



## Health Care Services

# “If You Don’t Ask, I’m Not Going to Tell You”: Using Community-Based Participatory Research to Inform Pregnancy Intention Screening Processes for Black and Latina Women in Primary Care



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## A B S T R A C T

**Background:** Public health and medical professional organizations recommend screening women of reproductive age for pregnancy intention (PI) routinely in primary care. Existing PI screening tools may not address the complexity of intentions for women of color or lower socioeconomic status or be well-suited to primary care settings. This study sought to inform recommendations for carrying out PI screening meaningfully in primary care settings.

**Methods:** This community-based participatory research project united staff from a research institution, community health organization, and federally qualified health center in a predominantly Latina community in New York City. The Community Advisory Board members designed the research question, developed qualitative interview guides, and conducted in-depth interviews with 30 English- and Spanish-speaking female federally qualified health center patients ages 15 to 49. Community Advisory Board members developed an initial codebook using an inductive approach and refined themes throughout the coding process. After coding, Community Advisory Board members created a conceptual map representing relationships between key themes, and generated data-informed recommendations for PI screening practices that are relevant and feasible in the community context.

**Results:** Participants expressed a range of experiences with PI screening processes, depending on medical histories, attitudes, norms, and perceived benefits of screening. Three central themes emerged through frequency of occurrence, consistency in content, and relevance as reflected in concept mapping: agency, judgment and shame, and expertise versus authority. Recommendations included specific strategies and wording providers could use to explain the rationale and context for discussing PI.

**Conclusions:** Future work should examine the experience and effectiveness of implementing these community-based participatory research-derived recommendations in primary care.

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Despite a recent decrease, 45% of pregnancies in the United States remain mistimed or unwanted (Finer & Zolna, 2016). Additionally, more than one-half of women of reproductive age (52%) report at least one preconception risk factor, including smoking, alcohol consumption, obesity, and diabetes (Denny, Floyd, Green, & Hayes, 2012; Gipson, Koenig, & Hindin, 2008; Hall, Benton, Copas, & Stephenson, 2017). To address this issue,

public health and medical professional organizations recommend screening women of reproductive age for pregnancy intention (PI) as a routine part of primary care (Farahi & Zolotor, 2013). Assessing PI in primary care aligns with patient-centered counseling, a key component of which is optimizing patients' decision making (Barry & Edgman-Levitan, 2012; Dehlendorf, Fox, Sobel, & Borrero, 2016). Numerous efforts have been made to develop standardized tools that 1) routinize and standardize the process of assessing primary care patients' PI (Allen, Hunter, Wood, & Beeson, 2017; Bellanca & Hunter, 2013; Bello, Adkins, Stulberg, & Rao, 2013; Callegari, Aiken, Dehlendorf, Cason, & Borrero, 2017), 2) can be integrated into the clinical record (Simons & Kohn, 2018; Thiel de Bocanegra, McKean, Darney, Saleeby, & Hulett, 2017), and 3) are able to inform surveillance of family planning service delivery on a population level (Gavin et al., 2014).

Increasing attention to reproductive justice, cultural relevance, and patient-centered care has sharpened the focus on PI screening and its impact on patients' contraceptive decision making, particularly for women of low socioeconomic status (SES) and women of color, who are more likely to experience an unwanted or mistimed pregnancy (Finer & Zolna, 2016) and to be affected by preconception risk factors (Creanga et al., 2014; Denny et al., 2012), contributing to disparities in maternal and child health outcomes (Association of State and Territorial Health Officials, 2012; Bryant, Worjolah, Caughey, & Washington, 2010; Mohllajee, Curtis, Morrow, & Marchbanks, 2007). Studies examining existing PI screening tools suggest that questions and response options may not address the complexity of women's intentions, feelings, desires, and life experiences regarding pregnancy, particularly for women of color or of lower SES (Bello et al., 2013; Borrero et al., 2015; Callegari et al., 2017). Such tools may fail to acknowledge how culture, race, ethnicity, and SES affect decisions about pregnancy (Borrero et al., 2015; Gomez & Wapman, 2017; Holliday et al., 2018; Morse & Moos, 2018; Stevens, 2015).

Integrating PI screening into the primary care setting—where a range of health concerns must be addressed within limited time—adds complexity (Akers, Gold, Borrero, Santucci, & Schwarz, 2010; Chuang et al., 2012). In primary care, discussions of PI are a critical antecedent or component of contraceptive counseling. Substantial qualitative work conducted around Latina and Black women's experiences with and preferences for contraceptive counseling has uncovered perceptions of implicit coercion in the counseling process (Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013; Donnelly, Foster, & Thompson, 2014; Gomez & Wapman, 2017; Yee & Simon, 2011). However, there is currently a notable gap in the literature exploring how to make the initial PI screening process patient-centered across all stages: when it occurs, how the conversations are initiated and by whom, and how PI screening responses are translated into service provision in the primary care setting.

To address this gap, a community-based participatory research (CBPR) project, described elsewhere in detail (Falletta et al., submitted), was conducted to examine patients' perspectives on how PI screening can be carried out meaningfully for women served in primary care settings. With a CBPR approach (Israel, Schulz, Parker, & Becker, 2001; Minkler & Wallerstein, 2008), this inquiry primarily sought to make recommendations that arose from the findings and reflected the needs, capacity, and lived experiences of the clinical and community partners who would implement them.

## Methods

### Study Setting

This CBPR project was a joint effort of three New York City-based organizations: 1) Columbia University Mailman School of Public Health (research principal investigator), 2) Public Health Solutions, a public health institute that provides program support and direct care (community principal investigator), and 3) Ryan Health/Women and Children's, a federally qualified health center (FQHC) in a predominantly Latino community in New York City. Two of the institutions (Ryan Health/Women and Children's and Public Health Solutions) had previously participated in a family planning capacity-building project. Through this prior project, providers received training on PI screening, and the electronic health record was modified to add a prompt for providers to systematically ask and record PI responses for all patients. The Community Advisory Board (CAB) comprised 16 members; all identified as women (although this was not a prerequisite for membership), and nine identified as Latina. CAB members who were not participating as part of their paid employment were compensated for being members of the CAB, as well as for attending any trainings and for conducting interviews.

### Ethics

All data collection procedures and materials were reviewed and approved by the institutional review boards of the research institution and the community institution. CAB members working on the project were listed as research staff on the institutional review board applications and completed required human subjects protection training in addition to extensive training provided as part of the CBPR project, described elsewhere (Falletta et al., submitted). Participants provided verbal informed consent. Parental consent was waived for participants under the age of 18. Participants received a gift card valued at \$25 for their participation.

### Recruitment

Given sample sizes of similar previous studies (Bello et al., 2013; Carvajal, Gioia, Mudafort, Brown, & Barnet, 2017), a sample size of 30 was established a priori, with the possibility of expanding the sample size if overall saturation of themes was not achieved. Potential participants were recruited through flyers and postcards (in both Spanish and English) posted in the FQHC, with separate recruitment materials for adolescents distributed on weekly "Teen Nights." All CAB members participated in the design of the recruitment materials. Adolescents and adults age 15 to 49 who identified as women and who had a family planning or primary care visit at the FQHC within the last year were eligible to participate in the study. Eligibility criteria did not explicitly exclude transwomen. Potential participants were screened for eligibility via telephone or in person.

### Data Collection Procedures

The interview guide with structured probes (Appendix) was developed over the course of several monthly CAB meetings. The first step in developing the interview guide was using Post-It notes to generate research questions as a group, which three CAB members (K.A.F., S.S., and S.G.) subsequently used to draft an initial guide. At subsequent CAB meetings, drafts of the interview

guide were discussed and refined. The interview guide (Appendix) asked participants about sociodemographics; how their most recent discussion with a provider about PI was introduced; their feelings about having a discussion about PI (perceived ease, emotions, how important it was); their PIs; their pregnancy history, and how it affected PI discussions; general health history and feelings about discussing it with providers; aspects of a health care visit (including provider characteristics) that would make PI discussions more or less comfortable; barriers to PI discussions; and preferences for who initiates PI discussions (patient or provider). The CAB, in developing the discussion guide, discussed at length how to collect information from participants. The CAB decided to formulate some questions in closed-ended format (religion, parity), but some questions about what CAB members perceived would be more sensitive in the community context (pregnancy history, including abortion) were formulated in open-ended format.

Eligible participants were then matched to one of five trained CAB member interviewers (M.C., K.A.F., L.R., S.S., J.T.) based on training completion status, availability (some interviews were conducted in the evening), and language (four of the interviewers were able to interview in Spanish). The trained CAB members conducted interviews at the FQHC from May through September 2017.

## Data Analysis

### Coding and analysis

Interviews were audio-recorded (without recording names) and transcribed verbatim. Interviews in Spanish were translated

by a bilingual CAB member who did not conduct the interview (D.B.); the translations were then reviewed by two other bilingual CAB members (S.S., K.A.F.), and discrepancies were resolved through consensus discussion. Thematic analysis was used to describe the data (Vaismoradi, Turunen, & Bondas, 2013). First, using an inductive approach, the two primary coders (K.A.F., S.S.) scanned a random selection of transcripts to generate initial codes. Working from these transcripts, the CAB created a codebook of major themes and specific categories emerging from the data and discussed the descriptions of each theme. The primary coders independently coded all transcripts using Dedoose 8.0.35 (SocioCultural Research Consultants, LLC, Los Angeles, CA), a web-based application for analyzing qualitative data, and discussed discrepancies in coding, clarified theme definitions, and collapsed or expanded themes. After jointly coding eight transcripts, inter-rater coding agreement was good (Kappa = 0.75) but increased to 0.95 after discussion and resolution of discrepancies. The coders met each week to clarify any confusion or discrepancies in coding; the codebook was updated each week to reflect these clarifications. In an iterative coding process, the primary coders further defined and described the themes; provided more detail on what concepts the themes did and did not include, given the content of the quotes; quantified the number of times each theme was coded; and quantified (and qualified with coded text) how frequently themes occurred together. CAB members were actively involved in data analysis, including developing and refining the codebook, reviewing and resolving discrepancies in coding that were not resolved by the primary coders, discussing proposed collapsing or expansion of themes, and interpreting results.

**Table 1**  
Sample Characteristics (N = 30)

Characteristic	Interviewed in English (n = 21)	Interviewed in Spanish (n = 9)	Total (N = 30)
Age (y)	28.6 (16–44)	30.3 (20–42)	29.1 (16–44)
Years coming to the FQHC	13.2 (2–34)	10.0 (3–19)	12.2 (2–34)
Race and ethnicity <sup>a</sup>			
Black and Hispanic/Latina	5 (24)	0	5 (17)
Black	7 (33)	0	7 (23)
Hispanic or Latina	8 (38)	9 (100)	17 (57)
Mixed (declined to identify further)	1 (5)	0	1 (3)
Language spoken at home			
English	17 (81)	0	17 (57)
Spanish	0	9 (100)	9 (30)
Both English and Spanish	4 (19)	0	4 (13)
Marital status <sup>b</sup>			
Single; separated; divorced and single	9 (43)	2 (22)	11 (37)
In a relationship but not married; single but in a relationship	8 (38)	3 (33)	11 (37)
Married	3 (14)	4 (44)	7 (23)
Something else	1 (5)	0	1 (3)
Religion			
Agnostic/no religion/spiritual	6 (29)	1 (11)	7 (23)
Baptist	3 (14)	0	3 (10)
Catholic	5 (24)	7 (78)	12 (40)
Christian	4 (19)	1 (11)	5 (17)
Muslim	1 (5)	0	1 (3)
Pentecostal	2 (10)	0	2 (7)
Parity			
No children	5 (25)	0	5 (18)
1 child	3 (15)	3 (38)	6 (21)
2 children	8 (40)	3 (38)	11 (39)
3 children	1 (5)	1 (13)	2 (7)
≥4 children	3 (15)	1 (13)	4 (14)

Missing data are not presented.

Values are mean (range) or numbers (%).

<sup>a</sup> Race, ethnicity, and religion were captured using open-ended items; categories reflect the terms used by participants.

<sup>b</sup> Marital status was captured using a semistructured question that included some response options (Appendix); participants' own words used above.

### Interpretation and synthesis of findings

After coding, CAB members reviewed all coded text associated with each of the 10 most commonly coded themes. They used these data to develop a conceptual map visually representing the relationship between themes and phrases identified (Burke et al., 2005). This process began with each CAB member drawing and presenting their own conceptual map, and then collaboratively integrating ideas to capture all perspectives in one map. Working from the coded texts and conceptual map, CAB members generated recommendations for PI screening practice that addressed the themes identified.

## Results

The 30 women interviewed ranged in age from 16 to 44 years; 17% were adolescents (<20 years old). Three-quarters identified as Hispanic/Latina (57%), one-quarter (23%) as Black, 17% as Black and Hispanic/Latina, and one participant declined to identify herself other than to describe herself as “mixed.” More than one-third (37%) were currently single or divorced, another 37% were in a relationship but not married, and 23% were currently married. Most (82%) had at least one child (Table 1). In total, 28 participants (93%) reported having public health insurance (Medicaid or Medicaid managed care), one participant had private insurance, and one participant said she was on parent's insurance but did not specify the carrier or type.

Although the interview guide, and the project as a whole, was intended to focus specifically on PI screening processes, in interviews patients frequently discussed related concepts of reproductive life planning (exploring a set of personal goals regarding whether, when, and how to have children) and contraceptive counseling (patient–provider discussions about safety, effectiveness, availability, and acceptability of contraceptive methods) (Callegari et al., 2017). Three central themes emerged through their frequency of occurrence, consistency in content, and perceived relevance as reflected in CAB members' concept mapping (Figure 1): agency, judgment and shame, and expertise versus authority.

### Theme 1: Agency

Most participants expressed possessing a strong sense of agency, defined by participants as one's perceived ability to have control over events or things that happen, and actions that one takes as a result of this perception. Participants discussed this sense of agency in reference to both the process of initiating or engaging in discussions with providers about PI, and about reproductive life planning more generally.

They are my decisions and my thoughts ... and I have the right to have them, so ... I don't care what the other person could ... think or feel about how I feel or what I think inside of ... my own person. (Age 35, Latina, Spanish)

Honestly the moment she asked me ... it was very easy to just kind of like rant out my whole situation and ask you know like, “Is there any other option? Because this just is not gonna work for me.” (Age 29, Black and Latina, English)

Reflecting agency, patients frequently spoke of coming to their visits with a plan or agenda, and explained the benefits of such planning:

I already like planned almost the whole conversation before I got there. And I like ... I was doing research for like a while before ... It made me feel grown up. And it made me feel like I was taking charge of my own body. (Age 18, Latina, English)

Patients with a strong sense of agency felt comfortable initiating a conversation with their provider about PI, reflecting both concerns that providers “don't know how to start that conversation,” and expectations that subsequent conversations about contraception would ensue:

It's my decision. It's my decision if I want [to get pregnant] or not. Then she would just let me know what are the methods ... she would let me know what methods I would use to prevent. (Age 28, Latina, Spanish)

Still, some participants demonstrated a reluctance to talk to providers about PI because they did not consider it appropriate to share unless asked about it specifically or because it did not seem relevant to the purpose of a primary care visit.

I feel like I'm more to myself unless I'm asked ... sometimes you have to keep things to yourself. (Age 17, Latina, English)

Unless you're thinking about it [pregnancy], like that's your plan, then you would just let the doctor ask you ... if you're not really thinking it then you wouldn't really bring it up. (Age 28, Latina, English)

Primary care patients with health conditions—in this sample, these included asthma, panic disorder, chronic back pain, eating disorders, post-traumatic stress disorder, and sickle cell anemia—expressed that they were driven to think more about their future health, and therefore drove discussions with their provider about desires to avoid an unintended pregnancy. Several participants with chronic conditions described feeling “scared” of the consequences of unintended pregnancy and described benefits of having PI discussions with providers who could take into account their health histories.

I have a panic disorder so sometimes when I get really scared really quickly, I tend to have comprehension issues, so most of the times it's me but I try to have them repeat it, even sometimes repeat it slow, and if I still don't grasp it for the moment, I ask them to print out information for me, so that's what helps me. But it makes it difficult too because I want to know right then and there, instead of having to wait and sit and know, research it myself, because when you do research it scares you more, it tells you more of a generalized sense instead of telling you specifically what's for you. (Age 26, Latina, English)

Reflecting the primary care setting, there are times when a patient's health status becomes the main focus of the visit and the PI conversation is less of a focus, or is postponed to a subsequent visit. Some patients expressed that they would be reluctant to engage in PI discussions in the context of more pressing health concerns.

I'm not gonna lie, like in the back of my mind I would be like, “Sir, I can't even breathe. What makes you think that I want to be pregnant right now?” But ... I would just answer ... because they're just doing their job, too. (Age 29, Black and Latina, English)

Regardless of the sense of agency expressed by the participant, the majority conveyed that the provider should be the one

to initiate a conversation about PI that is specific to the patient's thoughts and plans:

If you're not asking about details—I'm not about to tell you details. If you don't ask, I'm not going to tell you. But, if you ask specifically, I'll tell you specifically ... I don't got no problem getting specific, it's just I'm all about the questions you ask me. (Age 18, Black and Latina, English)

I'm not just going, "Yeah hey doctor let me tell you my thoughts," I'm just here strictly for the visit, it's not like a friendship thing. (Age 17, Black, English)

As shown in the concept map, participants who discussed high levels of agency were more likely to mention perceived benefits of PI screening, and were more likely to outline certain PIs.

### Theme 2: Judgment and Shame

Feeling judged, ashamed, or embarrassed, which led to a lack of confidence, was the most commonly cited barrier to discussing PI with a provider. Many participants recounted instances in which they felt judged by society in general and (to a lesser extent) by providers with regard to specific aspects of their sexual, reproductive, and health histories, including sexually transmitted infections, abortion, unintended pregnancy, use of natural medicine, alcohol and tobacco use, and intimate partner violence (IPV). Several women interviewed had children at a young age, which they felt was a primary focus of others' judgment.

If doctors, or just the older crowd, period, if they could just get over young parents that would be great because they, it's a large stigma they have on us, young people having multiples at that, or just one child, so it gets really uncomfortable, cause people always make a comment ... not normally with my doctors but you know, that stigma would be awesome to be left off of us young parents. (Age 26, Latina, English)

As a consequence of feeling judged, participants would avoid having open discussions with their providers or providing them with specific information relevant to their health care.

[If] I feel judged, I'm gonna immediately like, put that block up, like, you know what? Maybe I should get somebody else. But I feel like girls feel they're gonna get judged, and they hold back. (Age 29, Black and Latina, English)

In total, two participants described a history of IPV, and this was a specific instance of relevant information that was withheld from a clinician given concerns about judgment.

My partner became abusive during ... that time, like early in the pregnancy, and ... I'm not really wanting to tell them because then I know that they're gonna give me the whole run down about, like, "You don't stay in abusive [relationship]" ... So ... I kind of avoided a little bit with some of my doctors. (Age 29, "Mixed," English)

Both women with direct or indirect experience of parenting in adolescence and those who expressed low agency were more likely to discuss the theme of judgment and shame than other participants.

### Theme 3: Expertise versus Authority

Participants described their expectations and preferences in terms of the provider's role in PI discussions. Many participants

cited providers' experience, knowledge, and professional status as key factors in how PI conversations were introduced and relevant. A doctor was a preferred person with whom to discuss PI, and doctors were viewed as knowing what's best and being able to help, so that "you don't have to worry."

By them asking me I'm ... I'm realizing and seeing that, you know, they're concerned with what's best for me. (Age 44, Black, English)

Participants who expressed this view cited the benefits of the provider's expertise, stating that they do not have to worry and can be honest with the provider so that they could plan pregnancy out. But at times, this expertise could be perceived as having paternalistic undertones, particularly among younger and Spanish-speaking patients. As a result, some patients were reluctant to be open with the provider.

Me, for example, sometimes my doctor tells me, "Did you take your medicine?" I tell him yes, but I didn't.... So then I tell him yes. I don't tell him the truth because he can yell at me. He tells me, "But you know this and this and this can happen, why don't you [take] it?!" Like they acting like family sometimes you know like a father or whatever. I sometimes don't tell him. (Age 25, Latina, Spanish)

In some cases, participants described experiences in which the provider's expertise and knowledge, specifically about contraceptive methods, led to a power imbalance in which the provider wielded authority. They described PI discussions in which they felt the provider was coercive, trying to convince them, or telling not asking.

Like telling me. And he's always like, "Oh, you need to take the pill. Here's the pill." And I'm like, "Oh, I'm not taking it." "Well I'll refill it for you, you can start again." Like I guess kind of pushing it on me. (Age 28, Black, English)

Whether PI conversations were initiated by the provider or the patient, participants articulated benefits of having PI discussions, including intrinsic (knowing oneself, having a plan) and extrinsic (getting better advice) benefits. The theme intersected with the expertise/authority theme, with participants whose responses focused on expertise referring to the benefit of getting a professional opinion in making complex decisions about contraception or pregnancy.

Where you're having any questions in the future regarding pregnancy, then you're, you're already exposed to the topic. You already know ... kind of like what to do or what to expect. (Age 28, Latina, English)

These three central themes—of agency, shame or judgment, and the extent to which the patient emphasized a provider's authority versus expertise—were moderated by underlying attitudes and norms about sexual and reproductive health, including sexual behavior, use of contraception, and abortion. Participants, particularly adolescent participants, described having their attitudes and norms shaped by their parents', friends', and families' culture and experiences (particularly with parenting in adolescence).

I think, just growing up with immigrant parents in general makes you, like you have to be like in this independent mode most of the time ... I've always had to be like that you know, I had to have my own back and stuff. (Age 18, Latina, English)

My sister, uh, was pregnant at a very young age. Was pregnant at 15. So ... my parents when they found out, they were really

**Table 2**  
Recommendations to Improve PI Screening Processes in Primary Care Settings

Theme	Illustrative Quotes	Approach	CAB Members' Recommendations
Agency	<p>"I get anxiety when just things is everywhere. I like to be a little in control of my own life. Things that I can control, I like to control them because I have a problem with things I can't control. So ... planning is like a big thing for me." (Age 29, Black and Latina, English)</p> <p>"I wouldn't like to bring it up myself." (Age 38, Black, English)</p>	<p>Help patients understand their agency in decision-making in general</p> <p>Strive to maintain neutrality</p>	<p>Use PI screening as an opportunity to explain that patients are "in charge of their own pregnancy choices, either way."</p> <p>Doctors should initiate the PI screening conversation in a nonjudgmental way, with all patients.</p> <p>The provider should ask if the patient has questions, being there to help either way the patient decides. Support the agency of the patient. Not doing this will make patients not want to share.</p> <p>Hold a workshop led by a provider to discuss PI, patient education.</p> <p>Provide peer support of other women to discuss these topics (would be most beneficial for patients who are not the ones able to bring up these topics with providers). This would help women understand the choices and link to other patients with similar situations.</p> <p>Starting the conversation is important. Screening should start with giving the context and explain why the topic is being discussed. The patient will feel less judged.</p> <p>Make sure to explain why the provider is asking certain questions.</p> <p>Ask about PI more regularly in primary care so it is normalized.</p>
		<p>Link patients with a low sense of agency to support</p>	<p>Hold a workshop led by a provider to discuss PI, patient education.</p> <p>Provide peer support of other women to discuss these topics (would be most beneficial for patients who are not the ones able to bring up these topics with providers). This would help women understand the choices and link to other patients with similar situations.</p> <p>Starting the conversation is important. Screening should start with giving the context and explain why the topic is being discussed. The patient will feel less judged.</p> <p>Make sure to explain why the provider is asking certain questions.</p> <p>Ask about PI more regularly in primary care so it is normalized.</p>
		<p>Provide the context for asking PI questions.</p>	<p>Starting the conversation is important. Screening should start with giving the context and explain why the topic is being discussed. The patient will feel less judged.</p> <p>Make sure to explain why the provider is asking certain questions.</p> <p>Ask about PI more regularly in primary care so it is normalized.</p>
Judgment and shame	<p>"I was very young when I got pregnant ... They think that because I'm younger that I'm more irresponsible ... When in reality it isn't like that ... In having a baby so young is not good, but it's not the worst thing in the world." (Age 20, Latina, Spanish)</p>	<p>Normalize PI conversations</p>	<p>Ask about PI consistently and frequently.</p> <p>"The more you hear a question the more normal it will feel, but it has to be consistent so that patients don't feel singled out."</p> <p>Still ask patients who are using LARCs about their PI. Use questions like, "Can we help you with X or Y today?" or "What can we do for you?"</p> <p>"Give patients a heads up about the conversation"—that it will be discussed later if not at that appointment.</p> <p>Have the provider explain WHY they're asking about PI and related topics.</p> <p>Help the patient to understand the context.</p> <p>All staff interacting with patients should be able to discuss these topics.</p> <p>Have another staff member besides the provider available to discuss these topics.</p> <p>Make it clear to patients that there is "no wrong door" when it comes to reproductive goals and pregnancy plans/decisions.</p>
		<p>Use a "service orientation"</p>	<p>Use questions like, "Can we help you with X or Y today?" or "What can we do for you?"</p> <p>"Give patients a heads up about the conversation"—that it will be discussed later if not at that appointment.</p> <p>Have the provider explain WHY they're asking about PI and related topics.</p> <p>Help the patient to understand the context.</p> <p>All staff interacting with patients should be able to discuss these topics.</p> <p>Have another staff member besides the provider available to discuss these topics.</p> <p>Make it clear to patients that there is "no wrong door" when it comes to reproductive goals and pregnancy plans/decisions.</p>
		<p>Provide a bridge from other topics to bring up PI</p>	<p>"Give patients a heads up about the conversation"—that it will be discussed later if not at that appointment.</p> <p>Have the provider explain WHY they're asking about PI and related topics.</p> <p>Help the patient to understand the context.</p> <p>All staff interacting with patients should be able to discuss these topics.</p> <p>Have another staff member besides the provider available to discuss these topics.</p> <p>Make it clear to patients that there is "no wrong door" when it comes to reproductive goals and pregnancy plans/decisions.</p>
Expertise vs. authority	<p>"If I were not looking to get pregnant and I talk to him, I would feel good because he's my health provider, he is in charge of me, the one who knows about my health." (Age 22, Latina, Spanish)</p>	<p>Recognize the audience</p>	<p>Body language and terminology are important. Rapport is important. Provide resources for providers to build rapport with patients.</p> <p>Hold a provider workshop for providers to discuss ways to talk about difficult topics with patients and share experiences.</p> <p>In a setting with high turnover of patients and providers, the PI screening process should be consistent.</p> <p>Have a discussion guide for providers to use. Establish a link between what patients can do and why the provider is asking these questions. Emphasize to patients that "dealing with the issue is a step closer to solving it."</p>
		<p>Training for providers should be practice focused</p>	<p>Hold a provider workshop for providers to discuss ways to talk about difficult topics with patients and share experiences.</p> <p>In a setting with high turnover of patients and providers, the PI screening process should be consistent.</p> <p>Have a discussion guide for providers to use. Establish a link between what patients can do and why the provider is asking these questions. Emphasize to patients that "dealing with the issue is a step closer to solving it."</p>
		<p>Provide continuity of care for PI screening</p>	<p>In a setting with high turnover of patients and providers, the PI screening process should be consistent.</p> <p>Have a discussion guide for providers to use. Establish a link between what patients can do and why the provider is asking these questions. Emphasize to patients that "dealing with the issue is a step closer to solving it."</p>
		<p>Link well-being, health conditions, and pregnancy</p>	<p>Establish a link between what patients can do and why the provider is asking these questions. Emphasize to patients that "dealing with the issue is a step closer to solving it."</p>

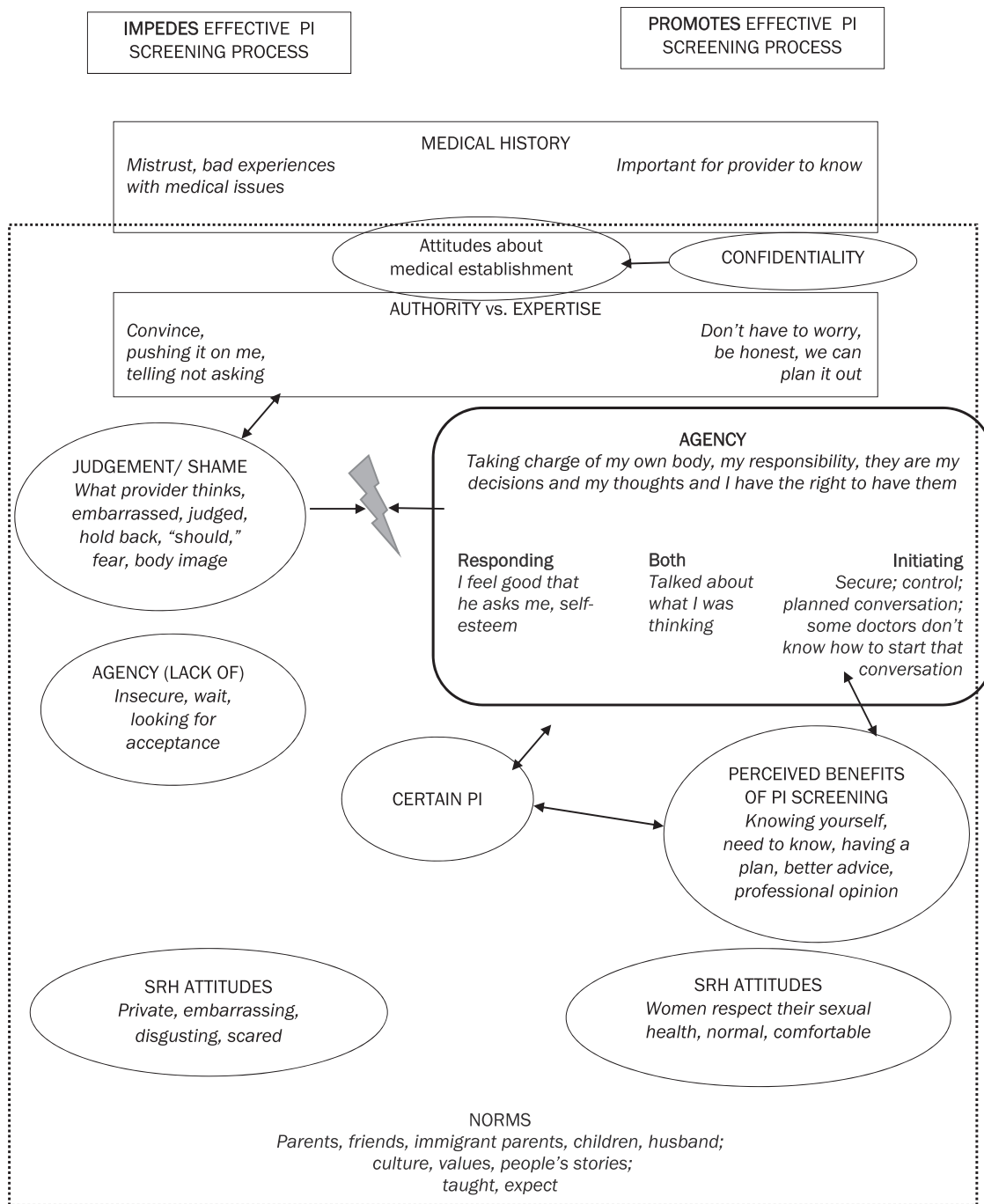
Abbreviation: PI, pregnancy intention.

Text in quotation marks indicates verbatim suggestion of community advisory board members.

angry at her because she was pregnant. And I think that ... I kind of ... I told my parents, I was like, you shouldn't be mad at her. It's not her fault. You guys weren't open about ... things ... with her. (Age 16, Latina, English)

## Discussion

In this sample of Black and Latina FQHC patients, participants expressed a range of experiences and levels of comfort



**Figure 1.** Concept map of identified themes. PI, pregnancy intention; SRH, sexual and reproductive health.

with engaging in the PI screening process, with prior experiences, attitudes, norms, and perceived benefits of PI screening shaping the extent to which these experiences or perceptions were positive or negative. Themes of agency and expertise versus authority resided on a continuum; what one patient perceives as a provider demonstrating expertise another may interpret as exerting authority. Our findings indicate that some patients who have low agency—because of perceived judgment or shame, perceived authority of providers, prior experiences of provider bias or judgment, and/or their medical history,

circumstances, norms, or attitudes—may not feel comfortable initiating a PI conversation. Specifically, consistent with other studies, we found that patients who reported a history of IPV (Battaglia, Finley, & Liebschutz, 2003; Overstreet & Quinn, 2013) and patients who had a direct or indirect (i.e., through family members or close friends) experience of early childbearing (SmithBattle, 2013) expressed concerns about judgment from providers and, in the case of teen parenting, from society more broadly. This was a barrier to open conversations with providers about PI.

These findings on patients' perspectives on PI screening comport with other studies examining reproductive life planning and contraceptive counseling. The theme of expertise versus agency, and the intersection of this theme with judgment and shame, echoes the centrality of a patient's relationship with the provider, as found in Carvajal et al. (2017). Reinforcing findings by Bello et al. (2013), patients described wanting their providers to initiate more conversations. Callegari et al. (2017) also cited judgment as a potential pitfall of reproductive life planning. Yet, whereas other studies conducted among similar populations evinced the specific themes of low reproductive control (Borrero et al., 2015) or barriers to formulating a plan (Callegari et al., 2017), we found a broader concept of agency that encompassed talking to providers about PI.

The challenges of integrating PI conversations in primary care from the patients' perspective in this inquiry mirror challenges expressed by primary care providers. Two studies among primary care providers noted that providers relied on patients to initiate conversations about PI, and recommended that providers should be proactive in starting these discussions (Akers et al., 2010; Chuang et al., 2012). Surprising in this study was the extent to which patients reported that they did not share pertinent health information or history with their providers that ultimately could affect subsequent care based on the result of their PI screening, either because of concerns of being judged or of not having a sense of agency to introduce the information.

Some limitations should be considered here. The study sample was heterogeneous, with only five adolescents interviewed, none of whom were interviewed in Spanish. We were unable to achieve saturation of themes in age- or language-defined subgroups. Some data on participants' characteristics, such as gender identity (beyond identifying as a woman), SES (beyond insurance type), and sexual orientation were not explicitly captured as part of the interview. The interviews were conducted by different interviewers, and differences in interviewing techniques may have influenced response patterns. Both community and academic CAB members brought in their own perspectives and experiences, although substantial effort, including trainings on reflexivity (Berger, 2015), was made to focus only on themes or recommendations that emanated from the data. These findings are specific to a given population and setting, and caution should be used in generalizing to broader populations.

Despite these limitations, this inquiry builds on prior research in several essential ways. The study was conducted in a FQHC that had implemented a project to systematize PI screening; the results found here, therefore, represent patients' actual experiences with the implementation of an evidence-based practice (Hallum-Montes, Middleton, Schlanger, & Romero, 2016), rather than abstract thoughts about the process. The use of CBPR in this inquiry is a key feature. This examination forges new ground in directly involving members of the community—both patients and FQHC staff—in the process of formulating questions, collecting data, analyzing the data, interpreting themes, and generating practicable recommendations that arise from the data. By including stakeholders in generating specific recommendations that emerge from the analyses, the recommendations for improving PI screening are more likely to be grounded in the experiences of the patients and providers, and be more feasible to implement.

This work also points the way to possible future lines of inquiry, consistent with CBPR approaches (Bordeaux et al.,

2007). After dissemination of these findings by CAB members within the participating clinical network (work that is ongoing), future work should examine the experience and effectiveness of implementing these CBPR-derived recommendations to improve PI screening, overall and for specific subgroups of patients whose unique experiences emerged in this inquiry, including women with a history of IPV and young mothers. Implementation of these recommendations may have a broader impact on other outcomes or processes beyond PI screening, including patients' general sense of agency, and future work should examine these.

#### *Implications for Policy and/or Practice*

This inquiry was designed to generate specific recommendations that could be implemented in a primary care setting. Building from the qualitative data analysis, the project compiled recommendations for the PI screening process in the CAB members' own words, as shown in Table 2. Several of the recommended approaches would conceptually link PI screening with broader aspects of providing patient-centered care (Dehlendorf et al., 2016; Robinson, Callister, Berry, & Dearing, 2008). To support a patient's sense of agency, for instance, it was recommended to use PI screening as an opportunity to point out that patients are "in charge of their own pregnancy choices, either way." Specific mechanisms, including peer support groups, were suggested to support patients' agency more broadly. To minimize judgment and shame, providers should normalize PI screening by asking all patients (regardless of their contraceptive method) regularly, explaining the reason for asking about PI, and using a service orientation by asking, "What can we do for you?" For patients who are not ready to discuss PI at a specific visit, providers can introduce the topic to prime them to discuss it at a subsequent visit; in addition, staff other than providers should be trained and on hand to discuss PI if the patient prefers. In settings with high provider turnover, training all staff and using discussion guides can support consistent and standardized PI screening processes. Training should be practice-focused, such as a workshop where providers can share their own experiences and discuss what works in PI screening.

#### **Conclusions**

This study among Black and Latina FQHC patients revealed barriers and opportunities to engaging in PI screening conversations. By using a CBPR approach, this project yielded feasible and unique recommendations for PI screening that can be incorporated into practice to support patient agency, a key theme that emerged. These steps include using a service orientation, explicitly referring to a patient's agency in PI conversations, and using innovative training approaches such as giving practitioners an opportunity to share what has worked for initiating PI conversations.

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## Supplementary Data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.whi.2019.08.004>.

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