***Views and experiences of Long-Acting Reversible Contraception amongst Ethnic Minorities in High Income Countries: A Systematic Review of Qualitative Studies***

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# Abstract

**Background:** Ethnic minorities in high income countries have higher rates of unintended pregnancies but are less likely to use highly efficacious Long-Acting Reversible Contraception (LARC). Reasons for this are unclear.

**Aim:** To understand the views and experiences of ethnic minorities within high income countries about LARC.

**Methodology:** Medline, CINAHL, EMBASE and Sociological abstracts were searched systematically to find qualitative articles about views on LARC. Titles and abstracts were screened to select qualitative studies about LARC whose participants were mainly from ethnic minorities in high-income countries. Quality assessment was conducted using the CASP tool. Thematic synthesis was conducted.

**Results:** Seventeen studies (19 articles) met the inclusion criteria, 14 of which were from the USA (227 participants identified as Latina, 222 Black, 15 multiracial, 4 Asian). Two studies included 32 Chinese women in the UK and Australia and one included 20 Aboriginal women in Australia. Factors influencing uptake of LARC included side-effects, convenience, and perceived efficacy of LARC compared to other methods; women’s ideas, concerns and expectations; and external influences (partner, family / friends, health professionals and society). Convenience of LARC, control over reproductive decisions and desire to prevent pregnancy were the main facilitators. Barriers included specific cultural concerns about irregular bleeding, concerns about racial discrimination, and family/friends having negative views on LARC.

**Conclusion:** Ethnic minority women often have additional needs and concerns about LARC, compared to the white majority. Further research is needed to develop and evaluate customised respectful counselling on contraception options for ethnic minority women and their partners.

**Word Count: 249 words**

# Key Messages

**What is already known on this topic**

Despite the effectiveness and relative accessibility of LARC in high income countries, ethnic minorities experience a greater proportion of unintended pregnancies and lower contraceptive use.

**What this study adds**

Key reasons for low LARC usage amongst ethnic minorities include misconceptions, concerns about racial discrimination and negative perceptions expressed by partners, family and friends.

**How this study might affect research, practice or policy**

Our findings suggest that respectful, inclusive counselling could help address concerns. Further research is needed on couples’ counselling for family planning amongst ethnic minorities.

# Introduction

Addressing ethnic health inequalities is an urgent priority for the UK’s National Health Service(1); sexual and reproductive health is no exception. The gap in maternal mortality between Black and White women is widening(2) in the UK and remains wide in the USA(3), although the contexts are different. In the UK, 4% of the population is black(4), whereas in the USA, Black and Hispanic women make up 13.6% and 19.1% of the population respectively(5). They have higher rates of unintended pregnancies than white women(6). These are associated with higher rates of adverse maternal and infant outcomes including maternal depression(7). Short inter-pregnancy intervals (<18 months) are associated with higher infant mortality, even in the USA(8). However, women from all ethnic minority groups in the USA are less likely to use contraception in general, and especially highly or moderately effective methods(9). Long-Acting Reversible Contraception (LARC) methods offer the highest level of protection against pregnancy and are independent of user action, which helps to overcome problems with adherence(10). In the UK, 8.7% of Asian women use LARC, compared to 14.4% of white women and 18.9% of Black women(11). Half of unintended pregnancies occur in women using contraception, therefore higher efficacy forms of contraception could reduce these rates(12) and the associated complications.

Due to their efficacy, LARCs have been widely encouraged by governments and healthcare professionals(13). However, this must be balanced with respect for women’s reproductive autonomy, especially in marginalised groups(14). Historically, policies of forced sterilisation and coercive practices, in countries such as the USA, disproportionately targeted women from ethnic minorities(14, 15).

In this context, it is important to understand patients' preferences, needs, values, and the system that constrains their options, which may explain the low uptake of LARC in ethnic minority women in high-income countries. This systematic review aims to understand the views and experiences regarding the usage of LARC, and to understand the barriers and facilitators towards accessing this form of contraception, amongst ethnic minorities within high income countries.

# Methods

The protocol for this review has been published on the PROSPERO database (CRD42022366178)(16). ENTREQ (ENhancing Transparency in REporting the synthesis of Qualitative research) reporting guidelines were followed(17).

## Search Strategy

Pre-planned searches were conducted in four different electronic databases (Medline, CINAHL, EMBASE and Sociological abstracts), from inception to 20th September 2022 (search strategies are in Supplementary Table 1). These included terms for LARC and qualitative research.

## Screening

The articles identified in the searches were imported into EndNote(18) to eliminate duplicates, then were imported into Rayyan(19). Two reviewers independently screened titles, abstracts and selected full texts against the inclusion criteria (qualitative studies regarding views and experiences of LARC amongst ethnic minorities in high-income countries). We defined “high-income” according to World Bank criteria(20). Disagreements were resolved by discussion with a third reviewer. We excluded articles which did not include a majority of participants from ethnic minority groups, which did not disaggregate results for ethnic minority respondents, and which did not focus on LARC methods.

## Quality Assessment

The Critical Appraisal Skills Programme (CASP) tool(21) was used to systematically assess the quality, trustworthiness and relevance of included papers. Ten percent of the articles were appraised by more than one reviewer, to establish a consensus.

## Data Extraction & Synthesis

All text under ‘results’ was coded according to its meaning and content. Two reviewers read and coded the first 5 papers, to establish a ‘coding framework’, which was then discussed and refined with a third reviewer (Supplementary Table 2). This framework was then applied to code other papers, using the software NVivo(22).

## Data Analysis

We used thematic synthesis(23) to group codes into key ‘descriptive themes’. These were then used to generate further ‘analytical themes’. Although we were specifically looking for barriers and facilitators, the process of deriving subthemes and constructs was inductive.

# Results

## Studies Included

We identified 2996 articles from database searches and a further 19 from citation searching of our selected papers. After screening against the inclusion criteria, a total of 19 articles(24-42) about 17 studies were included (Figure 1), including a total of 559 participants. Studies excluded at the full text stage are listed in Supplementary Table 3.

Fourteen studies (16 articles) were conducted in the USA (of 507 participants, 227 identified as Latina, 222 as Black, 15 multiracial, 4 Asian) (24-27, 29-32, 34-38, 40-42). Two studies focussed on Chinese women in the UK(39) and Australia (32 women)(28) and one on Aboriginal women in Australia (20 participants)(33). Four studies used focus groups(24, 29, 36, 42), twelve used interviews(25-28, 30-33, 35, 37-41) and one used both(34). Several studies also used surveys to collect demographic data. Most studies focused on the views of women using LARC, while one investigated parents’ views on teens, including male and female participants(42).

## Quality Assessment

All studies used appropriate methods to address the research questions (Supplementary Table 4). Only two studies(38, 42) addressed the relationship between the researcher and participants. These studies mention ‘moderator acceptor bias’, which highlights how participants may feel uncomfortable criticising interviewers, if they were known to be associated with an organisation such as a health service. Other studies did not report the influence of the researchers’ perspectives on their interpretation of results. Two studies(24, 42) failed to mention ethical approval. All studies derived clear themes which were consistent with the data provided, producing a meaningful insight into facilitators and barriers.

## Themes/Subthemes

Factors influencing uptake of LARC fell into four categories: Features of LARC methods, non-LARC methods, the woman’s ideas, concerns and expectations, and external influences (Figure 2).

## Perceptions of LARC Methods

### Side Effects

Most studies reported negative perceptions of changes in the menstrual cycle(24, 25, 34, 36, 39, 41), whether this was an increase, decrease, or absence of bleeding (Table 2). Chinese and Latina women liked knowing the timing and duration of their cycles, so they disliked irregular bleeding and “unnatural” changes in their cycle(39, 41). Chinese women valued regular menstruation, as they believed it ensured their body constitution was ‘in balance’(28). They associated amenorrhoea with infertility, weight gain and imbalanced body constitution(28, 39).

Increased or irregular bleeding caused women in several cultures to be restricted in their activities. For example, Somali culture prevents women from having sex during menstruation (table 2); women feared their husband leaving them to fulfil their sexual desires(24).

Although uterine perforation is very rare, many studies reported that participants were concerned that the IUD or implant could migrate and embed into other parts of the body(24, 29, 36, 40, 41).

Some black and Latina women in the USA felt that LARC caused fewer side effects compared to other methods, namely the oral contraceptive pill (OCP)(29, 31). Aboriginal women in Australia, where the implant was the most common contraceptive used, often perceived lighter periods as positive(33).

### Concerns with the LARC insertion/removal procedure

Many participants disliked the invasiveness of LARC insertion(27, 31, 34, 41, 42). Some feared needles and anaesthesia(34), whilst others were concerned about the perceived difficulty of removing the device(31). Somalian participants shared concerns about having to undress and reveal themselves(24). Some participants suggested that the implant would be a suitable alternative to the IUD, as it was not seen as so invasive(41). Some Chinese participants, who only wanted to seek professional help when absolutely medically necessary,(28) viewed LARC insertion/removal procedures as unwarranted and excessive, especially when other forms of contraception were readily available (Table 2). USA studies highlighted concerns about costs of the procedure. Some were told that they would be charged to have the device removed(37, 43).

### Convenience

African American and Latina women using LARC were pleased that they did not need to make regular appointments to obtain their contraception. This was often highlighted by women with low incomes, as they did not need to take time off work to attend these appointments(38). Women were satisfied that LARC devices are not dependent on the user remembering to take a pill every day(26, 38). This was particularly useful for new mothers, who found it harder to remember(38).

### Efficacy

Although participants did not mention effectiveness of LARC compared to non-LARC methods, some Latina women felt that an internal device was more effective(41). In contrast, many women did not find comfort that a device could last so long;(27, 34) others were concerned that it could potentially impact future fertility,(29, 34, 40) whilst one participant could not accept the idea that a device in their arm could effectively prevent pregnancy(41). In several studies, women cited instances where someone fell pregnant whilst using LARC(29, 34, 36, 41). Many perceived LARC to be ineffective or lacked knowledge about LARC effectiveness compared to other contraceptive methods(27, 40).

## Non-LARC Methods

Some women preferred using non-LARCs for reasons that were not exclusively linked to preventing an unintended pregnancy(34). Women may use contraception for acne control, they may rarely have penetrative sex or may want a method that is more inclusive of their male partner(14). Many preferred condoms because they also provide protection from sexually transmitted infections(26, 28, 34, 42) (table 2), can be used spontaneously and are more accessible than LARC methods, which require assistance from healthcare professionals(26). Despite condoms having higher failure rates than LARC, some users saw condoms as effective, as they reported not getting pregnant whilst using this method(26). Some did not feel the need to switch methods, if the lower efficacy methods worked well for them(26).

## Women’s Ideas/Concerns/Expectations

### Reproductive Freedom

Many studies, particularly in adolescents(34, 35, 40), reported that LARC methods are seen as empowering, as women were able to make reproductive decisions themselves and were in control of their own body(28, 30, 31, 34, 35, 40). Unlike condoms, which require partner cooperation, women were able to ensure pregnancy prevention through their own choices. The longevity of the LARC devices enabled women to focus on their careers and future, without having to worry about potential pregnancies(31, 34, 36).

Others believed that IUDs would reduce their choice regarding when to become pregnant. Women mentioned having a loss of bodily autonomy, as they believed they could not discontinue the method at will(31, 36, 41). One participant described LARC as ‘unreasonable’, particularly for low-income women of colour. She highlighted how black people must plan their lives day by day and suggested that LARC methods were suitable for more privileged women, who have a more stable life and are able to plan further in advance(31).

### Desire to be “natural”

Many studies reported that women wanted to keep their bodies “natural”(26, 36, 41, 42) and were concerned how long-term hormonal usage could potentially affect their body negatively long-term(26, 28, 34, 41), and affect future fertility(29, 34, 40). Some women were opposed to immediate post-partum LARC insertion(36). Many women and men did not like the idea of having a ‘foreign body’(27, 28, 40, 41) inside them (table 2).

### Concerns about racial discrimination

In the USA, several studies reported that some African American and Latino women were suspicious about the underlying agenda behind encouraging the uptake of LARC, as they believed it was a form of ‘population control’, to prevent their communities from growing(30, 34, 42) (table 2). Mothers and grandmothers, particularly from the black community, would often pass on their fears of discrimination to their adolescent daughters and highlight their scepticism regarding LARC(34). There was a deep resistance towards the implant specifically, as some black and Hispanic women believed they had been used as *“guinea pigs*”(34) in the past. In a US study of urban adolescents, girls feared that if they did choose to have an implant inserted, their peers would accuse them *“of being a victim for letting doctors cut her up”* (34). Participants mentioned being wary of clinicians and drug manufactures, as they believed they could have an ulterior motive, and would simply benefit themselves by prescribing LARC and performing procedures(34).

### Misconceptions

Many women lacked knowledge about LARC, with one of the most prevalent misconceptions being that women would become sterile with LARC use (table 2). Many believed that the device could not be removed earlier than intended(31, 36, 41). Various participants claimed that the IUD could kill them, cause cancer and abortions(41) or even choke the foetus,(29) if pregnancy did occur.

### Fertility Intentions

Desire to have more children is a barrier to any contraception. For example, in Somalian culture there is a great expectation for couples to have as many children as possible (table 2) as *‘children are seen as wealth’*(24). Conversely, some choose not to have children during a certain time period, so they can focus on other aspects of their life,(31, 34, 36) whilst other women choose to end childbearing completely. Some Latina women who no longer wanted to bear children stated they were committed to getting a sterilisation as it was “*100% effective”*(41).

## External Influences

### Partner/Relationships

Their partner’s attitude influences contraceptive decisions made by women (table 2), and some women prefer to discuss with their partner before making a decision(30). Supportive partners encouraged contraceptive use, with some advocating for specific methods like LARC, as they were concerned their partner would not remember to take their pills or attend their appointments(35). However, several partners discouraged contraceptive use. Most expressed concerns with potential side effects(35), some were uncomfortable with the idea of a foreign body(40), whilst others were against any contraceptive, as they wanted to have more children(24, 31, 34, 35).

A study of young Latina, Black and Asian women in the US reported that some had their LARC devices removed when they were not sexually active. Conversely, others switched to LARC when they were in a steady relationship and engaging in intercourse frequently(26). Whilst many women chose to involve their partners in their contraceptive making decisions, a few did not think this was necessary(28, 34, 35, 40). These women strongly valued their autonomy, and their partner’s opinions would not seem to influence their choices.

### Family / Friends

Many studies reported that women obtained LARC-related information from family or friends, who seemed to deeply influence their perceptions and choices. This can facilitate LARC uptake, when LARC methods are perceived favourably. For example, many Chinese participants chose the IUD as friends had previously used it and perceived it to have fewer side-effects than alternative methods(39).

However, many participants were persuaded by concerns raised by family/friends, who were either sharing their own negative experiences, or expressing their general dislike of LARC (table 2)(25, 29, 34, 36, 40). Many women seemed to put more weight on the opinions of family/friends than other sources, such as healthcare professionals(29, 39). We only found one quote(36) where a woman said she would actively seek advice both from female family/friends and from her pharmacist (and in this case, the pharmacist was also a family friend).

### Healthcare professionals/services

Clinicians who provided accurate information, whilst caring for the patient’s needs and desires, were seen as respected and trustworthy individuals(36, 38). Women praised counselling they received from healthcare professionals who did not pressure them, and conversely they did not appreciate feeling “pushed” into accepting LARC, particularly if immediate postpartum contraception was discussed during labour(30, 37, 38) (table 2).

Participants expected to receive comprehensive information, highlighting all the advantages/disadvantages for the various contraceptive options available. Hearing about possible side-effects did not necessarily deter women but helped them to balance the negatives against the positives(32). In the case of immediate postpartum contraception, they preferred to discuss the options during the antenatal clinic(38). However, some women did not receive all the necessary information, particularly when it involved the insertion/removal process of LARC devices. Many participants were concerned that the device could not be removed earlier than intended(27, 31, 36, 41). Furthermore, some participants were provided with inaccurate information by healthcare professionals - one was told that the IUD could lead to yeast infections,(29) whilst another was incorrectly informed she was not eligible for an IUD,(40) as she was underage.

Cost and lack of health insurance(29, 40, 41) was an issue in the USA. Some mentioned that contraception was not included in their insurance coverage, so they were restricted to using lower efficacy methods(29), such as condoms, as they could not afford LARC. Women were also told by healthcare providers that they would be charged for removal of the device(41).

Several Chinese women could not understand the information given by healthcare providers, due to language barriers(39). Many wished they had more knowledge regarding the side effects and effects on menstruation, as these issues were important to them; many also referred to social media to obtain knowledge about contraception(28).

### Society

Many women were influenced by negative online accounts of other people’s LARC experiences(36). Women who had positive experiences with LARC did not often share their experiences with others, whether online or in person(28, 34).

A few black and hispanic women, especially adolescents, reported or feared sexual harassment(34) because the implant was potentially visible, which would indicate that she was sexually active, and so could be perceived as promiscuous and possibly unfaithful to her partner(34). These negative perceptions/experiences could ultimately deter other women from using these devices. Conversely, the Aboriginal community in Australia were not ashamed to have an implant, nor did they report any unwanted attention(33).

# Importance of Inclusive, Respectful Counselling

Concerns about side effects and removal of the device were an important barrier, whether as a result of misconceptions(24, 29, 34, 36, 40, 41), negative experiences with LARC(38, 41), or language barriers(39) in understanding the side effects. If women are counselled correctly, they are better able to tolerate side effects(44). Conversely, women who were not counselled about side-effects or felt pressured with insufficient information were likely to discontinue the LARC and may even become more reluctant to engage with health services(30).

Different women have different needs and desires regarding their contraceptive choices, therefore they should not feel pressured to use a certain method(38). It is crucial that healthcare professionals listen to women they are counselling, especially those from ethnic minorities whose first language is different, and address their concerns, whether using interpreters or providing resources in their own language.

Furthermore, ethnic minority women greatly valued their autonomy and freedom to make their own reproductive decisions, whether using methods such as condoms, which could be used spontaneously, or LARC methods such as the IUD to keep ‘in control of their own bodies’(28, 34, 38, 40). However, some studies in the USA reported distrust and suspicions of racial discrimination stemming from the previous history of abuse that low income/women of colour have faced in a white medical system(34, 42). Ethnic minority women in the USA appeared to value the opinion and experiences of family/friends and other members of their community, which were often negative, over the views of healthcare professionals(34, 42). Therefore, it is also important to provide accurate information and counselling to male partners and community members(24, 28).

# Discussion

## Summary of findings, in comparison to the literature

The major factors influencing ethnic minority women’s decisions on contraception were their perceptions of the advantages and disadvantages of LARC and other methods; their own ideas, concerns and expectations; and external influences, from their partner, family and community. There was a wide range of ethnic minority experiences with varying histories across different countries.

Although only one included study specifically on LARC was based in the UK,(39) focussing on Chinese immigrants, other studies have explored the views of Pakistani women on contraception in general,(45, 46) which also reported fear of side-effects and the influence of family. Pakistani women were receptive to antenatal discussions about postnatal contraception,(45) so this should be provided more widely. Other qualitative studies (47, 48) have investigated ethnic minority views on contraception in general. Some reported cessation of hormonal contraceptives due to side effects(48), pressures from male partners who wanted more children(48), and preference for receiving and trusting information from family/friends rather than healthcare professionals(47). Of particular concern, one study in the USA reported that health professionals were providing incorrect information about the IUD in order to discourage black women from using it(49).

Studies in the general population have also found similar barriers to the uptake of LARCs such as irregular bleeding, misconceptions, and not wanting a foreign object to be inserted(50-52). Our review shows that women from ethnic minority backgrounds have additional concerns about irregular bleeding from LARC because of specific cultural beliefs and restrictions being imposed on their activities. Another study reports that Muslim Pakistani women felt unable to pray whilst bleeding(45).

However, the major difference in ethnic minorities, especially in the USA, is their concern about racial discrimination. There have been documented forced sterilisation programs in the USA, Canada and China(15). Although these have now been outlawed across most High-Income Countries, there are still cases of reproductive coercion. For example, in the 1990s, the US government marketed Norplant to poor women of colour by incentivising its use with welfare benefits and covering its insertion(14), but not its removal, under Medicaid. As recently as 2020, there have been reports of non-consensual hysterectomies being performed on detained immigrant women in Georgia (USA)(15). Over 20% of African Americans believe the government's family planning policies are intended to control the number of black people(53). As a result, more ethnic minority women feel safer gaining advice from people who are similar to them (such as family and friends), rather than health professionals in a system which is guilty of historical abuses. However, many ethnic minority women still appreciate counselling from healthcare professionals, particularly when they do not feel pressured to select a certain contraceptive(38).

In contrast, most Caucasian women listen to the opinions of healthcare professionals when discussing LARCs(54). Interestingly, fear of coercion was rarely mentioned by studies of Chinese women, although IUDs were previously mandatory after birth in China. Maybe this is because they were in a different country and realised that they were free to choose(39). Many Chinese migrant women viewed the IUD positively because they were familiar with it(28, 39), consistent with other studies from mainland China(55).

## Strengths and limitations

Strengths of this review include a comprehensive, systematic search and screening. The focus on qualitative studies allowed a deeper understanding of the factors important to ethnic minorities in high income countries. If the search had been extended to more databases, including the grey literature, more studies may have been identified. A limitation of most studies was that they did not consider the relationship between the interviewer and interviewee, and a mismatch in ethnicity may limit the richness of data. By not critically examining their own role, researchers did not consider the potential bias and influence they could have had over the participants and their interpretation of results. Furthermore, most of the studies were conducted in the US and therefore certain issues were specifically related to the structure and history of the US healthcare system.

## Implications for policy and practice

Paradoxically, the cost of LARC disproportionately affects ethnic minority women in the USA, as they are more likely to have a low income and to lack health insurance(56). The 2012 Affordable Care Act (ACA)(57) required private health insurance plans to cover all contraceptive methods without cost sharing. However this did not help women without any insurance(57). The healthcare system should offer all contraceptive options free of charge, to maximise choice for all women in their reproductive decision making.

All studies in this review mentioned side effects as a factor influencing LARC usage, therefore respectful, inclusive counselling is required to prepare women and to dispel any misconceptions which they or their partners may have. Contraceptive counselling must provide comprehensive, accurate information about the full range of contraceptive options and their potential side-effects, so that women are fully informed to make a decision best suited for them(14). As women from ethnic minorities particularly value their partners’ opinions, it is especially important to consider providing couples’ counselling, not only individual counselling for the woman alone. Many studies have found that interventions involving couples are more effective than those focussed on individual women(58). Couples’ counselling improved uptake of contraception in Egypt(59) and Pakistan(60).

## Priorities for future research

In the UK, further research is needed on the views of large ethnic minorities, particularly Asian groups, who have much lower uptake of LARC compared to White and Black women(11). It would be interesting to understand their opinions on issues such as how to tackle poor partner cooperation regarding contraception, and how they would feel about receiving counselling from health professionals who are also members of their community, or at least are themselves from ethnic minority groups. This would help to co-develop interventions such as couples’ counselling(61), to assist women and their partners to find contraceptive methods that align with their needs and preferences.

Couples’ counselling should be trialled more widely, including during the antenatal period to discuss immediate post-partum family planning(61). Outcome measures should include not only uptake of different contraceptive methods, but also person-centred metrics such as contraceptive access, autonomy, and satisfaction.

# Conclusion

Inclusive, respectful counselling and improved access are required to improve LARC usage amongst ethnic minorities. Counselling should include male partners and other influential family and community members. Further research is needed to develop and evaluate customised counselling on contraception options, including LARC, for couples from ethnic minorities, whose needs and concerns may differ from the white majority population.

# Footnotes

## Ethics statement

Not applicable. No ethical approval required.

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## Contributors

SA is the guarantor of this paper and responsible for the overall content. The study was conceived and planned by MLW and SA. Under the guidance and instruction of MLW, SA and AMD conceptualised and conducted the initial literature search, and jointly screened the search results. SA conducted the data extraction and thematic analysis of findings from 15 papers, with supervision and input from MLW. MC screened and conducted data extraction and thematic analysis of 4 additional references, under the supervision of MW. SA wrote the original draft, and all authors reviewed and revised the draft. MC, SA and MW edited the paper to incorporate the peer reviewers’ feedback. All authors read and approved the final version.

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## Competing Interests

No competing interests.

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## Table 1: Characteristics of included studies

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Author & Date of Publication** | **Location** | **Method of Recruitment** | **Ethnic Minority of Participants in the study** | **Type of Participant** | **Relevant No. of Participants** | **Types of Contraception Mentioned in the Study** | **Data Collection Method** | **Type of Analysis** |
| **Agbemenu et al**  **[2017] (24)** | Rochester, New York, United States of America | Somali Bantu community organisation & through word of mouth | Somali Bantu Women | Women entering country under refugee/asylum status (aged 18+) | 30 | Contraception (in general)/ Does mention Injection & IUD specifically | Focus Groups | Content Analysis |
| **Amico et al [2016] (25)** | Bronx, NY,  USA | 2 primary care clinics  Followed up patients with coded consultations of IUD from Jan 2014 - Aug 2014 | 9 Hispanic  4 Black  1 Multiracial  1 White | 18-35 years old | 16 | IUD - participants had considered early elective IUD removal | Semi-structured telephone interviews | Thematic analysis |
| **Berglas et al**  **[2021](26)** | San Francisco Bay Area, California | Youth-Serving Family planning clinics | Predominantly Latino & African American | Women who recently accessed emergency contraception (aged 15-25) | 20 | IUD/Implant/  Condoms/ OCP/ Emergency Contraceptive Pill | In-Depth Interviews | Thematic Analysis |
| **Coates et al [2018](27)** | Southern United States of America | Adolescent Medicine Clinic in an Urban Academic Medical Centre | All participants were African American except one | Sexually active girls who were not currently using LARC (aged 14-21) | 14 | Implant/IUD & OCP/  Injection | Semi-structured Interviews | Grounded Theory Analysis |
| **Dolan et al [2021] (28)** | Australia | Recruited from University campus/University health clinic/ Family planning clinics/Chinese Community Service Centre/ Waiting room from a non-profit family planning clinic/Online from Social Networking Sites (Oursteps & WeChat) | Migrant Chinese Women | Women who self-identified as ethnically Chinese/Living in Australia for no more than 10 years (aged 18-45) | 22 | IUD/OCP/ Condoms | Semi-Structured interviews (16 face-face & 6 phone interviews) | Thematic Analysis |
| **Gilliam et al [2004] (29)** | Chicago, United States of America | Outpatient Gynaecology Clinic & Community Site (Providing day care for children of low-income women) | Latino women (Mainly Mexican American) | Sexually active young Latino women (aged 18-26) | 40 | IUD/ Condoms/ OCP/ Injection | Focus groups | Content Analysis |
| **Gomez et al [2017](30) and [2018],(31) Downey et al [2017](32)** | San Francisco Bay area, California, United States of America | Craigslist and flyers at community colleges and social service agencies. | 19 Latina  20 Black  8 Multiracial | Black/African American/Latina/  Hispanic Women who have had vaginal sex in the last 3 months and not being/trying to become pregnant (aged 18-24) | 37 | IUD | In-Depth semi-structured individual interviews | Thematic Analysis, qualitative content analysis |
| **Griffiths et al [2016] (33)** | Australia | Primary care clinics in three remote Aboriginal communities | Australian Aboriginal Women | Aboriginal women (aged 16+) who presented to any of the three clinics and community yarning events. | 20 | IUD/Implant | Individual semi-structured interviews | Thematic Analysis |
| **Kuiper et al [1997] (34)** | San Francisco, United States of America | San Francisco General Hospital's Teen Family planning clinic | Hispanic/Black/Asian & Non-Hispanic White women | Sexually active clinic clients (women) who had received contraceptive counselling & were using pill/condoms/implant/injectable | 33 | Implant mainly/ Injection/  Condoms/  OCP | Focus groups / In-depth interview / Written questionnaire | Content Analysis |
| **Lewis et al [2012] (35)** | Chicago, United States of America | Referral from medical staff/social workers/community-based programmes/schools in Chicago | African American Women | Primiparous Chicago women < 13 weeks postpartum (aged 14-18) | 40 | IUD/OCP/  Injection/  Condoms | In-depth interviews & surveyed at 6 & 12 months | Thematic Analysis |
| **Livingood et al [2022] (36)** | United States of America (South-eastern US City) | Local community non-profit organisation (Helping women at an urban safety-net hospital) | Primarily African American | Women who receiving women's clinical services in the urban core (aged 18-35) | 44 | Implant & IUD / Does mention the OCP | Focus groups | Content Analysis |
| **Mann et al [2019](37)** | South Carolina, USA | Clinics, social service agencies, and community-based organisations.  Immediate postpartum LARC insertion. Insured by Medicaid. Given birth in the last 12 months | 18 Black  5 White  2 Biracial | Women aged 18–35, who  gave birth within 2 years of the interview in South Carolina while insured by Medicaid and received contraceptive  counselling about immediate postpartum LARC during their pregnancies. | 25 | LARCs; IUD and implant | Semi-structured individual face-to-face interviews | Not specified |
| **Sznajder et al [2020] (38)** | United States of America | Women who received immediate postpartum LARC from a medical centre & hospital | Latino/Black/  White/Other | Postpartum women | 13 | Postpartum LARC (Implant/IUD) | Semi-structured Interviews | Content Analysis |
| **Verran et al [2014] (39)** | West Midlands, United Kingdom | Specialist baby clinic for asylum seekers & through snowball sampling | Chinese Women | Asylum seekers (women) originally from mainland China, Mandarin speaking & with experience of childbearing | 10 | IUD/Implant/ Condoms | Semi-Structured Interviews (interpreter-facilitated cross-language interviews) | Thematic Analysis |
| **Weston et al [2012] (40)** | Chicago, United States of America | Referral from physicians/Social workers/labour & delivery nurses/housing & community-based programs/schools | African American Adolescents | Primiparous Women > 9 weeks postpartum, living in Chicago (aged 14-18 at childbirth) | 20 | IUD | Interviews | Grounded theory approach to content analysis |
| **White et al [2013] (41)** | El Paso, Texas, United States of America | Eligible women who had provided written consent to be contacted in the future, from previous prospective study | Latino women (Mexican Heritage) | Women who had two or more children, reported in last study they did not want more children, wanted sterilisation, not using permanent contraception methods (age 21+) | 120 | IUD/Implant/  Sterilisation | Semi- structured Interviews | Content Analysis |
| **White et al [2018] (42)** | Delaware, United States of America | Recruited via social networks/affinity resource groups of a hospital/workforce development program | Latino/Black/  White | Community researchers who were parents of teens (youth aged 9-20) | 23 | IUD/Implant | Focus groups | Thematic Analysis |

## Table 2: Themes and illustrative quotes

|  |  |  |
| --- | --- | --- |
| **Theme & Subtheme** | **Participant Quotes, illustrating Facilitator (F) or Barrier (B) for LARC** | |
| Features of LARC Methods  – Perception and consequences of **Side Effects** | *“Because bleeding a little or a lot … it’s not normal, because I am very … regular on my period, it comes this day and stops that day, and I know my periods and [if] it’s a different colour or something, I know my system. And, well, to get familiar with another method … it would scare me. It’s better that I stay on the same one that I [have used] up until now.”* (Latina woman, aged 29, 2 children)(41) | **B** |
| As one women predicted the long-term, personal risk of excessive bleeding, *“[your] husband can’t enjoy you as much as he could, and he goes outsides and finds someone else.”* (Somalian Bantu Woman)(24)  Most Somalians are Muslims. It is not permissible for a couple to engage in intercourse whilst the woman is bleeding due to cultural and religious reasons. | **B** |
| *“As a Chinese woman, having monthly menstrual bleeding cycle is a sign of your fertility. If you suddenly don’t have any periods, wouldn’t it feel like you are having menopause…if I tell my mother that I stopped having periods after taking the pill, she would think that I am having menopause and I can’t have any child in the future…she would have that sort of concerns and she would say, you have lost an important feature of womanhood”* (Chinese Woman, married, aged 18–30, no children)(28) | **B** |
| *“I always feel that every medicine is part poison, that is why I feel they [contraceptive pills] might, if you take them for long term, might have some impact on some body organs… I believe that and I just have that sort of fear, I just oppose taking pills”* (Chinese Woman, Married, aged 30–45, one child)(28) | **B** |
| *“It hasn’t affected my skin, so my hormones are in balance. I mean, I live a normal life”.* (Woman, aged 21, hormonal IUD user)(31) | **F** |
| Features of LARC Methods  – **Concerns with**  **procedure itself** | *“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?”* (Woman, aged 23, IUD user)(31) | **B** |
| *“Well, for me it’s more comfortable that they put something in my arm than in my uterus.”* (Latina Woman) (41) | **F** |
| Features of LARC Methods - **Convenience** | *“If I don’t have it [OCP] 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.”* (College student, aged 19) (31) | **F** |
| Features of LARC methods  - **Efficacy** | *“I see it [implant] as effective … because you have it inside your body, and in a place where you can see and feel it.”* (Latina Woman, aged 26, 2 children)(41) | **F** |
| *“‘Because, I used it [IUD] and got pregnant. And it didn’t move or anything, it was … in its place where it should have been … And there were two of us that got pregnant that way, my sister and me.”* (Latina woman, aged 36, 3 children)(41) | **B** |
| **Non-LARC Methods** | *“‘To me, it is not only about the condom being able to prevent unplanned pregnancy, it is also about it being able to prevent STIs. Although I am willing to believe that my partner is clean, but I think, to me, it is very important [preventing STIs]”* (Chinese Participant 1, not married, aged 18–30, no children)(28) | **B** |
| Woman’s Ideas/ Concerns/ Expectations - **Reproductive Freedom** | *“Things like this, women should make their own decisions... With IUDs, I am the one who is taking control, after having the IUD I feel this way, see, with condoms, in fact the control power is with the other half, see, am I right, you can’t do much if they don’t use condoms”* (Married Chinese woman, 30-45, one child)(28) | **F** |
| *“I feel like it would have control over me instead of me having control”* (Woman, aged 24, when comparing IUDs to a method that could be discontinued at will).(31) | **B** |
| *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.* (22 year-old Black woman, USA)(32) | **B** |
| **Desire to be natural** | *“Cause I don't know, I don't want any foreign object inside of me.”* (African American Woman)(27) | **B** |
| **Concerns about racial discrimination** | *“These questions that if [local healthcare system] is sponsoring it gives me the impression that [local healthcare system] is trying to target the Hispanic community for LARC. Then what’s the underlying agenda there? Is it that we’re overpopulating and there are too many kids coming out of our community, so let’s stop the population, so let’s give them LARC?* *Seriously I get very suspicious at first. I have read a lot of stories.”* (Latina woman)*. (42)* | **B** |
| *“Black people just skeptical of it [the implant] from the start. And they moms have a lot of influence. They just don’t wanna be guinea pigs.”* (Black peer counsellor) (34) | **B** |
| *“Like back in the … 60s, they’ll take women of color…or people who are poor and they’ll use them as guinea pigs ... that’s what a lot of people thought. My mother said stuff like that too.”* (Hispanic implant user)(34) | **B** |
| **Misconceptions** | “*When you want to have kids, are you gonna be able to? They tell you, ‘Oh, it’s gonna have side effects now,’...but what’s gonna happen later? They don’t tell you, ‘Oh, well, two or three years later from now she might go sterile.’”* (Adolescent Pill/condom user)(34) | **B** |
| **Fertility Intentions:**  Having more children is considered a desirable and a blessing | *‘‘Some women feel blessed to have a child and wouldn’t want to ‘block their blessing.’’* (African American Woman)(36) | **B** |
| *“My children are my wealth”* (Somalian Bantu woman)(24)  *“You give birth until we believe in God until God say that maybe [the children] is enough for her.”* (Somalian Bantu woman)(24) | **B** |
| Taboo to say you don’t want children | “*When you are still young, you are not allowed, in my tradition, to say, ‘I will not have another baby.’ That is forbidden. Don’t say that, because you are still married, you have your husband. Anything can happen, whether it is intentional or not intentional.”* (Somalian Bantu Woman)(24) | **B** |
| Desire to not get pregnant | *‘‘I had a really complicated pregnancy, and the birth was traumatic. I don’t want to go through that again so I got on birth control right after the birth of my last child.’’* (African American Woman)(36) | **F** |
| *“I feel at peace with it [the IUD, 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.”* (24-year-old, single, Latina mother of one, USA)(32) | **F** |
| External Influences – **Partner/**  **Relationships** | “*He was the person who basically talked me into getting birth control…I talked to him about the IUD and he agreed, so, it was like, I guess, he was all for it.* *I was all for it, so, we both just saw eye to eye to the whole situation.”* (African American Adolescent, aged 17) (40) | **F** |
| *“‘He say he want another baby. But I’m, I’m not ready. I don’t want one… Like he got mad at me because I wanted to get on the 5 year thing.”* (African American, Age 18)(40) | **B** |
| **Family/Friends** | *“When I ﬁrst had my ﬁrst baby, my doctor, my care given doctor and my midwife, she told me that he was going to put, I don’t know what its called, the ﬁve (sic) little sticks you have. . . I was so excited that I was going to get it . . . but then a lot of my friends and my mom told me that she had friends that had told her, that they show sometimes, or that they hurt, or that they travel. I heard all these thing, I just told her or him no, I never went back to him . . . I don’t know that just freak me out....”* (Somali Bantu Woman)(24) | **B** |
| *“I talk to my grandma, my friends, my auntie, and my pharmacy tech since my mom knows the pharmacist. I don’t discredit my mom, but I want a professional to ask [questions to about contraception]”* (African American Woman)*,(36)* | **F** |
| **Relationships with Healthcare Professionals/ Services:**  High quality counselling | *“They were actually caring. It wasn’t like they were pushing me, like, ‘Oh you shouldn’t have kids, and you need birth control [contraception].’ It wasn’t nothing like that. So, they were really caring and basically trying to look out for me, since I was young when I had my first daughter”* (Black woman, aged 26, referring to postpartum LARC).*(38)* | **F** |
| *“They actually showed us this* [Bedsider] *chart, and went through these* [methods] *with us, and definitely spent a lot of time on the top one* [IUDs, the implant*] about what’s maybe best. For the first group [of methods], they basically said those would be the most effective, especially for moms who really, really don’t want to be pregnant. Basically explaining, especially for the top group, what kind of things that you can expect as far as how long you can keep them, or whether you’re going to be cramping, whether you’re going to be experiencing mood swings and things like that. As far as the middle group* [pill, patch, ring, shot]*, they did spend time on that one, but did let us know that those are not as effective. Then for the last one* [e.g. withdrawal, fertility awareness]*, it wasn’t a joke, of course, but we briefly went over that one, because that one doesn’t work very well, obviously.”* (Black woman with one child, aged 28)(37) | **F** |
| Counselling about Side Effects | *That day I thought I was going to have that done [IUD removal] and then I changed my mind. …She was like, you know, to wait a little bit ‘cause I′m still new and then sometimes the body does change it.* (32-year-old Hispanic woman, copper IUD user, discussed IUD removal at 6 weeks, IUD not removed).(25) | **F** |
| *“I just basically had concerns about why am I getting irritated, and she just basically told me, “You wear panty liners?” I said, yes. She said, “Well stop wearing them, that's what's bothering you.” She was just basically like, “No. It's not true, it's not the IUD. It's just you and you were wearing panty liners.”* (24-year-old multiracial woman, hormonal IUD user, discussed IUD removal at 6 weeks, IUD not removed).(25) | **B** |
| Poor timing of Counselling | *“The doctor before I was checked in asked me* [about contraception] *right before they took me back, if anything, because she was trying to talk me into getting an IUD. I was like “ I don’t know, we’ll talk about it later. I’m in pain right now. I don’t want to talk… I just told her that I was really set on getting the shot and she was like “Are you sure?” and I was just like, “Yeah, if you don’t mind.”* (Multiracial woman, aged 24, on discussing immediate post-partum LARC when she was being admitted to hospital). (37) | **B** |
| Not necessary to seek medical advice/expertise for certain things | *“I think you only need to see a doctor when you have a problem that you need to fix, like the problem is already there, like falling pregnant accidentally. I don’t think I would choose to go and specifically see a doctor and ask how to avoid falling pregnant… also, I don’t know if it is the same in other cultures or countries, but in China, people tend to conceal one’s sickness rather than tell the doctor, sometimes you would have a cold but you would not want to go see a doctor. First, it is the trouble, second, after seeing a doctor, you would feel that your body is in an inferior state, you would have that sort of psychological hint.”* (Chinese woman, not married, 18-30, no children)(28) | **B** |
| Unaffordable Services | *“I've got to get rid of this thing. I don't want this. Take it out. Can you take it out for me? Take it out. I don't like it at all…The health department, they're going to take it out. I was going to get my primary care doctor to remove it, but she was like it's going to be $300 to just get it removed. I'm like, “No ma'am. I deny. No.” I can go somewhere else and get it done for free and get something else because I can't. I can't with this thing no more. I'm tired.”* (Black woman, aged 28, mother of three children, who had implant placed immediately postpartum).(37) | **B** |
| External Influences - **Society** | *“In fact there are people who used and liked it [hormonal IUD], in fact sometimes people do not bother to say something, because usually there is not a problem, you don’t pay attention to it, you are busy with other things. Those who talk about those things all day are those who had unresolved problems, that is why we hear unhappy views everywhere”* (Chinese woman, married, aged 30–45, one child)(28) | **B** |
| *“With regards to the coil, because everyone uses it and says that it is very tolerable, so I have also used it.”* (Chinese Asylum Seeker)(39) | **F** |
| When asked directly if there was any shame in having the implant in situ *“No, it’s in a good spot, private”* (Australian Aboriginal Woman) | **F** |