



Published in final edited form as:

*J Midwifery Womens Health*. 2011 January ; 56(1): 54–60. doi:10.1111/j.1542-2011.2010.00012.x.

## Urban minority women's perceptions of and preferences for postpartum contraceptive counseling

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### Abstract

**Objective**—Focused antenatal contraceptive counseling about postpartum contraception may reduce the risk of contraceptive nonuse and misuse, although the optimal timing, content, and communication style of such counseling remain controversial. This study used an in-depth qualitative approach in a population of young, postpartum, urban minority women in order to examine women's perspectives toward the optimal provision of comprehensive contraceptive counseling.

**Methods**—Brief surveys and semi-structured interviews were conducted with 30 consenting postpartum women. In-person one-on-one interviews were then reviewed for themes, using an iterative process. Qualitative analysis techniques identifying emergent themes were applied to interview data.

**Results**—In this cohort of African American (63%) and Hispanic (37%) women (median age 26), 73% had unplanned pregnancies. Women preferred frequent, short sessions of provider-initiated comprehensive contraceptive counseling throughout the antepartum period with reinforcement of decisions while postpartum. Participants valued patient-centered counseling that is inclusive of all appropriate methods and personalized to individual needs.

**Conclusion**—We recommend that frequent, provider-initiated, multiple-modality discussions of appropriate postpartum contraceptive options should take place throughout pregnancy in an open, individualized manner. Further work should address the long-term effects of improved patient-centered antenatal contraceptive counseling on rates of unintended pregnancy.

### Keywords

Postpartum contraception; contraception counseling; unintended pregnancy

## INTRODUCTION

In the United States, as many as 49% of pregnancies are unintended.<sup>1,2,3</sup> Consistent use of contraception can significantly reduce the likelihood of unintended pregnancy, yet many women experience gaps in contraceptive use even during times in which they are sexually active.<sup>4</sup> Although many patient-dependent risk factors are associated with contraceptive

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DISCLAIMERS: The authors have no conflicts of interest to report.

nonuse, contraceptive counseling is one area that is clearly modifiable by clinicians. Contraceptive counseling, particularly for women who have experienced an unwanted or mistimed pregnancy, is a key component of comprehensive women's health care. Yet, high-quality experimental or observational literature on whether good contraceptive counseling effectively reduces rates of unintended pregnancy is lacking, and the optimal timing of counseling on postpartum contraception remains controversial.<sup>5</sup>

Planning for postpartum contraception is particularly important for pregnant women at risk of repeat unintended pregnancy. Contraceptive counseling during pregnancy may be the first time some young women have received any education on contraception.<sup>6</sup> Several studies have concluded that focused contraceptive counseling in the postpartum or antepartum period is effective.<sup>7</sup> A 2008 randomized investigation of the use of both postpartum contraception educational leaflets and verbal counseling sessions found that women who were exposed to the intervention were more likely to have started contraception by the time of the postpartum follow-up visit, and were more likely to have chosen an effective method, compared to those who had not received the educational intervention.<sup>8</sup> Further, a recent systematic review of contraceptive counseling taking place in the postpartum period, including both short-term and multiple-contact interventions, found that postpartum contraceptive education led to more contraception use and fewer unplanned pregnancies.<sup>9</sup> In addition, some authors specifically recommend postpartum contraceptive counseling be offered antenatally.<sup>7</sup> A 1998 intervention conducted in a population of low-income women at high risk for repeat unintended pregnancy found that women who received antepartum, multicomponent contraceptive counseling about oral contraception as well as usual care were more likely to remain not pregnant after follow-up at 12 months, compared to those who received usual care only.<sup>10</sup>

Others have found antenatal counseling to have little long-term impact on subsequent pregnancy rates or contraception use.<sup>11</sup> Although a current unplanned pregnancy would certainly be a motivating factor to plan future pregnancies, once a woman is no longer pregnant and has distanced herself from the initial feelings of motivation, she may resume behaviors that place her at risk for repeat pregnancy. In a study of women in Scotland, South Africa and China, women were randomized to receive "expert contraceptive advice" or standard care during pregnancy, and then were followed up at 16 and 52 weeks after childbirth. In both groups and at all centers, contraceptive use rates were over 79% at one year. In the "expert advice" group, although women found the opportunity to discuss contraceptive methods antenatally helpful, there was no apparent effect on long-term contraceptive use rates; these women, notably, were largely using oral contraceptive pills or condoms.<sup>11</sup>

In addition to the timing of counseling, the most appropriate content, communication style, and method for such counseling are also debated. Some evidence suggests that single interventions of either written or verbal communication provide limited increases in patient knowledge, whereas a combination of written and verbal communication more significantly increases patient knowledge of topics such as reasons for pill failure, action following missed pills and emergency contraception.<sup>12</sup> Further, we know little about women's perceptions of and preferences for postpartum contraceptive counseling. A 2009 qualitative study of forty American women regarding lifetime experiences with family planning services found that women preferred personalized, caring, and nonjudgmental contraceptive counseling that respected their decision-making autonomy; however, no similar studies have specifically addressed postpartum contraception counseling.<sup>13</sup> Clearly, more work is needed to identify the optimal timing, method and content of effective patient-centered perinatal contraceptive counseling that results in sustainable knowledge and pregnancy prevention behaviors.

The purpose of this hypothesis-generating study was to apply a qualitative methodology to better understand women's attitudes toward postpartum contraceptive counseling, including optimal counseling timing, frequency, communication features and content. Using brief surveys and one-on-one semi-structured interviews, this study attempted to more fully understand the role of contraceptive counseling in the complex postpartum contraceptive decision-making process of an at-risk population.

## **MATERIALS AND METHODS**

### **Participants**

Thirty women in the immediate postpartum hospitalization were recruited from a large, urban academic medical center in Chicago. All English-speaking women over 18 years old who had attended the women's outpatient ambulatory care clinic for antenatal care and who delivered at this hospital were eligible for participation. This clinic serves a group of low-income women who receive public aid and are cared for by the residents in the Department of Obstetrics and Gynecology at this medical center. In this clinic, over 90% of women are English-speaking and over age 18, so the eligibility criteria included a majority of women receiving care. Women were primiparous or multiparous.

Recruitment was conducted as a non-probability convenience sample of women who were inpatients and who fit the inclusion criteria. Women were approached by the study team during their hospital stay, and written informed consent was obtained from those who were deemed eligible. Participants were given a \$10 gift certificate to a local grocery store upon completion.

Sample size was determined based on the goal of saturation in qualitative research, in which the data collected capture the range of experiences and variation in responses in a population. Each interview was transcribed immediately after it was conducted. Groups of three to five interviews were reviewed as the study progressed to iteratively code common themes and to examine if saturation of themes had been achieved. Upon collection of data from 30 participants, all members of the study team agreed that data saturation of the themes of interest was achieved. All participants provided written informed consent. This study was approved by the Institutional Review Board of Northwestern University.

### **Procedures**

Two methods of data collection were used. First, to identify demographic and obstetric data and to quantitatively assess contraceptive use history, participants completed a short survey. The survey consisted of eight demographic questions as well as six items about contraceptive use history. For this report on contraceptive counseling, only the demographic data and three contraceptive use questions (regarding use of contraception at the time of this conception, receipt of contraceptive counseling, and pregnancy intendedness) were utilized. Participants then participated in a semi-structured, face-to-face interview. A single member of the research team with prior interviewing experience conducted all interviews. Interviews lasted approximately 30 to 45 minutes. Women were asked specifically about attitudes towards and experiences with contraceptive counseling. Interviews were conducted privately in patient rooms, and women were encouraged to speak freely about their opinions. Participants were informed that: there were no correct or wrong answers; answers would not affect their medical care; and that they were free to not answer any questions.

### **Data Analyses**

Interviews were recorded using a digital audio recorder. Sessions were transcribed verbatim by the investigative team immediately after interview completion. We performed an iterative

process of interviewing and reviewing the interview responses until saturation was achieved. Using this technique of reviewing interview data in batches of three to five interviews before proceeding with additional interviews, informal analysis of themes from early interviews informed later data collection. Early review of interview responses allowed for clarification of themes during later interviews.

Responses to survey questions were analyzed using simple descriptive statistics using SPSS (Chicago, IL) software. Qualitative data analysis, including coding, data management, text retrieval, and content analysis, were conducted using NVivo (a qualitative data analysis software program). Formal data coding was conducted by both investigators to organize data by themes. Themes were not pre-developed, but rather emerged during exploration of data, using techniques similar to those described by Ulin, et al.<sup>14</sup> NVivo software was used to electronically organize coded data. Coded transcripts were reviewed and assessed for inter-reviewer agreement; discussion between investigators resolved inconsistencies of interpretation. Emergent themes were then identified using illustrative quotations and descriptive statistics.

## RESULTS

Between December 2007 and February 2008, 39 women were approached. Nine women (23%) approached declined participation; reasons included feeling ill, having too many guests, not liking surveys, or no interest. Ultimately 30 women participated in the study and were interviewed during the immediate postpartum period.

Median age was 26 (range 19-35); mean age was 26.6. All participants received Medicaid funding. Ethnicity was self-reported. Table 1 describes demographic characteristics of the study population. [TABLE 1] Mean and median gravidity among participants were 3.07 and 2.0, respectively. Mean and median parity were 2.17 and 2.0, respectively. Nine (30%) were primigravid, whereas 14 (46.6%) had experienced two to four pregnancies and seven (23.3%) had experienced five or more pregnancies. Nine (30%) had experienced one or more elective abortions. Twenty-three women (77%) did not use contraception at the time of conception, and twenty-two (73.3%) reported that this pregnancy was unplanned. Thirty (100%) desired postpartum contraception: intrauterine contraception (IUC) (10), sterilization (6), OCPs (8), DepoProvera (3), or condoms (3).

## QUALITATIVE RESULTS

Women in this study discussed multiple features of their antenatal contraceptive counseling experiences. In analyzing interview data, three major themes emerged. First, a majority of women in this population felt they had received adequate contraceptive counseling during this pregnancy. Second, women felt the counseling they had received was of high quality, and proceeded to describe features of “good counseling.” Finally, women discussed their preferred frequency, timing and method of counseling, and revealed preferences for frequent antenatal discussions using multiple learning modalities.

**Receipt of antenatal contraceptive counseling**—Women were asked to recall contraceptive counseling received during their current pregnancy. Twenty-three (76.7%) women recalled receiving counseling about contraceptive methods prior to childbirth; the same proportion of women reported that the counseling they received was adequate, in that they felt they had received sufficient information to make a choice of contraceptive method. Nineteen (63.4%) women did not want more contraceptive counseling, and 29 (96.7%) reported that they knew what contraceptive method they would start upon leaving the hospital. Interview data concurred with this survey data in that women largely agreed that

they received contraceptive counseling during their antenatal care for their current pregnancy.

Although not discussed extensively, one additional important finding was that many women who experienced prior elective or spontaneous abortions recalled receiving no or inadequate counseling at the time of their abortion and subsequently returned to previously failed methods. One woman who returned to using oral contraceptive pills (OCPs) after a prior unintended pregnancy while taking OCPs was asked if she would do anything differently to remember her pills this time. She reported, “Probably not! Because I mean I have to take pills now and always forget also, every day...so, I mean, I don’t know. Because I don’t know, I don’t like other types of birth control.”

**Perception of “Doing a good job” of contraceptive counseling**—Women largely felt that counseling during their most recent pregnancy was comprehensive, personalized, and sufficient for their needs. Features of a positive patient-centered counseling experience included: learning about multiple methods, being allowed to make an independent choice, feeling that care was individualized, receiving information about risks and side effects, receiving supplementary written information, having health care providers who took time to fully answer questions, and having frequent provider-initiated conversations. Considering one’s counseling experience to be “good” also required feeling that one’s health care provider was caring, empathetic, truthful, and interested in them. Women felt that providers who were “real nice, real attentive” were also more informative and did a better job of counseling. Feeling supported and reassured in this very personal decision was an important aspect of the positive counseling interaction. Table 2 illustrates examples of participants’ perceptions of positive counseling experiences. [TABLE 2]

**Optimizing counseling timing, frequency and content**—One goal of these interviews was to assess participant perceptions of optimal timing and frequency for counseling. Twenty-seven of the 30 participants recommended frequent, short episodes of contraceptive counseling throughout pregnancy, in order to explain contraception “step by step.” A 21 year-old mother of two felt the optimal time was “during the pregnancy. It’s good to talk about it...when you have time to decide...And you can think about it.” Women felt regular counseling addressed the need to plan ahead, process information and possibly change their mind during pregnancy. These women additionally recommended reviewing contraceptive options, reassuring them in their decisions, and reinforcing instructions in the immediate postpartum period and again at the postpartum clinic visit.

Regarding counseling quantity, it was clear that the optimal length of counseling depends on baseline knowledge and needs, rather than a set number of minutes. While some participants warned health care providers to respect individual decisions and felt it unnecessary to revisit contraception at each visit when a woman has made a choice, others applauded regular discussions until she felt certain in her decision.

Women in this study preferred a multimodal approach to counseling. Twenty-seven women expressed a preference for learning via “multiple ways.” Participants discussed the utility of counseling via a combination of lecture-style sessions, question-and-answer sessions, using written materials or websites, and models or demonstrations. Many women noted that tailoring a counseling session to a patient’s learning style would have the biggest impact on her knowledge. Hands-on methods, such as seeing an actual intrauterine device or vaginal contraceptive ring, were also appreciated. A 24 year-old mother of three described her preference for multiple teaching modalities:

I think giving you visuals, like the doctors were wearing pins of the little IUD thing! It's like, okay you have the visual of how it looks, you have the reading material of how it looks, and you can tell me how it looks for people who don't really understand it as well. Like some people can't comprehend reading on a piece of paper but they can comprehend if it's in their face...so I think that's a little bit better.

Table 3 illustrates examples of women's recommendations on how to conduct an optimal counseling experience. [TABLE 3]

## DISCUSSION

Although counseling regarding postpartum contraceptive choices comprises an important component of antenatal care, little is known about how best to carry out counseling efforts in high-risk populations. This study explores perceptions of contraceptive counseling in a population of young, minority women in the immediate postpartum period, a majority of whom experienced an unplanned pregnancy. No other studies have qualitatively assessed women's preferences for contraceptive counseling methods, timing, frequency, and communication strategies. Our data points to the complexity of contraceptive counseling; these high-risk young women reported on features of contraceptive counseling that are perhaps not always evident to health care professionals conducting routine contraceptive counseling.

Despite challenges in providing optimal counseling efforts, the antenatal health care delivery setting would seem to be an ideal time to conduct postpartum contraceptive counseling. Prior work assessing antenatal counseling efforts in an at-risk population found that antepartum patients expressed a high level of motivation to prevent unplanned pregnancy, as well as a high level of enthusiasm and confidence in their ability to use oral contraceptives effectively after the birth of their child.<sup>15</sup> Pregnancy is both a time of increased motivation to plan for future contraceptive use as well as a time of increased access to health care. Our population certainly expressed a strong interest in postpartum contraception. Enthusiasm, however, may mask a lack of understanding regarding method use, and health care providers can take advantage of this time period to correct misinformation and provide new information.

Data from our study suggest a number of ways to provide optimal contraceptive counseling to pregnant women. First, improved provider-patient communication is critical to the woman's receptivity to contraceptive information.<sup>4</sup> Women respect health care providers who can communicate clearly on a level to which they can relate, while providing support and continuing to be available for questions. Second, postpartum contraceptive counseling would ideally take place over frequent, short discussions throughout the antenatal care process, with reinforcement and reevaluation of the decision in the postpartum period. This finding that women prefer antenatal counseling is supported by other work that suggests antenatal counseling may lead to more desirable long-term outcomes.<sup>7</sup> Further, we propose that providers initiate conversations about contraceptive options early and then assess the woman's enthusiasm and baseline knowledge to individualize the content and frequency of these discussions in subsequent visits. Our data suggests provider-initiated contraceptive education is likely to be received well by women in this population. Finally, previous work has suggested that a combination of verbal and written communication increases knowledge about contraception more than a single teaching method alone.<sup>12</sup> Our work suggests optimal postpartum contraceptive counseling utilizes a multimodal approach to learning; women felt they learn best when information delivery is tailored to their learning style, which may include multiple teaching modalities. Ultimately, these women had strong opinions about

their contraceptive counseling experiences. Involving a woman in her counseling may be an important first step to providing effective contraceptive education.

This study had a number of limitations. Our participants were primarily Latina or African American, and thus it is difficult to make comparisons between these groups and the American population in general. Second, the small sample size, as is typical for a qualitative methods study, makes our quantitative data less powerful. However, we collected data until we reached saturation in the themes highlighted in this work. This study is also cross-sectional in design. As a result, there is no way to assess long-term outcomes or causality. Although we have more fully explored the optimal design of postpartum contraceptive counseling, it is not known if following such guidelines would affect repeat unintended pregnancy rates. It is also possible that the timing of these interviews in the early inpatient postpartum period when some women might be fatigued or physically uncomfortable could have influenced their attitudes or attention during the interview process. Finally, although our study sample parallels that of other urban, low-income women seeking care at Public Aid-funded clinics, findings drawn from this single hospital with a discrete group of resident physician providers and faculty physician mentors may not be generalizable to different clinical settings. However, we consider these limitations to be acceptable, as our data reached thematic saturation, and one purpose of qualitative work is to generate a framework for further discussion and exploration in an understudied area.

Future work may apply further in-depth quantitative study to this population in attempt to more fully understand the role of contraceptive counseling in the behavior patterns of women at risk for repeat unintended pregnancy. This work demonstrates that women have strong feelings about the counseling they receive, and that women desire to receive postpartum contraceptive counseling. Future work should include a broader sample of women representing more types of payer status, socioeconomic position, and racial/ethnic/cultural groups in designing optimal contraceptive counseling interventions. Ultimately, one goal of postpartum contraceptive counseling is to prevent repeat unintended pregnancy. Thus, future work must include both designing optimal patient-centered counseling interventions as well as long-term assessment of the success of these interventions at encouraging pregnancy prevention behaviors. We hope that the findings that emerged in this hypothesis-generating study can be used to improve the quality of contraceptive counseling for women in similar communities.

Pregnancy has been termed a “window of opportunity” for preventive health behavior counseling; for example, research on smoking has noted that smoking cessation interventions during pregnancy are effective at reducing the numbers of women continuing to smoke in the third trimester.<sup>16</sup> Ideally, contraceptive counseling should be offered to women throughout the period of her reproductive health, nevertheless, women presenting with unintended pregnancy present an important opportunity to offer further education on contraceptive options. Our data suggest that efforts at improved provider-driven contraceptive counseling may positively affect uptake of effective contraceptive methods. Counseling on postpartum contraceptive options should take place throughout the antenatal care process via thorough, frequent and providerinitiated discussions using multiple teaching modalities.

#### PRECIS

A population of young, minority postpartum women reported a preference for frequent, provider-initiated, brief sessions of contraceptive counseling throughout pregnancy.

## Acknowledgments

FUNDING: Dr. Simon is funded by a NIH K12 WRHR-HD050121-03 award

## BIOSKETCH

Dr. Yee is an obstetrics and gynecology resident at the University of California, San Francisco. She obtained her M.D. and M.P.H. at Northwestern University. Dr. Simon is an Assistant Professor in the Department of Obstetrics and Gynecology at Northwestern University, Feinberg School of Medicine.

## References

1. Jones RK, Zolna MRS, Henshaw SK, Finer LB. Abortion in the United States: Incidence and access to services, 2005. *Perspectives on Sexual and Reproductive Health*. 2008; 40:6–16. [PubMed: 18318867]
2. Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health*. 2006; 38:90–96. [PubMed: 16772190]
3. Henshaw S. Unintended pregnancy in the United States. *Family Planning Perspectives*. 1998; 30:24–29. 46. [PubMed: 9494812]
4. Frost JJ, Singh S, Finer LB. Factors associated with contraceptive use and nonuse, United States, 2004. *Perspectives on Sexual and Reproductive Health*. 2007; 39:90–99. [PubMed: 17565622]
5. Moos M-K, Bartholomew NE, Lohr KN. Counseling in the clinical setting to prevent unintended pregnancy: An evidence-based research agenda. *Contraception*. 2003; 67:115–132. [PubMed: 12586322]
6. Gilliam ML, Warden MM, Tapia B. Young Latinas recall contraceptive use before and after pregnancy: A focus group study. *Journal of Pediatric and Adolescent Gynecology*. 2004; 17:279–287. [PubMed: 15288030]
7. Glasier AF, Logan J, McGlew TJ. Who gives advice about postpartum contraception? *Contraception*. 1996; 53:217–220. [PubMed: 8706439]
8. Saeed GA, Fakhar S, Rahim F, Tabassum S. Change in trend of contraceptive uptake – effect of educational leaflets and counseling. *Contraception*. 2008; 77:377–81. [PubMed: 18402856]
9. Lopez LM, Hiller JE, Grimes DA. Education for contraceptive use by women after childbirth. *Cochrane Database of Systematic Reviews*. 2010; (1) Art. No.: CD001863.
10. Gilliam M, Knight S, McCarthy M. Success with oral contraceptives: A pilot study. *Contraception*. 2004; 69:413–418. [PubMed: 15105065]
11. Smith KB, van der Spuy ZM, Cheng L, Elton R, Glasier AF. Is postpartum contraceptive advice given antenatally of value? *Contraception*. 2002; 65:237–243. [PubMed: 11929646]
12. Little P, Griffin S, Kelly J, Dickson N, Sadler C. Effect of educational leaflets and questions on knowledge of contraception in women taking the combined contraception pill: Randomised controlled trial. *British Medical Journal*. 1998; 316:1948–1952. [PubMed: 9641933]
13. Becker D, Klassen AC, LaVeist TA, Sonenstein FL, Tsui AO. Women’s perspectives on family planning service quality: An exploration of differences by race, ethnicity and language. *Perspectives on Sexual and Reproductive Health*. 2009; 41(3):158–65. [PubMed: 19740233]
14. Ulin, P.; Robinson, ET.; Tolley, EE. *Qualitative Methods in Public Health: A field guide for applied researchers*. Jossey-Bass; San Francisco: 2005.
15. Gilliam ML, Knight S, McCarthy M. Importance and knowledge of oral contraceptives in antepartum, low-income, African American adolescents. *Journal of Pediatric and Adolescent Gynecology*. 2003; 16:355–360. [PubMed: 14642956]
16. Lumley J, Chamberlain C, Dowswell T, Oliver S, Oakley L, Watson L. Interventions for promoting smoking cessation during pregnancy. *Cochrane Database of Systematic Reviews*. 2009; (3)



**Table 1**

Descriptive characteristics of study participants (N = 30)

Characteristic	n (%)
Race or ethnicity	
Hispanic	11 (36.7)
African American	19 (63.3)
Marital status	
Married	5 (16.7)
Member of unmarried couple	10 (33.3)
Single	14 (46.7)
Divorced or separated	1 (3.3)
Education	
Less than high school	4 (13.3)
High school graduate	6 (20.0)
Some college or technical school	13 (43.3)
College graduate	7 (23.3)

**Table 2**

Participants' perceptions of positive counseling experiences

Features of positive counseling experiences	Examples of participant responses
Answering questions	She answered all my questions. Any question I asked, she answered. She was informative. (33y.o., 2 children) [W]ell the doctors over there asked me like what did I prefer, I mean what did you want to do afterwards. And they said we can get you some information on that, and they did, they got me some information from what I said that I wanted. They really didn't try to change my mind...The doctors pretty much answered all of my questions. (24y.o., 3 children)
Frequent discussions	Oh yeah, it was great. We talked about contraceptives before I was even 6 months pregnant, when I first came in...They gave me everything from before the baby to after the baby about what do you want to do. Which I felt was very great because you give a woman time to think about what she wants to do, you know?...It's really great here, with the information they give you and whatnot. (24y.o., 2 children)
Providing written information	They ask you periodically what you want to do, and they'll give you details if you ask, they'll give you literature if you ask. Every one of the doctors cared enough to print out some information for me on the rhythm method, that's where I started with that...They seem to pretty much respect what you say. (35y.o., 4 children)
Feeling supported	[I]t was, you know, reassuring me that the decision I was making was the best decision for me. You know, and giving me the information I need in order to keep this decision. (24y.o., 3 children)
Feeling connected to provider	Well while I was pregnant I got a good, good counseling. Now like I said, Dr. P. is very good, very helpful. I would highly recommend her...She's wonderful. Excellent doctor. Very real, very personable, very down to earth. She's on the people's level, if you know what I mean...I'm telling you, she's a very personable person. She's a person! You know how you have some doctors who are just like "oh, that's the doctor!" and you can't say this, or that doctor's not on your level? That doctor is real! (28y.o., 1 child)
Provider-initiated counseling	The doctor would bring it up, I liked that too. (34y.o., 4 children) The doctors, every doctor that I seen, because I never had a specific doctor, would ask me about birth control. So I would tell them yes I want Mirena...and they're like, oh okay, good, good, good. (23y.o., 1 child)

**Table 3**

Participants' recommendations for optimal frequency, timing, and mode of counseling

Recommended strategies for optimizing counseling	Examples of participant responses
Frequent antenatal counseling	<p>The more, the better. Because things change throughout pregnancy – your emotions change, you change mentally, physically, emotionally, so you need that each month. It helps - just like telling someone something in January, when December comes, they probably forgot half the things you told them in January! But if you consistently tell them in each month, when December comes, it's like, yeah, I know what to do, yeah! We talked about this several times, I'm educated [now], I know what's going on, I know what I want, and nothing's better than knowing what you want. (24y.o., 2 children)</p> <p>I think it's all the time, to be honest, just like how I got it – in the beginning, I got while I was in labor, you know, I got it afterwards. It's like a constant question, what's gonna be your contraception, what are you gonna do, I think that'll work, if you keep getting it drilled in your head...(24y.o., 3 children)</p>
Balancing “too much” counseling with regular reminders	<p>Because over here they...well, you know...they consistently, you know, what do you want to do? Have you been thinking about it? Ohh, ohh, ohh. You know, every appointment they would, you know, it's not like they would drill it in my head but you know...they would bring it up. (34y.o., 4 children)</p> <p>They wouldn't saturate you, you know, they wouldn't be like 'lalala,' but they did enough. You know, and then they would see your reaction and they would go from there. (34y.o., 4 children)</p>
Limiting further counseling when a decision has been reached	<p>I already had my mind set on what I was getting [a tubal ligation]...nothing could have changed my mind. (29y.o., 3 children)</p> <p>I pretty much knew about it so there was nothing to ask. They asked me what did I know about it and I basically told them, so there really wasn't much to talk about because I already knew about birth control. (22y.o., 1 child)</p>
Using a multimodal teaching approach	<p>Talking and reading materials. I mean, if you mention something to me and you give me literature on it and I'm open to hearing what you have to say first, then I will go home and research it myself. And then I'll come back and I, we can discuss it again. So I think that's the best method. (28y.o., 1 child)</p> <p>More than one thing. Telling me, giving me things to read, seeing visual, going to the internet and researching. (20y.o., 1 child)</p>