

Contraceptive counselling and social representations: a qualitative study

F. Bianchi-Demicheli^{a,b}, E. Perrin^{c,d}, A. Dupanloup^d, P. Dumont^e, J. Bonnet^e, M. Berthoud^d, R. Kulier^f, L. Bettoli^g, F. Lorenzi-Cioldi^b, D. Chardonens^f

^a Psychosomatic Gynaecology and Sexology Unit, Department of Psychiatry, Geneva University Hospitals, Geneva, Switzerland

^b Gynaecology and Reproductive Medicine Unit, Department of Obstetrics and Gynaecology, Geneva University Hospitals, Geneva, Switzerland

^c Liaison Psychiatry Unit, Department of Psychiatry, Geneva University Hospitals, Geneva, Switzerland

^d University of Applied Science, Health School, Geneva, Switzerland

^e Department of Nursing, Geneva University Hospitals, Geneva, Switzerland

^f Geneva Foundation for Medical Education and Research, Geneva, Switzerland

^g Family Planning Unit, Department of Community Medicine, Geneva University Hospitals, Geneva, Switzerland

^h Faculty of Psychology and Educational Sciences, University of Geneva, Geneva, Switzerland

Summary

Background: Contraceptive use is a complex issue and several studies have been conducted in an effort to understand user behaviour. It is of interest to explore the representations of professionals who give advice on contraception, since their views could have an impact on contraceptive use.

Methods: Individual in-depth interviews of 65 healthcare professionals likely to provide contraceptive advice to patients at a Swiss maternity unit.

Results: 83% of healthcare professionals interviewed were favourable to contraception in general while being highly critical of its practical efficacy. The methods most often spontaneously cited were oral contraceptive pills, male condom, intrauterine devices and hormonal implants. Theo-

retically, all methods should be proposed during contraceptive counselling but in practice interviewees have different social representations of user groups and associate them with specific contraceptive methods. Personal experience appears to play a bigger role than scientific knowledge.

Conclusions: The counsellor's social representations probably play an important role in determining user behaviour. These representations should be taken into consideration in the training of healthcare professionals in this field.

Key words: contraceptive counselling; healthcare professionals; contraceptive methods; social representations

Introduction

The effective use of contraceptive methods is a complex issue which is influenced by more than the simple availability of information [1–4].

Most studies on the behaviour of contraception users have been conducted in women requesting termination of pregnancy, and have shown that psychological, social and cultural factors very often play an important role in contraceptive failure [3, 5–13].

The concept of resistance to contraception has been investigated, as have beliefs associated with contraceptive uptake [5–7, 14–25]. This study was conducted as part of a research programme inves-

tigating various aspects of sexuality, partner relations and contraceptive practice after termination of pregnancy [3, 13]. The results showed that the overwhelming majority of women asking for an abortion had received information and had already used one or more contraceptive methods since the beginning of their sexual life. Over 50% also stated using a contraceptive method at the time of becoming pregnant. The abortion rate, although low in Switzerland as compared to other countries, still seemed too high to the health care professionals; the same was true of the rate of contraception failure. Our previous results also showed that it was

not an information issue as such but rather a problem of use and misuse of, or of trust in the various methods. This raised the question of the role of health care professionals in contraception counselling and in particular the social representations these professionals have about contraception.

By "social representations", we refer to a concept which has been elaborated in the sociological and psychological fields since the 1960s [26–35].

Social representations are determined by various factors, including informative, cognitive, ideological and normative aspects, and by beliefs, values, attitudes, opinions and images. "Social representations, acting as interpretative systems governing our relationship with the world and others, orient and organise the channels of social communication" [36].

In regard to contraception, potential users, like healthcare professionals, have different repre-

sentations of the various methods proposed. Healthcare professionals have social representations constructed from their scientific training and professional experience. Added to this, both users and healthcare professionals have a "common sense" knowledge of contraceptive methods, built up from their personal experience. All these representations play an important role in the counsellor/user relationship.

The aim of this study was to investigate the content of the social representations of contraceptive counselling providers. It is of interest to explore the representations of professionals who give advice on contraception since their views could have an impact on contraceptive use. In particular, it is of interest to investigate whether these professionals convey distrust, doubts and prejudices regarding some methods while favouring others.

Materials and methods

The study was conducted from February 2002 to June 2003 at the Gynaecology and Reproductive Medicine Unit of Geneva University Hospitals, Geneva, Switzerland. It was accepted by the hospital's ethics commission.

The chief of the Gynaecology and Reproductive Medicine Unit, heads of departments, chief nurses and midwives and the chief of the Family Planning Unit were informed of the study and gave their permission for the conduct of interviews during working hours.

Since this was a qualitative study aimed essentially at determining the range of representations rather than their relative statistical importance, a certain number of interviews had to be performed in order to reach saturation (repetition of the same elements). This number is usually found to be between 10 and 15 interviews in each category. Participation in the study was proposed to all gynaecologists (40), nurses (69), midwives (85), and family planning counsellors (5) working at the maternity unit. It was made on a voluntary basis, and thus we cannot rule out that the respondents were those who were favourable to contraception according to hospital policy. The procedure was well accepted by all participants, but was unfortu-

nately not compatible with an analysis of refusals. To ensure sufficient power for the study, we conducted 20 interviews in each professional group. However, this was not possible for family planning counsellors as they were only a team of 6, one of whom was part of the research team. Confidentiality and anonymity were guaranteed. Each interview was given a code number followed by three letters which identified the healthcare worker category of the interviewee.

Data collection

Six researchers (1 sociologist, 2 physicians, 2 nurses and 1 midwife) trained in qualitative research methods conducted 65 in-depth individual interviews. No researcher interviewed a healthcare worker of his/her own professional category, nor subordinates or co-workers in the ward where he/she worked or with whom he/she was acquainted, in order to avoid bias between interviewer and interviewee (e.g., if the interviewer was a physician, he/she would not interview a physician, nurse, midwife or family planning counsellor he/she worked with or knew). A protocol for the interview, structured in two parts, was established and tested beforehand. In the first part, the following question was asked: "I would like you to speak about your views on contraception in general and the different methods available". Answers to this question constituted the "spontaneous" part of the interview and gave access to interviewees' social representations. In some cases, interviewers rephrased certain comments to verify the interviewees' comprehension or asked for details, but made no suggestions. When interviewees thought they had said everything they could on the subject, the second part of the interview began, i.e. the "guided" part. The interviewer had a list of the main contraceptive methods (table 1) and asked the participant to speak about those which he/she had not mentioned before. The interviewees were also asked the following question: "For yourself, friends or relatives, what would you consider to be the best method/s? Why?" The interview ended with the following question: "Are there issues that you have not had the opportunity to raise and that you would like to discuss now?" All interviews were recorded.

The interviews were conducted with physicians (residents or fellows in gynaecology), nurses, midwives and

Table 1

List of contraceptive methods proposed in the 2nd part of the interview.

Oral contraceptive pills
Long-acting hormonal injections
Hormonal implants
Emergency pills
Copper intrauterine device
Progesterone intrauterine device
Diaphragm
Male condom
Female condom
Spermicide cream
Natural methods
Ogino method
Withdrawal
Fallopian tube ligation
Vasectomy

family planning counsellors involved in contraceptive counselling. Sociodemographic data were collected, including age, sex, marital status, number of children, diplomas/university degrees, nationality, languages, countries of long stay, present and original religious convictions.

Data analysis

Interviews were tape-recorded and transcribed. To define the categories for the analysis of text units, three researchers independently used 20 interviews to elaborate a first set of categories. This set was further refined while analysing the whole set of 65 interviews, using a constant comparative method. The total code included 373 categories and 5 free nodes. The following provides an example of coding: "I would say there is a method that has evolved and progressed, it is the pill [...]. However, it's more indicated for a women who has a stable sexual life ... with one partner." (Midwife, no. 303) This response was coded (2-31) (2-75) (2-97). In this example, a first code was attributed to indicate that this section of the interview concerned the spontaneous response of the interviewee (code 2); a second

code identified the type of method (in this example, the pill, code 31); a third identified the method in terms of advances and progress (code 75); and a fourth identified the target of the method (in this example, stable sexual life, code 97). A third step involved two researchers, sociologists specialising in content analysis, independently performing quality control to ensure homogeneity of codification. It was an empirically guided categorisation drawing on grounded-research theory [37].

Coded interviews were analysed using Nud*Ist (QSR N4 Classic) software for Macintosh. This content analysis programme presents results by frequency counts and crossed-tabulation. Each text unit corresponds to a code category. The analysis was structured around the following data obtained from the participants: sociodemographic data, contraceptive methods mentioned by the participants, contraceptive method/s used by the interviewee, method/s recommended to friends and relatives by the interviewee and the interviewee's references to personal experience and/or to scientific knowledge.

Results

Study sample characteristics

The study was conducted among 65 healthcare professionals at the maternity unit. Women constituted 88% of the study population; all men were

gynaecologists. The mean age of the study population was 41.5 (SD 8.6). The family planning counsellors were the oldest (mean age: 53.4; SD 6.9); the mean age of midwives was 43.2 (SD 10.3), of nurses 40.5 (SD 6.5) and of gynaecologists 37.7 (SD 6.1). Study sample characteristics are shown in table 2. The number of persons in each professional category was too limited to allow any significant comparisons between each group; the number of male interviewees was also too small to compare with female responders. The results are therefore based on the responses of the entire study sample.

General representations of contraception

In the spontaneous part of the interview, 83% of interviewees were favourable to contraception in general, 11% undecided or ambivalent, 5% unfavourable, and 1% expressed no opinion. Different reasons were given for being favourable, ambivalent or unfavourable to contraception. The following citations are transcribed precisely from the participants' words.

- *Contraception grants freedom to women and liberates sexuality* "It creates a real possibility of sexual freedom. I think the 1960s helped a lot, and contraception has very much helped female sexuality ... Yes, for me, it represents sexual freedom." (Nurse, no. 405)

"It has given freedom to women. It is obvious that it frees them from a constraint with their boyfriend, husband or lover. It allows women to manage their private lives, but also to plan their professional lives. It has played a great role in the liberation of women. It's also linked to equality between men and women, that's obvious." (Physician, no. 303)

Table 2
Study sample characteristics.

Professions	Interviewees (n = 65)	(%)
Physicians	20	30.8
Nurses	20	30.8
Midwives	20	30.8
Family planning counsellors	5	7.6
Total	65	100
Gender		
Female	57	87.7
Male*	8	12.3
Civil status		
Unmarried	14	21.5
Married and living together	41	63.1
Widowed, separated, divorced	10	15.4
Children		
None	22	33.9
One or more	43	66.1
Nationality		
Swiss	32	49.2
French	22	33.8
Other nationalities	11	17.0
Religion		
Catholic	25	38.5
Protestant	7	10.8
Other Christian religions	7	10.8
Other religions	10	15.3
None	16	24.6

* All males were physicians.

- *“Women’s rights. Family planning, spacing out births or making it possible to avoid pregnancy. At last, a major step forward for us. Unfortunately, not everyone around the world can benefit from it. We are only a small part of the world population who are lucky enough to have access to it and thus to be developed further.”* (Midwife, no. 504)
- *“In our society, family planning is a necessity “I am absolutely favourable to contraception. It is a necessary evil. It’s necessary, because we can’t allow ourselves to have children regardless. It makes it possible for us to plan pregnancies. In this day and age, it’s a good thing.”* (Midwife, no. 618)
- *“Contraception is better than an unwanted pregnancy, for the woman and/or the child “Because I think that if a pregnancy occurs because a contraception method failed, the acceptance or non-acceptance of this pregnancy will be difficult for the woman.”* (Midwife, no. 607)
- *“I think one should not have to go through an unwanted pregnancy and raise an unwanted child. Even when the pregnancy is desired, we know it is difficult to raise a child in proper conditions. What can these teenagers of 14 or 15 years old give to a child? If I look at these children who were not desired and have not been take care of correctly by their parents or by society, I think that is not right.”* (Midwife, no. 406)
- *“Contraception is better than abortion “I think that contraception is very important, because I am against abortion ... Well, unless it’s unavoidable ... So, if you are against abortion, you’ve got to have an efficient contraceptive method.”* (Midwife, no. 101)
- *“Contraception is necessary. It’s something that we’ve gained a right to and we can’t go back on that. It’s important that women are aware of this ... It’s true that a well-chosen contraceptive method should ensure a zero abortion rate. This is far from the reality and that leaves a lot of questions pending ...”* (Nurse, no. 303)
- *“Contraception protects from sexually transmitted infections and AIDS “Contraception is indispensable. Also in the long-term as a protection from sexually transmitted infections ... Both things go together.”* (Midwife, no. 406)
- *“Contraception can be unhealthy“ I always have in the back of my mind that it’s bad. There’s been a congress recently, on what can cause cancer and what doesn’t, and it’s still not clear [...] Anyway, to me, it’s something chemical. Now, it’s good that it exists. And on the professional level, it’s useful because it gives ... yes, it allows women not to have 15 children...”* (Nurse, no. 404)

Table 3
Comparison of contraceptive methods mentioned in spontaneous responses about their professional practice, used by healthcare professionals themselves, and proposed to their relatives and friends (categories are not mutually exclusive).

Contraceptive methods	Spontaneous responses about practice		Used by healthcare professionals		Proposed to relatives and friends	
	N = 65	%	N = 54	%	N = 46	%
Pill and mini-pill	63	97	41	76	40	87
Male condom	54	83	24	44	19	41
Copper intrauterine device	52	80	17	31	18	39
Implant	51	78	4	7	7	15
Depo-Provera	35	54	2	4	7	15
Diaphragm	30	46	5	9	–	–
Fallopian tube ligature	26	40	5	9	2	4
Progesterone intrauterine device	23	35	6	11	5	11
Emergency pill	23	35	3	6	2	4
Spermicide cream	22	34	11	20	2	4
Vasectomy	20	31	–	–	–	–
Ogino method	18	28	4	7	–	–
Temperature method	18	28	1	2	–	–
Female condom	17	26	4	7	–	–
Withdrawal	16	25	1	2	–	–
Hormones (no specific definition)	14	22	–	–	–	–
Natural methods (no definition)	9	14	3	6	–	–
Mucus self-observation	9	14	–	–	–	–
Abstinence	9	14	–	–	–	–
Computer	6	9	1	2	–	–
Absence of contraception	5	8	7(*)	13	1	2
Cervix self-observation	2	3	1	2	–	–
General signs	1	2	1	2	1	2

(*) Mentioned by 5 women over 46 years of age, and one woman and one man of reproductive age.

"I've always considered it [contraception] horrible. Can you imagine how it acts on the brain ... in the end you prevent normal physiological processes happening [...]" (Physician, no. 104)

Social representations of reliability and effectiveness of contraception

The interviewees' social representations reveal an attitude that is very demanding and nevertheless very critical towards currently available contraceptive methods. The first issue raised was the reliability and effectiveness of contraceptive methods, which 92% of the interviewees considered important criteria. It is noteworthy that 51% mentioned the gap between theoretical and practical efficacy, and 38% considered contraceptive methods completely unreliable.

Social representations of contraceptive methods

The oral contraceptive pill (97%), male condom (83%), copper intrauterine device (80%), and hormonal implant (78%) were the first and most frequent contraceptive methods mentioned spontaneously. These four methods form the common core of interviewees' social representations. Mention of other methods is more varied among interviewees: other hormonal methods (Depo-provera), 54%; progesterone intrauterine device, 35%; emergency contraceptive pills (35%); mechanical or barrier methods (diaphragm, 46%, spermicide, 34%, female condom, 26%); surgical sterilisation methods (fallopian tube ligation, 40%, vasectomy, 31%); natural methods, 28%; abstinence, 14% (table 3, first column).

Contraceptive methods used by health care professionals

Fifty-four participants out of 65 (83%) answered this question either spontaneously or in the second part of the interview. The most frequently used methods were the contraceptive pill (76%), male condom (44%) and copper intrauterine device (31%). These methods correspond to the common core of representations, except for the hormonal implant, which is more recent (table 3, second column).

Methods recommended to friends or relatives

Forty-six participants out of 65 (71%) answered either spontaneously or in the second part of the interview. The methods most often proposed were the pill (87%), male condom (41%), and copper intrauterine device (39%). A minority would advise the implant (15%), Depo-Provera (15%) or progesterone intrauterine device (11%) (table 3, third column).

Comparison between general representations, personal use and advice to relatives and friends

In the health care professionals' representations, only one method, i.e. the pill and mini-pill, can be proposed to advice seekers and friends or relatives as well; it is noteworthy that this method

has been used by three-quarters of the professionals themselves. All other methods are much less often mentioned in possible advice to friends or relatives than to advice seekers; and these methods have been much less used by the professionals themselves (table 3).

Modification of social representation of contraceptive methods by social representation of users

The interviewees did their best to remain neutral during contraceptive counselling:

"I think I tend to adopt a professional attitude, to say: 'there is this, this and this' and not to influence ..." (Midwife, no. 105)

"I suggest all existing methods and after it's the woman who decides what she wants, what's best for her." (Nurse, no. 400)

However, it can be observed that they had collective social representations of categories of users and of the most appropriate methods associated with each group.

Users' social representations revealed in the "spontaneous" part of the interview are based on different criteria: age (young age, women approaching menopause); children (having some, not having any, wishing to have more); partner/s (having or not having a stable partner, having several partners); lifestyle (regular or irregular); belonging to a low or marginal social category (women with little education or of foreign origin, drug addicts, prostitutes); and those with health problems (psychiatric problems or surgery).

The following results are based on 532 citations.

Associated with young people or teenagers, most frequently mentioned (133 times, or 25%) are the oral contraceptive pill, male condom, emergency contraceptive pills, hormonal implants or long-acting hormonal injections. An intrauterine device is associated with adults considered responsible and disciplined with a stable partner (113 citations, or 21.2%), and sterilisation with those who have children and are over 40 (120 citations, or 22.6%). Sterilisation is viewed as justified for women and their partners following more than one birth by caesarean section or having undergone several surgical interventions (6 citations, or 1.1%). Women without a stable partner, with several partners, or who have extraconjugal relations (70 citations, or 13.2%) are associated with the oral contraceptive pill and the male condom. Those who tend to forget to take the oral contraceptive pill are associated with long-acting hormonal injections or the hormonal implant (51 citations, or 9.6%). Women with little education, "borderlines" and psychiatric illnesses (29 citations, or 5.5%) are also associated with long-acting hormonal injections and hormonal implants, but also with intrauterine devices. Those of foreign origin (7 citations, or 1.3%) are associated with the oral contraceptive pill, long-acting hormonal injections, hormonal implants, and fallopian tube ligation. Drug addicts and prostitutes (3 citations, or 0.5%)

Table 4

Healthcare professional categories: references to personal experience and scientific knowledge (categories are mutually exclusive).

Healthcare categories	No reference		Scientific knowledge		Personal experience		Both		Total	
	N	%	N	%	N	%	N	%	N	%
Physicians	–	–	2	10	7	35	11	55	20	100
Nurses	1	5	1	5	5	25	13	65	20	100
Midwives	1	5	1	5	9	45	9	45	20	100
Family planning counsellors	–	–	–	–	3	60	2	40	5	100
Total	2	3	4	6	24	37	35	54	65	100

are associated with the male condom, protection against AIDS and sexually transmitted infections.

Contraceptive counselling, personal experience and scientific knowledge

On a practical basis, contraceptive counselling appears to be influenced by social representations based on both the personal experience and the scientific knowledge of interviewees. Indeed, one third of interviewees referred to their own experience of contraceptive methods exclusively (37%), half of interviewees both to their own experience of contraceptive methods and to their scientific knowledge (54%), and 6% to their scientific knowledge only. 3% of interviewees mentioned neither personal experience nor scientific knowledge (table 4). Personal experience therefore appears to play a more important role than scientific knowledge in contraceptive counselling. This result is confirmed by the results of the comparison between the general representations of the contraceptive methods that can be proposed to advice seekers and to friends or relatives and those used

by the professionals themselves. The methods they most often use are also those they recommend most willingly (table 3).

“(Talking about natural methods) One should mention their existence because in my job I have to be unbiased. But also that it’s one of the major risks of pregnancy, I can also say it, it’s in the statistics! (...) What I advise everybody to use, it’s what I got as advice when I was young.” (Nurse, no. 603)

“(Talking about IUD) It’s a good method I think. I wouldn’t have it myself (laugh). My twin sister had one, she’s had a child on her intrauterine device (...) So luckily I never advise it because I’m working with young people” (Family planning counsellor, no. 308)

“I’m in favour of it (IUD), I have one. It’s just great.” (Nurse, no. 615)

No obvious differences were noted between the different professions (physicians, nurses, midwives, family planning counsellors (table 4). This is of note since this result suggests that it is scarcely possible to provide contraceptive counselling without referring to personal experience, despite the differences in scientific knowledge and expertise.

Discussion

The aim of this study was to investigate the content of the social representations of providers of contraceptive counselling. Most healthcare professionals interviewed were favourable to contraception in general while displaying a critical attitude towards its practical efficacy. Nevertheless, the representations of interviewees were in agreement with the four methods most frequently cited spontaneously: the oral contraceptive pill, male condom, intrauterine device, and hormonal implants. According to the Handbook of Family Planning and Reproductive Healthcare, the most effective methods are intrauterine devices, hormonal implants, vasectomy, long-acting hormonal injections, female sterilisation, progesterone-only pills and combined oral contraceptive pills [39]. Male condoms have a failure rate well above all these methods (3% in theory, 14% in practice) but constitute the only protection against AIDS and sexually-transmitted diseases. In general, the social representations of our interviewees significantly marginalise male and female sterilisation, which is

not considered a contraceptive method since it is irreversible.

This is in line with the results of other studies indicating that social representations about contraception and abortion are constructed around a series of social and cultural factors. For example, avoiding the discussion of sterilisation as a contraceptive method can be related to factors such as low birth rates, fear of male impotence, fragility of couples and families, and increasing divorces rates [40].

Scientific medical knowledge tends to ignore users as social categories and is essentially preoccupied with the state of their health and individual risk factors. For example, the WHO Selected Practice Recommendations for Contraceptive Use [41] distinguishes only two categories of “clients with special needs”, namely “individuals with a physical disability” and “individuals with mental disability or with serious psychiatric disease”. These recommendations also mention another specific social category, “adolescents”, who are one

of the major preoccupations for healthcare professionals. This document indicates that "it is clear that many of the same eligibility criteria that apply to older clients apply to young people". It was of interest to investigate whether the healthcare professionals of the Geneva Maternity shared these recommendations. In practice, and as shown by our study, contraceptive counselling is influenced by the personal and professional experience of interviewees, who have social representations of user groups – including young people and teenagers, users with psychiatric diseases – and associate them with certain contraceptive methods over others. Only a few characteristics of the user groups, such as having a stable partner, being considered "responsible", and leading a regular life, are associated with all contraceptive methods.

The social representations of healthcare workers providing contraceptive counselling may well play an important role in determining user behaviour. Rationalisation of the contraceptive problem often conceals a personal, cultural and social unease and an intrapsychic conflict in healthcare professionals as users [17]. It would therefore be useful to take these factors into account in the basic or continued training of professionals. The results of our study may lead to more emphasis on the importance of a multidisciplinary approach (medical, psychological and social) in contraceptive counselling, as suggested in previous reports [15, 42].

This study has limitations which need to be acknowledged. All the health care providers interviewed worked in the same hospital, shared the same type of patients and information on contraceptive methods, and were thus imbued with the same organizational culture. Participation in the study was voluntary and we cannot rule out that the favourable attitude to contraception observed in the majority of respondents may be linked to

their agreement with hospital policy. Moreover, the mean age of the study population was over 40, and it cannot be ruled out that the various references to and representations of contraceptive methods are, at least partly, age-related. Hence the results cannot necessarily be generalised to other maternity units. However, this study stresses that whatever the representations of contraception, counselling can hardly avoid reference to personal experience, associated with scientific knowledge and expertise.

Future studies should address the issue of the influence of the social representations of contraceptive counselling providers on potential users when giving contraceptive advice, as these are shown to be based on their personal and professional experience as well as on scientific knowledge.

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Correspondence:

Dr Francesco Bianchi-Demicheli
Psychosomatic Gynaecology and Sexology Unit
Department of Psychiatry and
Gynaecology and Reproductive Medicine Unit
Department of Obstetrics and Gynaecology
Geneva University Hospitals
15, rue des Pitons
CH-1205 Geneva
Switzerland
E-Mail: Francesco.bianchi-demicheli@hcuge.ch

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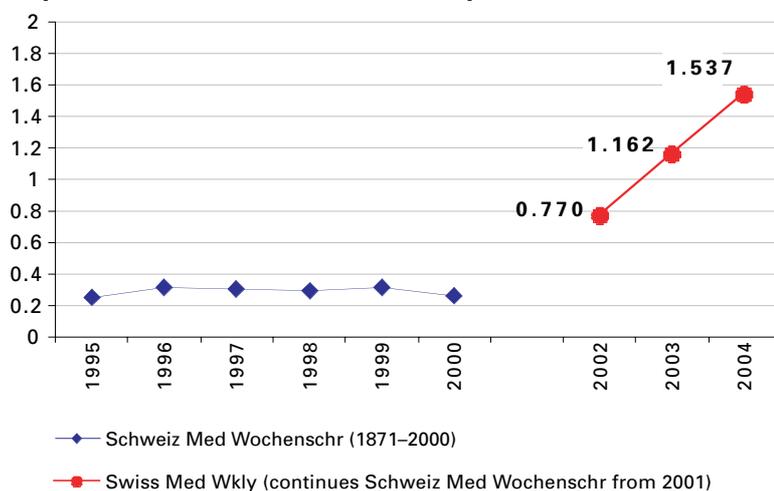
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