Family Planning Services in Adolescent Pregnancy Prevention: The Views of Key Informants In Four Countries

By Barbara A. Cromer and Maureen McCarthy

Context: *Rates of adolescent pregnancy vary widely in the developed world. The prevention of adolescent pregnancy in the United States might be improved by comparing the provision of family planning services in the United States with that in some other developed countries.*

Methods: *Face-to-face, semi-structured interviews were conducted with 75 key informants (clinicians, politicians, public health administrators, social and behavioral scientists, and antiabortion activists) in Great Britain, the Netherlands, Sweden and the United States. Inductive, systematic qualitative analysis was performed on verbatim transcripts of these interviews.*

Results: *Across all four countries, interviewees described optimal family planning services for adolescents as those that include accessible, comprehensive and multidisciplinary care provided in confidence by nonjudgmental staff with good counseling and communication skills. Interviewees in Sweden and the Netherlands described a close liaison between family planning services and local schools, while key informants in the United States reported parental resistance to such coordination. Interviewees in the Netherlands and Sweden observed that family planning staffs in their countries have a clear sense of "ownership" of family planning services and better job-related prestige than did interviewees in Great Britain. Respondents in all countries except Sweden reported that providers are not always comfortable providing confidential care to teenagers. This was a particular concern for family planning providers in Great Britain who have patients younger than 16. Respondents in all countries except the United States thought that a "user-friendly" procedure for contraceptive provision should not require a pelvic examination. Finally, interviewees felt that governmental support in the Netherlands and Sweden seems to have led to adequate financing of family planning services, while in the United States, interviewees reported that there seems to be little governmental, medical or familial support for preventive health care, including family planning services.*

Conclusions: *As described by key informants, the family planning services available to teenagers in the Netherlands and Sweden have many of the features identified by respondents from all four countries as those that would characterize ideal family planning services for adolescents.*

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While adolescent birthrates in the United States have decreased slightly since 1992,[1] these rates are still among the highest in the industrialized world, and are in sharp contrast to the very low teenage birthrates recorded in the Netherlands and Sweden. Great Britain, a country that is close to the United States politically and socially but is geographically proximal to the other two countries, has teenage birthrates between these two extremes.[2]

Thirteen years ago, The Alan Guttmacher Institute published the first comprehensive description of the issues that must be considered when comparing rates of adolescent pregnancy between industrialized countries and suggested that family planning services must be put into the context of the health care system in each country.[3]

For example, in Sweden, where such care is generally free, a large network of youth clinics staffed primarily by nurse-midwives has been established to provide family planning services. Alternatively, teenagers may access similar care in maternity clinics.

In the Netherlands, the primary care system is composed of general practitioners who provide most contraception, which is available for a small fee, to women of all ages. In addition, a network of public clinics (called Rutgers Stichting) provides family planning services for women of all ages.

In Great Britain, family planning is provided primarily by general practitioners and through a network of family planning clinics; in addition, there are the Brook Advisory Centres, which also provide birth control to young people. Contraception in Great Britain is paid for through the National Health Service.

In the United States, family planning services for teenagers are concentrated in federally funded family planning clinics such as Planned Parenthood affiliates and local health departments, but may also be available from physicians, either in clinics or in private offices, who specialize in gynecology, adolescent medicine and family practice. Public insurance pays for family planning services in the United States; many private insurance carriers do not.

Changes have occurred in the number and function of family planning services available to adolescents since the time of the Guttmacher report. For example, the number of Brook Advisory Centres in Great Britain has decreased from 80 in 1985 to 19.[4] (However, more family planning services are currently being created for teenagers in Great Britain, as decreasing the rate of adolescent pregnancy was listed as a priority in the 1992 Health of the Nation targets.) The number of Rutgers Stichting clinics in the Netherlands decreased from 40 to seven over the past 15 years.[5] In the United States, in 1983 there were 2,462 publicly funded family planning agencies; in 1995 there were 3,119 such agencies.[6] The number of youth clinics in Sweden increased over the same period, from 30 to 210.[7]

One of the aims of our project was to update some of the information contained in the Guttmacher report. We employed a qualitative research design to obtain the impressions of key informants, those persons professionally or politically involved with the provision of family planning services in these countries.

Methods

Study Population

The study population included 75 professionals who had particular expertise or interest in adolescent pregnancy, from a variety of perspectives. A contact person in each country, identified through the principal author's professional organization, made an initial list of potential interviewees. Before arriving in each country, the principal author corresponded with the suggested individuals, repre-

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Table 1. Number of interviewees, by professional background, according to country

	Great Britain	United* States	Netherlands	Sweden
Health care provider	**11**	**10**	**9**	**12**
Physician	7	9	6	7
Nurse	1	0	2	4
Psychologist	1	0	1	0
Social worker	2	1	0	1
Nonclinicians	**8**	**8**	**9**	**8**
Public health administrator	3	5	5	4
Politician	2	1	0	3
Antiabortion activist	2	2	1	0
Health educator	1	0	1	0
Anthropologist	0	0	1	0
Sociologist	0	0	0	1
Sexologist	0	0	1	0
Total	19	18	18	20

sentatives of national public health and political organizations, as well as local antiabortion agencies.

At each contact, inquiries were made regarding the individual with the most expertise in adolescent health issues. Once identified, this individual was then asked to participate in the study. No one refused to be interviewed. During the selection process, an attempt was made to have about half of the sample consist of mental and physical health care providers and the rest be a mixture of professional backgrounds, including some who opposed making contraceptive care available to young people. Public health administrators involved in making policy decisions related to contraceptive care were also included.

The group of interviews from Sweden (n=20) was completed first; the samples of subjects in the remaining countries (18 in the United States, 19 in the Netherlands, and 18 in Great Britain) were then matched to the professional backgrounds of the Swedish sample. The breakdown of country participants by backgrounds is given in Table 1. Of note is that nurses were overrepresented in Sweden, physicians were overrepresented in the United States and no politicians were interviewed in the Netherlands. Although no antiabortion activist per se was interviewed in Sweden, one of the politicians there represented the antiabortion constituency, thus offering some representation of this viewpoint in that country.

Procedure

The principal author conducted each interview, which lasted between one-half hour and one hour, in English. The interviews had a semi-structured format and covered the following topics with reference to the interviewee's country of residence: the definition of the problem of teenage pregnancy; risk factors for adolescent pregnancy; the most and least successful approaches to its prevention; the impact of recent health care reforms on adolescent health care, pregnancy and abortion; and what changes the interviewee would institute to lower the incidence of teenage pregnancy. In Sweden, the interviews were conducted in the fourth quarter of 1993; in the United States, the Netherlands and Great Britain, they were conducted during the first, second and third quarters of 1994, respectively. Written informed consent was not obtained (with the approval of the Human Subjects Research Committee, Columbus Children's Hospital), since the study sample consisted only of adult professionals.

The interviews were audiotaped and transcribed verbatim, which yielded more than 700 pages of narrative data. The transcripts were then analyzed in order to identify themes.[8] The first step in the analysis was to break down the interviews into individual data bits as units of analysis. The data bits ranged in size from a few words to several paragraphs, with each bit containing one idea or one piece of information. As the transcripts were color-coded, each bit could easily be identified according to country. Each bit was also letter-coded by the professional background of the interviewee.

Both authors reviewed the first two sets of interviews (each set represented two interviews from each country, or a total of eight interviews) together in order to reach a consensus about what comprised a data bit. Then, the second author broke down the remaining interviews and all bits were transferred to index cards and shuffled to achieve random order. The two authors independently assigned the data bits to particular thematic categories and then compared their choices, as an ongoing check on interrater reliability. There was in excess of 90% agreement between the data sets of the authors, and discussion and consensus for all data bits resolved remaining differences in category assignment.

The rough list of categories that was outlined from the first two sets of interviews was extended and modified with each new data set. The analysis of the entire data set yielded eight major categories, of which family planning services was one. Because overlapping themes were identified in three other major categories, the pertinent bits from these other categories were also included in the next step of analysis. After examining the content of individual bits, we assigned distinctive concepts within each category to subcategories. Upon further discussion, we moved bits among the original subcategories and, as a result, subcategories were shuffled, collapsed and retitled.

The analysis of the family planning services major category was ultimately divided into the following final subcategories: access, school liaison with family planning services, staff, confidentiality, personal and family attitudes, and governmental financing of family planning services. Each final subcategory was reviewed in detail, discussed between the two authors and compared with other subcategories. Each bit was also reviewed in the context of its location in the complete transcript, to ensure that we had not misconstrued the original meaning.

Finally, bits within each subcategory were compared with one another in order to find unifying themes. Through this iterative process, the themes for each subcategory emerged and were then compared within and across professional backgrounds and countries. Because our interest had been to conduct an international comparison and the differences among countries were much more pronounced than those seen across professional background, the emphasis in this report is on intercountry comparisons.

Results

Quantitative Data

In order to compare the actual amount of information collected within each subcategory of the family planning services category, we first did some quantitative assessment (Table 2). To avoid any bias from counting information reported by the same interviewee twice, we calculated the percentage of respondents from whom data bits were collected within each subcategory.

First, significantly more Swedish interviewees provided bits related to comprehensive care than did interviewees in the other countries (χ^2=8.66). Second, more British respondents reported data bits related to confidentiality than did respondents in the United States or Sweden (χ^2=22.80). Last, significantly fewer members of the American sample provided data bits related to staff than the samples in the other three countries (χ^2=15.87).

While differences among the comprehensive care and confidentiality subcategories may have reflected the content focus of the interviewees, the lack of information from American interviewees regarding staff may have reflected a bias of the interviewer, who is an American contraceptive care provider.

Access

There was a consensus among interviewees that family planning services optimally are located in close proximity to either the residences or schools of teenagers. Swedish and American respondents noted that fewer services were located in suburban or rural residences: [US] "…we don't set up routes in rural areas for kids to get to the family planning clinic"; [S] "If you live in a suburb, you must go into the city to get birth control." American and British interviewees also mentioned lack of transportation as another limitation resulting in impaired access to family planning services.

There was also consensus that the hours of operation for family planning services for adolescents should be convenient for the age-group: [S] "[family planning services] must be a very good service with easy access, open summertime, open evenings."

It was also generally considered important that family planning services be low-cost for adolescents, as they have limited financial resources. However, by itself, low cost was not thought to be sufficient to provide teenagers with optimal access to family planning services. Respondents in the Netherlands and Sweden, on the other hand, noted that family planning should not be totally free, so that teenagers must take some responsibility for the provision.

A consistent theme across countries was that outreach is important and that there is not enough of it: [US] "We don't have the community nurses going out with condoms in the bags to hand out to potentially sexually active kids."

Several respondents mentioned the importance of the point of entry for teenagers into family planning services. A British interviewee felt that a clinic offering family planning should be labeled a general clinic so that "nobody knows specifically what [the adolescents] are going for," a sentiment echoed by an American interviewee. Also, it was noted that some high-risk adolescents living on the "fringes of the community" might have more difficulty obtaining a [US] "point of entry into the health care system for birth control purposes." One point mentioned in all countries except the Netherlands was that a missed period prompts adolescent girls to seek pregnancy testing, at a variety of venues, from family planning clinics to pregnancy distress centers.

In Sweden and the Netherlands, interviewees described two clearly identified pathways by which teenagers may access family planning services; interviewees in the United States and Great Britain, in contrast, described a wide variety of venues that could potentially provide family planning services to adolescents. However, these venues were not necessarily designed as family planning services for adolescents. Thus, they varied in their ability to be receptive to teenagers. In these two countries, the interviewees did not always seem clear about which services would be particularly receptive to teenagers, including which would provide family planning services in confidence.

Table 2. Percentage of respondents who mentioned a particular theme about family planning services for adolescents, by category, according to country

Category and theme	Great Britain	United States	Netherlands	Sweden
Access				
Availability	61	39	35	63
Outreach	17	11	35	21
Individuals				
Personal attitudes	61	50	59	37
Family attitudes	0	11	17	22
Content				
Counseling	61	28	47	42
Comprehensive care*	11	17	6	42
Confidentiality**	50	11	33	6
Procedure for contraception	22	11	41	21
School-based health services	22	33	22	53
Staff				
Roles**	67	6	47	58
Attitudes	44	33	41	26
Financing				
Financing family planning services and research	50	22	35	58
Personal resources	6	11	12	21
Cost/coverage	22	22	41	47
Provider pay	11	6	12	11

*Intercountry differences are statistically significant at p<.05. **Intercountry differences are statistically significant at p<.01.

Schools and Family Planning Services

The liaison between family planning services and schools appeared to be more functional for youth in Sweden and the Netherlands than in the United States and Great Britain. Specifically, in Sweden, clinics were strategically placed near schools and "field trips" to the clinic were routinely scheduled by schools: [S] "Each class goes to the clinic before [students are] 15 years of age and once in high school." In both Sweden and the Netherlands, family planning clinic employees visited schools and instructed staff and students. In the Netherlands and Great Britain, school nurses facilitated the referral of students to family planning services. In Great Britain and Sweden, condoms can be obtained at school.

A barrier to the referral of adolescents to family planning services in Great Britain was school nurses' confusion about the legality of providing family planning to adolescents under the age of 16: [GB] "School nurses have quite a few hang-ups on what their position is legally." Reported barriers to the successful access of adolescents to family planning services in the United States included the tendency of parents to closely monitor any medical care their children receive at school, as well as the political sensitivity of school boards and other administrative bodies toward providing family planning to students: [US] "The school boards made the ultimate decision;" "…this community planning body decided they really needed to put some health services in a school and [the services] were up and running; right-to-life groups said that these were direct referral systems to abortion clinics…they [the planning body] are very sensitive to political feedback."

Staff

There were significant differences between family planning service staff in the Netherlands and Sweden and similar staff in Great Britain. First, the Netherlands and Sweden seemed to provide a higher level of training in family planning services, including during medical school, than was true in Great Britain. In addition, there appeared to be an organized system of responsibility for such care among general practitioners in the Netherlands and among midwives in Sweden: [N] "The family doctors among themselves decided this should become their responsibility;" [S] "The idea was to have midwives with knowledge about youth and sexually transmitted diseases and birth control spread out to small youth clinics so that people had easy access to them."

In Great Britain, by contrast, the inter-

viewees viewed training in the provision of family planning services as inadequate and reported that the commitment by general practitioners to taking responsibility for providing family planning services was variable: [GB] "They [general practitioners] don't deal with sexual issues; they don't have the time, the patience, the training." In addition, although certification was available, none was required for a physician to provide family planning services. Because there is no standard for provider credentials and because the jobs pay relatively poorly, family planning provision was not viewed as prestigious work in Great Britain: "It [family planning work] doesn't earn money and it's not very popular." Swedish midwives, on the other hand, expressed a sense of pride in their role as a provider of family planning services: "It [family planning work] is really a profession that one can be proud of."

Respondents in all four countries felt that optimal family planning service care for teenagers should have a friendly, nonjudgmental staff, from receptionist to care provider. Further, interviewees from all countries felt that staff counseling around issues of sexuality is a crucial part of family planning services. Interviewees in all countries agreed that the content of such counseling should include a discussion of the physical and psychosocial risks of sexual activity. It was also generally felt that good communication skills are important if counseling is to be effective.

Assessment of the current general level of communication skills among service providers differed among the interviewees. Interviewees in Sweden and the Netherlands expressed confidence in local practitioners: [S] "Youth clinics do quite a good job talking about sex;" [N] "General practitioners are much better and more equipped to talk about sexual items.") In contrast, there was less enthusiasm about the communication skills and training of the general practitioners in Great Britain: "My personal feeling is that no doctor in this country is actually trained to communicate well with teenage people."

Confidentiality

Except for Sweden, where confidentiality is not an issue, the general feeling among interviewees was that primary care providers are not comfortable providing confidential care to adolescents. In the Netherlands, because general practitioners have been caring for many adolescents since birth and may also have a long-term relationship with the parents of their adolescent patients, both physicians and teenagers may be uncomfortable discussing family planning. At Rutgers Stichting, in contrast, there reportedly were "golden rules about confidentiality."

In the United States, the provider bills that often go home to parents may compromise confidential medical services for adolescents. Further, in the United States and Great Britain, primary care providers expressed hesitation about providing family planning services to teenagers, for fear of parental reaction: [US] "…legally we are protected, but parents still yell and scream;" [GB] "General practitioners are terribly worried about parental reaction."

The feelings of general practitioners in Great Britain may have been affected by the 1985 Gillick ruling,[9] a high court decision that resulted from a lawsuit brought against a physician for prescribing contraceptives to a minor. Although a lower court approved the suit, a higher court overturned the decision. The end result was that physicians were legally protected if they provide family planning to minors, even to those under the age of 16. Protracted controversy in the media ensued and what resulted was confusion and unease among both general practitioners and teenagers about confidential care for young people, particularly those younger than 16, which has persisted to the present: "This is a very contentious issue;" "…on a survey of [a general practitioner] sample, 50% would not see [those under the age of] 16 without parental consent;" "the [Gillick ruling] caused the young people to worry about [confidential care]; "the [Gillick ruling] had a terrible effect on family planning services." Some respondents noted that this kind of unease may be exacerbated by some general practitioners' moral objection to providing confidential care to young teenagers, in both Great Britain and the United States.

Comprehensive Care

Comprehensive care is an umbrella term that we used to identify themes that interviewees raised about preventive health care. Many Swedish interviewees mentioned the importance of prevention ("Prevention work is a big job and it is so important") and identified midwives as significant providers of preventive care. The view that preventive health care is crucial and cost-effective was shared by interviewees in both Sweden and the Netherlands. American interviewees generally felt that the United States performs poorly in the area of preventive health care: "They [the health care industry] don't intervene until there is a problem."

Interviewees in all four countries felt that a multidisciplinary team is needed in order to provide comprehensive health care, as it is difficult for individual providers to deliver optimal comprehensive care by themselves. Along these lines, most interviewees said that family planning services should offer more than just contraceptive options: [GB] "The best contraceptive services, of course, do provide more than that;" [N] "…all the problems, like drugs and sex, should be integrated in this more regular care." Finally, continuity of care was viewed by most as an important component of comprehensive care: [US] "I don't think that we can do that well in a setting where the patient does not see the same doctor every time."

Procedure for Contraception

Generally, interviewees said that optimal family planning services for teenagers provide contraceptives in an accessible way. One factor commonly identified as important to user-friendly care was the provision of emergency contraception and a reminder of its availability at routine family planning visits. Reminders about emergency contraception appeared to be in use in all countries except the United States.

U.S. teenagers seemed to have more contraceptive method options available than teenagers in other countries, including the injectable and the hormonal implant. (In the other countries, oral contraceptives are overwhelmingly the method of choice for adolescents.) In Great Britain and Sweden, a public dialogue about making oral contraceptives available over the counter was ongoing at the time of the interviews. In Sweden, an interviewee observed that a year-long prescription of oral contraceptives, compared with those that require more frequent visits, was associated with lower pregnancy and abortion rates.

Interviewees in the European countries generally felt that a required pelvic examination was an unnecessary barrier to contraception: [GB] "It [pelvic exam] isn't relevant;" "Why should you introduce this medical barrier if they use contraception?" [N] "It's possible for a teenager to have the pills for years without the pelvic if they have no problem." This view directly contrasted to those of the U.S. interviewees, who generally felt that a pelvic exam should be required, even for resistant teenagers, and who were willing to use a therapeutic approach to facilitate this examination: "If you have a teenager who does not want to be examined, the expressive therapist will sit with them and spend time and then I find the anxiety relieved, eliminated and then they say yes."

Personal and Family Attitudes

The interviewees were asked to discuss their general perceptions about the level of family planning knowledge or comfort among teenagers who access family planning services in their countries. Those in the Netherlands and Sweden generally felt that adolescents in their countries had a high level of knowledge about sexual and contraceptive issues: [S] "…there is very little of these facts that are really new to them." In contrast, interviewees perceived a relatively low level of knowledge about family planning services among American teenagers ([US] "I don't know that they…are aware of what is out there to help them") and among British teenagers, especially knowledge about confidential care ([UK] "Young people [under the age of 16] don't actually know whether they have the right to seek confidential advice or not").

In all four countries, interviewees agreed that three beliefs were associated with adolescents' having comfort in their ability to access family planning services. First, adolescents must believe that the staff is trustworthy: [US] "The number one test is whether they trust me or not and they test that." Second, adolescents must feel that accessing family planning services is an issue of personal responsibility: [N] "…they become sexually active and need to take some responsibility for that." Finally, interviewees said that teenagers must have the courage to access family planning services.

In the Netherlands, interviewees felt that teenagers prefer to be mixed in with adults when they seek family planning services: "…[teenagers] like very much that they are seen as adults." American respondents felt that some teenagers have negative attitudes toward federally funded clinics, that those facilities are impersonal and that some groups, particularly rural teenagers and antiabortion activists, view federally funded family planning clinics as a "route to possible termination of pregnancy."

There were clear differences between countries regarding family attitudes toward family planning services. In the Netherlands and Sweden, interviewees reported few parental complaints directed toward family planning services, and said that parents in their countries were comfortable about their teenagers' choosing contraception: [N] "Parents also accept that their very young children have sex and that they choose…contraception rather than telling them not to have sex."

American interviewees reported parental complaints about their practices. For example, American families may experience conflict between teenagers and parents about contraception: [US] "[Kids say] I am not going to be sexually active and their mom says I want you on birth control anyway." American parents also reportedly object to contraceptive provision to their teenage daughters. However, parents could be mollified after speaking with the provider: [US] "As angry as people sometimes get, once you spend time with them…they end up realizing we didn't do anything bad." Again, American interviewees mentioned the lack of focus on prevention: "…anything of a sexual nature is postponed by family and doctors until it is urgent."

Financing of Family Planning Services

Similar themes in this category appeared consistently among interviewees in Sweden and the Netherlands, whereas respondents in Great Britain and United States did not voice uniform themes. Dutch and Swedish interviewees reported that there was government support for family planning services at the time of their initial organization in the 1970s and remarked that this contributed toward having adequate financing: [N] "The moment the government decided okay, this is a good decision to invest in family planning and birth control, in a way they formalized the work of the sexual reform." Also, in both Sweden and the Netherlands, politicians appeared to be regularly involved with family planning services: [N] "We have regular talks with the ministry every two months…;" [S] "Politicians are very interested in their health system."

Finally, there appeared to be more government support for research on topics related to family planning services in Sweden and the Netherlands than in other countries: [N] "If the problem is to be researched quite well…I think the ministries will certainly be prepared to get money." A cautionary theme also emerged among interviewees in these two countries about their concern for the future of family planning services as their national health care systems undergo significant change.

Interviewees from the United States noted that their health care system did not emphasize preventive care, which is the primary focus of most family planning services: "We're [the government is] willing to pay for acute care and not for preventive care." One consistent theme among all four countries was that family planning service financing had received additional funding from AIDS prevention programming: [GB] "…government set aside money for HIV and AIDS—through that expense we'll get funding for birth control."

Discussion

We identified several themes from our qualitative examination of family planning services in the United States, Great Britain, Sweden and the Netherlands. Interviewees felt that services should be "teenager friendly," with flexible hours, close location, low cost and outreach efforts. Previous research regarding whether youth-focused clinics increase functional access to family planning services in the United States found that when patient education was targeted to those at a relatively immature level of cognitive development, reassurance was offered about the pelvic exam and confidentiality, and the provision of contraception was split into two separate visits, youth at the intervention clinics demonstrated significantly higher levels of knowledge about and use of contraceptives, as well as lower pregnancy rates, after six months than did adolescents who attended ordinary clinics.[10] However, there were no differences in satisfaction, nor did an observed increase in the use of contraceptives (compared with control sites) persist for an entire year.

European interviewees "generally felt that a required pelvic examination was an unnecessary barrier [for teenagers]…; U.S. interviewees…generally felt that a pelvic exam should be required."

Other research about U.S. adolescents' access to family planning services compared clinics in counties in which an average of 75% of teenagers at risk for pregnancy were served ("successful clinics") with those clinics in counties in which an average of 28% of teenagers at risk were served ("unsuccessful clinics"). Successful clinics offered more hours of service per week, more often had special outreach programs for teenagers, more often had a caregiver willing to provide family planning to a minor without parental consent and were more likely to see a patient without an appointment than were unsuccessful clinics.[11]

One factor in our study that seemed to be linked to successful service provision in Sweden and the Netherlands was the

arranged contact between family planning staff and students. Similarly, an evaluation of pregnancy prevention programs in Baltimore found that "an important feature of the program was the accessibility of [family planning services] clinic staff in the schools themselves."[12]

Regarding staff issues in Great Britain, other research has acknowledged a problem in communication between teenagers and general practitioners,[13] and the lack of curricula in sexual health for general practitioners: "Many doctors find it difficult to discuss the sexual details of their patients' lives. The development of sexual medicine is fragmented and there is [a] lack of liaison between royal colleges."[14] Some professionals have expressed a desire for the British government to provide training in sexual medicine for doctors at the undergraduate and postgraduate levels.[15]

In the Netherlands, we found that special training in adolescent development was not viewed as beneficial for family planning staff. By contrast, a meta-analysis of the effect of provider variables on contraceptive programs in the United States found that specialized training and additional counseling about sexuality was significantly associated with successful programs.[16]

Except in Sweden, primary care providers were not generally comfortable with providing confidential care for adolescents. In Great Britain, this was particularly true regarding adolescents younger than 16. The British national guidelines issued in 1980 suggest that general practitioners "should seek to persuade the child to involve the parent,"[17] but this preceded the 1985 Gillick ruling. Consequently, practitioners' willingness to prescribe family planning in confidence to teenagers appears to vary widely in Great Britain. In 1993, specific guidelines about confidentiality were circulated nationally to all clinicians who provide care to teenagers younger than 16. The guidelines stress the obligation of physicians to maintain confidentiality when providing contraceptive care.[18] The guidelines, which state that "disregarding confidentiality in such circumstances is a serious breach of professional ethics," have been received with enthusiasm among part of the profession.

The United States appears to have a similar problem with teenagers, family planning and confidentiality. Although physicians are legally protected if they prescribe contraceptive care to adolescents, previous research suggests that 20% of family planning clinics in the United States require parental consent from clients younger than 16.[19] Further, adolescent fear of parental notification has been cited as one explanation for the substantial delay in adolescents' obtaining family planning services in the United States.[20]

Previous research documented that in the Netherlands, it was common for young teenagers to obtain family planning services from Rutgers Stichting for one or two years, and then return to their general practitioners for contraceptive care when it is "more acceptable." The Dutch interviewees in our study did not indicate that the circumstances relevant to confidentiality had changed over the past 13 years.

Family planning practitioners interviewed in the European countries said that they do not require a pelvic exam before dispensing contraceptives to adolescents. Fear of a pelvic exam has been found to delay adolescents' visits to family planning clinics and to be a significant barrier to American adolescents obtaining family planning services.[21] Our European interviewees generally shared this perception. The standard of care that includes annual pelvic examinations for American teenagers is currently being debated.[22]

In Great Britain, clinical guidelines for emergency contraception were introduced in 1974; currently, public knowledge about the method is "fairly high,"[23] and there is discussion about making it available without a prescription. In the Netherlands, emergency contraception has been used since 1964, is not considered an abortifacient and is considered acceptable for teenagers.[24] By contrast, in the United States, emergency contraception has been considered an abortifacient by many members of both the professional and lay population,[25] and is only now being packaged for more widespread use.

Another finding consistent with previous research is that adolescents in Great Britain and the United States seem to have poor levels of knowledge regarding family planning services. Further, our interviewees suggest that American parents are more willing to challenge providers and are generally more vigilant over their children's family planning care. In Sweden and the Netherlands, it is generally accepted that parents should not obstruct their teenager's access to family planning services.

Government commitment to the financing of family planning services seemed to be on firmer ground, from its inception to the present, in Sweden and the Netherlands than in Great Britain or the United States. In reviewing the historical context of governmental financing of family planning services in the United States, researchers have acknowledged that adolescent sexuality has generally been viewed as "politically dangerous."[26]

In Great Britain, although the National Health Service has covered family planning services since its inception, British interviewees were divided as to whether the government provides adequate support for family planning services. Although many British respondents were encouraged that the problem of adolescent pregnancy was selected as a national priority in 1992, not all were sanguine that substantive changes to improve family planning services for teenagers would ensue. As of 1997, there had been no decrease in the rate of teenage pregnancy since the 1992 priority document was circulated.[27]

Family planning services appeared to differ among the countries. Respondents in the Netherlands and Sweden frequently described their countries' family planning services as having the features identified by respondents from all four countries as characteristic of ideal family planning services for adolescents.

Interviewees in Great Britain focused on confidentiality as a confusing issue among family planning providers and patients. In addition, in Great Britain, interviewees felt that medical personnel do not receive adequate training in family planning services or confidentiality. In the United States, the possibility of ever creating a liaison between family planning services and schools seems problematic, due to the resistance of parents and, therefore, school boards. In addition, a central theme for American interviewees was that there is little governmental, provider or familial support for preventive health care.

Recommendations

We integrated the characteristics of ideal family planning services for adolescents into one hypothesis by compiling the qualities listed above which were identified with each subcategory and which were endorsed by at least one interviewee in every country. These qualities included: multidisciplinary staff who are friendly and nonjudgmental; continuity of care; counseling to be included in the family planning visit; outreach efforts by staff to inform teenagers regarding the services; the location of services close to teenagers' residences or schools; flexible hours; and low cost for services.

Moreover, at least one interviewee in each country identified certain qualities of adolescents that may be associated with their ability to successfully access family planning services. These qualities included: trust in the staff; the courage to "walk through the door"; and a sense of personal responsibility.

Because of particular methodological limitations, caution should be taken in the interpretation of our results. First, our collected data reflect the perceptions of persons with a particular interest or expertise in adolescent health care and may not have reflected actual circumstances. Also, the data were collected more than five years ago. In light of the recent health care reforms within each of the four countries, family planning services may have changed since the beginning of this study.

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