ARTICLE

A Qualitative Exploration of Past Family Planning Counselling of Adolescent and Young Mothers

Examen qualitatif de l'historique du counseling en planification familiale offert à des mères adolescentes et jeunes adultes

Katherine Gerster, BSc, MD, FRCSC, Beth Murray-Davis, BA, BHSc, MA, PhD, Ebernella Shirin Dason, BSc, MD, and Dustin Costescu, BSc, MD, FRCSC

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ABSTRACT

Objective: This study explores the family planning counselling that adolescents receive during pregnancy care, with the aim of identifying those factors that make counselling effective or ineffective.

Methods: The study population consisted of ten adolescents who had recently given birth and ten health care providers. Adolescents were recruited using posters; providers, by email. Individual semistructured interviews were conducted and analyzed in keeping with grounded theory. Analysis consisted of open coding (identification of initial concepts), axial coding (drawing connections between repetitive and similar concepts), and selective coding (clustering of categories to identify themes).

Results: The adolescent participants desired detailed information about pregnancy and motherhood, were challenged by the disruptive effects of pregnancy, and were strongly reliant on nonmedical support people. Our participants described that the adolescent-provider relationship was strengthened when providers sought to empower adolescents and to provide a balance of support and independence. Judgment and bias interfered with relationship building. Postpartum continuity with the pregnancy care provider and a positive relationship with the family physician were both highly desirable yet highly variable. In general, the adolescents found family planning counselling an awkward and intimate undertaking and preferred providers to slowly progress towards explicit counselling. The adolescents who opted not to initiate postpartum contraception still found the counselling process informative and beneficial.

Conclusion: Effective family planning counselling is not information driven but rather gradual, individualized, and context focused.

KEYWORDS

family planning, contraceptive counselling, adolescent pregnancy, rapid repeat pregnancy, adolescent obstetrics

This article has been peer reviewed.

RÉSUMÉ

Objectif: Cette étude se penche sur le counseling en planification familiale que les adolescentes reçoivent durant leur grossesse, afin de cerner les facteurs qui le rendent efficace ou non.

Méthodes: La population de l'étude comprenait dix adolescentes qui avaient récemment accouché et dix fournisseurs de soins. Les adolescentes ont été recrutées par des affiches, tandis que les fournisseurs l'ont été par courriel. Des entrevues individuelles semi-structurées ont été réalisées, puis analysées conformément à la théorie ancrée dans la pratique. L'analyse a consisté en un codage ouvert (l'identification des concepts initiaux), un codage axial (l'établissement de liens entre les concepts répétitifs et semblables) et un codage sélectif (le regroupement des catégories pour dégager les thèmes).

Résultats: Les participantes adolescentes souhaitaient des renseignements détaillés sur la grossesse et la maternité, étaient aux prises avec les effets perturbateurs de la grossesse et dépendaient fortement d'un soutien non médical. Nos participantes ont raconté que la relation adolescente-fournisseur s'était consolidée lorsque les fournisseurs ont cherché à aider les adolescentes à se prendre en charge et à assurer un équilibre entre le soutien et l'indépendance. Les critiques et les préjugés ont nui au développement des relations. La continuité postnatale avec le fournisseur des soins pendant la grossesse et une relation positive avec le médecin de famille étaient toutes deux très souhaitables, mais ont été très variables. En général, les adolescentes ont trouvé que le counseling en planification familiale était une intervention gênante et intime, et préféraient que les fournisseurs progressent lentement vers un counseling explicite. Les adolescentes qui ont choisi de ne pas commencer une contraception postnatale ont quand même trouvé le processus de counseling instructif et bénéfique.

Conclusion: Le counseling efficace en planification familiale n'est pas axé sur l'information, mais plutôt

graduel, personnalisé et centré sur le contexte.

MOTS-CLÉS

planification familiale, counseling contraceptif, grossesse chez les adolescentes, nouvelle grossesse à bref délai, obstétrique pour les adolescentes

Cet article a été évalué par un comité de lecture.

INTRODUCTION

The negative health implications of adolescent pregnancy are well established.[1,2] The link between pregnancy in adolescence and negative effects on health is even stronger with subsequent pregnancies , especially when the pregnancies are closely spaced.[3–5] Unfortunately, the strategies used to prevent adolescent pregnancy in general may not be effective in the prevention of subsequent pregnancies.[6–10] Adolescent mothers' decision making regarding contraception is affected by complex motivations with regard to motherhood, education, and career.[5] It is unclear how health care providers (HCPs) can best explore these issues; there is a paucity of studies that directly examine patient-provider interactions.[11] Therefore, qualitative research may help by exploring those factors that make family planning counselling effective or ineffective.

METHODS

We designed a qualitative, grounded theory study to explore the phenomenon and allow participants to describe their experiences freely. After obtaining ethical approval from the McMaster University Research Ethics Board (#15-385), we collected data between January and December of 2016. Data were collected through semistructured interviews with adolescents and HCPs. We began by asking participants open-ended questions about what they recalled, liked, and disliked about family planning counselling, then asked follow-up questions for clarification.

The ten adolescent participants came from Hamilton, Ontario, and the surrounding region. All were women aged 13–21 years who had given birth at least once in the previous 2 years and who had had at least one antenatal or postpartum visit with an HCP. We recruited adolescent participants via posters on the postpartum wards of two hospitals in Hamilton, in HCPs' offices around the city, and in youth shelters and residences for pregnant and parenting young women. Interested adolescents contacted the research team directly.

The participating HCPs were recruited by email through their affiliation with McMaster University. The HCPs—three midwives, two family physicians, one nurse practitioner, and four obstetricians—self-identified as working regularly with pregnant adolescents. Interested HCPs contacted the principal investigator directly.

Participants were assigned a code to maintain anonymity, and HCPs were not aware if their own patients participated in the study. We required participants to be fluent in English. For both groups, we selected participants on a first-come, first-serve basis. Adolescents received a gift card for participating.

Following consent, participants completed a single face-to-face semistructured interview lasting 30 to 45 minutes with the primary investigator. Interviews were recorded and transcribed verbatim. Participants were emailed interview transcripts and invited to offer clarifications.[12] Data collection continued until theoretical saturation was reached.[13]

Data analysis began with line-by-line open coding of each interview transcript by the principal investigator. Following the second interview, we initiated a constant comparative method: each interview was coded and compared with previous interviews to identify recurring concepts. We then performed axial coding, in which codes from adolescent and provider interviews were grouped into similar categories. Finally, we performed

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selective coding to identify overarching themes.[14] As this process proceeded, we developed new interview questions to explore the developing themes, and we discarded questions that did not generate useful information.[15] Selected transcripts and developing themes were independently reviewed by an advisor experienced with qualitative research, in order to ensure methodological rigour.[16]

RESULTS

Understanding the Adolescent Experience

Nearly all the adolescent participants expressed a strong desire to learn about their health in order to take good care of themselves and their infants. However, they did not always communicate this desire to their HCPs, citing the stress of pregnancy, fear of birth, or discomfort at the provider's office as barriers. In hindsight, some regretted this.

Adolescent participants generally valued advice and input from nonmedical support people and in many cases felt more able to share personal information and ask questions in a nonmedical context. Adolescents had varying opinions about the appropriateness of an HCP's asking questions about their personal lives; while some felt that such questioning made the atmosphere more casual and less stressful, others felt that it was not within the scope of the HCP .

Many HCPs noted that adolescents were more likely to begin pregnancy in complicated or turbulent social situations, which made prenatal care more challenging. Also, adolescent pregnancies were sometimes unintended and disruptive. As one midwife noted:

> *They might be the only one in their…social circle that has a baby now… They may be dealing with a lot of different things…The loss of a dream, you know, if their friends are all going off to university and they're not.*

On the other hand, several HCPs observed that many adolescents make efforts to enact positive life changes, as recounted by one family physician:

> *I've been really amazed by some of my adolescent patients at how the pregnancy, although unplanned, has changed their outlook on things and drastically improved their maturity. It's pretty inspiring to see the positive effects that pregnancy can have.*

Building Strong Relationships between Adolescents and Health Care Providers

Almost all the study's health care providers felt that effective, individualized family planning counselling of adolescents requires a rapport with the adolescent–often a challenging, time-consuming undertaking. One family physician described the importance of an individualized approach as follows:

> *I think it just helps you build rapport … if they feel that you know their circumstances and their life, rather than just being, like, "You're a teenager, you're pregnant, you definitely need birth control."*

The HCPs who held this view recognized that adolescents are often sensitive to judgment. Several HCPs described deliberately reflecting on their own preconceived notions in an effort to approach the

relationship with minimal judgment.

On initial questioning, adolescent participants generally claimed to prefer that their HCPs maintain a narrow, medical focus. However, on further questioning, this preference was found not to be universal. One adolescent participant stated the following:

> *I've known my family doctor for years, so I wouldn't mind if he brought that up with me, but if it was…my OB or some other random doctor saying it, I would be very uncomfortable.*

The adolescent participants were sensitive to the idea that they should use birth control, and they appreciated their HCPs' seeking to empower them to make choices rather than trying to steer them towards the "right" choice. One adolescent said, "Just explain it to her instead of pushing birth control down her throat." Another said, "My obstetrician kind of was…giving me hints that it's a good idea that you get on birth control." A third said that HCPs should not be pushy: "Someone might take it as, 'You don't want me to get pregnant again'…and I'm not really feeling that."

Health care providers felt that managing social issues was one of the more challenging aspects of providing prenatal care to adolescents. All acknowledged the importance of social workers and children's aid workers, but many recognized that offering these referrals could be detrimental to the relationship. One family physician described this tension as follows:

> *I feel like social work…that capacity, that skill set is…so valuable, and yet it's also used as a bargaining chip in a way.*

Finally, HCPs disagreed on the degree to which adolescents should be held accountable for their decisions and for their participation in care. One family physician felt it important to remember that an adolescent's ability to follow through on a plan is not necessarily indicative of her desire to do so, or valuation of the plan.

> *A lot of…people are in more chaotic environments, where they actually need more support to access the resource. And I don't think just because they don't access it…doesn't always mean that they don't want to.*

One adolescent participant expressed similar sentiments:

> *Everything is just so much work. Especially just having a baby, you obviously want to get on birth control.*

Acknowledging Limitations of the Health Care System

Health care providers felt that the model of pregnancy care in Canada works much better for antenatal care than for postpartum care. As one family physician stated, "I think the focus is making the pregnancy healthy versus what we can do to make their life healthy after."

All types of HCPs acknowledged the challenges of postpartum transition. Obstetricians would sometimes delegate family planning discussions to the family physician for various reasons, including ease of long-term follow-up, the ability to handle social issues, long-standing relationships, and convenience (if the family physician was also providing baby care). One obstetrician described feeling the following way about some of these challenges:

> *I have a pretty good idea of the community services, but I try not to be the… connector, because ultimately I'm not going to be able to continue that relationship…But you can always call the family doctor and say…"these are the things that I've suggested. Can you follow up?"*

Another obstetrician said the following:

> *My getting into those things is always driven by the clinical quandary in front of me, because I'm a specialist and a consultant, and I problem-solve rather than doing holistic care.*

However, one family physician was wary of so much deference and stated, "You're assuming they're going to go see their family doctor. They're seeing you now."

Adolescent participants generally had little understanding of the HCPs' different scopes, often

leading to frustration when it was discovered that a well-liked provider could not provide ongoing care.

Redefining Success in Family Planning Counselling

The HCPs acknowledged both a feeling of success when an adolescent makes a plan for contraception and an understanding that this often does not predict long-term compliance. Many adolescent participants were no longer in relationships by the time of giving birth and had no immediate plans to resume sexual activity; hence, they felt that creating a specific plan for contraception was neither practical nor necessary. One adolescent said, "My doctor's pushing for it, but…I'm not with anybody yet." Another stated, "When I'm ready for it, I'll go to my doctor for it."

Despite these feelings, most adolescent participants appreciated being given information about contraception. Many had questions about various methods and were interested in learning new things even if they had not made a specific contraception plan.

Many HCPs described professional satisfaction if the adolescent was interested and engaged in family planning. They would often ease into a discussion of contraception by first asking about the adolescent's sexual activity, relationship status , and life plan in an effort to avoid seeming judgmental. Several providers spoke about specifically casting contraception as a tool to achieve life goals rather than as a goal in and of itself. One obstetrician described this as follows:

> *Asking them what their goals are in the future. Where do they see themselves in 2 or 3 years? And then trying to show them how that goal is attainable if they don't have another pregnancy.*

Adolescent participants often bristled if HCPs simply assumed that they would not want to become pregnant again or that unplanned pregnancies were always unwanted. Most appreciated being able to direct the conversation and ask as many questions as desired but quickly grew frustrated if an HCP seemed not to respect or remember their priorities.

> *I don't like feeling rushed. I want you to go through these things with me. I don't want you to say that's not important right now. 'Cause I had done that before and made a list of things, and he's, like, "Oh, that's not important."…I'm, like, these are things I want to go through.*

One family physician described prioritizing a realistic discussion of the challenges and limitations of various methods of contraception:

> *Going over what previous methods they used and maybe where that fell down. And just acknowledging that memory is really hard…and instead of being judgmental about it…There are methods that are easier to remember.…Lots of people have a hard time remembering.*

Several HCPs were wary of adolescents who gave palatable rather than honest answers to questions. Once a contraception plan was made, adolescents appreciated feeling that their HCPs trusted them to carry out the plan.

DISCUSSION

Family planning is a complex and sensitive undertaking for the pregnant adolescent.[5] Since this study began, more research has been published acknowledging the challenges of adolescent initiation to and the continued use of contraception .[17] The following discusses factors that facilitate or hinder counselling.

As described by our participants, the counselling received by adolescents was enhanced when HCPs sought to understand the adolescent experience and take a personalized approach to relationship building. The importance of the relationship was acknowledged by a recent mixed-methods study whose qualitative data showed that repeat pregnancies are less likely for young mothers with goals and aspirations and that HCP support may promote the pursuit of those goals.[18] Similarly, another qualitative study highlighted the role of academic achievement in pregnancy prevention.[19]

Counselling was hindered by the limitations of the health care system, specifically during the postpartum transition–although clear communication between adolescent and HCP, as well as between members of the health care team,

was felt to mitigate these limitations. The specific strategies for effective counselling as described by our participants included beginning early in care, moving slowly, letting the adolescent set the pace, and remaining open to new ideas yet respectfully pushing back when necessary, all of which is in keeping with another recent mixed-methods study highlighting the importance of adolescent engagement and empowerment in family planning.[20] Our data indicate that effective counselling is not a single conversation but an ongoing process.

The limitations of this study include its small number of participants and the fact that those participants were self-selected . We cannot extrapolate the experiences of adolescents or HCPs who chose not to participate. In particular, many of the HCPs who chose to participate were already specifically interested in adolescent pregnancy care and therefore may approach it differently from HCPs who do not seek to work in that area.

Furthermore, the research team was composed of HCPs who work in the region from which the participants were drawn, and the interviews were conducted by a local resident physician. Thus, while interview subjects were encouraged to be honest, the adolescents, in particular, may have been less than completely candid.

CONCLUSION

Having explored some of the factors that either enable or impede effective family planning counselling, we submit that the consideration of all these factors may help health care providers contextualize family planning within general life goals. Many of this study's adolescent participants had no immediate plans to resume sexual activity and therefore did not see the relevance of family planning. We hope that adolescents who come to value the role of contraception in their life may be more likely to seek out contraception when they need it.

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AUTHOR BIOGRAPHIES

Katherine Gerster is affiliated with the Department of Obstetrics and Gynecology, Peterborough Regional Health Centre, Peterborough, Ontario.

Beth Murray-Davis and Dustin Costescu are affiliated with the Department of Obstetrics and Gynecology, McMaster University, Hamilton, Ontario.

Ebernella Shirin Dason is affiliated with the Department of Obstetrics and Gynecology, University of Toronto, Toronto, Ontario.