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A Qualitative Study of Factors That Influence Contraceptive Choice among Adolescent School-Based Health Center Patients

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Abstract

Study Objective—Long-acting reversible contraceptive (LARC) methods can prevent teen pregnancy yet remain underutilized by adolescents in the United States. Pediatric providers are well positioned to discuss LARCs with adolescents, but little is known about how counseling should occur in pediatric primary care settings. We explored adolescent women's attitudes and experiences with LARCs to inform the development of adolescent-centered LARC counseling strategies.

Design—Qualitative analysis of one-on-one interviews.

Setting—Participants were recruited from 2 urban school-based, primary care centers.

Participants—Thirty adolescent women aged 14–18 years, diverse in race/ethnicity, and sexual experience.

Interventions—Interviews were audio-recorded, transcribed, and coded using inductive and deductive coding.

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None represent a conflict of interest related to this project.

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Supplementary Data

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.jpag.2015.09.011>.

Main Outcome Measure—Major themes were identified to integrate LARC-specific adolescent preferences into existing counseling approaches.

Results—Participants (mean age, 16.2 years; range, 14–18 years) represented a diverse range of racial and/or ethnic identities. Half (15/30) were sexually active and 17% (5/30) reported current or past LARC use. Five themes emerged regarding key factors that influence LARC choice, including: (1) strong preferences about device-specific characteristics; (2) previous exposure to information about LARCs from peers, family members, or health counseling sessions; (3) knowledge gaps about LARC methods that affect informed decision-making; (4) personal circumstances or experiences that motivate a desire for effective and/or long-acting contraception; and (5) environmental constraints and supports that might influence adolescent access to LARCs.

Conclusion—We identified 5 factors that influence LARC choice among adolescent women and propose a framework for incorporating these factors into contraceptive counseling services in pediatric primary care settings.

Keywords

Contraception counseling; Adolescent health services; Intrauterine device; Contraceptive device; Qualitative methods

Introduction

Although adolescent pregnancy has declined in the United States, rates remain high compared with other high-income countries.¹ Most teen pregnancies are unintended and preventable.² Long-acting reversible contraceptive (LARC) devices, including intrauterine devices (IUDs) and contraceptive implants, are highly effective at preventing pregnancy, do not require user action when placed, and thus are considered first-line for adolescents.³ However, uptake of these methods remains low among US adolescents.⁴

Initiatives to increase LARC access have shown dramatic reductions in teen pregnancy rates. In Colorado, a privately funded statewide initiative that subsidized the cost of LARC devices resulted in a 40% reduction in teen pregnancy, and a similar initiative in St Louis showed teen pregnancy rates that were one-fifth that among sexually experienced teens in the United States.^{5,6} These efforts have focused on family planning clinic settings, where providers are trained to provide client-based contraceptive counseling. The few studies that have examined LARC experiences of adolescents in a primary care setting note substantial patient and provider-level barriers to LARC acceptability and uptake.^{7,8}

Client-based contraceptive counseling approaches that consider a woman's reproductive goals, social needs, and contraceptive preferences while addressing information gaps are key strategies for increasing contraception uptake among adult and adolescent women.⁹ Existing tools including efficacy-based counseling have been shown to increase LARC use among adolescents in a family planning setting.^{10–12} However, these counseling strategies are time-consuming and designed for use in settings where patients are typically highly motivated to initiate contraception. These approaches are not tailored for use in primary care settings where there might be significant knowledge gaps regarding LARCs among providers, few staff skilled at delivering contraceptive counseling, and where patients might have limited to

no knowledge about contraceptive options and might not yet be sexually active. No validated tools exist for use by pediatric primary care providers. The purpose of this study was to explore attitudes and experiences related to pregnancy and contraception in a diverse population of female adolescents to inform the development of LARC counseling strategies for use in primary care settings.

Materials and Methods

Recruitment and Interview Procedures

We recruited female adolescents aged 13–19 years from 2 urban school-based health centers (SBHCs) in Washington State that offer contraception services including LARC. English-speaking women younger than 18 years were eligible if they received parental permission to access SBHC primary care services. Before recruitment, the research team mailed a letter to parents and/or guardians of female students who met inclusion criteria to give them an opportunity to opt their child out of participation. After this period, recruitment flyers were posted at the SBHCs and distributed to age-eligible women during clinic appointment check-in.

After obtaining written informed consent, 2 investigators conducted interviews in private rooms at the SBHC after school hours. Parental consent beyond opt-out was waived on the basis of state law that permits women to consent for reproductive services at any age.¹³ The interview guide was on the basis of principles of Social Cognitive Learning theory and previous studies and included questions about key domains of influence (eg, family, peers) on adolescents' contraceptive behaviors, activities, reproductive life plan, previous experiences with contraception and LARC devices (ie, levonorgestrel intrauterine system, copper IUD, and etonogestrel subdermal contraceptive implant), and experiences with their SBHC (Appendix A).^{14–21} Broad, open-ended questions were followed by targeted questions to clarify responses and opinions. Interviews lasted 30–60 minutes and took place from December 2013 to January 2014. After the interviews, participants completed a brief demographic questionnaire. The University of Washington Human Subjects Division approved the study.

Statistical Analyses

Interviews were audio recorded, transcribed, reviewed, and then coded using ATLAS.ti version 7.0. An a priori list of codes was initially used to deductively code interviews on the basis of interview guide themes. We subsequently used grounded theory to inductively review the data for new codes and themes that did not apply to the a priori categories, which were discussed and reconciled in regular meetings during data analysis. Interviewers met weekly to review major themes and determine when thematic saturation was reached. Upon completion, we recoded all transcripts using the constant comparison method to confirm that new codes represented unique themes and warranted inclusion, and then reread codes in context to enhance understanding of the emerging picture. Finally, investigators classified codes into broader themes and identified the most prevalent and explanatory codes within themes, specifically to find quotations that were representative of or inconsistent with the codes of interest.

Results

Sample

We conducted 30 interviews (mean age of the participants was 16.2 years; range, 14–18 years). Similar to school demographic characteristics, 37% (11/30) of participants self-identified as white, 23% (7/10) Hispanic, 10% (3/10) black, and 10% (3/10) as Asian/Pacific Islander. Seventy percent (21/30) received free and/or reduced lunch, half (15/30) reported being sexually active, and 17% (5/30) had used LARCs (Table 1).

Central Themes

Five key themes emerged. Participants emphasized the importance of: (1) preferences about device-specific characteristics of IUDs and implants; (2) previous exposure to information about LARCs from peers, family members, or health counseling sessions; (3) knowledge gaps about LARCs critical to informed decision-making; (4) salient circumstances or experiences that might motivate a desire for effective and/or long-acting contraception; and (5) environmental constraints and supports that might influence adolescent access to and ability to initiate LARCs. Although interviews focused on LARCs, participants' narratives also reflected their contraceptive choice process more broadly.

Preferences about Device-Specific Characteristics of IUDs and Implants

Participants described strong preferences about device-specific characteristics that shaped willingness to consider LARCs. Some characteristics had broad appeal, including high effectiveness at preventing pregnancy and not having to remember a daily method. As one participant stated, “The IUD just seems better. You get it in. You’re done, and you’re good. You don’t have to remember, because taking pills is a hassle.” (From a 16-year-old depot medroxyprogesterone user.) Other characteristics received mixed reviews, such as the longer duration of action, which was seen as beneficial for some: “Five to 7 years... that seems nice maybe in college or something,” (From a 16-year-old depot medroxyprogesterone user.) Others believed the duration was excessive, particularly during periods of sexual inactivity: “My friend... had [the implant] taken out. because her boyfriend lives far away... so for her to have that in her arm doesn’t really do her any good.” (From an 18-year-old contraceptive patch user.) For many participants, the degree of user- vs clinician-control over the device was a major consideration. One participant explained this preference by stating “I’d probably use the pill just because I would be the one responsible for it.” (From a 15-year-old nonuser.) Another commented, “It’s kind of scary because it’s something that’s in you, rather than something you can just take off.” (From an 18-year-old contraceptive patch user.)

Participants held beliefs regarding appropriate timing of LARC initiation. For example, a number of participants referenced IUDs as something specifically for “older” women, sometimes for reasons of confidentiality: “I was thinking about an IUD, but then I don’t want my periods to stop. Because my mom would find out.” (From a 14-year-old contraceptive ring user.) Other participants believed non-LARC methods, like pills, were more appropriate for managing menstrual symptoms in nonsexually active women and LARC methods were better for pregnancy prevention. “Perhaps when I’m an adult woman... but [an IUD] really wouldn’t make sense now.” (From a 15-year-old oral contraceptive user.)

Participants described concerns about implantable devices. Some expressed fear of or had experienced discomfort with the placement or removal procedures. “The arm implant... hurt getting it in. I don’t like that pain...” (From a 17-year-old implant user.) Others tolerated the procedure well or balanced the drawback of placement discomfort with subsequent method satisfaction. “The IUD’s the best one because you don’t have worry about anything plus you won’t have periods, so it’s awesome... Getting it inserted was very uncomfortable but it’s worth it.” (From a 17-year-old IUD user.) Multiple participants found the idea of a foreign body (particularly the implant) unappealing with concerns about persistent pain, complications, or it being “gross” or “weird.” “I’m scared to death of the implant. I don’t want anything in my arm... It just feels like a tracking device or something.” (From a 17-year-old oral contraceptive user.)

Many participants identified potential side effects as disadvantageous or advantageous. Irregular bleeding was commonly cited as negatively influencing attitudes about LARCs. “[The IUD] kind of messes with [your period] and then you don’t get it at all. I kind of like having it just as a friendly reminder like, Hey, you’re not pregnant, by the way.” (From a 17-year-old oral contraceptive user.) That LARC devices were not associated with weight gain and was viewed as positive. “I needed something that fit me, wouldn’t make me gain weight, and I could remember. The 3-year [implant] worked best.” (From a 17-year-old implant user.)

Previous Exposure to Information about LARC

Participants shared insights about LARC they had received from social references, such as friends, family, or health care providers. The experiences of these social references were strongly tied to participant’s own views and opinions. Few participants with a friend or relative who had used a LARC device relayed positive experiences. Negative anecdotes about LARCs were common, including placement experiences, negative side effects, and complications. “My sister went to the doctor and [the IUD] had messed up her walls or something in her vagina... something caused her not to have kids anymore.” (From a 17-year-old implant user.)

Information about LARC received from peers, whether positive or negative, was particularly influential. “My friend who has [an IUD]... said that it hurt a lot when they put it in, and that felt like she had been lied to.” (From a 15-year-old oral contraceptive user.) Another participant shared a more positive experience, “[My friend] said it’s actually a great experience... she was really cranky and moody at first... But she said [the IUD] is really good. And her periods have stopped.” (From a 14-year-old contraceptive ring user.)

Some participants had encountered previous counseling from a provider, which could balance negative peer anecdotes. “I just heard [from the provider] that it stops periods. It’s way more effective than the regular stuff. It’s better because it lasts longer and you don’t even know that it’s there.” (From a 14-year-old contraceptive ring user.)

Knowledge Gaps about LARC

Although most participants were somewhat familiar with LARCs, the amount and accuracy of knowledge was variable. Some were aware of the high efficacy of LARCs compared with

other contraceptive methods; many incorrectly described placement procedures, mechanism, or duration of action. One participant described that an IUD “seals the uterus and the ovaries” (a 17-year-old nonuser) and another expressed that she would “probably have [her] mom [place the IUD] if she was able to.” (From an 18-year-old contraceptive ring user.) Some participants acknowledged their knowledge gaps about LARCs. “I don’t even know about half of that stuff.” (From a 15-year-old nonuser.) Further, difficulties with the abstract nature of LARC mechanisms (ie, they cannot be seen when placed) were described as a barrier to LARC use for some participants. “I just felt like it was sketchy. I can’t physically see it, so sometimes I’d forget it’s in my arm... I need the physical reminder to reassure myself.” (From an 18-year-old contraceptive patch user.)

Circumstances That Motivate a Desire for Effective and/or Long-acting Contraception

Participants identified salient, discrete circumstances that might motivate an adolescent to initiate long-acting contraception. For example, a desire to delay childbearing, often for a specific time interval, or plans to attend college were mentioned as motivators for a long-acting contraceptive method. These factors were not always explicitly linked to a desire for LARCs, but represented opportunities on which providers can capitalize to engage in a discussion about contraceptive choice. As one participant stated, “I wanted something that I would have for a while and not have to worry. Because I don’t want to end up accidentally getting pregnant, during my college years.” (From a 17-year-old contraceptive ring user.) Many participants described unstable living arrangements or frequent moving experiences, sometimes involving separation from family members, running away, or immigration, and others discussed plans to relocate to another region after graduation, highlighting risk of interruption in continuity of medical care and inconsistent access to short-acting contraceptive methods. “Since I’m graduating, I can’t keep coming back to the teen health center.” (From an 18-year-old oral contraceptive user.)

Exposure to teen motherhood was common, and observation of peers and family members in teen parenting circumstances was frequently described as motivation for contraceptive initiation. Although a few participants commented on appealing aspects of early pregnancy or childbearing, most highlighted the challenges inherent in becoming a teen parent. “[Teen motherhood] can either go okay or it can go really bad, but it definitely never goes really good.” (From an 18-year-old contraceptive patch user.) A substantial portion of participants had experienced “pregnancy scares” themselves, and 3 (10%) disclosed a history of unintended pregnancy resulting in abortion or miscarriage. “Being concerned that I am pregnant and then finding out that I am not and then just finding like a stable birth control method.” (From a 17-year-old oral contraceptive user.) Others described beliefs against abortion and reported that they would continue an unintended pregnancy if it occurred. “Me and my friends don’t believe in abortions.” (From an 18-year-old contraceptive patch user.)

Environmental Constraints and Supports

We identified a common theme of environmental influences on adolescents’ support and access to initiate LARC. The family environment, particularly parental attitudes about adolescent sexuality and contraception, were discussed frequently during the interviews. Participants who described parents as open and supportive of discussing sexual health had

often spoken with a parent about choosing LARCs. “[My mom] would just say that she trusts my decision and that she thinks it’s a good one to be protected.” (From a 15-year-old oral contraceptive user.) Others described parental discomfort in discussion of teen sexuality. “Parents and stuff, it’s awkward, because... they are very opinionated about teens and sex.” (From a 17-year-old pill user.)

Participants referenced a social norm that contraceptive use implies sexual activity, not only among parents, but also peers and romantic sexual partners, despite an interest among many to use LARCs and other contraception methods for noncontraceptive benefits. “The word birth control is very subtle, but behind the word it’s like, ‘You’re having sex.’ That’s most parents’ go-to answer.” (From an 18-year-old contraceptive patch user.)

Finally, many described how a supportive SBHC environment directly promoted access to contraception information and services for themselves and their peers. “If I was to need something like birth control, I would definitely come. I think I will come here more than my doctor, because I feel like it’s more safe here.” (From a 17-year-old nonuser). Most reported positive SBHC experiences, either with placement or removal of a LARC device or receipt of general reproductive health counseling from SBHC staff.

Discussion

Using words and experiences of a diverse primary care sample of adolescent women, we identified factors that influence adolescent decision-making about contraception including and especially LARCs. Adolescents identified 5 key factors that most influence their contraceptive decisions, particularly pertaining to LARC choice: preferences for method-specific characteristics, anecdotes from social references, informational gaps, situational motivations, and environmental barriers and facilitators of method adoption.

A potential application of these findings is the development of a counseling framework to introduce and discuss LARC devices with patients in a manner that acknowledges these factors. A mnemonic derived from our findings such as PRIME (Preferences, References, Information, Motivators, and Environment) could prompt a provider to address domains highlighted by adolescents. This framework might provide an opportunity to discuss all methods inclusive of long-acting methods and explore some of the potential barriers to knowledge and acceptability of LARCs. Our proposed PRIME mnemonic is illustrated in Figure 1 and might be further explored in a feasibility and validation study.

The components of the PRIME framework draw from Social Cognitive Learning theory as described in the Methods and motivational interviewing strategies for contraceptive counseling.^{10,12,21} The contextual approach of PRIME is consistent with adolescent contraceptive counseling principles developed by other investigators, which combine strategies of directive counseling with an emphasis on informed choice.^{19,22} These approaches promote shared decision-making and reduce potential for reproductive coercion. This framework’s emphasis on preferences is consistent with recent research showing that multiple contraceptive attributes influence decision-making in contraceptive choice, highlighting the importance of individualized counseling. PRIME also acknowledges the

established role of social communication in shaping contraceptive preferences of young women.^{23–25} Thus, it represents a potentially promising framework for counseling adolescents about LARC and other forms of contraception and should be formally tested in future research.

Our results confirmed previous findings that LARC knowledge and acceptability is variable among adolescents, with many who report discomfort with device-specific characteristics or fear of insertion and removal procedures.^{7,20,26–28} Our interviews also revealed additional domains that influence adolescent interest in highly effective contraception methods, generating opportunities for adolescent-centered counseling to explore peer, family, and other contextual influences. Notably, we identified many factors beyond efficacy of a device that are important to adolescent contraception decision-making. Although existing tools prioritizing method efficacy have been shown to increase adolescent uptake in a family planning clinic setting, PRIME might be appropriate for use by primary care providers who see adolescents with a broader range of sexual experience and interest in contraception.

This study was qualitative and exploratory, thus is subject to limitations including a nonrandom sample of participants who lived in 1 geographical region. Participants volunteered to be interviewed, thus the self-selected sample might have specific opinions or experiences about contraception not shared by other members of the recruitment population. However, our sample represented great diversity in race/ethnicity and a range of ages and experiences with sexual activity and contraception. Moreover, the consistency of our findings with those of other studies on contraceptive preferences (especially LARC preferences) among adolescents supports the validity of our findings. Interview responses might have been influenced by social desirability bias, and the positionality of the interviewers, a physician and public health student, might have further affected the context of the interviews. However, the interview length and one-on-one nature allowed for more in-depth discussions about psychosocial context than many qualitative studies related to contraception.

Conclusion

Pediatric primary care providers are poised to provide contraceptive education and counseling to adolescent patients. Our findings highlight adolescents' unique counseling needs inclusive of LARC methods. Further study is necessary to evaluate PRIME and other LARC-inclusive approaches for their effects on provider and patient acceptability and contraceptive uptake.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Fig. 1.

Elements of the Preferences, References, Information, Motivators, and Environment (PRIME) counseling framework. LARC, long-acting reversible contraceptive.

Table 1

Participant Demographic Characteristics

Characteristic	n	%
Age, years		
Mean	16.2	
Range	14–18	
Race or ethnicity		
White, non-Hispanic	11	36.7
Hispanic or Latina	7	23.3
Multiracial	6	20.0
Black, non-Hispanic	3	10.0
Asian	2	6.7
Hawaii native or Pacific Islander	1	3.3
Free or reduced lunch-eligible		
Yes	16	53.3
No	5	16.7
Don't know or skip	9	30
Current or previous experience with LARC device		
Yes	5	16.7
No	25	83.3
Ever pregnant		
Yes	3	10.0
No	27	90.0
Total participants	30	100.0