Concerns about contraceptive side effects among young Latinas: a focus-group approach

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Abstract

To identify perceptions and attitudes about contraceptive side effects in young, low-income Latina adolescents through focus-group conversations. We conducted seven focus-group discussions with Latino females in an outpatient clinic and community setting. Qualitative methodology was used to analyze data. Participants were recruited from the outpatient gynecology clinic at the University of Illinois at Chicago, and from the Easter Seals Day Care Center. Women were recruited if they were Latino and between the ages of 18 and 26 years \( N = 40 \). Participants cited both perceptions of side effects as well as personal experience with side effects as reasons for not using or discontinuing the use of contraception. Women also demonstrated incorrect knowledge about contraception, and tended to value anecdotal information over information from health professionals. These factors led to reliance on less-effective methods of contraception, placing participants at risk for unintended pregnancy. Concern about side effects, fear of health consequences and misinformation were identified as barriers to effective contraceptive use in young, low-income Latinas. Providers caring for this population should address potential concerns about side effects of contraception as well as assess patients' understanding in light of cultural and language barriers. © 2004 Elsevier Inc. All rights reserved.

Keywords: Latinos; Adolescents; Contraception; Side effects

1. Introduction

Latino youth living in the United States have higher rates of sexual activity and lower rates of contraceptive use than the general teenage population. In 1995 (the most recently published National Survey of Family Growth), 51% of all girls between the ages of 15 and 19 reported having sexual intercourse [1]. Fifty-six percent of Latinas of the same age range reported sexual activity. Of unmarried girls, 49% reported having sexual intercourse, while 52% of unmarried Latinas reported sexual intercourse. In 1995, 47% of Latina teen girls reported not using contraception of any form at first coitus, compared to 29% of all girls in this same age range. Overall teen pregnancy rate in the United States decreased from 1990 to 1997 by 18.9%. But for Latinas, the decrease was only 4.6%. In 1997, the Latina teen pregnancy rate for girls aged 15 to 19 was 148.7 per 1000, which exceeded the national average of 94.3 per 1000. In 2002, 30% of all teen births were to Latinas [2]. In this year, the birth rate to Latina teenagers was 82.9 per 1000 compared to the national rate of 42.9 per 1000. While there are more pregnancies among African American teenagers, Latinas have a higher birthrate as they are less likely to have an abortion.

High rates of pregnancy among young Latinas are due to a number of complex factors, one of which is contraceptive nonuse and misuse. Concern about side effects and health risks have been identified as a poorly recognized barrier to contraceptive use among women [3]. For many teenagers, concerns about their health may be a reason not to initiate oral contraceptives (OCs) or to discontinue them when side effects occur [4,5]. Similarly, poor compliance may lead to more side effects and further noncompliance [6]. The challenge of correctly understanding the risks, benefits and effectiveness of contraceptives should not be underestimated. A survey of young women at a private university in New England showed that even highly educated women consistently underestimate the health benefits of OCs and...
overestimate the risks [7]. Using contraception effectively may pose particular difficulties for Latinas, where language, culture and economics can bar access to medical care. Level of education, cultural insensitivity of providers and poor health literacy may provide additional barriers in some circumstances [8].

We sought to better understand barriers to contraceptive use among Latino adolescents by conducting focus groups with Latinas ages 18–26, almost all of whom had one or more pregnancies as a teenager. We chose to speak to Latinos in their late adolescent and early adult years in hopes that they would have better insight into reasons for unintended pregnancy than would early adolescents. In each of our focus groups, we found that our conversations regarding hormonal and barrier methods of contraception quickly turned into a discussion of contraceptive side effects and stories that they had heard about the health risks of contraception. Such concerns and beliefs are important as they may contribute to contraceptive nonuse and misuse. Further, they provide insight into areas where additional counseling may be of value.

2. Methods

2.1. Participants

Young Latino women were recruited from two sites: the gynecology clinic at the Outpatient Care Center at the University of Illinois at Chicago and Easter Seals Day Care (a community site providing day care for children of low-income women). Flyers were posted at each site and staff members were available to collect names of interested women. Sexually active Latinas ages 18 to 26 were eligible for this study. We conducted five initial focus-group discussions (n = 23). Two additional focus groups were held following a videotape about Latinas and contraception (n = 17) [9]. We indicate which comments are from the latter focus groups. All focus groups were conducted between May 18, 2000 and December 18, 2001. The goal of qualitative research is to capture the range of experience and variations in responses. One is considered to have achieved saturation at the time when addition of further groups yields no new information [10]. All members of the study team agreed that we had achieved saturation of data. All participants provided informed written consent. This study was approved by the Institutional Review Board of the University of Illinois at Chicago.

2.2. Procedures

An experienced bilingual Latino healthcare professional and the primary author moderated all focus groups. Focus groups were conducted based on a predetermined transcript of open-ended questions with set probes to help stimulate conversation. English and Spanish were spoken during the sessions (based on participant choice); all study materials were available in both languages. Research questions were based on the current theoretical and empirical literature on adolescent pregnancy, Latinos and contraceptive compliance. Women were asked about their attitudes toward childbearing and pregnancy prevention, their sources of contraceptive knowledge, their attitudes regarding contraception, and perceived barriers to contraceptive use. Participants were informed that there were no right or wrong answers and were encouraged to provide their opinions [11].

2.3. Data analyses

Sessions were audiotaped and transcribed verbatim; all transcripts were reviewed for accuracy. A codebook with operational definitions was created and agreed upon. ATLAS/ti® (a qualitative data analysis software program) was used for coding, text retrieval, data management and content analysis of data [12]. Two independent researchers coded the transcripts and organized data according to themes, allowing in-depth study of individual groups of data. Coded transcripts were reviewed; overall, there was high agreement between investigators. In the few instances where agreement was not achieved, a discussion was held between all researchers to resolve inconsistencies of interpretation [13,14]. Emergent themes were identified and descriptive statistics were used to characterize the study sample.

3. Results

Demographic variables appear in Table 1.

3.1. Concerns about side effects

Women in our focus groups expressed concerns about the side effects of hormonal contraception as one of the main reasons for contraceptive nonuse. Some common side effects expressed by participants and their sources are shown in Table 2. Depression, moodiness, bleeding, weight gain, acne and nausea were the side effects most concerning to our participants. They associated these side effects with OCs and/or depo-medroxyprogesterone acetate (DMPA). In the words of one participant, “The first thing I worried about was the side effects. I didn’t want any side effects.” Many had heard of these side effects rather than experienced them. These fears were often sufficient to prevent women from ever trying hormonal methods of contraception. A typical comment is as follows:

I never used birth control. What I heard about it, not so much the routines and stuff, I heard about the side effects. That’s what scared me the most. I didn’t want to feel grouchy all the time . . . why was I going to take this thing for one thing, and presuming all these other things? It made no sense.
Other members of our groups had tried birth control and based their concerns on actual experience. Women discussed feeling depressed, crying easily and being short-tempered. Others shared their experiences with prolonged bleeding. One said, “You know what happened to me after I had my daughter I went on that shot and I had my period for like a whole year, throughout the whole year.

Another described her experience as follows:

. . . after I had my second son they started to give me the shot, for five months straight I had a period nonstop.

Then I gain so much weight; you think I would be losing it. While losing all that blood but no I gained about thirty pounds, I wasn’t eating just keeping all that water.

Other contraceptive side effects experienced by these women were harder to characterize. One described being sluggish and in a daze while on OCs. Another participant went back and forth to her doctor and had the dose lowered and says she still felt as if she had no energy.

Another comment we heard from a few participants was that being on birth control felt like being pregnant. One participant said:

Table 1
Descriptive characteristics for focus-group participants* (N = 39b)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
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<tr>
<td>Country of origin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States (not Puerto Rico)</td>
<td>21</td>
<td>53.8</td>
</tr>
<tr>
<td>Mexico</td>
<td>13</td>
<td>33.3</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>5</td>
<td>12.8</td>
</tr>
<tr>
<td>Highest level of education completed</td>
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<td></td>
</tr>
<tr>
<td>Grade school</td>
<td>3</td>
<td>7.7</td>
</tr>
<tr>
<td>Some high school</td>
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<td>38.5</td>
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<tr>
<td>High school</td>
<td>14</td>
<td>35.9</td>
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<tr>
<td>Some college</td>
<td>4</td>
<td>10.3</td>
</tr>
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<td>7.7</td>
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<tr>
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<tr>
<td>Spanish</td>
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<td>41.0</td>
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<td>38.5</td>
</tr>
<tr>
<td>Marital statusc</td>
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<td></td>
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<td>26.3</td>
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<tr>
<td>Living w/partner</td>
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<td>23.7</td>
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<tr>
<td>Married</td>
<td>16</td>
<td>42.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>7.9</td>
</tr>
<tr>
<td>No. of pregnancies</td>
<td></td>
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</tr>
<tr>
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<td>4</td>
<td>10.3</td>
</tr>
<tr>
<td>1</td>
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<tr>
<td>3</td>
<td>12</td>
<td>30.8</td>
</tr>
<tr>
<td>&gt;3</td>
<td>4</td>
<td>10.3</td>
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<tr>
<td>No. of children</td>
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</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2.6</td>
</tr>
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</table>

Table 2
Side effects mentioned by participants, by frequency and source

<table>
<thead>
<tr>
<th>Source</th>
<th>b</th>
<th>c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonly mentioneda</td>
<td></td>
<td></td>
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<tr>
<td>General concern about side effects</td>
<td></td>
<td></td>
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<tr>
<td>Weight gain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acne</td>
<td></td>
<td></td>
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<tr>
<td>Depression</td>
<td></td>
<td></td>
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<tr>
<td>Moodiness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often mentionedb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sluggishness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerous (OCs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCs “stay” in stomach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stories from Mexico</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older women in family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasionally mentionedc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norplant travels inside body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare providers</td>
<td></td>
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</tbody>
</table>

* Appearing in all sessions, all agreed it is a concern.
b Mentioned in three or more focus groups, though no clear consensus.
c Mentioned in one or two sessions.

Yeah, when I was on the pill it felt like I was pregnant. I had all the symptoms of a pregnancy. But I wasn’t, I just had so much hormones in my body, and it was reacting like I was pregnant.

Another knew about this problem from a friend:

Yeah, I had a friend that said the same thing about being on the pill or the shot, that they felt just as scared after having intercourse because they still felt like they were pregnant. You know, because they were nauseous, sick and everything. So, they would still have to pay more money for a pregnancy test, just to be sure, you know. To take a test to make sure they weren’t pregnant.

Others commonly described a feeling of lethargy with contraceptive use and told of the relief and improvement they felt upon discontinuation. One said that when she discontinued them, it was as if she “woke up.” Another remarked that when she stopped OCs, she suddenly had more energy.

3.2. Method switching and discontinuation due to side effects

Side effects were given as a reason for not initiating contraception and as a main reason for either switching methods or discontinuing hormonal contraception altogether. The IUD seemed a particularly popular choice for women who were having difficulty with hormonal contraception. For example, one woman said, “I have the IUD and I don’t have to worry about it. It’s just in there. Well, I took the pill before and it gave me bad acne and weight gain, so
I stopped taking it.” Another decided on the IUD after having trouble remembering to take OCs and gaining weight while taking DMPA.

For others, frequent switching led to periods of time without contraception and finally discontinuation of contraception altogether. One participant described her frustration this way:

It made me gain more weight, and it gave me acne, and I just didn’t like it. Then I stopped for a long time. Then I started again and this time it was even worse. So, I said no, I don’t want this.

3.3. Misinformation about contraception

We found that many women in our cohort had incorrect information about contraceptive use, risks and benefits. The misinformation applied to many methods of contraception. For example, one woman mentioned that if you are 2 days late for DMPA you can get pregnant. Another provided an example of incorrect information on the effectiveness of condoms: “First of all for me, they are safer. In terms of condoms are clinically proven over and over studies have been done that I’d say are about 99%.” We suggested that her information might not refer to contraceptive efficacy and eventually she agreed that she might be thinking about protection from sexually transmitted infections.

When we asked how they learned about contraception, most described informal sources of information such as friends and family. Another said that her mother had a bad reaction to birth control and she would never use them, but when pressed, she was not certain what had really happened. Yet, she felt that they were dangerous:

For me, it is more of a health risk. That I definitely think.

I mean everything you intake. I mean everything you see around you is toxic anyhow. So, but I don’t know . . . I will never get on the pill.

Members of one group felt the side effects were unpredictable, saying there were so many stories about contraception and that each person had a different reaction to them. Further, information was not based on detailed conversations, rather it consisted of anecdotes and rumors through their social network. One myth that recurred in several of the groups was that OCs do not dissolve after discontinuation of contraception and that each person had a different reaction to it. In another session we were told that they blocked the intestines when they did not dissolve.

Women also told stories regarding their concerns about the IUD. One such story heard from a participant’s family was as follows:

Well I have a sister, her sister-in-law . . . she got pregnant, and that um, the thing was, the little string that was around her [the fetus’] neck and the doctor said that that was dangerous for her not to put that on no more, and she was pregnant already. And I don’t know if they took the thing out around her neck. I don’t know what they did but they said that that’s bad.

Another was told that the IUD was bad because if pregnancy occurred it would choke the fetus: “They say that it’s bad because if you get pregnant it could go out the baby’s neck and it could choke, or it could die and stuff like that.”

For some women, it seemed that the informal sources of information were more convincing than the advice given by a health care provider. For example, one woman had been counseled by a midwife and a physician regarding Norplant and elected to use it, but the rumors she heard dissuaded her:

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 . . .

So despite the fact that she had been counseled about the method of contraception, stories she heard from her family and friends superceded the providers’ information.

3.4. Misinformation associated with healthcare professionals

In addition to anecdotes that appeared farfetched or based on rumor, we also heard a number of comments about contraception that appeared to come from health professionals themselves. For example, one woman described her experience with birth control and concluded that birth control pills were not effective for her because her system was “too strong.” Another woman attributed her child’s chromosomal abnormality to the use of contraception. Here, she described the information she received from a medical professional:

When I was on birth control pills with my first daughter, I had gotten strep throat . . . within those 3 months of having the birth control and the antibiotics, I got pregnant, and I was taking both of those at the same time, and now I have a baby with down syndrome (sic), so they think that maybe the birth control and the antibiotics at the same time. I didn’t find out until I was 3 months pregnant I was taking both those at the same time, they
think that maybe that would have caused that effects, the
down syndrome.

Another was told after the birth of her baby not to use an
IUD as it would prevent her from having future pregnancies.
Another heard that using an IUD would lead to infections:
I heard something about the IUD they said that ummh,
some women cannot, they are so weak that they can’t
handle it inside them, they get infections, and it causes a
lot of yeast infection is the problem with a lot of women.

Thus, they felt that health professionals also provided
them with a negative impression of contraception.

3.5. Risk of unintended pregnancy

We found in our sessions that confusion and concerns
about hormonal contraception led women to rely on less-
effective contraceptive methods or not to use contraception
at all. For example, we found widespread acceptance of
condoms. Indeed, in one session when women were asked
which contraceptive method they preferred, the unanimous
response was condoms. A typical comment was, “I never
used the pill or whatever. We just used condoms.” Another
echoed, “For me, it was the same thing. I haven’t used any
form of birth control except for like condoms, which is a
form of birth control.” Yet, the majority said that they did
not use condoms all of the time. One participant attributed
her unplanned pregnancy to her experience with side effects
and the cost of contraception:
I was like 20 or 21 and my estrogen was so built up that
I would get sick from it. So, I had to get off the pill. And
then, I didn’t have the insurance coverage to get any-
thing else. You know, the pill is one of the few things
you can get without your parents actually knowing. And
if you want to get like a Depo shot, it is like $100. That’s
not the kind of money you have when you are 18 or 19,
you know? So, I think this is why I got pregnant because
I could not afford to get birth control, and the birth
control I could afford was just not working.

Thus, many had unprotected intercourse.

4. Discussion

This study explores contraceptive attitudes among a co-
hort of predominately Mexican American adolescents and
young adults, almost all of whom experienced unintended
pregnancy. Our other work has focused on cultural and
social factors that may limit contraceptive use [15]. Here,
we identify concern about side effects, fear of health con-
sequences and misinformation as additional barriers to ef-
ective contraceptive use. Doubts, skepticism and concern
about hormonal contraception were pervasive in each of our
sessions. This finding is important as negative attitudes
towards contraception have been associated with contracep-
tive nonuse among Mexican American adolescents [16].

Our findings in late adolescents and young adult mothers are
similar to focus-group findings of Guendelman and col-
leagues in which 70% of Latinas (compared to 41% of
non-Latinas) were ambivalent about the safety of oral and
injectable contraceptives [17]. In this research too, social
networks and personal experience were more important than
medical advice [17]. Other authors have explored contra-
ceptive concerns among diverse groups of women and
adolescents. These authors have also cited side effects as a
reason for discontinuation of hormonal contraception. For
example, Serafty notes that bleeding side effects undermine
confidence in the contraceptive agent as well as the provider
[18]. Further, they necessitate phone calls and additional
visits [18]. Such troubleshooting may be particularly diffi-
cult for a low-income Latino population in which language
and financial barriers may limit access to reproductive
health care in general and contraceptive care in particular.

Additional studies have shown that teenagers who have
corns about the health effects or the effect of OCs on
their physical appearance are less likely to initiate this
method [19]. Clark suggests considering compliance issues
when prescribing low-dose contraceptives as these may lead
to increased breakthrough bleeding [5].

Misconceptions about contraception may be common.
Scott and colleagues [20] explored concerns about hor-
monal contraception among African American and Latino
adolescents and found that these concerns included many
inaccuracies, such as contraception stunts growth, causes
infertility and contains harmful chemicals. To our knowl-
edge, anecdotes concerning OCs not dissolving and IUDs
strangling a fetus have not been previously reported. In
Scott’s study, participants also voiced concerns about blood
clots, hypertension and cancer [20]. Surprisingly, women in
our study did not mention any of the true health risks
associated with hormonal contraception.

Data from our study suggest that poor physician–patient
communication may also contribute to difficulties with con-
traceptive adherence. In general, women in our cohort relied
on informal sources such as friends and family for contra-
ceptive information. Stories and rumors superceded infor-
mation provided by medical professionals. Further, we
found many examples of contraceptive misinformation that
appeared to result from conversations with medical provid-
ners. It is unclear whether the practitioner provided incorrect
information or the patient misunderstood. In one study of
low-income women, compared to African American and
White women, Latinas were the least likely to have made a
healthcare visit in the past year and were most likely to be
dissatisfied with the contraceptive care that they had re-
ceived, predominately because of language and perceived
cultural insensitivity on the part of the provider [21]. In light
of such issues, misinformation and miscommunication be-
tween provider and patients merit particular attention. This
finding may be related to poor health literacy, language
barriers or poor recall, all of which have been associated
with trouble complying with contraception [22,23]. While
health literacy and patient–provider communication have been shown to be an issue for many populations, language and cultural differences may pose additional obstacles for Latinas when interacting with healthcare providers of different ethnic backgrounds. Further, our studies indicate that compliance is a dynamic process with the onus resting on both the provider and the patient. We found it particularly concerning that one participant associated her child’s Down’s syndrome with the use of OCs, based on information received from a doctor.

It is encouraging that some women in our cohort were able to use the IUD effectively. A few women who were struggling with hormonal contraception had heard of intrauterine contraception and hoped to have one placed. This desire to use long-acting and nonhormonal contraception is consistent with findings from the 1995 National Survey of Family Growth when rates of hormonal contraceptive use among Latinas decreased and sterilization and condom use increased [24]. Despite studies to support use, many clinicians do not provide intrauterine contraception to teenaged and nulliparous women. Therefore, there is still a need to help youth use hormonal contraception.

Our study has a number of limitations. First, our participants were predominately Mexican American (though a few women were from Puerto Rico and Central America). By focusing on one population, we are unable to say whether such findings are specific to young Mexican Americans or whether we can generalize to other subpopulations of Latinas. Yet, we felt narrowing our approach was necessary as Latinos are heterogeneous and demonstrate different rates of contraceptive use and pregnancy. Further, we did not compare the views of women in this group with those of African American and White women. We chose this approach in light of the extensive research regarding African American and White adolescent populations compared to the dearth of information on Latinas, especially young, parenting Latinas. Given our study design, we were unable to explore the role of exposure to US culture and whether women who were born in the United States have different views than those who were not. Immigration status has been associated with risk behaviors of Latino adolescents [25]. Surely, immigration status and comfort with language also affect access to care and communication with providers. Overall, it must be understood that focus groups are hypothesis-generating in nature and represent a point of initiation when a subject is poorly understood. Future research might focus on comparing these attitudes to those of other subpopulations of Latinas and to American women in general.

Here, we demonstrate that concerns about future health, childbearing and side effects play an important role in acceptance and use of contraception among a cohort of young Latinas. This work is particularly important as rates of pregnancy to primary and repeat pregnancy among Latinas are extremely high and continue to rise.

Studies among adolescents in general show that such pregnancies are associated with limited educational achievement, poor health outcomes for both the mother and her offspring and a risk for continued poverty [26–28]. These findings indicate that counseling regarding side effects is of particular importance for women such as these who start with great skepticism and limited information regarding contraception. It also suggests that certain patients are at risk of receiving incomplete and incorrect information. Given that women in our cohort were more likely to subscribe to advice of friends over healthcare professionals, poor comprehension only undermines this relationship further. Therefore, providers need to assess the information that their patients receive, particularly when cultural and language barriers exist. Some authors have suggested particular counseling techniques that may be effective in promoting compliance among teenagers [5] and women in general [29]. These include open communication, directed counseling and querying regarding particular fears and negative information. Such advice appears particularly relevant when the provider and patient have different cultural backgrounds.

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References


