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Review Article

Women's and healthcare providers' experiences of contraceptive counselling: a qualitative systematic review

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ABSTRACT

Background: Persistent inequalities shape women's access to and experiences of contraceptive care. Improving care quality requires a clearer understanding of women-provider interactions. This study aimed to synthesise women's and healthcare providers' experiences of contraceptive counselling.
Methods: This qualitative systematic review with inductive thematic synthesis followed the JBI methodology. Eligible studies in English, Portuguese, or Spanish published from database inception to 16 June 2025 were identified in CINAHL Ultimate, MedicLatina, MEDLINE Ultimate, the Psychology and Behavioral Sciences Collection, and Scopus. An initial limited search, development of search terms, and comprehensive database searches were undertaken; the PRISMA flow diagram summarised study selection. Two reviewers independently appraised quality using the JBI Critical Appraisal Checklist for Qualitative Research, and extracted data on study objectives, design, setting, participants, and main themes using a standardised form.
Results: Nine studies met the inclusion criteria. Six explored women's experiences, two examined healthcare providers' experiences, and one addressed both. Three overarching themes emerged: Contraceptive Engagement, Woman-Provider Relationship, and Decision-Making Process. Women and healthcare providers identified economic constraints, religious beliefs, and information gaps as common obstacles to contraceptive engagement. Healthcare providers emphasised woman-centred care, aligning with women's preference for non-judgemental, proactive, and respectful counselling. The decision-making process was the most prominent theme, with informed and respected decisions serving as central facilitators.
Conclusion: High-quality counselling requires recognising women's needs and adopting empowerment strategies. Integrating these insights into services and expanding counselling delivered by trained healthcare providers are essential to improve access and quality. Further research should inform education and training programmes.

Introduction

Contraceptive counselling has evolved from a predominantly biomedical model focused on method provision and risk management to approaches that integrate psychosocial and relational dimensions [1,2]. This shift highlights the importance of effective communication and women's empowerment in achieving high-quality care [3,4]. Nevertheless, contraceptive rights, central to the United Nations Sustainable Development Goals, remain unevenly realised. Approximately 257 million women of reproductive age still experiencing an unmet need for modern methods [5].

Inadequate discussion of side effects has been associated with method discontinuation [6], while trust, relational sensitivity, and cultural awareness support informed and autonomous decision-making [7].

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Depending on the clinical and interpersonal dynamics, counselling may range from genuinely shared decision-making to more directive or even coercive approaches.

Policy innovations, such as task-sharing, over-the-counter access to emergency contraception, and telemedicine, have shown promise but remain inconsistently implemented [8,9]. Challenges include safeguarding confidentiality during telecontraception, managing moral distress where contraceptive options are limited, and addressing insufficient training, time constraints, and implicit bias that can hinder the relationship between women and providers [10,11]. In response to these persistent gaps, global health agencies have established standards for high-quality counselling that require accessible, ethically sound, and culturally responsive services delivered by competent healthcare providers [12,13].

Women and healthcare providers hold nuanced, sometimes divergent perspectives, particularly regarding trust, cultural responsiveness, and shared decision-making [7,14]. Previous reviews have primarily assessed the effectiveness of interventions and predated recent innovations in contraceptive care delivery, including enhanced counselling and follow-up services, advanced provision of emergency contraception, and the integration of patient-centred and technology-supported models[15]. Other reviews have focused on the perspective of a single actor within the counselling process [11,14,16–18].

This qualitative systematic review, therefore, aimed to synthesise adult women's and healthcare providers' experiences of contraceptive counselling. Integrating both viewpoints enables a comprehensive understanding of the relational and communicative processes that shape contraceptive counselling. Healthcare providers include nurses, midwives, family physicians, general practitioners, and obstetrician-gynaecologists, reflecting the multidisciplinary nature of contraceptive care.

Accordingly, the following research questions were addressed:

1. What are women's experiences of contraceptive counselling received?
2. What are healthcare providers' experiences of contraceptive counselling delivered?

Methods

Study design

A qualitative systematic review was conducted in accordance with the Joanna Briggs Institute (JBI) methodology, which provides a structured and transparent process for synthesising qualitative evidence while preserving interpretive depth and contextual understanding[19]. The review followed an *a priori* protocol [20].

Eligibility criteria for the studies

The inclusion criteria comprised primary qualitative studies or mixed-methods studies in which the qualitative component was clearly identified, extracted, and analysed. Eligible studies explored the experiences of adult women or healthcare providers, including nurses, midwives, family doctors, general practitioners, gynaecologists/obstetricians, who represent the core workforce identified in World Health Organization guidance[21,22]. Eligible studies also focused on contraceptive counselling in high-income countries[23], ensuring conceptual coherence across comparable health systems and minimising potential confounding effects related to structural or resource disparities.

Studies in English, Portuguese, or Spanish published from database inception to 16 June 2025 were included, reflecting both the predominant languages of relevant qualitative research and the linguistic expertise of the research team.

Eligibility criteria were structured using the Population, Phenomenon of Interest, and Context (PICo) framework[19], summarised in Table 1.

Table 1
Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Population: Adult women (≥18 years) and healthcare providers (nurses, midwives, family physicians, general practitioners, gynaecologists/obstetricians).	Male clients or students in health-related fields.
Phenomenon of Interest: Experiences of contraceptive counselling.	Studies focusing mainly on contraceptive methods, provider bias, coercion, or migration issues.
Context: High-income countries.	–
Study characteristics: Qualitative or mixed-methods studies with a clearly identifiable qualitative component; published in English, Portuguese, or Spanish.	Quantitative studies or mixed-methods studies without a distinct qualitative component.

Search strategies

The search strategy was developed following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines[24] and the JBI methodology[19]. An initial limited search was undertaken to identify relevant studies and examine key terms in titles, abstracts, and indexing fields. These findings informed the development of comprehensive search strategies for each database (see Appendix A for details). Final search strategies incorporated all identified keywords and index terms and were adapted for CINAHL Ultimate, MedicLatina, MEDLINE Ultimate, the Psychology and Behavioral Sciences Collection, and Scopus. Reference lists of included studies were screened through backward citation searching to identify additional relevant studies.

Study selection

All retrieved studies were imported into EndNote 20® (Clarivate Analytics, Philadelphia, USA) and Rayyan (version 1.6.1; Rayyan Systems Inc., Doha, Qatar), where duplicates were removed. Following a pilot screening, two reviewers independently assessed titles and abstracts against the eligibility criteria. Full texts of potentially relevant studies were then obtained and reviewed in detail by the same two reviewers. Most disagreements were resolved through discussion, with only one case requiring consultation with a third reviewer to achieve consensus.

Quality appraisal

Two reviewers independently appraised the methodological quality of the included studies using the JBI Critical Appraisal Checklist for Qualitative Research[19]. This checklist was selected for its conceptual congruence with the JBI methodology, ensuring coherence between appraisal, synthesis, and confidence assessment. Before formal appraisal, the checklist was piloted on two studies independently selected to calibrate reviewers' interpretations of each criterion and ensure a consistent application. Disagreements during appraisal were resolved through discussion.

Data analysis

Data were thematically synthesised following Thomas and Harden's approach[25] using ATLAS.ti software (version 23; ATLAS.ti Scientific Software Development GmbH, Berlin, Germany). Text segments from the results and discussion sections were independently coded line by line by two researchers, considering first-order (participants' expressions) and second-order (authors' categorisation) constructs. Codes were

grouped into descriptive themes, which were discussed and refined by consensus. Analytical themes were subsequently generated inductively [26] through iterative comparison and linkage of codes, supported by diagrams and mind maps illustrating relationships between themes. Disagreements were resolved through discussion; no further reviewer involvement or author contact was required for clarification or missing data.

Confidence assessment

To ensure transparency and methodological rigour, confidence in the synthesised findings was evaluated using the JBI ConQual approach [19]. This framework provides a structured process for determining confidence levels in qualitative evidence attributed to each synthesised finding, based on two core domains: dependability, referring to the consistency and stability of the research process; and credibility, reflecting the trustworthiness and plausibility of the findings.

Results and discussion

A total of 15,750 studies were initially identified. After removing duplicates, 8787 studies were screened by title and abstract. The 29 studies remaining after title and abstract screening were read in full. Reasons for exclusion at the full-text stage were documented and are presented in Appendix B. No additional studies were identified through backward citation searching. Nine studies met the inclusion criteria and were included in the final review, as illustrated in Fig. 1.

The included studies were published between 2009 and 2022 and conducted in the United States, Sweden, and Spain. Six of them explored women's experiences of contraceptive counselling, two examined healthcare providers' experiences, and one addressed both. Across studies, data were contributed by at least 213 adult women (one study did not specify the exact number), 11 nurses, 22 midwives, nine family physicians/general practitioners, and 10 gynaecologists/obstetricians. Eight studies adopted qualitative designs, and one employed a mixed-methods design with a clearly identifiable qualitative component. Table 2 summarises the characteristics of the included studies.

Seven studies were rated as moderate quality[27–33], and two as of high quality[2,7], indicating that the findings are credible and broadly transferable across comparable contexts. Most studies lacked an explicit philosophical or theoretical framework, limiting transparency regarding their epistemological stance. Reflexivity was generally limited: only one study explicitly addressed researcher reflexivity and considered power dynamics during fieldwork[2], while another acknowledged the researcher's position without analytical depth[7]. Ethical approval and informed consent were reported across all included studies, and all conclusions were congruent with the analyses presented. Appraisal results are summarised in Table 2, with a detailed visualisation provided in Appendix C.

All studies were retained for data extraction and synthesis regardless of methodological quality. Studies meeting eight or more of the ten JBI domains were considered to provide higher-confidence evidence, informing the central analytical categories. Those with lower ratings contributed primarily to contextual and nuanced understanding.

A transparent overview of the confidence assessment results is provided in Appendix D.

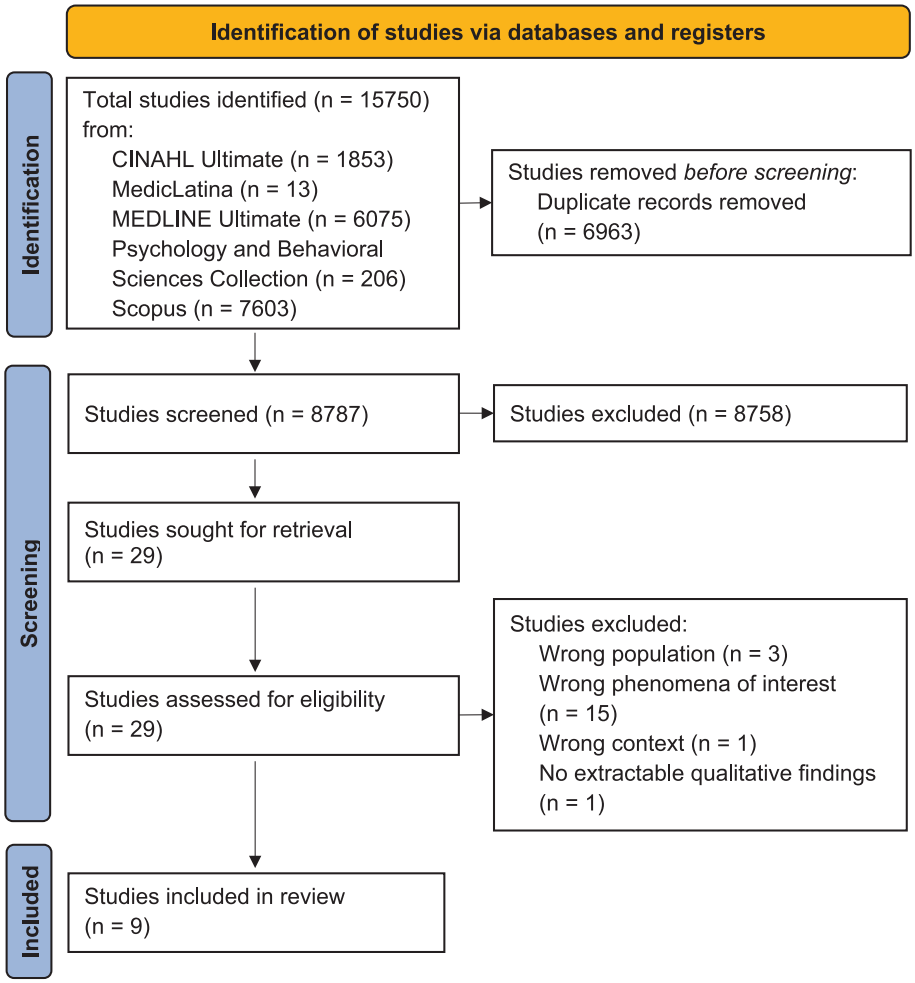

Fig. 1. Flow diagram of the study selection process.

Table 2
Characteristics of the included studies and quality appraisal.

Study and review question (number)	Author, year, country	Objectives	Method and setting	Results (main themes)	Quality appraisal
S1 (1)	Becker *et al.* (2009) United States	To learn about women's perceptions of and experiences with family planning services.	Qualitative descriptive study. Thematic analysis using both deductive and inductive approaches. 40 women (9 Black, 8 White, 20 Latina, and 3 mixed of these backgrounds) aged 18–36 years, recruited from 2 Title X-funded family planning clinics in the San Francisco Bay Area.	*"Accessibility"* *"Information provision"* *"Attention to client comfort"* *"Engagement and personalization"* *"Service organizational features"* *"Care/empathy/concern"* *"Technical quality"* *"Respect for autonomy"*	7/10
S2 (1)	Yee & Simon (2011) United States	To better understand women's attitudes towards postpartum contraceptive counselling, including optimal counselling timing, frequency, communication features, and content.	Qualitative descriptive study. Thematic analysis informed by grounded theory using an inductive approach. 30 women aged 18 years and older, in the postpartum period, recruited from a large, urban, academic medical centre in Chicago.	*"Receipt of Antenatal Contraceptive Counseling"* *"Perception of 'Doing a Good Job' of Contraceptive Counseling"* *"Optimizing Counseling Timing, Frequency, and Content"*	7/10
S3 (2)	Wätterbjörk *et al.* (2011) Sweden	To consider how Swedish nurse-midwives think and act in their role as contraceptive counsellors.	Qualitative study. Analysis informed by Graneheim and Lundman framework using an inductive approach. 18 nurse-midwives from primary healthcare centres and youth clinics in a Swedish county, recruited through convenience sampling (only 16 interviews were considered).	*"Exploring the woman's situation"* *"Providing information about contraceptive methods"* *"Performing medical evaluation"* *"Guiding the decision-making process"* *"Following up on the counselling"*	7/10
S4 (1)	Dehlendorf *et al.* (2013) United States	To assess patients' preferences about birth control counselling, with a focus on the decision-making process.	Qualitative study. Analysis informed by modified grounded theory using both deductive and inductive approaches. 42 women (10 Black, 10 White, and 22 Latina) aged 18 years and older, recruited at 5 clinics in the San Francisco Bay Area.	*"Control over contraceptive decision making"* *"Interpersonal relationship with provider"* *"Preferences for information"* *"Social networking"* *"Differences by race and ethnicity"*	6/10
S5 (1)	Sundstrom *et al.* (2018) United States	To investigate women's perceptions of contraceptive options and counselling in the outpatient postpartum period.	Qualitative study. Thematic analysis informed by grounded theory using an inductive approach. 47 women aged 18 to 39 years, recruited from an outpatient clinic in the Southeastern United States (postpartum appointment).	*"Negotiation control"* *"Trusting relationship-centered care"*	7/10
S6 (1)	Thiel de Bocanegra *et al.* (2020) United States	To better understand the contraceptive counselling experience of women with a preterm birth, their contraceptive method preference, and contraceptive initiation and continuation in the postpartum period.	Qualitative study. Thematic analysis using an inductive approach. 35 women aged 18 to 42 years, who had a recent preterm birth and did not undergo tubal ligation at delivery.	*"Timing and frequency of contraceptive counseling"* *"Quality of the patient–provider interaction"* *"Women's personal experiences with contraceptive use and experiences of other women"* *"Context in which contraceptive counseling was framed"* *"Systemic barriers to contraceptive use"*	7/10
S7 (1, 2)	Reyes-Martí *et al.* (2021) Spain	To explore the experiences and needs of users and practitioners during contraceptive counselling using the Quality of Contraceptive Counselling Framework.	Qualitative study. Thematic analysis informed by Braun and Clarke's framework, using both inductive and deductive approaches. 64 contraceptive counselling users and 19 practitioners were recruited through convenience sampling (snowball sampling, WhatsApp groups, and email lists). Only young women aged 18 to 29 years and adult women aged 30 years and older were considered in the analysis.	*"Explore the needs, preferences and previous experiences withcontraceptives, to adapt communication to specific needs and concerns"* *"Facilitate decision-making for the choice of method providing up-to-date information on all options: effectiveness, mechanism of action, side effects, contraindications, barriers to use, etc., neutrally and comprehensibly"* *"Respect the choice of method in a context of shared decision-making, incorporating information for the use of the method and its monitoring"*	8/10

(*continued on next page*)

Table 2 (*continued*)

Study and review question (number)	Author, year, country	Objectives	Method and setting	Results (main themes)	Quality appraisal
S8 (1)	Kolak *et al.* (2022) Sweden	To explore immigrant women's perspectives on contraceptive counselling provided by midwives in Sweden.	Qualitative study. Analysis informed by Graneheim and Lundman framework using an inductive approach. 19 immigrant women (foreign-born), aged 19 to 49 years, residing in Sweden for at least one year, who had received contraceptive counselling from a Swedish midwife within the past ten years.	*"Contraceptive counselling – a private matter"* *"Lacking fundamental knowledge about reproductive physiology, anatomy and contraceptives for making informed choices"* *"Preconceptions and previous experience with contraceptives needing due consideration"* *"Contraceptive counselling – an interplay between women's and midwives' views of each other"*	8/10
S9 (2)	Mann *et al.* (2022) United States	To assess both positive and negative influences across multiple primary care specialties and practice settings to identify the most salient issues and strategies to improve care.	Cross-sectional qualitative study. Thematic analysis informed by Braun and Clarke's framework, using an inductive approach. 24 providers (4 family physicians, 7 obstetricians/ gynaecologists, and 8 nurse practitioners) were recruited through purposive and snowball sampling. The 5 paediatricians were excluded from the analysis.	*"Organizational"* *"Provider-related"* *"Structural and policy"* *"Patient-related"* *"Community"* *"Absence of barriers or influences"* *"Sources of information about contraception"*	7/10

Eight descriptive categories were organised under three overarching themes: Contraceptive Engagement, Woman-Provider Relationship, and Decision-Making Process. The relative prominence of subcategories is illustrated by the cluster sizes in Fig. 2, where subcategories identified by women are shown in pink, those identified by healthcare providers in blue, and those reported by both groups in purple.

Synthesised themes, categories, and subcategories are presented descriptively first, followed by an interpretive discussion that situates the findings within broader theoretical and contextual frameworks.

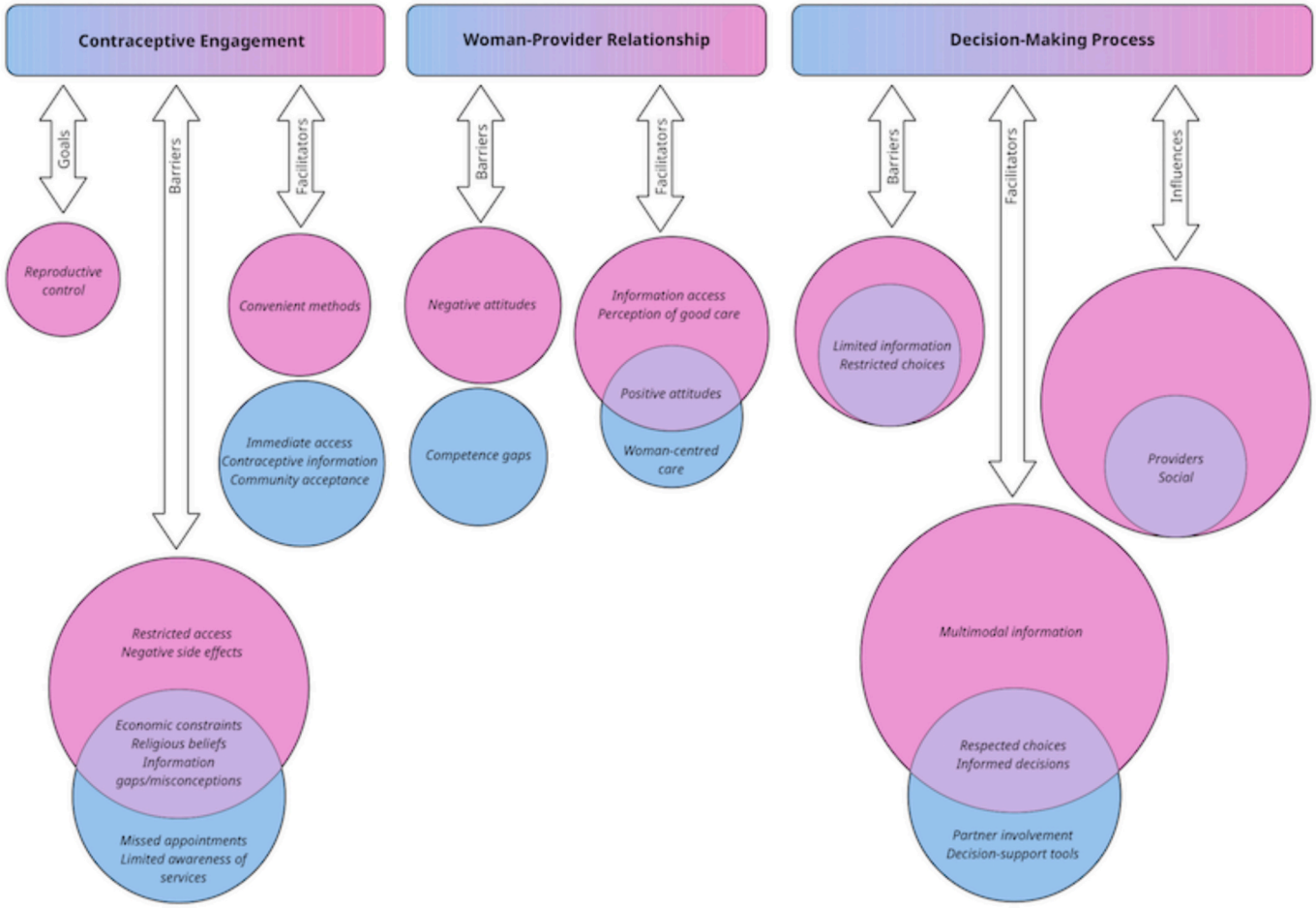

Fig. 2. Contraceptive Counselling: main themes, categories, and subcategories.

Theme 1. Contraceptive Engagement

This theme comprises three categories: *Contraceptive goals*, *Barriers to engagement*, and *Facilitators of engagement*.

Category 1.1 – Contraceptive goals.

Articulated exclusively by women, this category identifies *reproductive control* as a central subcategory.

While modern contraceptives are recognised as key means for women to control fertility and prevent unintended pregnancies[34,35], significant gaps persist between guidelines for person-centred, non-coercive counselling[36], and service delivery. A multi-site study demonstrated this disconnect, finding that nearly half of women who desired but did not achieve postpartum permanent contraception failed to receive any effective method within a year[37]. This underscores the importance of contraceptive autonomy, which encompasses the capacity for informed, free choice and recognises that autonomous non-use can itself be a valid expression of reproductive agency when aligned with personal goals[38].

Category 1.2 – Barriers to engagement.

Reported by both women and healthcare providers, this category includes *economic constraints*, *religious beliefs*, and *information gaps/misconceptions* subcategories. Women further describe *restricted access* and *negative side effects*, while healthcare providers emphasise *missed appointments* and *limited awareness of services* subcategories.

Financial barriers have been commonly reported in previous studies. In the United States, cost-limited access to long-acting reversible contraception was also found in a study among low-income women[39]. Other studies on refugee, asylum-seeking, and immigrant women described how they faced compounded barriers, including language difficulties, discrimination, and restrictive cultural norms, even among those with high educational attainment[40–42]. Furthermore, misinformation and fear of side effects significantly constrained contraceptive uptake, while myths, peer disapproval, and knowledge deficits discouraged adolescents, and immigrant women reported inadequate counselling despite strong interest in family planning[43,44]. Finally, other studies conclude that missed appointments reflected structural obstacles such as transport and communication failures, disproportionately affecting women without private insurance, who encountered limited access and increased out-of-pocket costs[45,46].

Category 1.3 – Facilitators of engagement.

This category includes the subcategories of *convenient methods*, reported by women, and *immediate access*, reported by providers, illustrating a shared emphasis on accessibility and ease of use. Providers also highlight the subcategories *contraceptive information* and *community acceptance*.

These findings are shared by studies where the proximity of services and diversity of methods, alongside discreet and user-friendly options with few side effects, enhanced contraceptive uptake[47,48]. Another study found that community engagement and accountability mechanisms further supported programmes, although stigma at the community level remained a persistent challenge[49].

Theme 2. Woman-Provider Relationship

This theme comprises two categories: *Barriers to relationship* and *Facilitators of relationship*.

Category 2.1 – Barriers to relationship.

This category includes providers' *negative attitudes* subcategory, reported by women as judgemental, distrustful, and unsupportive. Healthcare providers acknowledge the *competence gaps* subcategory.

These direct findings are critically supported and contextualised by the wider literature. For instance, the mistrust resulting from such attitudes is explicitly linked in one study to client dissatisfaction and a perception of provider bias[50]. Furthermore, the impact of these competence gaps is severely exacerbated by systemic barriers. Broader research confirms that staffing shortages and time constraints fundamentally undermine the quality and continuity of counselling, creating an environment where addressing these interpersonal issues becomes even more difficult[51,52].

Category 2.2 – Facilitators of relationship.

This category was emphasised by both groups. Women value the subcategories *information access*, *perception of good care*, especially when providers displays *positive attitudes* such as proactivity, support, non-judgement, and respect. Providers highlight the subcategory *woman-centred care*, which fostered trust and empathy, strengthening communication and helping women feel heard and supported during decision-making.

The identified facilitators are strongly supported by the wider literature as key to effective health outcomes. The emphasis on non-judgmental, respectful communication aligns with studies where compassionate relationships, even under resource constraints, were associated with improved contraceptive uptake and continuation[53]. Women appreciated counselling that considered their medical history, preferences, and life context, particularly when discussions about side effects were open and individualised[1,54]. Providers reported using open-ended questions and maintaining a direct yet non-judgemental tone to encourage shared decision-making[55].

Theme 3. Decision-Making Process

This theme comprises three categories: *Barriers to decision-making*, *Facilitators of decision-making*, and *Influences on decision-making*.

Category 3.1 – Barriers to decision-making.

Both groups noted this category, which relates primarily to the subcategories *limited information* and *restricted choices*.

These findings are illustrated by the wider literature, where women report lacking explicit decision-making power, with some resorting to covert contraceptive use as an act of agency against structural constraints[56]. Furthermore, other research confirms that women frequently receive limited guidance on menstrual cycles and method effectiveness[57], and perceived providers as dismissive which force them to seek information elsewhere[58]. Studies also show that while healthcare providers seek to support autonomy, stockouts, time pressures, and heavy workloads directly undermine the quality of counselling[51,59].

Category 3.2 –Facilitators of decision-making.

This category includes *respected choices* and *informed decisions* subcategories, noted by both groups. Healthcare providers also identify the subcategories *partner involvement* and *decision-support tools*, while women emphasise the *multimodal information* subcategory.

Participation and autonomy were linked to positive outcomes, though social and contextual factors shaped women's engagement. These findings underscore a core principle of effective care, fostering women's empowerment, and highlighting that effective contraceptive counselling relies on empathetic communication, relational competence, and women's empowerment within everyday clinical encounters [3,4]. This aligns with the wider literature where empowerment factors such as sexual self-esteem and contraceptive responsibility are shown to underpin healthier decisions[60]. The tools highlighted are also supported by evidence; for example, digital and printed decision aids have been proven to improve knowledge, clarify values, and strengthen communication between women and providers[61]. Furthermore, this review's recognition that "social and contextual factors shape engagement" is critically illustrated by studies of vulnerable populations. Research with female sex workers, for example, shows that even high knowledge levels can be thwarted by barriers such as partner dynamics, violence, and systemic healthcare access issues[62], emphasising that facilitative counselling must actively address these external constraints.

Category 3.3 – Influences on decision-making.

This category was identified by both groups, with the subcategory *providers* emerging as more influential than *social*.

This central finding is nuanced by the wider literature. While studies

confirm that providers balance women's preferences with clinical considerations[59], their influence becomes detrimental with biased information or discouragement of method switching, undermining autonomy[54]. The influence of social networks and "word of mouth" from trusted female relatives and peers powerfully shapes choices across contexts[63–65]. Furthermore, while standardised counselling could reduce bias, it carries the risk of reinforcing inequities[66].

This review shows that high-quality contraceptive counselling rests on three interdependent pillars: Contraceptive Engagement, which ensures informed choice through availability, clarity, and continuity; Woman-Provider Relationship, where relational quality, rooted in trust, empathy, and respect, transforms counselling into an equitable partnership; and Decision-Making Process, where shared decision-making emerges as a dynamic balance between women's agency and providers' guidance, shaped by contextual realities. By integrating women's and providers' experiences, this review shows that counselling competence extends beyond technical proficiency to embrace communication, equity, and care ethics across these three pillars. Table 3 provides an overview of the categories and subcategories, illustrated with supporting quotations and organised through the lens of the phenomenon of interest.

Implications for practice, policy and research.

Contraceptive counselling should evolve beyond information transfer towards active deliberation, respect for individual preferences, and shared decision-making. Persistent barriers, including limited consultation time, restricted availability of novel methods, and financial constraints, continue to hinder informed choice, particularly when providers are reluctant to recommend methods they would not personally use. Health systems must ensure equitable access to a full range of contraceptive options through appropriate funding and service delivery models.

Healthcare providers face constraints in their practice, particularly midwives, whose limited autonomy continues to restrict their contribution to the phenomenon of interest. Expanding their scope of practice through clear regulation and targeted training would strengthen both the quality and continuity of care. Addressing provider bias and enhancing education in empathy, cultural competence, and relational communication are also essential to align counselling with women's lived realities and promote equitable, person-centred care. Further research should extend beyond adult women to include men and individuals of diverse gender identities, and to explore how peers, partners, families, and wider social networks influence contraceptive decision-making. It should also encompass diverse demographic and sociocultural groups, thereby contributing to more inclusive and equitable family planning practices. Finally, future studies should investigate healthcare providers' approaches to counselling. Qualitative research involving clients and providers within the same settings, particularly in high-income countries, is needed to strengthen the evidence base and improve the transferability of findings across health systems.

Strengths and limitations

The review title was refined to explicitly state the methodological design, ensuring full transparency regarding the review approach. Another protocol deviation concerned the restriction of the eligibility criteria to high-income settings to enhance comparability across healthcare contexts. As a consequence, studies involving subgroup-specific populations of women may have remained outside the scope of this review. However, evidence from low- and middle-income contexts was acknowledged and drawn upon in the discussion where relevant, given shared barriers, provider bias, and the centrality of autonomy.

Despite a comprehensive search, relevant studies may have been missed, particularly those published in languages other than English, Portuguese, or Spanish. Translation processes may also have masked

Table 3
Contraceptive Counselling: categories, subcategories and illustrative quotes (number).

Categories	Subcategories	Example of supporting quotes (study number)	Studies
"Facilitators of contraceptive counselling" (68)	*Convenient methods* and *Immediate access* (9)	*"[It is] almost like an effortless form of birth control, you don't have to take a pill every day."* (S5) *"More same day visits. If somebody calls and says, "I want birth control'' they want birth control', they want it then. In two weeks they may change their mind." Family nurse practitioner, college campus* (S9)	S5, S8, S9
	Contraceptive multimodal information, *Information access*, and *Decision-support tools* (20)	*"They explained everything to you clearly, and if you decided to do something other than what they advised you to do, they wouldn't get judgmental. They would give you options." English-speaking Latina, 20* (S1) *"…(DST) if there is a lot of text it won't be read…. I'm an odd case, I like reading a lot, (…) people see 4–5 things and run away." YW2* (S7) *"… it is essential to explain how it works, how it is used, if it has any side effect… if there is any change… for example, if we talk about the implant, the first thing that is explained is the percentage likelihood of amenorrhea, the percentage likelihood of irregular bleeding…" Midwife, >50 years of age* (S7)	S1, S2, S3, S4, S5, S7, S8
	Perception of good care, *Woman-centred care*, *Respected choices*, and *Informed decisions* (28)	*"I personally think [my doctor] considers my needs a whole lot, treats me as an individual based on my lifestyle or things that I consider important. Not so by the book."* (S5) *"… that's why there are so many contraceptive methods, because there are many profiles of women. The first thing I explain is what she asks me for. I make sure she asks me for it because she knows about it, I clear up any doubts and if she is still interested, okay. What I think is that, if she leaves the office with a different method from the one she has decided for, she*	S1, S2, S3, S4, S5, S7

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Table 3 (*continued*)

Categories	Subcategories	Example of supporting quotes (study number)	Studies
		won't use it…" family doctor, 41–50 years of age (S7)	
	Providers' positive attitudes (9)	*"I just think over time you get comfortable. It's like knowing someone. He doesn't just make me feel like I'm a patient. He makes me feel like he's really concerned and like I'm a family member." (S4)* *"I give the responsibility to the woman to contact me if the contraceptive method does not work." Participant 15* (S3)	S1, S2, S3, S4
	Community acceptance and *Partner involvement* (2)	*"When a woman cannot decide I give her the brochures and say: 'Maybe you should think about this a little bit more together with your partner and you could decide together what is best for your relationship." Participant 14* (S3) *"… the community at large is largely receptive to the provision of contraceptive services." OB/Gyn, private practice* (S9)	S3, S9
"Barriers to contraceptive counselling" (51)	*Economic constraints, Restricted access*, and *Limited awareness of services* (9)	*"A sexually active person with four condoms a month, it's not fair. But I told them, and no, they didn't do anything. They never gave me more than that." Spanish-speaking Latina, age 24* (S1) *"I do have several patients that have decided just to go with the OCP's because that's what they can afford. Because they can't afford $600, $700 for the placement of an IUD or $800 for Nexplanon." OBGYN, private practice, rural area* (S9)	S1, S6, S7, S9
	Religious beliefs and *Negative side effects* (7)	*"I decided to try a hormonal method, the pill in my case… I noticed it changed my character and that I was in a bad mood… and also blemishes on the skin with the ring… I've got blemishes on the skin…" AW1* (S7) *"We do have quite a few in this particular practice that are adverse [to providing contraception] for their own religious beliefs. They tend to refer them to some of us who are comfortable with doing contraceptive care. I'd say that probably there's a greater group than I would have expected to see that are not willing to prescribe or use any kind of contraception for their patients." Family nurse practitioner, health center* (S9)	S5, S7, S8, S9
	Information gaps/ misconceptions and *Limited information/ choices* (27)	*"I didn't feel like I really was well informed, and so… what she said was what I did.… She was like, 'Oh, you can choose from any of these things on this paper, [but] most people just do this,' and then you just go with that…. Not being informed is… pushing you towards what they believe is right, because you don't have a clear idea of what each thing does." White, age 23* (S1) *"I think it's still a little bit of a taboo to talk about contraception. For a long time I think the only form of contraception was abstinence, so to even suggest that there was something to do, to use to prevent pregnancy other than abstinence was just unheard of. That still we shouldn't be talking about those things and you shouldn't need to worry about contraception because you're not going to have sex until you're married." Family Physician, academic setting, suburban area* (S9)	S1, S4, S5, S6, S7, S8, S9
	Providers' negative attitudes and *Competence gaps*(8)	*"… there are practitioners who, faced with a request for combined hormonal contraceptives, because they don't know, continue to give "Loeb", "Sibilla" or "Diane 35", although the guidelines say they shouldn't be prescribed… this happens because we don't refresh… and if we ourselves don't know the characteristics of the methods, how are we going to explain or prescribe them?" Midwife, 20–30 years of age* (S7) *"Sometimes I believe midwives are thinking contraceptives are being something forbidden to us … having own*	S5, S7, S8, S9

(*continued on next page*)

Table 3 (*continued*)

Categories	Subcategories	Example of supporting quotes (study number)	Studies
		perceptions about us coming from other countries … but they should just ask … sometimes I have the feeling that they don't believe we will take the medicine anyway." P18 (S8)	
"Contraceptive counselling goals" (2)	*Reproductive control* (2)	*"As women, we need to take control as much as possible of our reproductive health."* (S5) *"… I looked above all that it was effective because… although getting pregnant wouldn't be a drama, I don't want it to happen…" YW3* (S7)	S5, S7
"Influences on contraceptive counselling" (28)	*Providers* (21)	*"When I told them I wanted to take the Depo-Provera, they [said] that's really not a good birth control method. It has so many negative side effects, and they seemed, like, it would be too hard on my body because I'm so small. They thought the [IUD] would be better for me…." English-speaking Latina, early 30s* (S1) *"… you have to limit the information according to the characteristics of the patient, her medical condition, and what you think will best suit her… because sometimes what is best for your patient in your medical opinion, is not what she wants…" family doctor, >50 years of age* (S7)	S1, S2, S4, S5, S6, S7
	Social (7)	*"I was going to discuss with my friends, how does the IUD work, if it hurt them, if everything is fine, to see since it is going to be my first time using the IUD." 28 years, Hispanic* (S6) *"(…) so there's a great predisposition towards this or that method, or they want to use one because it works well for such-and such, and so they are completely unaware of the side effects, or if it's suitable for her or not." Gynaecologist, 31–40 years of age* (S7)	S4, S6, S7

certain cultural nuances. Most included studies were conducted in the United States, which may limit transferability to other high-income contexts. The small number of eligible studies and their methodological heterogeneity further constrained direct comparisons.

Many primary studies lacked explicit theoretical frameworks and demonstrated limited reflexivity, potentially restricting analytic depth. As in all qualitative syntheses, the findings are shaped by the richness and quality of the original studies as well as by the reviewers' interpretations.

A key strength of this review lies in the composition of the research team. Five authors are nurse-midwives, and three have practised contraceptive counselling until very recently. This clinical expertise provided an informed understanding of the phenomenon under study, enhancing the analytical sensitivity, contextual accuracy, and practical relevance of the synthesis.

Conclusion

Contraceptive counselling operates at the intersection of structural conditions, interpersonal dynamics, and individual agency. Women and providers share common ground in their goals and relational priorities but differ in their experiences of autonomy, power, and participation in decision-making. Strengthening facilitators while addressing intersectional barriers offers a clear path towards enhanced woman-centred and equitable counselling. Healthcare providers play a pivotal role in this process. Counselling should be both evidence-based and individualised, integrating technical expertise with relational competence, and supported by targeted training to foster compassionate and effective practice.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.srhc.2025.101173.

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