**Appendix Table 1.** Key Questions for Systematic Review

| Key question number | Question |
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| 1 | Is there a relationship between contraceptive counseling interventions and improved health outcomes of family planning services? |
| 2 | Is there a relationship between contraceptive counseling interventions and improved behavioral outcomes of family planning services? |
| 3 | Is there a relationship between contraceptive counseling interventions and (a) client experience and/or (b) improved psychosocial outcomes (e.g., increased knowledge) of family planning services? |
| 4 | What are the barriers and facilitators for clinics in adopting and implementing contraceptive counseling interventions in the family planning setting? |
| 5 | Are there unintended negative consequences associated with contraceptive counseling interventions when used in the family planning setting? |
| 6 | What are clients' preferences with regard to contraceptive counseling approaches in the family planning setting? |

*Note:* Questions are contextualized by the analytic framework presented in Figure 1.

**Appendix Table 2.** Search Term Sets for Systematic Review Series and Key Question 6

| Set number | Concept | PubMed search terms [a] |
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| 1 | Family planning | "family planning"[All fields] OR<br>"family planning services"[MeSH][b] OR<br>"family planning services"[All fields] OR<br>"family planning policy"[MeSH] OR<br>"family planning policy"[All fields] OR<br>"reproductive health services"[MeSH] OR<br>"reproductive health services"[All fields] OR<br>"Title X"[All fields] OR<br>"Planned Parenthood"[All fields] |
| 2 | Contraception | contraception[MeSH] OR<br>contracept*[All fields] OR<br>"contraceptive agents"[MeSH] OR<br>"contraceptive agents"[All fields] OR<br>"contraceptive devices"[MeSH] OR<br>"contraceptive devices"[All fields] OR<br>"birth control"[All fields] OR<br>"contraception behavior"[MeSH] OR<br>"contraception behavior"[All fields] |
| 3 | Counseling | counseling[MeSH] OR<br>counseling[All fields] OR<br>"patient-centered"[All fields] OR<br>"patient comprehension"[All fields] OR<br>"patient understanding"[All fields] OR<br>"patient participation"[MeSH] OR<br>"patient participation"[All fields] OR<br>"patient autonomy"[All fields] OR<br>"decision making"[MeSH] OR<br>"decision making"[All fields] OR<br>"active decision"[All fields] OR<br>"informed decision"[All fields] OR<br>"informed choice"[All fields] OR<br>"informed patient"[All fields] OR<br>"informed client"[All fields] OR<br>"informed consent"[MeSH] OR<br>"informed consent"[All fields] |
| 4 | Communication | "communication"[All fields] OR<br>"health communication"[MeSH] OR<br>"health communication"[All fields] OR<br>"risk communication"[All fields] OR<br>"communicating risk"[All fields] OR<br>"communication barriers"[MeSH] OR<br>"communication barriers"[All fields] OR<br>"patient communication"[All fields] OR |

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| | | "professional-patient relations"[MeSH:NoExp] OR<br>"professional-patient relations"[All fields] OR<br>"nurse-patient relations"[MeSH] OR<br>"nurse-patient relations"[All fields] OR<br>"physician-patient relations"[MeSH] OR<br>"physician-patient relations"[All fields] OR<br>"information dissemination"[MeSH] OR<br>"information dissemination"[All fields] OR<br>"access to information"[MeSH] OR<br>"access to information"[All fields] OR<br>"information seeking behavior"[MeSH] OR<br>"information seeking behavior"[All fields] OR<br>"truth disclosure"[MeSH] OR<br>"truth disclosure"[All fields] OR<br>"risk perception"[All fields] OR<br>"perceived risk"[All fields] OR<br>"perception of risk"[All fields] OR<br>"risk management"[MeSH] OR<br>"risk management"[All fields] OR<br>"patient safety"[All fields] |
| 5 | Follow-up/Continuity of care | "continuity of patient care"[MeSH] OR<br>"continuity of patient care"[All fields] OR<br>"followup"[All fields] OR<br>"follow up"[All fields] |
| 6 | Education | "health education"[MeSH] OR<br>"health education"[All fields] OR<br>"health educator"[All fields] OR<br>"patient education as topic"[MeSH] OR<br>"patient education"[All fields] OR<br>"health literacy"[All fields] |
| 7 | Patient preference[c] | "patient preference"[MeSH] OR<br>"patient preference"[All fields] OR<br>"patient-centered care"[MeSH] OR<br>"patient-centered care"[All fields] OR<br>attitude*[d][All fields] OR<br>percept*[d][All fields] OR<br>experience*[d][All fields] OR<br>perspect*[d][All fields] |
| 8 | All sets combined | ((#1) OR (#2)) AND ((#3) OR (#4) OR (#5) OR (#6)) AND (#7) |

[a]Adapted as needed for searches of other databases.
[b]Medical Subject Headings.
[c]Terms used for targeted search for studies published from October 1992 through February 2011. Terms in this set except those indicated by [d] were included in the Counseling set (#3) used in the search for studies published from March 2011 through November 30.
[d]Terms only used for targeted search for studies published from October 1992 through February 2011.

**Appendix Table 3.** Evidence on Client Preferences for Contraceptive Counseling

| Reference, funding, location | Population | Research question(s) | Results | Design, quality, generalizability |
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| Becker and Tsui, 2008[9]<br><br>Funding: NR<br><br>Location: U.S. (nationally representative) | Low income women (n=1,741) who had received family planning care<br><br>Year of data collection: 1995<br><br>Age distribution: 18–34 years<br><br>Race/Ethnicity/Language: black 21%, Spanish-speaking Latina 6%, English-speaking Latina 10%, white 63% | What are racial/ethnic and/or language differences in low-income women's preferences and perspectives on quality of family planning care? | English- and Spanish-speaking Latina participants were significantly more likely to prefer a female clinician (46% and 58% respectively, compared with 36% of white participants; AOR 1.8 and 3.6) and were significantly more likely to express high value for clinician continuity (77% and 83% respectively, compared with 66% of white participants; AOR 1.7 and 2.2). English-speaking Latina and black participants were significantly more likely to prefer receiving reproductive health care in general healthcare settings (62% and 61%, respectively, compared with 50% of white participants; AOR 1.5 and 1.6). | Level II-2, correlational (quantitative surveys)<br><br>Strengths: Large, nationally representative sample allowing for comparison between racial/ethnic groups; random sampling design; high response rate minimizes non-response bias<br><br>Limitations: Little exploration of client preferences due to nature of the survey; data analysis occurred more than a decade after data collection<br><br>Generalizability: Moderate |
| Becker et al., 2009[25]<br><br>Funding: Population, Family, and Reproductive Health Department and the GFEF, JHSPH | Women (n=40) visiting clinics for family planning care<br><br>Years of data collection: 2007<br><br>Age distribution: 18–36 years<br><br>Race/Ethnicity/Language: black 22.5%, English- | What factors influence women's assessment of family planning services? Are there any differences among women of different racial, ethnic and language groups in reported family planning service experiences or | With regard to the counseling interaction, women valued detailed and personalized contraceptive information; empathetic, non-judgmental providers; and respect for decision autonomy. Spanish-speaking Latinas preferred language-appropriate care and contraceptive information; no other differences by language | Level III, descriptive (qualitative interviews)<br><br>Strengths: In-depth interviews about lifetime experiences captured broad range of experiences; patients were approached on different days of the week, including evening and weekend hours, to reach diverse patients; relatively large sample for a qualitative study |

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| Location: San Francisco, California | speaking Latina 20%, white 20%, Spanish-speaking Latina 30%, mixed ethnicity 7.5% | service-related preferences or values? | or racial/ethnic groups were found. | Limitations: Potential social desirability bias; qualitative data limits comparisons across race/ethnicity/language<br><br>Generalizability: Low |
| Brown et al., 2013[18]<br><br>Funding: NIH, UCSF-CTSI<br><br>Location: San Francisco, California | Nulliparous adolescents (n=20) with a history of IUD use<br><br>Years of data collection: 2010–2011<br><br>Age distribution: 15–24 years<br><br>Race/Ethnicity: Latina 40%, African American 30%, Asian 15%, white 10%, Pacific Islander 5% | What is the IUD adoption process among nulliparous adolescents? What is the role of the medical provider in this trajectory? | Preferences for counseling included friendly dynamics with providers, use of IUD insertion models, and personalized contraceptive information, including on side effects and addressing misinformation learned from friends and family. | Level III, descriptive (qualitative interviews)<br><br>Strengths: Rich data collection; interviews conducted until saturation of dominant themes reached<br><br>Limitations: Single recruitment site; convenience sample where half of eligible participants not interviewed due to logistics; no non-users of LARC included to understand their decision making processes and preferences<br><br>Generalizability: Low |
| Carvajal et al., 2017[19,b]<br><br>Funding: RWJF<br><br>Location: Baltimore, Maryland | Young Latina women (n=16), most of whom were immigrants<br><br>Years of data collection: 2014–2015<br><br>Age distribution: 15–24 years<br><br>Population Race/Ethnicity: Latina 100% | What are Latinas' perspectives regarding specific factors that influence their contraceptive decision making, and their perspectives about the role of PCPs in decision making? | Participants strongly preferred relationships with their PCPs built on trust and communication, and valued assurance of visit confidentiality. Participants desired complete contraceptive information including information on side effects and method efficacy. Participants expressed strong desire not to be pressured in their method | Level III, descriptive (qualitative interviews and focus groups<br><br>Strengths: Rich data collection; recruitment continued until saturation of themes reached; focus on specific experiences and preferences of Latina clients, which had not been specifically addressed in research on this topic |

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| | Language: Spanish 94%, English 6%. | | decisions, and linked experiences of pressure with racial/ethnic bias among providers. | Limitations: Focus groups were small (8 participants total in 3 groups), and some participants may not have felt comfortable sharing in groups<br><br>Generalizability: Low |
| Chernick et al., 2017[20]<br><br>Funding: NIH, NCATS<br><br>Location: Unspecified urban setting in U.S. | Female adolescents (n=14) seeking care in emergency departments<br><br>Years of data collection: 2013<br><br>Age distribution: 14–19 years<br><br>Race/Ethnicity: Hispanic 93%, other races/ethnicities NR | What are the preferences of teens seeking emergency care for the delivery, content, and structure of texts in a text message program about pregnancy prevention? | Participants expressed preference for texts that were brief, professional, personalized, non-accusatory, and had links to websites. They valued information on multiple contraception options and information to correct common misconceptions about birth control. | Level III, descriptive (qualitative interviews)<br><br>Strengths: Rich data collection<br><br>Limitations: Convenience sample from single recruitment site; no comparison to acceptability of texts in other healthcare settings<br><br>Generalizability: Low |
| Dasari et al., 2016[35]<br><br>Funding: NR<br><br>Location: Pittsburgh, Pennsylvania | Young women (n=15) who had experienced homelessness in the past 12 months<br><br>Years of data collection: NR<br><br>Age distribution: 18–24 years<br><br>Race/Ethnicity: black 54%, white 33%, multiracial 13% | What role does provider communication play in women's ability to access LARC? | Participants perceived that providers withheld contraceptive methods to influence method choice, and desired complete and detailed information including information on side effects in order to make informed decisions. Participants also liked the use of visual aids during counseling and receiving information to take with them after visits. | Level III, descriptive (mixed methods, surveys and guided interviews)<br><br>Strengths: Mixed-methods design allows both quantitative and qualitative understanding of experiences; recruitment from multiple locations and by multiple methods for heterogeneity<br><br>Limitations: Small convenience sample<br><br>Generalizability: Low |

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| Dehlendorf et al., 2010[31]<br><br>Funding: SFP, NIH, NCRR,UCSF-CTSI<br><br>Location: San Francisco Bay Area, California | Women (n=257) receiving post-abortion contraceptive counseling/care at a large urban abortion clinic<br><br>Years of data collection: 2008–2009<br><br>Age distribution: 19–31 years<br><br>Race/Ethnicity: black 38%, Latina 23%, white 17%, Asian/API 13%, other 8% | What are preferences regarding contraceptive decision making among women at high risk for unintended pregnancy? How do these preferences compare to those regarding general health decision making? | Women were more likely to desire making decisions autonomously in their contraceptive care than in general health care (50% vs 19%, $p<0.001$). This finding was strongest for women with Medicaid insurance (51% vs 17%, $p<0.001$). No patient characteristics were associated with contraceptive decision-making preferences. | Level III, descriptive (quantitative surveys)<br><br>Strengths: Use of validated Problem-Solving Decision-Making Scale[45] to compare decision making preferences in multiple healthcare contexts<br><br>Limitations: Participants only eligible if they selected a short-acting method post-abortion; thus results may not generalize to populations choosing from full range of methods; data collection from a single site<br><br>Generalizability: Moderate |
| Dehlendorf et al., 2013[3]<br><br>Funding: The Fellowship in Family Planning, NIH, NCATS, UCSF-CTSI<br><br>Location: San Francisco Bay Area, California | Black, Latina, and white women (n=42) receiving contraceptive counseling<br><br>Years of data collection: 2009<br><br>Age distribution: 19–46 years<br><br>Race/Ethnicity/Language: non-Latina white 24%, black 24%, Latina Spanish-Speaking 31%, Latina English-speaking 21% | What are patients' preferences about birth control counseling, and specifically for the decision making process? | Women preferred comprehensive contraceptive information, particularly about side effects. Patients preferred intimate and friend-like relationships with their providers. They preferred their providers be involved in the decision-making process but emphasize that the patient make the final method decision. Compared with white and English-speaking Latina participants, black and Spanish-speaking Latina participants felt more strongly that providers should only share their opinion | Level III, descriptive (qualitative interviews)<br><br>Strengths: Rich data collection; relatively large sample size; participants recruited from 5 different locations<br><br>Limitations: Differences in preferences observed in study may be due to socioeconomic factors not explored; qualitative data limits comparisons across race/ethnicity/language<br><br>Generalizability: Low |

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| | | | if deemed appropriate by the patient. | |
| Guendelman et al., 2000[7]<br><br>Funding: The Office of Family Planning in the CA DHS, the CA DSS and the Center for Latino Policy Research at University of California, Berkeley<br><br>Location: Three counties in California | Adult women (n=59) participating in a longitudinal study of Aid to Families with Dependent Children (AFDC), who were initially recruited from a randomly selected list of household heads<br><br>Years of data collection: 1996<br><br>Age distribution: 21–43 years<br><br>Race/Ethnicity/Language: 32% Latina Spanish-speaking, 36% Latina English-speaking, 32% white non-Latina English-speaking | What perceptions do women have of interactions with the medical systems when accessing contraception? What are the different perceptions of Spanish-speaking Latina, English-speaking Latina and white non-Latina participants? | Participants desired detailed and personalized information from providers. Participants were especially concerned about method side effects and desired information in this area, and disliked counseling in which they felt pressure to use specific methods. | Level III, descriptive (mixed methods, focus groups and questionnaires)<br><br>Strengths: Relatively large sample size; recruitment originated from random sampling design in larger study<br><br>Limitations: Limited ability to draw comparisons between different groups due to small sample size in each group; little exploration of counseling preferences.<br><br>Generalizability: Low |
| Hickey and White, 2015[21]<br><br>Funding: The Adelphi University Faculty Development program<br><br>Location: Tri-state area of Northeast U.S. | Female college students (n=24) who had purchased EC<br><br>Years of data collection: 2009<br><br>Age distribution: 19–24 years | What are the perceptions and experiences of college women regarding receipt of over-the-counter emergency contraception? | Participants emphasized the importance of confidentiality and said they would not use campus health services if the reason for their visit would not remain confidential. | Level III, descriptive (qualitative focus groups)<br><br>Strengths: Multiple recruitment methods (flyer and snowball sampling)<br><br>Limitations: Convenience sample; as only previous users of EC were included, barriers and preferences were not explored among students who had not |

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| | Race/Ethnicity: White 83%, Black 13%, Latina 4% | | | previously accessed EC; some participants previously knew lead professor, possibly influencing discussion<br><br>Generalizability: Low |
| Johnson et al., 2015[36]<br><br>Funding: NR<br><br>Location: Boston, Massachusetts | Adolescent women (n=20) who had experienced pregnancy and were seeking reproductive health care<br><br>Years of data collection: 2009<br><br>Age distribution: 16–20 years<br><br>Race/Ethnicity: NR, but clinic described as serving primarily black and Hispanic clients | What are the perspectives of adolescents who had experienced pregnancy on family planning services at a community health center? | Participants wanted providers with good communication skills who were patient, understanding, trustworthy, and non-judgmental. A barrier to seeking contraception from a provider was fear of disapproval or judgment. | Level III, descriptive (mixed methods, surveys and interviews)<br><br>Strengths: Rich data collection on the perspectives of young women who had experienced pregnancy<br><br>Limitations: Small convenience sample<br><br>Generalizability: Low |
| Lowe, 2005[26]<br><br>Funding: ESRC<br><br>Location: Coventry, England | Women (n=22) receiving care at a general practice for surgery and a family planning clinic<br><br>Years of data collection: NR<br><br>Age distribution: 30–39 years<br><br>Race/Ethnicity: Percentages NR; mostly white | What is the nature of the complex power relationships affecting women's contraceptive decisions? | Participants valued provider trust as a component of the contraceptive decision making process. They preferred family planning clinics to a general surgery clinic because of the focus on women's care, and preferred seeing female providers because of their perceived embodied knowledge about contraception. | Level III, descriptive (qualitative interviews)<br><br>Strengths: Rich data collection; analysis informed by history and theory related to medicalization of contraception and power dynamics in family planning care<br><br>Limitations: Small homogenous convenience sample, including limited age distribution<br><br>Generalizability: Low |

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| Marshall et al., 2017[22]<br><br>Funding: NR<br><br>Location: Oakland, California | Women (n=21) seeking contraceptive care<br><br>Years of data collection: 2014–2015<br><br>Age distribution: 18–29 years<br><br>Race/Ethnicity: Majority (86%) non-Hispanic black or Hispanic/Latina; other races/ethnicities NR | What are patients' perceptions of the value of a contraceptive decision support tool? | Participants found the decision support tool to be valuable because it provided relevant information and facilitated their decision making process by starting the process of narrowing down the contraceptive options. Participants felt the tool could prepare them for a visit with their healthcare provider by helping to identify questions for their provider. | Level III, descriptive (qualitative interviews)<br><br>Strengths: Rich data collection on client interaction with a decision support tool<br><br>Limitations: Small convenience sample; participants not necessarily seeking contraception initiation or method-change, so evaluation of the tool is hypothetical<br><br>Generalizability: Low |
| Matulich et al., 2014[28]<br><br>Funding: SFP; Ibis Reproductive Health<br><br>Location: Northern California | Women (n=199) presenting for first-trimester surgical abortion<br><br>Years of data collection: 2012–2013<br><br>Age distribution: 18–31 years<br><br>Race: Caucasian 63%, African American 13%, Asian 5%, Native American 4%, other 1%, unanswered 5%<br><br>Ethnicity: not Hispanic 75%, Hispanic 16%, unanswered 9% | Do women presenting for a first-trimester abortion want to discuss contraception on the day of their procedure? If so, what information are they interested in learning about? | More than half (64%) of participants did not want to receive contraceptive counseling on the day of their abortion. About half of these participants reported they did not want counseling because they already knew what they wanted to use for contraception as the reason. | Level III, descriptive (quantitative surveys)<br><br>Strengths: Anonymous data collection on sensitive topic<br><br>Limitations: No response rate ascertained; potential for response bias unknown; brief survey with little opportunity for depth on the topic; recruitment at a single site<br><br>Generalizability: Low |

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| Mollen et al., 2013[29]<br><br>Funding: The Nicholas Crognale Chair of Emergency Medicine at the Children's Hospital of Philadelphia<br><br>Location: Philadelphia, Pennsylvania | Adolescents (n=223) seeking care in children's EDs<br><br>Years of data collection: 2008–2009<br><br>Age distribution: 15–17 years<br><br>Race/Ethnicity: African American 70%, white 20%, Hispanic 5%, mixed race 5%, Asian 0.04% | What are adolescents' preferences for the delivery of ED-based education on EC, specifically in terms of who delivers the education, length, and context of the appointment? | Participants preferred education delivered from a person, rather than from videos, written materials, or something on a computer. They particularly preferred getting information from a doctor or nurse, rather than a peer educator. They also preferred education directed at patients seeking care in the ED for complaints potentially related to sexual activity, rather than for injuries or illnesses not related to sexual health. | Level III, descriptive (quantitative surveys)<br><br>Quality: Level III<br><br>Strengths: Multiple recruitment locations; survey had been pilot tested with adolescents prior to use; computerized module for standardized survey administration<br><br>Limitations: High refusal rate (50%)<br><br>Generalizability: Low |
| Peremans et al., 2000[27]<br><br>Funding: NR<br><br>Location: Antwerp, Belgium | 17-year-old girls (n=26) attending secondary schools<br><br>Years of data collection: 1996<br><br>Age distribution: 17 years<br><br>Race/Ethnicity: NR | What are the needs and expectations of adolescents with regard to accessing contraceptive services? What are their attitudes towards their healthcare providers? | Participants preferred to seek care from their general practitioner, rather than at school health centers, due to pre-existing relationships. They most often seek contraceptive care from their general practitioner. Confidentiality, adequate consultation time, and easy accessibility were important to participants. | Level III, descriptive (qualitative focus groups)<br><br>Strengths: Focus on the needs of adolescents<br><br>Limitations: Focus group participants were classmates and knew each other, likely influencing discussion; sampling was based on selection of classes by school principals<br><br>Generalizability: Low |
| Pilgrim et al., 2014[34]<br><br>Funding: The Office of Public | Women (n=748) receiving Title X services for the first time<br><br>Years of data collection: 2008–2009 | What are factors associated with first-time Title X patients' perceptions of quality of care | Clients who reported the provider primarily made the decision about the birth control method had significantly lower odds of agreeing they received high quality care (AOR 0.14), | Level II-2, correlational (quantitative survey)<br><br>Strengths: Relatively large sample; regimented survey administration |

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| Health and Science<br><br>Location: Three states (unspecified) in the U.S. | Age distribution: mean age 24 years<br><br>Race/Ethnicity: Hispanic 33%, black 29%, white 24% | and satisfaction with services? | compared with clients who made the decision themselves. Clients who were not counseled with visual aids during their visits had significantly lower odds of agreeing they received high quality care, compared with those counseled using visual aids (AOR 0.25). | Limitations: Potential sampling bias, as clinics self-selected to participate in study may have perceived own ability to score highly; potential for social desirability bias in patient responses<br><br>Generalizability: Moderate |
| Rubin et al., 2016[24]<br><br>Funding: NIH, NICHD<br><br>Location: Bronx, New York | Adolescents (n=27) who had chosen to use the IUD<br><br>Years of data collection: 2013–2014<br><br>Age distribution: 16–25 years<br><br>Race/Ethnicity: Latina 56%, other races/ethnicities NR | What are adolescent and young adults' priorities, values, and preferences for care affecting the choice to use an IUD? | Participants described their healthcare provider to be the most influential person in their decision to use an IUD. Participants valued receiving accurate and reliable information from providers, as well as seeing a visual model of IUD insertion. They also valued trusting relationships with their providers. | Level III, descriptive (qualitative interviews)<br><br>Strengths: Rich data collection<br><br>Limitations: Small sample from one clinic; non-IUD users and those who did not arrive to appointments not included<br><br>Generalizability: Low |
| Sangraula et al., 2016[23]<br><br>Funding: NR<br><br>Location: Upper Manhattan and Bronx, New York | Adolescents (n=18) receiving care at SBHCs<br><br>Years of data collection: NR<br><br>Age distribution: 15–19 years<br><br>Race/Ethnicity: NR | What are adolescents' perceptions of services to inform specific strategies for improving LARC services at 3 SBHCs? | Participants desired to receive detailed information, particularly information to correct misconceptions. They also expressed a need not to be overwhelmed by too much information. Participants highly valued autonomy in the decision making process and trusting relationships with providers with the assurance of confidentiality. The need for confidentiality led participants to prefer verbal communication | Level III, descriptive (qualitative interviews)<br><br>Strengths: Rich data collection; interviews conducted until saturation of themes reached<br><br>Limitations: Small convenience sample based on which students receiving survey were able to be reached over summer months<br><br>Generalizability: Low |

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| | | | of contraceptive information over written forms of information. | |
| Schwarz et al., 2013[38]<br><br>Funding: SFP, CHCF, HRSA Maternal and Child Health Research Program<br><br>Location: Western Pennsylvania | Women (n=198) seeking acute care in urgent care settings<br><br>Years of data collection: 2011<br><br>Age distribution: 18–45 years<br><br>Race/Ethnicity: black 29%, white 65%, other 11% | What is the acceptability and feasibility of a computerized program for contraceptive counseling? | Most participants who used the program responded at 3 months that they would prefer to talk to a healthcare provider about their contraceptive choice, as opposed to the computerized program. Nevertheless, most participants (95%) said the program was easy to use, and 85% would recommend it to a friend. | Level III, descriptive (quantitative, survey)<br><br>Strengths: Provides information on client acceptability of an intervention tested in an RCT to effect contraceptive knowledge<br><br>Limitations: Little exploration of acceptability of computerized program<br><br>Generalizability: Low |
| Soleimanpour et al., 2010[37]<br><br>Funding: Alameda County Health Care Services Agency<br><br>Location: Alameda County, California | Adolescents receiving care at school health centers (n=286 for quantitative sample and n=105 for qualitative sample)<br><br>Years of data collection: 2007–2008<br><br>Age distribution: not specified<br><br>Race/Ethnicity: non-Hispanic African American 33%, Hispanic 26%, Asian/Pacific Islander 16%, non-Hispanic white 10%, biracial or multiracial 5%, other 4%, missing 6% | What is the role of school health centers in healthcare access and client outcomes? | Focus groups revealed that students felt school health centers improved access to counseling and family planning services. Students liked the assurance of confidentiality at the centers as well as the youth-friendliness of staff. | Level III, descriptive (mixed methods, survey and focus groups)<br><br>Strengths: In-depth mixed methods data collection at multiple sites; large sample size<br><br>Limitations: Minimal exploration of the counseling dynamic<br><br>Generalizability: Low |

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| Sonenstein et al., 1995[31]<br><br>Funding: The Henry J. Kaiser Family Foundation<br><br>Location: U.S. | Women (n=1,093) who had received reproductive health care<br><br>Years of data collection: 1993<br><br>Age distribution: 28–40 years<br><br>Race/Ethnicity: NR | What are women's experiences with and preferences for reproductive health care? | Participants preferred to receive care at private physicians' offices as opposed to family planning and other clinics. | Level III, descriptive (quantitative survey)<br><br>Strengths: Large sample size<br><br>Limitations: Lack of clarity on classification of different healthcare sites<br><br>Generalizability: Moderate |
| Weisman et al., 2002[33]<br><br>Funding: NR<br><br>Location: Michigan | Women (n=898) who had received contraceptive counseling in managed care<br><br>Years of data collection: NR<br><br>Age distribution: 18–44 years<br><br>Race/Ethnicity: Among participants at risk for unintended pregnancy: African American 8%, Asian 4%, white/ non-Hispanic 83%, Hispanic 2%, other 3%; among those not at risk for unintended pregnancy: African American 5%, Asian 1%, white/non-Hispanic 90%, Hispanic 3%, other 1.1% | What is the relationship between counseling and women's contraceptive attitudes and practices? | Participants who reported receiving personalized counseling (as opposed to no counseling or only informational counseling) had significantly higher odds of increased satisfaction with counseling (OR 3.1 personalized counseling compared with no counseling, versus OR 1.5 informational counseling compared with no counseling). | Level II-2, correlational (quantitative survey)<br><br>Strengths: Large sample size<br><br>Limitations: Potential recall bias in data related to receipt of counseling, due to data being collected on appointments that occurred up to 2 years prior<br><br>Generalizability: Moderate |

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| Yee and Simon, 2011a[16]<br><br>Yee and Simon, 2011b[17]<br><br>Funding: NIH<br><br>Location: Chicago, Illinois | Women (n=30) receiving prenatal care in an ambulatory outpatient clinic<br><br>Years of data collection: 2007–2008<br><br>Age distribution: 19–35 years<br><br>Race/Ethnicity: Hispanic 37%, African American 63% | What are women's preferences for the provision of contraceptive counseling in the prenatal and postpartum periods? What are negative contraception counseling experiences as described by women of color living in an urban setting? | Participants preferred frequent, short, comprehensive, and patient-centered counseling throughout prenatal care and into the postpartum period. Participants preferred that providers initiate counseling to help reinforce decision making throughout prenatal and postpartum care.<br><br>Counseling experiences considered negative included feeling ignored or receiving impersonal counseling. Participants reported feeling coerced when their contraceptive choice differed from their providers' recommendations. Some participants reported feeling racially discriminated against during their counseling. | Level III , descriptive (qualitative interviews)<br><br>Strengths: Rich data collection<br><br>Limitations: Small convenience sample<br><br>Generalizability: Low |
| Yee et al., 2015[30]<br><br>Funding: NR<br><br>Location: Chicago, Illinois | Women seeking antenatal/postpartum care (n=57)<br><br>Years of data collection: NR<br><br>Age distribution: 21–31 years<br><br>Race/Ethnicity: African American 64%, Hispanic 24%, Asian 9%, white 4% | What are the preferences of underserved pregnant and postpartum women regarding contraception use and counseling? | Most participants (84%) reported that the best time to receive contraceptive counseling was both before and after childbirth. | Level III, descriptive (quantitative survey)<br><br>Strengths: Relatively large sample size for qualitative study<br><br>Limitations: Limited exploration of client preferences (e.g., preferred timing during pregnancy)<br><br>Generalizability: Moderate |

[a]USPSTF hierarchy of research design: Level I: properly powered and conducted RCT; well-conducted systematic review or meta-analysis of homogeneous RCTs. Level II-1: well-designed controlled trial without randomization. Level II-2: cohort or case-control analytic study. Level II-3: multiple time series with or without an intervention; dramatic results from uncontrolled experiments. Level III: opinions of respected authorities, based on clinical experience; descriptive studies or case reports; reports of expert committees.
[b]Though the publication year is 2017, the article was identified in the search of literature published prior to November 30, 2016 due to early online availability.

CA DHS, California Department of Health Services; CA DSS, California Department of Social Services; CHCF, California Health Care Foundation; EC, emergency contraception; ED, emergency department; ESRC, Economic and Social Research Council; GFEF, Global Field Experience Fund; HRSA, Health Resources & Services Administration; IUD, intrauterine device; JHSPH, Johns Hopkins Bloomberg School of Public Health; LARC, long-acting reversible contraception; NCATS, National Center for Advancing Translational Sciences; NCRR, National Center for Research Resources; NICHD, National Institute of Child Health and Human Development; NR, not reported; PCP, primary care provider; RWJF, Robert Wood Johnson Foundation; SBHC, Schools Based Health Center; SFP, Society of Family Planning; UCSF-CTSI, University of California, San Francisco, Clinical & Translational Science Institute; USPSTF, United States Preventive Services Task Force