another, suggesting they actively resist a solely “scientific” view not because they do not understand it, but in part because they find it irrelevant to their experience. In Martin’s study, women who embraced a solely “scientific” view (of menstruation) were left alienated from their bodies’ functions and changes.

Many evidence-based approaches to contraception rely on normative understandings of “correct” and “consistent” usage, with evidence typically conceived of as empirical research (Halpern, Lopez, Grimes, Stockton, & Gallo, 2013; Harper et al., 2013; Stanback, Steiner, Dorflinger, Solo, & Cates, 2015). Increasingly, correct and

consistent usage refers to choosing a highly effective method, continuing use throughout one's sexual history, and using a method precisely as prescribed by a family planning provider. For young women in particular, operating outside the dominant evidence-based paradigm is framed as risky or troubling (Barcelos & Gubrium, 2014; Elliott, 2014; Jaccard & Levitz, 2013; Logan, Holcombe, Manlove, & Ryan, 2007).

Contraceptive decision-making is a highly contextual process: women engage factors such as side effects, personal values, relationship status, and/or preference for types of medication (Arteaga & Gomez, 2016; Dehlendorf et al., 2016; Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013; Manning, Longmore, & Giordano, 2000). With recent emphasis on LARC, method effectiveness may be the primary factor guiding contraceptive counseling. For example, in tiered effectiveness counseling approaches, women are presented information on methods in order of effectiveness. LARCs are presented first, regardless of women's preferences, priorities, and experiences (Harper et al., 2013; Madden et al., 2013). Counseling that privileges this type of evidence or is perceived by the patient as one-sided may result in patients feeling stigmatized, isolated, and reluctant to seek care, undermining a foundational goal of health promotion (Dehlendorf et al., 2016). Particular attention must be paid to the contraceptive preferences of racialized groups considered at "high" risk of unintended pregnancy, such as Black and Latina women (Finer & Zolna, 2016), in light of historic and ongoing structural oppressions related to contraception and other health-related issues (Dehlendorf et al., 2013; Daniels & Schulz, 2006). For example, research indicates that patient mistrust of family planning care and healthcare is deeply tied to historic violence, such as the Tuskegee Syphilis Study, forced sterilization, and promotion of Norplant among poor

women of color (Roberts, 1999; Sacks, 2015). Encouraging use of one method based on the association of a single patient with a particular population's behaviors may replicate patterns of oppression used to devalue women of color's fertility (Roberts, 1999).

"LARC-first" for "high-risk" patients (e.g., young women, women of color) obscures the reality that many women, even with comprehensive counseling and no barriers, will not choose LARCs for a host of reasons that are neglected when method effectiveness is centered rather than patient preferences (Dehlendorf, Fox, Sobel, & Borrero, 2016; Giscombé & Lobel, 2005; Gomez, Fuentes, & Allina, 2014; Gubrium et. al, 2016b).

The present qualitative analysis investigates the following questions regarding evidence and contraceptive decision-making: how do women experience the definition of evidence these counseling protocols uptake; and where and how do women's experiences fit into these paradigms? This study is informed by calls to make contraceptive counseling more patient-centered and for a more holistic, life-course approach to sexual and reproductive health informed this study (Bay-Cheng, Robinson, & Zucker, 2009; Dehlendorf, 2013; Gubrium et al., 2016a; Luke, Clark, & Zulu, 2011).

Methods

This analysis draws on semi-structured, qualitative interview data from 38 young Black and Latina women in the San Francisco Bay Area, collected in 2013. The study's objective was to understand contraceptive decision-making processes and perspectives on IUDs among young women who identified with racial and ethnic groups: (1) considered at high-risk of unintended pregnancy (Finer & Zolna, 2016); and (2) that have historically experienced constraints to reproductive freedom, such as forced sterilization, denial of

maternal and child health programs, or forced adoption (Briggs, 2003; Roberts, 1999). Study eligibility requirements included identifying as female; as Black, African-American, Latina, and/or Hispanic; being between the ages of 18 and 24; having had vaginal sex in the last three months; and not being pregnant or trying to become pregnant. Table 1 provides sample characteristics. Respondents were recruited via flyers at community colleges and organizations, and Craigslist. A total of 192 women were screened via a survey completed online or over the telephone, and 63 met the eligibility criteria, with 38 ultimately participating in the study (Table 1). Recruitment ceased when thematic saturation was achieved. The San Francisco State University Internal Review Board approved the study protocol. Participants provided written informed consent prior to the interview, completed a brief demographic survey, and received an incentive of \$30. Interviews elicited an in-depth history of contraceptive decision-making processes, including initiation and discontinuation, and the context surrounding these decisions. All interviews were conducted in English. Interviewers included the last author (the study's principal investigator, PI) and two masters-level research assistants. To attend to reflexivity, interviewers met regularly to discuss data collection and emerging findings, reflecting on the ways their roles and identities may impact interviews and interpretation of data and completed, shared and discussed field notes. Additionally, the PI regularly reviewed interview recordings and conferred with research assistants regarding the impact of the researchers' values, perspectives and assumption on data collection.

In order to establish rapport, interviewers established common ground and empathy with all participants by asking about career goals, relationships, work experience, and family. The interview guide contained specific questions regarding

perceptions of IUDs and long-acting methods, as well as a detailed narrative history of each participant's contraceptive use, including reasons for choosing and discontinuing methods and salient influences in decision-making, including peers, family, partners and healthcare providers.

Interviews were digitally recorded and professionally transcribed verbatim. Following Apgar's (1996) recommendation, prior to analysis, the first author read all interviews in their entirety and listened to a sample of four corresponding audio recordings order to gain a comprehensive sense of the narratives. The construct of contraceptive decision-making as a journey and related themes emerged through *ex post facto* content analysis. The first author summarized data related to contraceptive decision-making, entered data into a spreadsheet, and further analyzed for deeper understanding of the themes using qualitative content analysis (Hsieh, 2005; Miles, Huberman, & Saldaña, 2014). We utilized a conventional content analysis approach, with coding categories derived directly from the textual data. The first author read coded data repeatedly to achieve immersion and subsequently read transcripts word by word to derive themes. All authors then reached consensus on the conceptual framing of these themes and consulted on an as-needed basis.

Table 1. Demographic Characteristics

Characteristic	N	%
Race/Ethnicity		
Latina	19	50.0
Black	19	50.0
Relationship status		
In a serious relationship	23	60.5
In a casual relationship	14	36.8
Single	1	2.6
Educational attainment		
High school or less	7	18.4
Some college	21	55.3
Bachelor's degree	7	18.4
Other	3	7.9
Employed	29	76.3
Ever experienced an unintended pregnancy	19	50.0
Parenting	13	34.2

Results

Contraceptive decision-making as a journey: Iterative

Our analysis suggests that contraceptive decision-making is a journey, not a destination on a linear path ending in the most effective method. Throughout contraceptive histories, all participants described experiences evolving to create a cumulative base from which decision-making power was drawn. Decisions were iterative: an overwhelming majority

of participants revisited the same decisions, with knowledge accrued along the way. Revisiting a decision was a key part of the process involved in initiating, continuing, discontinuing, or not using particular methods. Nearly all participants described seeking out methods with which they were previously uncomfortable. Frequently, women were not categorically opposed to a given method, but timing and experience underscored their considerations. A 23-year-old Latina woman shared: “Maybe in the future I’ll be more comfortable [with the IUD]. Just like with the pill, I wasn’t comfortable at first, but then I was later on, and I think it’ll be the same with the IUD.”

Pregnancies and childbirth were hallmarks of the journey, creating pivot points to revisit decisions, with half of participants having experienced at least one unintended pregnancy. Women often felt ready to initiate a change in their method or return to a method following a pregnancy and/or childbirth. A 23-year-old Latina woman described:

After I gave birth and after recovery, I got the Mirena. I had to get a checkup at the doctor’s...they recommended the Mirena, and I’m like, “That sounds really nice.” I read the symptoms and all the warning signs, and I’m like, “That sounds scary, but I’m willing to take the chance because I can’t afford another child.”

As this participant highlighted, one part of iteratively navigating a contraceptive decision-making journey was cost-benefit analysis. Cost and benefits changed and accumulated in women’s lives (e.g., based on whether or not they can afford another child) and thus created contexts in which to revisit decisions. Here, the participant felt her sense she could not financially or otherwise provide for another child outweighed fears associated with side effects. Making the decision in the context of childbirth helped her feel ready.

Contraceptive decision-making as a journey: Relational

Contraceptive decisions converged with other decisions and priorities, especially relationship status and commitment. For all participants, relationship status (how women categorized intimate partnerships; e.g. hooking up, serious, cohabiting) and commitment (a sense of how long the relationship will continue at its current level and/or deepen in commitment) intersected with choices across the contraceptive landscape, from condoms to withdrawal to hormonal IUDs. Relationship status and commitment served as part of the available body of information from which women decided on a method at a given time. Nearly all women also interpreted their relationships and contraceptive options as these two converged in terms of cost-benefit analysis: the investment of time, emotions, energy, and/or resources compared with the return. For example, a 23-year-old Black woman reflected on using condoms in a short-term, casual relationship and shifting methods when she sensed the relationship transitioning to something more serious. She affirmed monogamy played a role in her decision to initiate oral contraceptives (OCs), stating: “We always started off with condoms, then...I felt more comfortable with him so we stopped. Like this is my relationship...he was only with me and me only. I felt at the time we don’t need to use condoms.” A 23-year-old Latina woman framed her contraceptive use in terms of evolving comfort in partnerships:

When I first became sexually active we used condoms only, with my first partner or for my first several partners. It wasn’t until I started dating my current partner that I switched over to the pill. I think the switch [happened] because I knew that it was a lot more long-term, and it was just more comfortable for both of us...it definitely made me feel that it was the best choice for me.

Moreover, contraceptive use may end with a relationship, based on an understanding of the degree to which contraception is invasive, inconvenient, unnecessary, and “not worth it.” A relationship can make contraceptive use relevant, and not being in a relationship can render use, as a 24-year-old Black woman termed it, “pointless.” She described discontinuing OC use after a break-up: “I feel like you’re just taking medicine every day; if you’re not having sex, like why do you need to take birth control pills?” Referring to IUDs, she stated, “I don’t feel like I would need it if I’m not in a relationship.” For her, being in a long-term relationship would make LARC more appropriate and appealing: “I would start something like that [a LARC] maybe if I had a partner and that’s something that my partner was okay with.” Without relational motivations, she was doubtful that she would consider a LARC, even though she expected removal to be “not too complicated.”

Contraceptive decision-making as a journey: Reflective

In addition to women’s reflections *on* their iterative experiences with contraception and the intersections with their relationships, a few women also noted how contraceptive decision-making was reflective *of* their values. Contemplation of personal values informed decisions. For a 22-year-old Black woman, the capacity to self-direct contraceptive initiation and termination in the context of relationships was reflective of her values at the time, one being freedom from an unwarranted responsibility. This juxtaposition – freedom versus responsibility – is especially meaningful considering the ways in which contraception (particularly OCs) has been constructed as *creating* freedom for women from or in their relationships (Bailey, 2006; Takeshita, 2012). Here, *not* having an IUD is connected to freedom. She said, “But I like the freedom of being able to stop this, the Nuvaring. I can just pull it out any time I want, but as far as the

IUD, you can't pull that out, you have to go to the doctor to get that removed...when I broke up with the last guy I pulled it [the Nuvaring] out. I didn't have to worry or anything." A 24-year-old Black woman reflected on her personal value of independence, particularly in relation to healthcare providers, in her process:

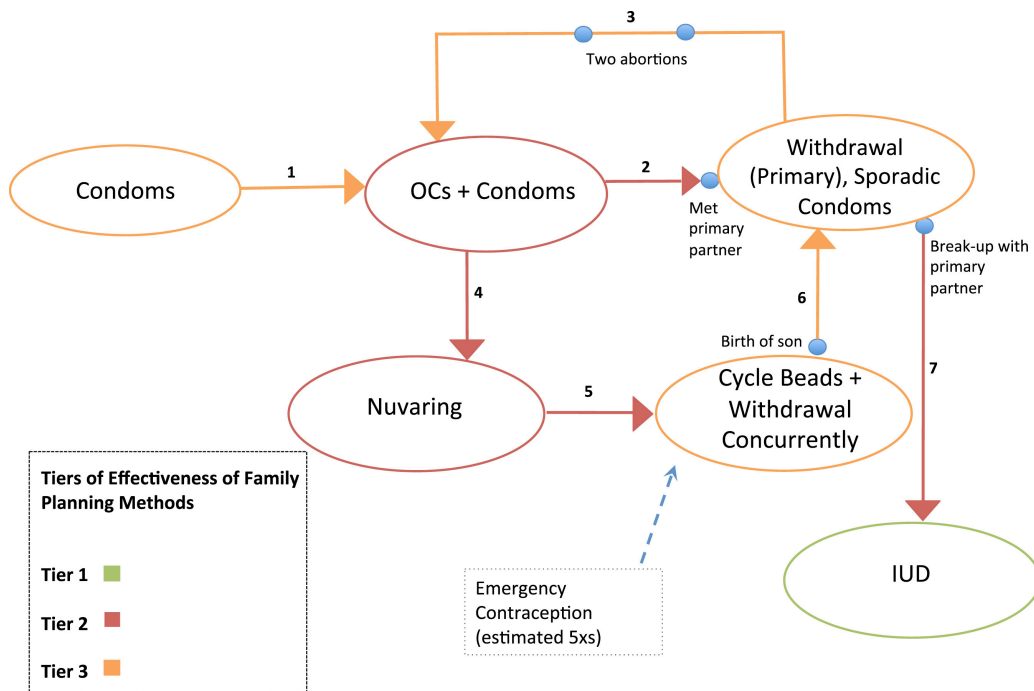
[L]et me make my choice on my own. Don't tell me what I need. I rebel a lot lately...You tell me what to do, and I'm gonna prove you wrong...and that's kind of how I am now. Like I'm gonna do what I'm gonna do regardless, and it's like, don't coach my ideas. So I research whatever I want to do.

This participant did not reject research evidence outright but wanted the research and decision-making process to reflect her personal value of independence. Her experiences with research, her reflections of personal values, and relationships with providers, partners, family, and herself comprised her evidence-base. Additionally, we consider a 23-year-old Black woman who initiated a Paragard at 17, became pregnant a few months later, had an abortion, and immediately initiated another Paragard, post-abortion. She preferred the Paragard primarily owing to its lack of hormones and secondarily for effectiveness, though she never intended to use it for the full FDA-approved period of ten years. Though generally satisfied with the Paragard, she described plans to have it removed in the next six months owing to overwhelming concerns about side effects, impact on fertility, and a strong sense of invasiveness related to timing. The longer an IUD was present, the stronger her sense of invasiveness. What felt acceptable at 17, she reflected, no longer did: "[When I got the IUD,] I was young, I was like 'Oh, 5 years,' it seemed so long ago. I'm kinda nervous to get it out because it's been there for a long time, but I still just want to get it out now." She planned to use condoms immediately

following IUD removal and then seek a different type of (unspecified) birth control. This participant reflected on a set of diverse experiences (personal, familial, clinical, portrayals in the media) as well as her own sense of timing to create an evidence base. Some providers might focus on her desire to discontinue a “top-tier” method or her lack of a plan to initiate another similarly effective method as the health outcome of concern, neglecting her salient apprehension about hormonal contraceptive use and her reflections on four years of Paragard use (including two insertions and an expulsion) that informed her desires.

Contraceptive use mapping to elucidate the journey: A case study

The following case study provides an opportunity for an in-depth illustration of one participant’s journey. A contraceptive use map (Figure 1) visually represents the concept of contraceptive decision-making as an *iterative, relational* and *reflective* journey.



This participant was a 24-year-old, single, Latina mother of one and a community college student with aspirations to attend graduate school. Her map outlines an eight-year

contraception journey. At the upper bound of the age limit for study eligibility, she had one of the longer journeys in the sample, trying many contraceptive methods in adolescence and young adulthood. She began her journey with condom use at age 15 (which her partner initiated and explained to her; 1). Shortly after, she initiated OC use while continuing condom use with this partner (2). After they broke up, she discontinued OCs, stating the side effects were “not worth it.”

With her second and primary partner (her longest relationship and the father of her son), she used withdrawal first and primarily, owing to increased comfort, pleasure, and intimacy. They sporadically used condoms as well. She stated that their increased sexual communication facilitated withdrawal use. As their relationship intensified, she returned to OCs (3), discontinuing use after one month owing to concerns about side effects. She then used Nuvaring (4) for approximately one year, which she preferred over OCs owing to minimal side effects and a shared (with her partner) sense of convenience. When this relationship ended for a time, she discontinued Nuvaring use. When the relationship restarted, she began a different contraceptive method in accordance with her shifting feelings about the relationship (stating, “we were closer” and “we talked more”), using cycle beads and withdrawal concurrently (5). Her provider suggested cycle beads after learning the participant discontinued OCs owing to side effects. She preferred her partner did not withdraw, as this made sex mutually less stressful and more pleasurable. The decision to withdraw or not was agreed upon at each encounter. During this period of cycle bead and withdrawal use, she used emergency contraception approximately five times. She also became pregnant with her son. After his birth, she and her partner were intermittently together, primarily using withdrawal and occasionally condoms (6).

For this participant, a relationship ending was previously the reason for *ceasing* contraceptive use. It was also the reason for *initiating* a method, in this case, the copper IUD (7). After she and her partner broke up, she chose the copper IUD for its non-hormonal nature, owing to longstanding concerns about hormonal contraception's negative impact on her physical appearance and physical, mental, and emotional health, such as weight gain or exacerbation of her depression. Thinking back to her abortions, she reflected, "I feel at peace with it [having had abortions], but if only I had got the IUD sooner...if I could have just got this a long time ago, that would never have happened." At this point in her journey, she expressed a different type of relationship commitment: commitment to a break-up, and by virtue of this, commitment to a relationship with herself. She committed to the *absence* of her relationship from her life, one that made getting an IUD feel more appropriate because her level of commitment to her relationship status was commensurate with her commitment to her method. Relational dynamics created pivot points in decision-making. Revisiting decisions was also key: this participant reflected on the ways in which her contraceptive experiences built on each other, informing one another. She also shared how her own sense of self-discovery is reflected in her contraceptive decision-making journey:

I realize it slowly progressed. Like okay, first birth control pills, then I – and I can't remember the word; in Spanish, they say the *animas*, and you would say you dare to try it. I dared to try the Nuvaring and now the IUD as I got older, so maybe that's what it was. I'm just discovering stuff right now about myself.

Providers may read a case study like this, wherein a patient reflected, "If I had only known, I would have sought an IUD out earlier," and conclude that the best course of

action for this patient would have been to initiate IUD use at the start of the contraceptive journey, and that it is the provider's role to guide such a choice. However, previous contraceptive experiences prepared this young woman to feel confident and capable in choosing an IUD. This perspective asks providers and researchers to unpack their notions of expert or authoritative knowledge – if we accept that women are always negotiating relationships and therefore contraceptive options, then we must accept that they are the experts of their own lives when they discontinue a method.

Discussion

Through the holistic examination of young women's contraceptive decision-making narratives, this analysis highlighted iterative, relational, and reflective contraceptive journeys. Women in the sample endorsed multiple forms of contraception at varying points in their lives. This created a cumulative contraceptive decision-making process that emphasized the journey (the act of moving from one decision to another) rather than the destination (arriving at and maintaining one method above all others in perpetuity). For example, many women returned to condoms or withdrawal after OCs, or to OCs or condoms after LARCs. Additionally, all women endorsed changing methods based on their relationship context. These results highlight the expansive evidence-base women use to make contraceptive decisions and indicate the need for providers to expand the notion of best available evidence-base. While it is critical that patients are provided updated, medically accurate data on method effectiveness, side effects, and contraindications to use, providers must recognize that this is but only one aspect of

evidence from a patient perspective. Improving provider understanding of women's relationship to contraceptive decision-making may improve provider-patient communication, and therefore women's health (Dehlendorf et al., 2013).

Existing literature on contraceptive decision-making indicates providers engage with and create evidence differently than patients (Donnelly, Foster, & Thompson, 2014; Mann, 2013; Stevens, 2015). Several studies on providers' own contraceptive use and/or attitudes suggest that they prioritize individual choice, readiness, and long-term planning (Stern et al., 2015; Stevens, 2015). These factors may reflect differential consumption and valuation of evidence, as well as divergent contraceptive preferences when compared to patients. For example, a qualitative study suggests that providers consume and value evidence based on what is considered most empirically valid, while also being informed by their own relatively higher socioeconomic status (SES) (Stevens, 2015). Providers' positionalities, including professional status and SES, can result in internalization of "normative readiness," or the notion of preparedness for pregnancy and parenting relying on non-medical criteria, including not being a teenager, being married or in a long-term relationship, having sufficient financial means, and having a steady job (i.e., life factors similar to their own) (Stevens, 2015). Rather than relying on normative readiness, we suggest that women's experiences and preferences build over time to create a meaningful body of evidence with which providers must engage in order to ensure the healthiest patient outcomes (Gubrium et al., 2016a). In evidence-based family planning practice, there is an understanding that evidence should take into account patient-level factors, despite the historical obscuring of patient preference and experience owing to the field's reliance on a particular form of scientific knowledge to constitute "evidence" (Hardee,

Wright, & Spicehandler, 2015). Engaging with women's self-identified and self-created evidence as described in this analysis (alongside improved access to information and education around family planning) is a means of authentically implementing evidence-based services.

Given the exploratory nature of this study, several limitations impacted the analysis. For example, analysis was based on self-reported, often retrospective, individual experience. Relational influences were critical to contraceptive journeys; the importance of couple dynamics should be explored in future research. This analysis did not exhaustively explore the relationship between race, class, or other categories and contraceptive decision-making journeys. We did not collect data on income and therefore cannot stratify results based on this factor. Finally, the sample was limited to women having heterosexual sex around the time of interview, making it difficult to generalize the results to sexual and gender minorities.

Implications for Practice

The tension between lived, holistic experiences and clinical norms is not new. With family planning this tension is particularly salient: unintended pregnancy prevention is critical to women's health and wellbeing, yet pregnancy (irrespective of intention) is not a disease. This analysis highlighted the iterative, relational, and reflective nature of decision-making among young women, which may appear "irrational" from a strictly clinical perspective. Jones and colleagues (2016) exemplified this chasm between holistic and discrete in their study of perceptions of agency and pregnancy among women ages 18-30. The authors observed that fatalism is intrinsically linked to how women think

about fertility – preventing pregnancy and becoming pregnant when desired. They wrote, “Given that women are not expected to have complete control over their ability to get pregnant it is, perhaps, unrealistic to expect them to believe that they have complete control over preventing pregnancy.” The expectation that women will have perfect control over preventing pregnancy goes against the lived experience and knowledge that informs contraceptive decision-making. A framework of iterative, relational, and reflective contraceptive decision-making is part of effective, acceptable, and accessible family planning care that allows women to control their fertility, to time their pregnancies, and lead healthy lives (Dixon, Herbert, Loxton, & Lucke, 2014). Providers are partners in this journey, offering tools and information during clinical encounters, but should not see themselves as drivers of decisions. For contraceptive counseling methods to be truly evidence-based, counseling *itself* (and not only the science behind the methods described within) must be grounded in patient experience. At a minimum, providers can ask patients to articulate their histories, experiences, social and intimate relationships, and preferences regarding contraceptive use and revisit these questions whenever possible. (Dehlendorf et al., 2013). Providers might also consider reflecting on their own implicit assumptions and beliefs about contraceptive methods through values clarification exercises (Hart, Fulkerson, & Turner, 2013). Locating contraceptive decision-making within a highly contextual journey can facilitate holistic counseling that recognizes evidence beyond method effectiveness the provision of high-quality, patient-centered care.

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