

Patient-Centered Contraceptive Counseling: A Reproductive Justice-Informed Shift to Shared Decision-Making

Commentary by David A. Klein, MD, MPH; Ryan L. Williamson, DO, MS; and Emily A. Yocom, DO

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CASE SCENARIO

As someone who takes pride in maintaining meaningful patient-clinician relationships, I was upset to learn that a 38-year-old Black patient, whom I have seen multiple times in my clinic, requested a referral for contraception management. She has one living child, a previous pregnancy termination, and a history of obesity, hypertension, and depression. I have extensive experience in contraceptive management and believe that assisting patients with sexual and reproductive health care is a priority in primary care.

In a previous visit, I had suggested an intrauterine device as a potential contraception method, but she seemed ambivalent about the recommendation at the time. On reflection, I did not adequately discuss her sexual and reproductive health goals and contraceptive method preferences. I also did not consider her experiences of discrimination in health care, history of sexual trauma, or other issues that may impede her ability to trust clinicians, especially regarding sensitive topics.

As a male physician from a different cultural background, could I have unintentionally created a perception of a hidden agenda? How can I improve my approach to sexual and reproductive health care to understand patients' experiences and better meet their needs?

COMMENTARY

The complex dynamics of patient encounters such as this scenario are common across care settings. Implicit or explicit biases, subtle pressures, or even coercion on the part of the clinician can profoundly influence contraception counseling sessions.¹ Clinicians are sometimes unaware of power dynamics that influence the visit and may inadvertently evoke patient perceptions of coercion and an unsafe health care environment.²

Many patients or those close to them have encountered or heard first-hand accounts of government-sponsored forced sterilizations, experimentation with contraceptives without consent, eugenics, and other ethnicity- or race-based mistreatment in

sexual and reproductive health care. Such experiences can have a lasting influence and be reminiscent of some recent unbalanced sexual and reproductive health care initiatives, including provision of select no-cost options (e.g., long-acting reversible contraception) for those with limited resources who cannot afford their preferred method. This background converges with racism, sexual violence, and unsafe health care environments to enhance mistrust and vigilance in health care settings even when health care professionals are well-intentioned.^{1,3} Medical mistrust is often a part of the individual and collective consciousness in communities of color.⁴ Providing health care and conducting research, especially in sensitive areas such as contraceptive care, necessitates ongoing calibration with current cultural and societal contexts.⁵

To best serve patients, clinicians should strive to understand the effect of mistreatment regarding sexual and reproductive health, conceptually, for those who have been historically underserved, marginalized, and excluded.¹ This population includes people of color, immigrants, and people who have disabilities, lower income, younger age, sexual or gender-diverse identities, or substance use disorder. It also includes those whose sexual and reproductive health care concerns have been devalued. The goal is to eliminate the occurrence and sequelae

DAVID A. KLEIN, MD, MPH, David Grant Medical Center, Travis Air Force Base, California, and Uniformed Services University of the Health Sciences, Bethesda, Maryland

RYAN L. WILLIAMSON, DO, MS; and EMILY A. YOCOM, DO, David Grant Medical Center Family Medicine Residence Program, Travis Air Force Base, California

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Address correspondence to David A. Klein, MD, MPH, at david.a.klein26.mil@health.mil.

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Send scenarios to afpjournal@aaafp.org. Materials are edited to retain confidentiality.

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of biases and barriers, including those that are systemic and structural, contributing to mistreatment.^{1,6,7}

The American College of Obstetricians and Gynecologists and the American Public Health Association explicitly recommend a patient-centered, reproductive justice–based contraception counseling framework^{1,8} (Table 1^{1,2,6,8,9}); yet, many people are not using their preferred method.¹⁰ To achieve this goal, the clinician should focus on ensuring universal access to the widest range of contraceptives, including, but not limited to, long-acting reversible contraception.^{6,8,9} Well-intentioned efforts to increase access to long-acting reversible contraception, without deliberate planning, could be misconstrued as an effort to “push” this contraception on an individual patient, causing unintended harm. Instead, the clinician should recognize that some people may prioritize other factors such as attaining regular, tolerable menses over the most effective option in preventing pregnancy because unintended pregnancy is not always viewed as a negative outcome by patients.^{6,8,9}

Practical Approach

Patients value comprehensive counseling, personalized information, autonomy, decision-making support, confidentiality, and

positive interpersonal environments when receiving contraceptive counseling.^{11,12} For example, adolescents may particularly value social context such as friends’ experiences.¹² A systematic review and meta-analysis not specific to any racial or ethnic groups found that enhanced counseling interventions (e.g., with shared decision-making components) increased contraceptive use by 39% 3 to 6 months later (risk ratio = 1.39; 95% CI, 1.16 to 1.72; 10 trials; n = 5,239) compared with usual care.⁵ Improving the patient’s experience of care can increase continuation of and satisfaction with contraception, optimize method use, and reduce unintended pregnancy.^{2,13,14}

Setting the Stage. At any clinical visit, a clinician can ask whether the patient would like to talk about contraception. Alternatively, or in sequence, a clinician can ask whether the patient wants or plans to become pregnant in the next year; One Key Question offers an iterative approach to begin the conversation about pregnancy desires.¹⁵ Note that when asked in isolation, questions about pregnancy intention are not particularly sensitive for detecting interest in contraceptive care. With relevant follow-up questions, either approach can identify reproductive health goals, priority for pregnancy prevention (including in the peripartum timeframe), and need for preconception services.¹⁶⁻¹⁸

TABLE 1

Approaches to Contraception Counseling

Counseling approach	Features	Disadvantages
Patient-centered approach*	Focuses on achieving a person’s described sexual and reproductive health goals, primarily through shared decision-making (with flexibility to switch to another approach if requested by the patient), based on the person’s values, lived experiences, and preferences	May require additional clinician thoughtfulness and reflection, taking more time in clinical encounters
Tiered-effectiveness model	Encourages clinicians to prioritize discussions around the most effective options for pregnancy prevention	Does not intrinsically elucidate the range of patient goals Can be perceived as coercive Clinicians may inadvertently conflate population-level indicators such as contraceptive method uptake and unintended pregnancy rates with an individual patient’s needs
Menu-based approach	Clinicians provide education but limit influence based on order of method presentation to avoid coercion, improve autonomy, and improve counseling efficiency	Many patients desire clinician input when making decisions around contraception Decision tools structured in alphabetical order may be difficult for some people to follow
Physician-directed approach	Clinicians recommend specific methods based on perceived patient benefit; common in the care of adolescents	Does not intrinsically elucidate the range of patient goals Can be perceived as coercive

*—Preferred method.

Information from references 1, 2, 6, 8, and 9.

Not everyone desires or can achieve pregnancy, and preferences may be complex; therefore, sensitivity is paramount.² If contraception counseling is indicated, the clinician should elicit information that would help determine medical eligibility criteria.¹⁹

Shared Decision-Making Process. Shared-decision processes begin with questions such as, “Do you have a sense/idea of what is important to you about your method?”²⁰ Such open approaches root the discussion in clear patient-centered terms while avoiding immediate anchoring on specific methods. It also helps clarify the extent to which the patient desires education and feedback.²⁰

For patients who are unsure about their contraceptive method preferences, the clinician can prompt the patient: “Methods differ in how they are used, their effect on periods,

how reliable they are in preventing pregnancy, and other ways. Can we talk about your feelings around these factors?”²⁰

A patient-centered visual aid that does not exclusively focus on effectiveness can guide next steps. Ideally, a table or chart organized by patient-centered priority items should clearly display effects on menstrual bleeding, possible adverse effects, noncontraceptive benefits, and other factors patients may find valuable (eFigure A). Alternatives without such organizing principles (e.g., methods listed in alphabetical order) may be difficult for some patients to follow. Bedsider.org is an online evidence-based resource that allows individuals to review side-by-side profiles of options. Interactive phone apps are also becoming increasingly available. It is vital for the clinician to understand that if patients

TABLE 2

Patient-Centered Contraceptive Counseling Techniques

Counseling element	Example statements
Initiating the conversation	Do you have a sense/idea of what is important to you about your method? What kind of birth control methods have you considered?
Eliciting preferences	Methods differ in how often you take them, how they affect your bleeding, and how effective they are at preventing pregnancy, among other things. Here is a chart that summarizes some of the features of the different methods. Tell me about what is most important to you. Some methods involve taking a pill, getting a shot, applying a patch on your skin, inserting a vaginal ring, timing ovulation, using a barrier, or placing protection under the skin of your arm or in your uterus. Do you have preferences or questions about any of these options? Great, I'll avoid talking about methods that you cannot switch quickly. I appreciate your telling me that you want a method that is easy to remember using.
Reflective listening	Thank you for sharing your thoughts about that method and trusting me with that information. That's good to hear. It helps me to provide you with some extra details you may be interested in to make your decision. Thanks for telling me you have already picked a method. Do you have any questions about this or other methods? I just want to make sure you know all the options.
Responding to concerns or objections	Absolutely! A lot of people feel more comfortable when they have a regular period. Let's talk about options that generally lead to regular periods, but I want you to know that it is safe if the method you pick reduces menstrual bleeding. It's unfortunate that your friend had mood changes and weight gain when they used that method. This can happen, but it is unlikely overall. If you choose that method, we can quickly make a change at your request. It is true that some people like your friend experience irregular menstrual bleeding with the contraceptive implant, but steps can be taken that may help if that happens.
Summing the factors that inform the patient's decision	It sounds like your biggest priorities in choosing a method today are not getting pregnant and not having to remember to take a pill every day or come in for a shot. Is that correct? Based on your goals and the information we talked about, what method do you think would be the right fit for you?

Information from references 20 and 21.

have the perception that conversations are influenced by the clinician's method preference or agenda, the patients are at greater risk of method dissatisfaction than those without this perception.¹³ Cost may also be a leading deciding factor.

Patient-centered counseling techniques can prevent or address misconceptions in discussions (Table 2^{20,21}). When the patient voices a concern, the clinician can reflectively listen; provide a genuine, empathetic statement; and summarize the concern. It can be helpful to acknowledge that others may have experienced the concern or adverse effect in question. After these validating statements, the clinician can check in with the patient to ensure the concern is understood and offer further clarifying information if needed.²⁰ During these responses, the patient is invited to be the final decision-maker.¹

After the patient selects a method, the clinician should start the method if medically safe.^{22,23} Then, to optimize satisfaction with and continuation of the chosen method, anticipatory counseling on initiation, use, and potential adverse effects should be provided. Finally, the clinician should ensure that the patient has an extended supply and address any related needs (e.g., sexually transmitted infection testing and prevention). Seamless clinic access, such as virtually or through a patient portal, should be offered to address any immediate questions or concerns about the method as they arise. Follow-up visits can examine factors in the patient's life that might interfere with sexual and reproductive health goals or consistent method use, such as family plans, lifestyles, or noncontraceptive needs.² To preserve a patient's autonomy, method switching or discontinuation must occur promptly in response to a patient's request.^{1,2,6}

CASE RESOLUTION

In this scenario, the clinician should honor the patient's request for a referral. If the patient-clinician rapport allows for additional discussion, the clinician can sensitively offer, in preparation for the referral consultation, to assist in facilitating any of her personal sexual and reproductive health-related goals and preferences and inquire how he can better serve her ongoing health needs in other areas. Lessons learned about patient-centered care from this interaction could lead to more meaningful and effective future patient-clinician interactions and outcomes for sexual and reproductive health and other services.

The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the Uniformed Services University of the Health Sciences, the U.S. Air Force, the U.S. Department of Defense, or the U.S. government.

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eFIGURE A








Birth Control Methods Chart

Designed for providers to help clients consider their birth control options, this chart takes client autonomy into account and presents methods that clients can start and stop on their own and those that require provider involvement (prescription or procedure). The chart highlights method characteristics, including use & frequency, so clients can make informed decisions, based on their own preferences. Note: Within each table, the methods are listed in order of pregnancy risk, and side effects are alphabetized within each method.

CLIENTS CAN START AND STOP ON THEIR OWN

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Pill (progestin-only), Opill 	9 out of 100	Client takes by mouth same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Available OTC. Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.
Condom (external) 	13 out of 100	Client rolls onto erect penis (external) every time has sex.	None	Allergic reactions, vaginal irritation	Method prevents STIs. Requires a cooperative partner.
Fertility Awareness-based (FAB) 	15–24 out of 100 (depends on specific FAB method)	Client tracks signs of fertility daily and abstains from sex on fertile days.	None	None	Must have regular cycles and be comfortable tracking basal body temperature and cervical mucus.
Spermicide or vaginal sponge 	21 (spermicide alone) or 9 (sponge) out of 100	Client inserts into vagina before penile-vaginal sex every time.	None	Vaginal irritation	Pair with another method for back-up.
Condom (internal) 	21 out of 100	Client inserts into vagina (internal) every time has sex.	None	Allergic reactions, vaginal irritation	Method prevents STIs. Requires a cooperative partner.
Withdrawal 	25 out of 100	Partner with penis ejaculates outside of and away from vagina.	None	None	Requires a cooperative partner.

REQUIRES PROVIDER TO START WITH A PRESCRIPTION (CLIENTS CAN STOP ON THEIR OWN)—CONTINUED ON OTHER SIDE

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Shot (IM/SC) progestin-only 	4 out of 100	Provider administers shot (IM), or the client self-administers (SC) shot every 12–15 weeks.	Spotting, lighter period, or no period	Bone density loss, headache, weight gain	Delay in fertility return. Not visible to others.
Patch (transdermal system estrogen + progestin) 	7 out of 100	Client places patch on back, butt, or belly. Every month, changes patch weekly for 3 weeks and no patch for 1 week.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, skin irritation, stomach pain	May be less effective in people with a BMI of 30 or over. Extended/continuous use option.
Pill (combined estrogen + progestin) 	7 out of 100	Client takes by mouth daily.	Temporary spotting or lighter period	Breast tenderness, headache, nausea, risk for blood clots	May reduce acne, cramping, and PMS. Extended/continuous use option.
Ring (estrogen + progestin) 	7 out of 100	Client places ring into vagina. Every month, keeps ring in vagina for 3 weeks and then removes for 1 week.	Lighter period or temporary spotting	Breast tenderness, nausea	Two types: monthly and yearly. May reduce acne, cramping, and PMS. Not visible but can be felt by partners.
Pill (progestin-only, "the mini pill") 	9 out of 100	Client takes by mouth at the same time every day.	Spotting or bleeding between periods. May not have traditional withdrawal bleeding	Acne, breast tenderness, headache, nausea, weight gain	Safe for people with high blood pressure, blood clot history, and those who can't take estrogen.



*The number of people out of every 100 who have an unintended pregnancy within the first year of typical use of each method.

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eFIGURE A (continued)



REQUIRES PROVIDER TO START WITH A PRESCRIPTION (CLIENTS CAN STOP ON THEIR OWN)—CONTINUED

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Vaginal contraceptive gel (Phexxi) 	14 out of 100	Client inserts into vagina before each act of penile-vaginal sex.	None	Allergic reactions, UTI, vaginal irritation	May act as lubricant for dryness.
Diaphragm or cervical cap 	17 (diaphragm) and 29 (cap w/spermicide) out of 100	Client inserts into vagina with spermicide before every instance of penile-vaginal sex.	None	Allergic reactions, UTI, vaginal irritation	Same device may be used for two years.




REQUIRES PROVIDER FOR CLIENTS TO START AND STOP (REVERSIBLE METHODS)

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Implant (progestin-only) 	<0.1 out of 100	Provider inserts rod under skin in upper arm. Lasts up to 5 years and can be removed earlier.	Unpredictable spotting, lighter period, or no period	Acne, depressed mood, headache, mood swings, weight gain	Mild pain with placement. Not visible but can be felt by partners.
Levonorgestrel IUD (progestin-only) 	<0.2 out of 100	Provider inserts device into uterus. Varies by type, up to 8 years, and can be removed earlier.	Spotting, lighter period, or no period	Cramping pain with placement	Not visible but can be felt by partners.
Non-hormonal copper IUD 	0.8 out of 100	Provider inserts device into uterus. Lasts up to 12 years and can be removed earlier.	Spotting or heavier period	Cramping pain with placement	Effective as EC within 7 days of unprotected sex. Not visible but can be felt by partners.

REQUIRES PROVIDER TO PERFORM PROCEDURE (PERMANENT METHODS)

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Tubal ligation 	<0.1 out of 100	Single surgical procedure done at a hospital.	None	Bleeding, surgical pain	Requires anesthesia and up to 2 weeks of recovery.
Vasectomy 	1 out of 100	Single outpatient surgical procedure.	NA	Bleeding, surgical pain	Up to 2 days for recovery.

EMERGENCY CONTRACEPTION

Method	Pregnancy Risk*	Use & Frequency	Period Changes	Potential Side Effects	Other Considerations
Non-hormonal copper IUD 	0.8 out of 100	Provider inserts device into uterus within 7 days of unprotected sex.	Spotting or heavier period	Cramping pain with placement	Lasts up to 12 years and can be removed earlier.
Ulipristal acetate (ella) 	1 out of 100	Client takes by mouth as soon as possible within 5 days of unprotected sex.	Spotting or period at new time	Abdominal pain, dizziness, headache, nausea	Requires prescription. May be less effective in people over 194 pounds.
Levonorgestrel 1.5mg pill (Plan B) 	1–2 out of 100	Client takes by mouth within 120 hours (~5 days) of unprotected sex.	May induce spotting or period	Breast tenderness, dizziness, headache, nausea, stomach pain, tiredness, vomiting	Available OTC. May be less effective in people over 165 pounds.

*The number of people out of every 100 who have an unintended pregnancy within the first year of typical use of each method.

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