

“I was told it was the pill that suits me”: A qualitative study of women’s perceptions and experiences of medical reasons for non-preferred contraceptive use

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Abstract

Background: People have contraceptive autonomy when they can obtain their preferred contraceptive method. Non-preferred method use may result from inappropriate medical contraindications, which occur when providers apply incorrect contraceptive eligibility criteria during consultations. Non-preferred method use and inappropriate medical contraindications are understudied in the Global South, partially due to measurement challenges.

Objectives: This study provides the first evidence in over two decades that inappropriate medical contraindications are still a barrier to preferred method use in the Global South and offer a new conceptual frame for a neglected medical barrier to contraceptive use.

Design: We collected qualitative data from 49 in-depth interviews and 17 focus group discussions (n = 146) with women of reproductive age (15–49) in an anonymized African country.

Methods: We deductively identified instances of preferred method denial for medical reasons, then analyzed these episodes to determine whether the medical reasons for denial were evidence-based.

Results: We found that many women who reported preferred method denial described being offered medical reasons discordant with evidence-based guidelines, often resulting in what we determined to be contraceptive coercion. Specifically, we identified that (1) women experienced bi-directional contraceptive coercion with medical rationales, (2) women trusted providers' medical authority and felt unable to ask for more information, and finally, (3) women's personal reasons for their contraceptive preferences were rendered illegitimate by providers' use of biomedical language and (often incorrect) medical rationales. Consequentially, some women self-reported information indicating a legitimate contraindication to the non-preferred method their provider encouraged them to use.

Conclusion: Inappropriate medical contraindications are an under-studied facility-level barrier to contraceptive access that can result in contraceptive coercion, negative health outcomes, discontinuation of wanted methods, and loss of reproductive autonomy. Addressing inappropriate medical contraindications will require solutions that negotiate both structural factors and individual provider behavior to improve the quality of contraceptive service provision.

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Plan language summary

A qualitative study of medical reasons for non-preferred contraceptive use:

We conducted interviews and focus groups with women in an anonymized African country to discuss their experiences with getting contraception, especially any struggles they had with getting their preferred method of contraception. We found that many women reported being told they had a medical reason they could not use their preferred method, but the medical reasons they were provided did not align with evidence-based medical guidance. We have three main findings: First, some women were given medical reasons why they had to use a specific method of contraception, and then others were given medical reasons to prevent use a specific method. Second, women trusted provider's medical authority and felt uncomfortable asking questions, which sometimes resulted in women using methods that were actually medically contraindicated for them to use. Finally, women's personal reasons for wanting to use specific contraceptive methods were often seen as not good enough, especially when compared to the medical reasons offered by providers. Contraceptive service providers need to ensure that they are up to date on medical guidelines when offering family planning services. Policy makers need to address other factors that can result in providers giving incorrect medical information, including improving working conditions for providers and making sure they have a functional supply chain where all contraceptive methods are available. Finally, researchers need to do more research on when women report non-evidenced-based reasons they cannot use preferred contraceptive methods, to understand if this is an issue with how patients are understanding information, an issue with the accuracy of the provider's knowledge, or if providers are using their medical authority to misdirect women purposefully. Contraceptive choice is an important part of women's health, and therefore we should take steps to prevent women from having to use a non-preferred contraceptive method.

Keywords

family planning, contraception, barriers to contraceptive access, inappropriate medical contraindications

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Introduction

Access to preferred contraceptive methods improves public health and provides individuals with the means to exercise reproductive autonomy.^{1–3} However, people encounter a variety of facility-level barriers when attempting to obtain contraception, including long wait times, few trained providers, or insufficient supplies. One important set of facility-level barriers to contraceptive care are provider-imposed medical barriers that lack scientific justification, such as restrictive eligibility criteria or inappropriate medical contraindications, both of which were on Shelton et al.'s list of medical barriers from 1992.^{4–9}

Since 1992, restrictive eligibility criteria resulting from provider biases have been widely studied across Africa; research has documented how providers have denied contraception to women for reasons such as age, parity, and marital status.^{5,10–12} However, little has been done to identify how providers use their medical authority to deny women preferred contraceptives, especially when they apply *inappropriate medical contraindications*. Inappropriate medical contraindications are distinct from legitimate, evidence-based medical contraindications. There are little data on rates of legitimate contraindications for contraception in African settings, but in insurance database or facility-based samples in the United States, the prevalence of legitimate contraindications ranged from 13% for methods with estrogen to between 2% and 4% for progestin-only methods.^{13,14} Inappropriate medical contraindications are a broad category of medical barriers that can include medically unnecessary

testing before the provision of contraception and the use of outdated or non-evidence-based contraindication criteria to deny or encourage the use of specific contraceptives.^{4–6} Previous work on these medical barriers focused on inappropriate testing before contraceptive provision, such as unnecessary requirements for pregnancy tests or proof of menstruation.^{15,16} Very few studies have reported on the women whose contraceptive choices are constrained by the application of inappropriate medical contraindications. Therefore, we have limited information on the prevalence of inappropriate medical contraindications, the extent to which they negatively affect women's ability to exercise contraceptive choice, and how global reproductive health programs can address this facility-level barrier to high-quality contraceptive care.^{17,18}

We also have little information on why inappropriate medical contraindications are applied. Providers may be unintentionally applying outdated contraindication criteria because of missed medical training, lack of access to updated evidence-based guidance, or difficulty understanding how and when to apply these newer criteria. Providers must remain up-to-date when contraceptive contraindications change as the evidence base expands and must be familiar with their country's guidelines, as not all countries or medical governing bodies apply the same medical eligibility criteria for contraceptive use.¹⁹ In other cases, providers could be citing medical reasons for refusing to give women their preferred method when their concerns are actually related to availability of the method, their perceptions of the woman's ability to use the method

correctly, or the acceptability of the method for certain groups of women, for example, unmarried or nulliparous women.⁴

The small number of studies on this topic is partially attributable to methodological constraints. Due to social desirability bias, providers who deliberately use medical terminology or inappropriate contraindications to hide other overt biases are unlikely to reveal this to researchers in interviews. A 2001 study in Ghana attempted to address these issues by identifying clinics with a high “barrier index” and interviewing providers about their restrictive practices.¹⁸ They found that some providers used medical rationales to justify other restrictions, such as denying IUDs to unmarried women citing a higher risk of infections.¹⁸ To avoid social desirability bias, this study reviewed patient records to verify provider statements, finding orders for unnecessary tests and procedures in 74% of locations.¹⁸ This study found evidence of inappropriate medical contraindications but only using a time and labor-intensive design dependent on provider documentation. Since 2001, there is a significant literature gap around the prevalence of inappropriate medical contraindications, their root causes, and their impact on contraceptive satisfaction, especially in low- and middle-income countries (LMICs).^{17,18} There are recent studies in LMICs that have examined provider knowledge of appropriate contraindications, but these studies cannot determine if lack of knowledge directly impacts contraceptive access.^{20–23} Still, there is evidence that inappropriate medical contraindications persist and negatively affect contraceptive choice for women in LMICs; for example, in a 2020 study, providers reported removing wanted implants early due to weight gain or high blood pressure, neither of which are contraindications or medically appropriate reasons for implant removal.²⁴ This article does not detail if women whose implants were removed early were directed to use a non-preferred method or left without contraceptive coverage.

This lack of research means that not much is currently known about how inappropriate medical contraindications impact women’s contraceptive options in LMICs and how programs can ensure they are providing high-quality contraceptive care.^{4,5,10} As the global contraceptive field emphasizes choice and voluntariness in contraceptive service provision, we must understand if and how inappropriate medical contraindications might be restricting women’s ability to exercise contraceptive autonomy. In this article, we used two types of qualitative data to provide new descriptive evidence on non-preferred method use for medical reasons, including an analysis of this issue using the theoretical lens of contraceptive coercion.²⁵ Our aim was to shine a new light on this neglected topic by exploring qualitative descriptions of preferred method denials for medical reasons to first identify if medical reasons for preferred method denial were medically appropriate, and then determine the extent to which inappropriate medical contraindications were a barrier to obtaining preferred

contraceptive methods, providing new conceptual tools to guide future study of medical barriers to preferred method use.

Methods

Ethics and positionality statement

We first approach this work with an acknowledgment of the global and local power structures that influence this study and the reporting of these data. As students and faculty members from large U.S.-based universities with training in anthropology, public health, epidemiology, and demography, we bring together theories and methods from multiple fields to this study. However, many of these fields originated as tools of the colonial and neocolonial oppression of citizens of the Global South, and this history has shaped the training we have received.^{26,27} This research is situated within the history of stratified reproduction and contraceptive coercion; without acknowledging this, we cannot work to dismantle these oppressive structures.^{25,28,29} In approaching this work, we employed critical perspectives to interrogate the systems and structures that continue to perpetuate neocolonial forms of reproductive coercion in the Global South.

International family planning programs were initially developed with the explicit goal of fertility reduction in low-income countries. This objective relied on the colonial framing of leading “underdeveloped” countries into prosperity through controlling their reproduction and that was sometimes operationalized through violations of reproductive autonomy including forced sterilizations and financial pressure on governments and individuals to adopt contraceptive methods in high numbers.^{25,28,30–32} While the 1994 Cairo Programme of Action signaled a new era of placing emphasis on individual human rights in family planning services, including the right for women to control their own fertility, recent research has shown that coercive practices and structural pressure to control fertility in the Global South still exist and actively cause harm to women today.^{25,29,31,33,34} On a global scale, contemporary family planning programs have not yet fully incorporated principles of reproductive autonomy into their goal-setting, performance metrics, and research agendas.^{28,31} Family planning provision in countries of the Global South is still deeply embedded in global power structures that control the reproductive health and choices of women of color, including the women who participated in this study. Therefore, we focused this article on the impact of inappropriate medical contraindications on women’s contraceptive autonomy rather than on potential impacts on contraceptive uptake, discontinuation, or other usage metrics that do not prioritize individual autonomy.

As we used theories of contraceptive coercion in the analysis of these data, the authors have agreed that the location of this study must be anonymized for the safety and

continued provision of reproductive health care to those who participated in this study. This decision was made in conjunction with local researchers who participated in this study. Data were collected in a low-income country in Africa with an award-winning family planning program. Original data collection was reviewed and approved by the Institutional Review Board of the Office of Human Research Administration at Harvard University, the national ethics committee of this country, and a local ethics committee at one of the research locations. For all participants over the age of 20, written and informed consent was obtained. For participants aged 15–19 who assented, parents provided written informed consent. No identifying information about the respondents was retained. The analysis presented in this article was deemed not to constitute human subjects research by the Institutional Review Board of the Office of Human Research Ethics at the University of North Carolina. We adhere to the Standards for Reporting Qualitative Research recommendations in this methodology section (Supplemental Material).³⁵

Study design

Data collection for the parent study was designed as an exploratory sequential mixed-methods study, with qualitative data collection used to: first understand lived experiences of contraceptive coercion, and then as formative data to design a quantitative study to quantify phenomena identified in the qualitative data.³⁶ During primary analysis for the parent study, we found that medical reasons were a significant contributor to non-preferred method use among contraceptive users in our sample.³⁷ To address this finding, here we present a secondary analysis of the qualitative data to provide new perspectives on the denial of preferred methods for medical reasons.

The qualitative data include 49 semi-structured in-depth interviews (IDIs) and 17 focus group discussions (FGDs; $n=146$) conducted in one urban and one rural location within the study site over 5 weeks between July and August 2017. Female enumerators were trained to carry out IDIs and FGDs in either the colonial language or in the two most common local languages. IDIs took around 90 min and were conducted in private locations near respondent's homes or businesses. FGDs took around 2 hours and were conducted in private locations, like classrooms or community centers. Guides for the IDIs and FGDs focused on past experiences with family planning services and contraceptive use, reproductive desires, and contraceptive and childbearing decision-making. Sample questions included: *Are you currently using a method of contraception? How did you start to use /not use a method of contraception? What influenced your choice of method?* Questions were also asked around experiences of contraceptive pressure or coercion, including: *Have you or anyone you know been encouraged or pressured to adopt a method of contraception that you would have preferred not*

to use? Have you or anyone you know been encouraged or pressured to continue using a method contraception that you would have preferred to stop?

Purposive sampling of eligible participants was restricted to women between 15 and 49 years old who lived in the catchment areas and spoke one of the three study languages. FGDs had between 6 and 11 participants, with all participants being in the same age groups (15–24 or 25–49) and marital statuses (married or unmarried). An a priori sampling framework originally planned for 48 IDIs and 12 FGDs. This framework was based on research that suggested that age and marital status were significant factors affecting contraceptive decision-making. Notably, qualitative participants were not sampled with the goal of reaching data saturation,^{38,39} but rather were sampled to maximize diversity (marital status, ethnic group, socioeconomic status, religion, contraceptive use, etc.) among participants to gain multiple perspectives and insights on contraceptive coercion in this context. For the FGDs, stratification by age and marital status was intended to reduce hierarchies and encourage sharing within a peer group. To reach the goal of a diverse sample, an additional IDI and five additional FGDs were added for a total of 49 IDIs and 17 FGDs.

Urban respondents were chosen in collaboration with the study team, led by A4, from formal and informal neighborhoods in five urban areas. The study team recruited rural respondents from 11 villages in the rural study location. Field supervisors and community leaders from established local research platforms aided with identifying and approaching potential respondents for IDIs or FGDs. Additionally, the field supervisors recruited key informants from neighborhood groups and women's associations to identify other potential respondents across ages, marital status, educational attainment, and religions. Women had to be between 15 and 49 years old and be able to provide verbal consent in one of the three study languages. All respondents were given household soap or a similar small item to express gratitude for their participation. All IDIs and FGDs were audio-recorded, translated into the colonial language, transcribed verbatim, and de-identified. All names given are pseudonyms.

Motivation

The purpose of this study is to better understand a finding that emerged from analysis of the quantitative portion of the mixed methods study: women using non-preferred methods reported that they could not use a preferred method for "medical reasons."^{37,40} In the primary quantitative analysis, 37% of all contraceptive users ($n=1210$) had indicated some form of non-preferred method use, either in that (a) they had another method they would rather be using or (b) that their current method was not the method they had wanted at the time of method acquisition. In this second group ($n=88$), 55% reported that they were using a

non-preferred method for “Medical Reasons.”³⁷ No additional information was available from the survey to assess whether the medical reasons for non-use were appropriate. By contrast, in the qualitative data, women described medical reasons for contraceptive non-use or non-preferred method use, many of which were not consistent with accepted medical guidelines.

Data analysis

We used a deductive approach to identify instances of preferred method denial for medical reasons, then analyzed these episodes to identify common patterns. Specifically, we investigated whether the medical reasons for denial aligned with broadly accepted medical consensus. We recognize the need for positionality in determining if a contraceptive contraindication is appropriate or inappropriate, especially as different countries have different national guidelines.¹⁹ Therefore, we defined broadly accepted medical consensus by the recommendations provided by the evidence-based World Health Organization (WHO) guidelines, as the published medical guidelines for the anonymized country have followed the WHO four-level system for categorizing medical contraindications for contraception since 2009.^{41,42} Since these data were collected between 2017 and 2018 and asked women to reflect on past experiences, we used *Family Planning: A Global Handbook For Providers*, published in 2018, and the third edition of WHO’s *Selected Practice Recommendations For Contraceptive Use*, published in 2016.^{41,42}

In the primary analysis, reported elsewhere,²⁵ a multidisciplinary team of researchers, including A1 and A4, inductively developed a codebook, double-coded all FGD transcripts, and iteratively adapted the codebook to code the IDIs. For this analysis, A1 read all transcripts, memos, and interview summaries written by additional coders, documenting instances when women in the IDIs or FGDs discussed contraception with providers, being denied a preferred method, or being pressured to change their mind about a method. When medical rationales were used to try to change a woman’s opinion or contraceptive choice, A1 checked this against the WHO guidelines, then documented the excerpts to discuss and analyze with A3 and A4. Final determinations regarding alignment or misalignment with the WHO guidance was assigned when consensus was reached. We analyzed these cumulative experiences for patterns of denial, creating a matrix to understand how the theory of contraceptive coercion (described below) interacted with medical rationales for preferred method denial.

Theoretical framework: Contraceptive coercion

While our primary goal was to provide explicit examples of women using non-preferred methods for medical reasons and identify the application of inappropriate medical

contraindications, a secondary goal was to understand the different aspects of contraceptive coercion present in these experiences. Senderowicz’s theory of contraceptive coercion first establishes coercion as bidirectional, in that it could present as preventing women from using preferred methods or forcing women to use non-preferred methods.²⁵ We hypothesized that inappropriate medical contraindications could be used to prevent women from using a preferred method, but also that inappropriate medical rationales could be used to pressure a woman to use a specific non-preferred method. Senderowicz places coercion on a spectrum from subtle, such as providing incorrect medical information, to overt actions, such as refusing to remove an implant.²⁵ Inappropriate medical rationales could be used as tools of coercion, to give weight to other pressure from providers. Finally, this theory illustrates how coercion can be structural when providers face pressure to meet contraceptive targets or do not get “credit” for a contraceptive visit that ends without method uptake.²⁵ We sought to understand if women viewed the denial of their preferred method as legitimate and how they responded to or recognized subtle forms of coercion from providers. Additionally, we analyzed the examples of inappropriate medical contraindications for the presence of structural limitations, such as stockouts of available contraceptive commodities, as potential influences on preferred method denial for medical reasons.

Results

Sociodemographic characteristics of the 49 women who participated in the IDIs can be found in Table 1, and sociodemographic characteristics of the 17 FGDs can be found in Table 2. Participants were evenly divided between the urban and rural location, with 51% of IDI participants and 52% of FGD participants recruited from the urban area. In the IDIs, about 40% of participants were not current contraceptive users, but 45% of non-users had used contraception in the past. In this context, marital status was more salient than age for social distinction; 28% of FGD participants were unmarried, as were 30% of IDI participants. While we did not collect data on this specifically, participants reported seeking care at a variety of facility types, including public and private clinics and hospitals, across the anonymized country.

Across the IDIs and FGDs, we identified three primary themes: (1) inappropriate medical reasons for preferred method denial resulted in bi-directional contraceptive coercion, (2) women trusted providers’ medical authority and felt unable to ask for more information when denied a method due to a medical reason, which occasionally resulted in use of a non-preferred and legitimately contraindicated method, and (3) women’s personal reasons for their contraceptive preferences were rendered illegitimate by providers use of biomedical language and (often incorrect) medical rationales.

Table 1. Descriptive characteristics of 49 women who participated in in-depth interviews by study site.

Sociodemographic characteristics	Urban	Rural
Total interviews	25	24
Marital status		
Married	17	17
Unmarried	8	7
Age group		
15–19	6	8
20–24	10	5
25–29	1	3
30–34	1	2
35–39	2	3
40–44	1	2
45–49	4	1
Religion		
Christian	13	12
Muslim	12	12
Ethnicity		
Predominant ethnicity	22	2
Ethnic minority 1	1	3
Ethnic minority 2	0	4
Ethnic minority 3	0	12
Ethnic minority 4	2	0
Ethnic minority 5	0	1
Ethnic minority 6	0	2
Education		
Primary or lower	9	15
Secondary or higher	16	9
Number of children		
0	7	6
1	9	7
2	2	3
3	1	2
4	2	3
5+	3	3
Student status		
Current student	8	6
Not student	13	18
Contraceptive use		
Current use	15	14
Former use	6	3
Never used	4	7

Theme 1: Inappropriate medical reasons for preferred method denial resulted in bi-directional contraceptive coercion

Senderowicz's theory of contraceptive coercion defines upward coercion, where women are forced to uptake methods they do not want to use, and downward coercion, where women are prevented from using methods they want to use.²⁵ In this analysis, we have examples of medical reasons used as justifications for why women were

required to use a specific method, and as justification to prevent the use of preferred methods.

Cesarean sections (C-sections) were a common medical reason women were given to require long-acting reversible contraception (LARC) uptake, with providers emphasizing – incorrectly – that women must specifically use modern contraception to meet longer-than-recommended birth intervals after C-sections. Miriam, a 24-year-old woman in the urban area, had a long list of fears around contraceptive side effects. When asked about how she prevented pregnancy before her last birth, she said:

Miriam: I used to count my days (the calendar method). . . I was scared, that was why I only counted my days. . . It was the products I was afraid of. . . Some said if you take them your periods would stop coming normally. So, I, too, had made the choice not to use them and to use the calendar method only.

When asked why she was using the implant despite her earlier emphasis that she wanted to avoid modern contraception and contraceptive side effects, Miriam described the line where she waited for 7h before her C-section wound was examined. She had no intention of getting a contraceptive method that day, having previously relied on the calendar method, but was presented with the pill and the implant and told to choose.

Miriam: I asked if there weren't other methods, and [the health provider] told me no. That as I give birth by caesarean section, not to use another method, only to use the implant. . . He said that the implant is the only right thing.

While birth intervals of 24 months are recommended after a C-section, nothing in the WHO guidelines state that use of contraceptive implants are required after a C-section.⁴¹ However, women in the FGDs and IDIs reported providers insisting on the use of modern methods, especially LARCs, after a C-section. Miriam was reassured that she could get the implant removed later if she chose – however, when she sought removal after experiencing negative side effects, including heavy periods and back pain, she was turned away because she did not want to use another method after removal. Miriam felt that at the hospital there had not been enough time for her to get adequate information on the two methods she was forced to choose between. For Miriam, medicalized emphasis on *needing* a form of modern contraception after a C-section resulted in forced uptake and forced continued long-term use of a non-preferred method.

Table 2. Sociodemographic characteristics of focus groups.

Focus group	N	Site	Religion	Age group	Education	Marital status
1	10	Urban	Mixed	25–49	Some school	Married
2	7	Urban	Mixed	25–49	Some school	Married
3	10	Urban	Mixed	25–49	No school	Married
4	10	Urban	Mixed	25–49	No school	Married
5	8	Urban	Mixed	15–24	Some school	Married
6	10	Urban	Mixed	15–24	No school	Married
7	11	Urban	Mixed	15–24	Some school	Unmarried
8	10	Urban	Mixed	15–24	Some school	Unmarried
9	9	Rural	Muslim	25–49	No school	Married
10	8	Rural	Muslim	25–49	No school	Married
11	6	Rural	Christian	25–49	No school	Married
12	6	Rural	Christian	25–49	No school	Married
13	11	Rural	Christian	25–49	No school	Married
14	10	Rural	Muslim	15–24	Some school	Married
15	6	Rural	Christian	15–24	No school	Unmarried
16	8	Rural	Christian	15–24	Some school	Unmarried
17	6	Rural	Muslim	15–24	Mixed	Unmarried
Total	146					

Marie had the opposite issue – her provider gave her inappropriate medical reasons why she could not use her preferred method, which resulted in non-use of a desired modern method. Marie, a 34-year-old woman with four children in the urban area, was denied her preferred method due to her weight. During her postpartum visit, Marie asked to return to her pre-pregnancy method, the injection, and was denied.

Marie: She told me that she offered me the IUD because of my weight. I'm fat; that's what will be good for me. But if I take the pills, my weight may increase or if my weight increases it won't be good. The injectable can also increase my weight. She said that, since my weight is too high, she offers me the IUD.

When asked if it felt like she was being forced to use this method, Marie said:

Marie: (laughs) Ah what am I going to say to that? I had said that I wanted to use the injectable because I knew that with the injectable it was going to be good. . . but she told me no, that with my weight it is better to use the IUD. . . the IUD is clean, that when you use the IUD, you just have to be hygienic and you won't have a problem with it. Additionally, she said that as the

IUD doesn't pass through the blood, I will not get fat.

While WHO guidelines state that weight can be part of clinical decision-making for certain methods of contraception, the 2018 and 2016 WHO recommendations for providers do not recognize weight as a medical reason to deny injections.^{41,42} Marie expressed that she felt that there was nothing she could say in response to the list of medical reasons given by her provider, despite discomfort with the focus on her weight. Marie's experience of downward contraceptive coercion due to medical reasons prevented her from using a wanted contraceptive method, despite concern that without, she would become pregnant again soon. At the time of the interview, Marie was not using a modern method of contraception.

Theme 2: Women trusted providers' medical authority and felt unable to ask for more information when denied a method due to a medical reason, which occasionally resulted in use of non-preferred and legitimately contraindicated method

While all of the women who reported non-preferred method use due to medical reasons had experienced a threat to their contraceptive autonomy, some of the women in our sample also experienced a threat to their physical health. Eloise, a 24-year-old woman with one child in the

urban location, was denied her preferred method due to high blood pressure. When asked why she was using the injectable, she said:

Eloise: When I went to the [health center], in my head what I wanted to use first was the implant. But when I gave birth my blood pressure was now high . . . and they told me that I couldn't use the implant because my blood pressure was getting too high, that if I used the implant, it wouldn't be good for me. It's because of all that that I decided I was going to use the injectable.

Interviewer: You were saying your blood pressure was rising?

Eloise: Yes, my blood pressure was only going up and they told me that because I have high blood pressure that I can't use the implant. Otherwise, it can create sicknesses for me, but they didn't tell me what kind of sickness. They told me to change the method, that I can't use this, and that's why I decided that I was going to use the injection.

Eloise was convinced by her provider not to use her preferred method, the implant, and to use the injectable instead due to her high blood pressure, but was given no details about the "sickness" that prevented implant use. While WHO guidelines recommend taking blood pressure before starting a hormonal method, high blood pressure is not a contraindication to implant use.^{41,42} In contrast, the 2018 guidelines for both progestin-only injectables and monthly injectables do recommend using a different method if a woman is being treated for high blood pressure.⁴¹ While Eloise did not know what her blood pressure was – only that it was high – her desired method was a category 1 for mild or moderate hypertension (systolic 120–159 and diastolic 80–99) and a category 2 for severe hypertension (systolic over 160 or diastolic over 100), both of which indicate that providers should have offered her desired method.⁴¹ However, the method that she was directed to use, injectables, has higher risk categories. It is likely that Eloise was using a progestin-only injectable (like DMPA-IM) given she describes going every 3 months for an injection; still, progestin-only injectables are a category 2 for mild or moderate hypertension (systolic 120–159 and diastolic 80–99) and a category 3 for severe hypertension (systolic over 160 or diastolic over 100), which would indicate use of a more appropriate method if Eloise's blood pressure was high.⁴¹ In either case, continued blood pressure monitoring and treatment are both indicated, neither of which Eloise received. Inappropriate

medical contraindications not only prevented Eloise from using her preferred method, they resulted in Eloise using a non-preferred method that carried the potential for higher medical risk.

Anne, a 35-year-old woman in the urban location, knew little about the heart problem that doctors said prevented her from using a long-acting method. Anne was a pill user, despite concerning side effects and her worry about forgetting to take the pill every day. When she asked for a long-acting method at her postpartum appointment, she was told she could not use the implant or injection because of her heart problem.

Anne: At that moment, you are alone with the provider, and he tells you what you should take. If you have a disease, you tell him that you have such a problem. He will tell you which medicine is right for you. It is you who makes the choice, if you have a problem [with what he tells you] you choose what you want; but if you want peace, you choose the method the provider advises you to choose.

Interviewer: Have you ever felt pressure to use a method you didn't really want to use?

Anne: I was told that it is the pill that suits me, because if I follow what I want to do by taking [the implant], it will tire me. . . For the injection, I was told that it slows down childbirth so if you only have two children, you can't use it. You must have at least three children before you are given the shot. But since they said that it can cause me problems, I don't even ask about it. I only know what I'm told is good.

When asked if she felt she could refuse the pill to use a longer-acting method, Anne emphasized that the providers had much more education than she did, and much more medical knowledge.

Anne: Yes, you just have to follow [what the provider says]. Because they are the ones who are trained in this and they know everything. If you have studied a little and you know a little, that is fine. But if you don't know and they show you what's going with you and you refuse; if you suffer afterwards, that's your problem.

The "suffering" that could come from refusing to follow a provider's medical advice could encompass a variety of

potential consequences. Possibilities mentioned by Anne and other participants ranged from being lectured by the provider if you experienced later medical issues, to being refused prenatal care after getting pregnant again. Anne was forced to weigh her options: she could follow the provider's recommendation and choose "peace" or she could ask more questions and risk "suffering." Unfortunately for Anne, the combined oral contraceptive pill is often not the best choice for women with heart issues – the implant is considered by the WHO to be a much safer method for women with any heart conditions.⁴¹ While Anne may have been using a progestin-only pill, in this setting progestin-only pills are typically reserved only for breastfeeding mothers. Regardless, Anne would have preferred to use a long-acting method due to her adherence issues with the pill, but her trust in her providers meant that she was deeply afraid of long-acting methods, and was concerned about their impact on her heart. Even after she had four children and wanted to cease childbearing, she continued using the pill, and had two more unplanned pregnancies.

Theme 3: Women's personal reasons for their contraceptive preferences were rendered illegitimate by providers' use of biomedical language and (often incorrect) medical rationales

Women in our sample had strong personal reasons behind their contraceptive preferences but often found that providers used biomedical language and medical rationales to pressure them into making different choices. Hannah, a 25-year-old in the rural area, was denied her preferred LARC during a postpartum visit. She wanted the implant, viewing it as a discrete method that did not require repeat clinic visits but was denied because she was breastfeeding.

Hannah: For example, at the [postpartum check-up], you are offered contraceptives. And if you chose the implant, they do not give it to you because it would prevent the production of breast milk, which will affect the baby's diet. If you choose the injectable there is no problem, but if you want the implant, you can come back in 6 months when the baby will be big. . . The implant has more contact with the blood than the injectable.

As Hannah was motivated to prevent pregnancy and to continue breastfeeding, she felt that she had to choose the option that was offered to her. Unfortunately for Hannah, the provider's information was medically inaccurate; the WHO guidelines have no contraindications for using a

contraceptive implant while breastfeeding, as implants do not contain estrogen.⁴¹ However, as Hannah believed that there was a medical risk to her *and* her child if she used her preferred method of contraception, she accepted the injection, despite her desire to avoid having to return to the clinic every 3 months.

Janine, a rural woman with seven children, wanted to ensure that contraception would be compatible with her body. She was open to allowing the provider to guide method choice, but later faced issues having her preferences respected. She said that when first seeking contraception, the provider tested her blood:

Janine: They asked me what method I wanted and I said that I didn't know. So they tested my blood to see if the [implant] was going to work for me.

When Janine began experiencing negative side effects and wanted to switch methods, providers said her back pain and fatigue were not attributable to the implant and refused to remove it. Five years later, when the implant expired, she asked to switch to the injection, but was denied by the provider.

Janine: He told me that my pregnancies have made me very tired, that my tubes were no longer strong, that I had to wait 5 years before having another child.

Interviewer: So, it was because of the time that he chose the [implant]?

Janine: Yes, that's it. Because if he said that if he did the injections, there will be a time when I would refuse to come back. . . because he noticed my tubes were tired, if I got pregnant I would have had to give birth by C-section. I had to wait 5 years, and eventually I would not respect the appointments.

Janine was denied the chance to make an informed decision among the options that were available to her – the provider used the non-existent condition of "tired tubes" and a non-existent "blood test" to decide for her. Janine was not the only participant to mention a "blood test" for contraception – however, no such test for determining the compatibility of methods for individuals exists. It is unclear what test was performed or how providers described these tests to patients, but it is clear that the biomedical language of "blood tests" were used to assign greater importance to the provider recommendation than to patient preferences. Once Janine did develop a preference, she was still denied the opportunity to change methods. Notably, the provider's

insistence that Janine use the implant indicated a desire to exert control not only over method adoption, but method continuation. This provider was prioritizing his desire for Janine to have a 5-year spacing between births over Janine's right to choose her preferred contraceptive method and decide when to discontinue and used the threat of a C-section to override Janine's complaints about the implant's side effects and her preference for the injection. Once Janine's implant expired and she was finally able to switch to the injectable, she was relieved that her back pain and fatigue disappeared.

We also note two descriptive findings across the many instances of non-preferred method use for medical reasons. First, weight and high blood pressure were the most common medical reasons used to prevent women from using their preferred method, as experienced by Marie and Eloise. Second, women faced increased contraceptive coercion using medical rationale in the postpartum period, either after a C-section or during their 6-week follow-up visit post-delivery – all of the stories reported above, bar Janine's, occurred in the postpartum period.

Discussion

These data provide some of the first evidence in nearly 20 years that women are experiencing threats to their contraceptive autonomy due to providers denying women their preferred methods based on incorrect medical information. In some cases, women were prevented from using a preferred method due to a medical reason, but that medical reason would be a legitimate contraindication to the non-preferred method a provider directed them to use. We also found that the power imbalance between providers and patients led to a devaluing of women's contraceptive preferences when positioned against provider opinion, which included incorrect medical information and misapplication of medical eligibility criteria. These examples of contraceptive coercion with medical rationales point to an urgent need for family planning programs to better understand why providers deny women preferred contraceptive methods for medical reasons and what steps can be taken to address this issue.

Understanding why providers apply inappropriate medical contraindications is complex, especially when relying only on patient perspectives. When using patient-reported data, researchers or subjects must be familiar enough with evidence-based guidelines to separate legitimate from illegitimate denials. Some researchers have tried to assess providers' medical knowledge of contraceptive side effects and contraindications to identify if a provider is at risk of applying an inappropriate medical contraindication, but this does not provide information on the quality of day-to-day care actually offered by providers.^{20,21} Still, it is worth considering how provider's reasons for applying inappropriate medical contraindications may be similar to reasons

providers apply other medical barriers. During counseling, multiple aspects of a patient's identity can impact the care they receive, including age, parity, ethnicity, education, or marital status.^{43,44} The imposition of age or parity restrictions on contraception has been widely explored, with some providers justifying their decisions based on concerns about future fertility and other common misconceptions about contraception.^{5,11,12,45} Like other studies,^{11,12,46,47} we found examples of inappropriate medical contraindications being imposed on specific women due to their sociodemographic characteristics. For example, a provider refused to offer Anne a method by applying a parity restriction with a non-evidence-based medical rationale. An underexplored reason for denial in our results was inappropriate medical denial of contraceptive methods based on patient weight. While there have been calls for reduction in weight-related stigma in healthcare⁴⁸ and recent recognition of unmet contraceptive care needs for individuals of larger body size,⁴⁹ more research is needed in this area.

Our findings highlight a pattern of medical paternalism, which occurs when providers' medical expertise is viewed as a reason to disregard or override patient autonomy, by either patient or provider. Many of our participants felt unable to push back on medical decisions or ask for clarity on the medical reasons they were denied their preferred method. We saw the impact of this imbalance across age, marital status, parity, and education level, indicating that any woman could face this form of medical paternalism. Our results are consistent with findings from a study in Nigeria examining provider-patient interactions, in which patients also reported discomfort and uncertainty caused by limited health information disclosure and medical paternalism.⁴⁴ Still, viewing individual providers as bad actors with malicious intent is inaccurate and disregards important contextual information. When asked about medical paternalism in African contexts, providers have pointed to broader challenges such as communicating medical information across educational levels, limited time with patients, and cultural expectations of providers as barriers to collaborative care.⁵⁰⁻⁵²

We did find that systemic issues may contribute to some of the examples of the application of inappropriate medical contraindications that we reported. For example, Miriam was forced to decide between two hormonal methods, and when asked, her provider said that there were no other options available. Senderowicz points to structural coercion, which can include limited method availability due to structural (as opposed to interpersonal) causes, as an important driver of contraceptive coercion.²⁵ The limited method options offered to some participants may indicate that limited method availability could influence restrictive provider behavior. Using the same data used in this analysis, Senderowicz also found structural coercion in the form of targets, where quotas and reporting structures created incentives for providers to promote contraceptive uptake.²⁵

These incentives, in addition to other structural pressures, may have caused providers to offer inaccurate medical information to encourage uptake of specific methods. Finally, there is growing recognition that providers in LMICs face high levels of burnout, low pay, heavy workloads, staff shortages, and material shortages, all of which are structural issues that contribute to low quality of care.^{53–55} There have also been calls to formalize health care providers' right to continued professional development (CPD), where medical information can be kept up to date, in the light of many structural barriers to CPD.⁵⁶ Barriers to CPD in this and similar contexts include lack of financial resources, healthcare worker shortages for coverage during CPD, and disparities in CPD opportunities and access.⁵⁷ Rather than finding fault in individual providers, policy-makers and researchers should focus on improving provider working conditions and supporting providers to meet their duty of care to offer high-quality services, even when working in overburdened healthcare systems.

Addressing provider bias or provider knowledge of medical contraindications has proven complex; previous research has shown the limited effectiveness of job aids or increased provider training.^{20,47,58} Some of this limited effectiveness is explained by provider reluctance to appear unknowledgeable in front of patients, or the “know-do gap,” where best practices are known but not consistently implemented.^{12,58} Other studies demonstrated success with self-care options: one study reported that when provided with accurate information, self-screening for hormonal contraception was comparable to nurse screening for non-eligibility in low-income settings.⁵⁹ However, long-lasting and sustainable interventions to address inappropriate medical contraindications will require much additional research with providers and a greater understanding of the structural factors that affect this medical barrier. Future work should include formative qualitative research to understand provider medical decision-making during contraceptive consultations, development of survey questions to capture preferred method denial for both accurate and inappropriate medical reasons, and development of interventions to reduce inappropriate denial of preferred contraceptive methods for medical reasons.

Strengths and limitations

This study did not collect data from providers and thus can only reflect the patient perspectives from the provider–patient interaction. We report on what women remembered from their clinical interaction, and how they personally understood their method denial. While it is important to study how women understand their own healthcare experiences, the absence of provider perspectives makes it difficult to differentiate legitimate from illegitimate medical reasons for preferred method denial. As this analysis was not planned a priori, the IDI and FGD guides did not contain

explicit questions about medical reasons for non-preferred method use that could be used for this purpose.

The strength of this analysis was the breadth of the qualitative sample, which included almost 200 women from a range of socioeconomic backgrounds, education levels, religions, and life stages. In the IDIs especially, women were incredibly detailed in their descriptions of the barriers they faced in accessing preferred contraceptive methods, which allowed us to compare their reported medical reasons for denial with the WHO guidelines. Given the difficulty of identifying inappropriate medical contraindications in quantitative research, this analysis provides important evidence that this medical barrier is still salient for women seeking contraception.




Conclusions

The application of inappropriate medical contraindications is a medical barrier to preferred contraceptive method use and a form of contraceptive coercion. Given the challenges in collecting data on inappropriate medical contraindications, our study is the only one in the last two decades, to our knowledge, that describes this neglected medical barrier and its impact on women's ability to exercise their contraceptive preferences. We found that women reporting non-preferred contraceptive method use also often reported experiencing denial of a preferred method for medical reasons, many of which were inappropriate medical reasons. As programs prioritize contraceptive preferences, future research must explore different methods of collecting data to identify instances of providers inappropriately applying medical criteria. We must also identify potential pathways that could be used to address this medical barrier to preferred method use and improve contraceptive service provision for women globally.

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Ethical considerations

Data were collected in a low-income country in Africa with an award-winning family planning program. Since we explicitly discuss coercion, a highly politicized topic, and since family planning programs in this country are funded by a variety of global funders, we have anonymized the location of this research to protect

programs in this country from targeted repercussions that could affect their funding and ability to continue providing services. This was discussed over email with an Editor-in-Chief of *Women's Health* (Dr. Jeannette M. Wade), and this anonymization is not a barrier to publication. Original data collection was reviewed and approved by the Institutional Review Board of the Office of Human Research Administration at the Harvard University, the national ethics committee of this country, and a local ethics committee at one of the research locations. The analysis presented in this article was deemed not to constitute human subjects research by the Institutional Review Board of the Office of Human Research Ethics at the University of North Carolina, Chapel Hill.

Consent to participate

For all participants over the age of 20, written and informed consent was obtained. For participants aged 15–19 who assented, parents provided written informed consent. No identifying information about the respondents was retained.

Author contributions

Stephanie Chung: Conceptualization; Formal analysis; Methodology; Software; Writing – original draft; Writing – review & editing.

Katherine Tumlinson: Conceptualization; Resources; Supervision; Writing – review & editing.

Aunchalee Palmquist: Conceptualization; Methodology; Resources; Supervision; Writing – review & editing.

Leigh Senderowicz: Conceptualization; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Writing – review & editing.

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The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Data availability statement

Due to sensitive content and potentially identifiable information, the data that support the findings of this study are not openly available under the terms of our ethics approval. Data may be made available on a case-by-case basis upon reasonable request and ethical approval by qualified researchers. Inquiries may be made to the corresponding author, or to the IRB and Office of Human Research Ethics at the University of North Carolina, Chapel Hill (irb_questions@unc.edu).

Supplemental material

Supplemental material for this article is available online.

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