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ORIGINAL ARTICLE

Women's attitudes towards pessary self-care: a qualitative study

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Abstract

Introduction and hypothesis Patients with vaginal pessaries can learn to care for their pessary by themselves or they can have provider-led care, which requires more frequent follow-up visits. We aimed to understand motivations for and barriers to learning self-care of a pessary to inform strategies to promote pessary self-care.

Methods In this qualitative study, we recruited patients recently fitted with a pessary for stress incontinence or pelvic organ prolapse, and providers who perform pessary fittings. Semi-structured, one-on-one interviews were completed to data saturation. A constructivist approach to thematic analysis using the constant comparison method was used to analyze interviews. A coding frame was created following independent review of a subset of interviews by three members of the research team and this frame was used to code interviews and develop themes through interpretive engagement with the data.

Results Ten pessary users and four health care providers (physicians and nurses) participated. Three major themes were identified: motivators, benefits, and barriers. There were several motivators for learning self-care, including care provider advice, personal hygiene, and ease of care. Benefits of learning self-care included autonomy, convenience, facilitation of sexual relations, avoidance of complications, and decreased burden on the health care system. Barriers to self-care included physical, structural, mental, and emotional barriers; lack of knowledge; lack of time; and social taboo.

Conclusions Promotion of pessary self-care should focus on patient education about benefits and ways of mitigating common barriers while focusing on normalizing patient engagement in pessary self-care.

Keywords Pessary · Pelvic organ prolapse · Stress urinary incontinence

Introduction

Pelvic organ prolapse and stress incontinence are common conditions that affect 50% and 30% of women respectively [1, 2]. Over 70% of women with these conditions can be successfully fitted with a vaginal pessary for relief of symptoms [3]. Pessaries may be used indefinitely with regular follow-up or may be used as a temporizing measure for symptom relief while awaiting surgery.

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Many patients fitted with a vaginal pessary can learn removal and reinsertion of the pessary independently. This is known as pessary self-care. The ability to perform self-care provides several advantages to patients and the health care system, including less frequent scheduled follow-up visits, the ability to follow up with primary care providers who do not have pessary care experience, and the opportunity to take more frequent brief pessary breaks. These pessary breaks can be scheduled weekly and may decrease the risk of complications such as vaginal discharge or erosions, which are common reasons for pessary discontinuation.

Previous exploratory studies on pessary use have found pessaries to be a highly acceptable treatment modality in a range of different populations [4]. Support and encouragement from members of the health care team seems to positively influence patients' desire to pursue a pessary fitting and continue with pessary use. Given the burden of pelvic floor disorders in our aging population [5] and the high demand for pessary care in our region, we aimed to develop strategies to optimize the proportion of women doing regular pessary self-care to promote access and minimize system burden while

ensuring effective, safe care. We have not encountered prior studies that explore patient and provider perspectives on what limits or encourages women to learn pessary self-care. The objective of this study was to explore the attitudes and beliefs related to pessary self-management among patients recently fitted with a pessary and providers who facilitate pessary fittings to inform strategies to promote pessary self-care.

Materials and methods

Setting and design

In this qualitative study, patients being fitted with pessaries and health care providers who regularly provide pessary care were invited to complete semi-structured interviews. Patients were invited to participate at the time of the pessary fitting appointment with either a nurse continence advisor or urogynecologist. Patients who expressed an interest in participating were contacted by phone by a member of the research team to obtain consent and for interview scheduling. Patients were eligible if they were 18 years of age or older, spoke English, and did not have significant cognitive impairment (defined as a documented diagnosis of dementia, mild cognitive impairment, traumatic brain injury, or global developmental delay). Health care provider participants (nurse continence advisors and urogynecologists) were invited to contact the research team if they were interested in participating following an announcement at a divisional meeting. There was no incentive provided for participating in the study.

Sample size was determined by data saturation, which we defined for the purposes of this study as theoretical sufficiency to generate thematic meaning to address our research question [6]. This occurred after 14 interviews.

Data collection

Interviews were completed by two medical students (PG and AE) who have experience in facilitating qualitative interviews. They had both interviewed for previous qualitative studies including pelvic floor-related subject matter (AE). Interviews were guided by a semi-structured interview guide (Supplemental file 1). The patient interviews lasted 19 min on average (range: 13 to 27 min). All interviews were recorded and transcribed by a research assistant (AvD) verbatim.

Data analysis

A constructivist approach to codebook thematic analysis was undertaken using the constant comparison method. The initial coding framework was a modification of that used by Nissen et al. [4] in their study, which was aimed at understanding the experiences of long-term pessary users in Tanzania. The coding framework was applied to the data, which was coded according to the created categories. Interviews were independently reviewed by three investigators (PG, JS, and AC) who refined the coding framework iteratively using consensus as themes emerged and converged employing methods described by Braun and Clarke [7]. We took a factual standpoint (assuming data to be accurate representations of reality), focusing on manifest content of the data (i.e., descriptions of what is said, rather than interpreting sighs, posture, laughter, etc.). When 20% of the data was coded, the coding framework was reviewed, and new categories added inductively (Table 1). NVivo 12 was used for the coding and data analysis.

Results

Fourteen participants from The Ottawa Hospital were recruited for this study. Ten of 11 patients, and 4 of 8 health care providers who were approached agreed to participate. Amongst those who completed interviews, 10 participants were patients using pessaries and 4 participants were health

Table 1 The theme "motivation" and sub-themes with participant quotes

Sub-theme	Quotes
Care provider advice	Patient 7: "Well, I thought [self-care] was the only option, basically. Well, I know if there was a problem, I can probably make an appointment and go back to the clinic…I got the impression that basically that's it, that's for me now to take care of it."
	Staff 4: "You know you say, "well you need to learn how to do [self-care].""
Personal hygiene	Patient 1: "It is like personal hygiene, like brushing your teeth or any other personal care."
	Staff 3: "[…] some people just feel cleaner–I don't say that because it definitely doesn't cause infection, but when it's in, it moves with the body and promotes more mucus production…some people don't like that…so they can take it out and rinse it and put it back in. They feel fresher, so that's a real plus."
Ease	Patient 10: "I did it myself, it was a lot easier because it had the little grooves on all four sides […]"
	Patient 6: "And that's fine, it is pretty easy to manage, it's not a high maintenance device."

care providers (physicians or nurses) fitting pessaries and teaching self-care. The median age of patients was 66 years (range 42 to 85). Eight patient participants had used the pessary for less than 3 months but 2 had used a pessary for more than 5 years and recently underwent re-fitting. All patients could describe their pessary, but 9 out of 10 did not know the formal name or size. All patients except one were engaged in self-care following the initial fitting.

The data were coded into basic themes within three categories: motivations, benefits, and barriers. In each category, codes were grouped into organizing themes as patterns were identified through interpretive engagement with the data [8].

Motivations for pessary self-care

The most common motivators for learning pessary self-care were ease, personal hygiene, and health care provider advice (Table 1). Patients described learning to insert and remove their pessary as a relatively simple procedure and expressed that they felt capable of performing this on their own after initial instruction.

Many patients described caring for their pessary as important for hygienic reasons. They compared learning pessary self-care to other routine hygiene activities such as changing undergarments and brushing teeth. Providers highlighted the minimization of vaginal discharge associated with regular removal and cleaning as a means of promoting patients' perception of cleanliness. Providers felt that maintaining cleanliness was a motivator for patients.

Health care providers also played a prominent role in motivating patients to learn self-care. Health care providers described the importance of explaining the benefits of self-care, taking time to ensure patient understanding with step-by-step instructions, and providing reference pamphlets to aid in success with self-care outside of the visit. Providers described their role as normalizing self-care and strongly encouraging patients to learn self-care. Some patients also believed self-care was the standard practice and expressed that they did not feel that they were offered provider-led care. Moreover, many patients described being comfortable with the health care provider as an important facilitator for learning self-care. Patient 6 stated,

> "They were very good listeners and very positive so then you feel more relaxed and confident."

Benefits of pessary self-care

Several benefits of self-care were described by participants (Table 2). Caring for their own pessary provided patients with autonomy of care. Nine out of 10 patients felt capable of inserting and removing their device following their pessary-fitting appointment, which includes self-care education. Patient 4 explains her experience:

> "When I insert it myself, it's just more responsible–no it makes more sense, you know it's my body, and if there is anything wrong, I'm more aware of it. I suppose that's instead of having someone else look at it."

Patients also felt that self-care fosters independence, which they greatly valued. They believed it was important to learn to manage their pessary rather than depending on

Table 2 The theme "perceived benefits" and sub-themes with participant quotes

Sub-theme	Quotes
Autonomy of care/independence	Patient 2: "But I didn't want to leave something in there that shouldn't be in there without cleaning it. So, it was important for me to take care of it myself and be independent."
	Staff 2: "I feel like they have more liberty, and they will feel more free when they can do it themselves, so I try to teach it to every one of my patients."
Sexual relations	Patient 7: "…if you have intercourse, you have to remove it."
	Staff 2: "I think it's even more important for the ones who are sexually active and they kind of need to remove it, so that's one of the most important factors."
Convenience	Patient 1: "I live outside of the city and I don't have to travel back and forth. I can just take care of it myself."
	Patient 4: "I think the biggest one would be convenience. It's convenient, you just do it when you need to remove it, clean it."
Burdened health care system	Patient 2: "And it would certainly take a big burden off our health system since I could take care of it myself."
	Patient 9: "Well, it would be sort of a waste of time, I think. If I'm taking it in and out once a week, I mean that's crazy, right? If you think of the cost of that. And the fact that you have to wait so long to get into these things in the first place, I'm taking up, basically pessary real estate, if you want to call it that."
Avoidance of complications	Staff 2: "I think for patients that cannot use local estrogen as well, to remove it more frequently I think they have less complications, like erosion or laceration from the pessary use if they remove it more often."
	Staff 3: "But the main thing is the tissue status, just preventing erosion, preventing irritation, it just makes it a healthier treatment choice if they can take it out."

health care providers. Health care providers held similar beliefs, stating that self-care gives patients more control over their body and ownership over the management of their condition.

Participants described self-care as being beneficial to their sexual relationships, as 4 out of 5 sexually active patients indicated that they were removing their pessary for intercourse. Four of the 9 patients who did self-care were not sexually active, but providers described desire for sexual activity to be a strong patient driver in engaging in self-care and reported discussing sexual activity as part of their counseling to promote self-care.

Both patients and health care providers described self-care as more convenient in terms of time dedicated to care. They specifically highlighted that self-care minimized the number of follow-up visits required. Some patients did not live near the clinic, and they highlighted the decreased number of follow-up visits as a major benefit because it minimized the requirement for travel. Several patients described engagement in self-care as a means of helping to reduce the burden on the health care system, with one commenting that the current 8-month wait time for a fitting appointment was long. They expressed a sense of duty to perform self-care to promote access to others and minimize their contribution to an overburdened system. Providers echoed this benefit and described that the default strategy at the clinic among providers at the time of the study was to teach self-care owing to a lack of appointment availability. Health care providers also noted an additional benefit that was not expressed by patients interviewed in the study: they described that pessary self-care reduces complications such as tissue irritation, erosion, laceration, bleeding, and discharge build up. The health care providers reported that they often mention this benefit to patients.

Barriers to pessary self-care

Patients and providers faced barriers to learning or teaching pessary self-care (Table 3). Some patients described physical limitations due to medical conditions such as arthritis or obesity or age-related physical changes such as decreased flexibility. Patients also described structural limitations related to the pessary itself, including difficulty grasping the pessary without a handle and challenges in bending the pessary during insertion. They expressed that their physical limitations were compounded by structural

Table 3 The theme "perceived barriers" and sub-themes with participant quotes

Sub-theme	Quotes
Physical	Patient 3: "It's not easy, because I have [chronic pain] in both my hands and arms […] sometimes I can't use my hands very well." Staff 4: "Women who have arthritis, who have balance issues, or back issues…it could be difficult for them to remove a pessary… A woman who is obese, it's very difficult for her to be able to reach in to remove a pessary."
Structural	Patient 3: "Just the fact that it doesn't have a handle, like to put it in is hard to hold it […] and to take it out is really hard without the dental floss." Patient 6: "[…] now I always found the pessary hard to manage, it's very stiff and inclined to spring open, so I always found it a bit of a challenge."
Mental	Staff 1: [for some patients]"right off the bat they have a limiting belief that they won't be able to [remove it], they won't succeed." Staff 4: "It comes down to mindset honestly. If they are like 'I'm not going to touch myself, it's not something I do.' So, it depends on the mindset. Mental health comes in too…If they're very upset or impulsive…it makes very difficult for us… then if you throw in some dementia or Alzheimer's then those are very difficult."
Emotional	Patient 8: "Like, I don't think I'd want to touch it myself. I'd be afraid." Staff 4: "My main thing, a lot of people come to their first appointment, and they are very apprehensive, and 'I don't want this, I don't think I want this.'"
Lack of knowledge	Staff 2: "I think when there is a language barrier, and we need an interpreter to be there, that's a big factor. It can make it uncomfortable or take even longer to teach it." Staff 3: "We need them better prepared when they come for the fitting. Having been given something to read paper-wise and had an opportunity for questions already with the physician."
Lack of time	Patient 7: "There's so many things I have to deal with, I basically just forget about [caring for the pessary], I think one of the barriers is being very busy, and very many things to deal with." Staff 2: "I think the biggest thing is lack of time in clinic, it does take sometimes an extra 15–30 min to stay with the patient, to let them try and try again and then place it again. It takes extra time, and I think time is the biggest factor."
Social taboo	Staff 1: "Some people don't want to tell anybody that they're doing it, that they have a pessary inside, so if they have to be removing it at home, that means there's the chance of it being discovered on the counter or something…They think they're the only one in the world having it and they want to keep it a big secret." Patient 5: "I have never heard any women, or my friends discuss having a pessary or pessary care…I'm embarrassed to bring up the subject; you don't want people to know."

limitations to make self-care more challenging. Importantly, many patients described succeeding in self-care despite physical limitations and highlighted modifications such as the addition of a loop of dental floss or having a supportive partner assist them in performing self-care as a means of mitigating the impact of structural barriers.

Other patients reported facing mental barriers and these were also reported by providers when describing unsuccessful self-care teaching during pessary fittings. Some patients self-identified as lacking the mindset to learn self-care, whereas others reported believing that health care provider-led care resulted in improved health outcomes. Providers described some patients as having negative attributions toward self-care from the outset of the appointment and identified this mindset as a major barrier to consideration of self-care. Providers also described teaching self-care to patients with some medical conditions, such as dementia, as challenging and potentially futile. Finally, providers expressed that they suspected that some patients preferred frequent follow-up visits owing to the social nature of appointments, particularly in the context of limited social interactions during the COVID-19 pandemic.

Both patients and health care providers noted that negative emotions, including anxiety and fear, can pose a challenge to learning self-care. Health care providers found that it was harder to facilitate self-care in patients who did not have appropriate prior counselling or knowledge of pessaries, or who were not able to understand self-care as effectively owing to language barriers.

Time was noted as a barrier for patients and health care providers. One patient mentioned that caring for the pessary was time consuming and conflicted with her work schedule. In the clinical setting, health care providers faced time constraints when teaching self-care. Providers described the challenge of taking adequate time to counsel and coach patients to ensure capability and promote feelings of self-efficacy around self-care prior to the completion of an appointment. Providers highlighted that this was particularly challenging in clinical situations where multiple fittings were completed to find the perfect pessary fit for the patient, as these appointments often run over the scheduled time to perform the fitting alone. No patients mentioned a time limit to the appointments, but patient 8 returned twice after some vaginal irritation with her initial fitting and expressed gratitude to the nurse who found a successful pessary:

> "I had an excellent nurse…This particular nurse did not give up…Now we have a pessary that works."

Last, social taboo emerged as a barrier to self-care. Both patients and providers expressed that there is a desire among some users for secrecy around pessary use. Some patients expressed embarrassment around the requirement for pessary use. Additionally, many interviewees highlighted the lack of knowledge around the prevalence of pelvic floor disorders and pessary use as drivers of feelings of isolation and shame around pessary use. The desire for discretion was highlighted as a driver of engagement in health care provider-led care.

Discussion

This study builds on previous literature that evaluated patients' experiences with pessary care in general by exploring patient and provider perspectives on engagement in pessary self-care. Three major themes around self-care of pessaries were identified: motivators, benefits, and barriers. The patients interviewed were generally comfortable to try to learn self-care, and they were motivated to succeed in caring for their own pessary. The major motivators were ease of self-care, personal hygiene, and health care provider advice. Participants noted several benefits to self-care, including autonomy, convenience, decreased burden on the health care system, maintenance of sexual relations, and reduced complications. Despite these advantages, barriers were identified that challenged patients' ability to perform self-care. Physical, mental, or emotional conditions, structural issues, and social taboos posed barriers to learning pessary self-care. A lack of knowledge and limited time were factors that seemed to challenge the ability to learn self-care. Many patients expressed being able to overcome some of these barriers to engage in self-care.

Our findings contrast with those of another Canadian study that found that most women preferred regular appointments with health care providers to the option of self-care [9]. Storey et al. [9] identified psychological comfort with touching oneself as a factor in choice for provider-led care and hypothesized that this might be related to generational differences and patient age [10]. Our study, completed 13 years later, included patients with a similar median age but noted a much higher acceptability of self-care. Previous literature has noted that younger age is associated with higher rates of self-care and perhaps the distribution of patients who find self-care to be acceptable will grow as our population ages. This may suggest decreasing social taboo around pelvic floor disorders, or simply that as our population ages, generational barriers are less prevalent.

The social taboo around pelvic floor disorders was noted as a possible barrier to self-care by some, but 9 out of 10 patients expressed challenges with physical and structural limitations of maneuvering the device. Holubyeva et al. [11] noted that patients with a higher body mass index, advanced arthritis, and cognitive impairment had a lower rate of self-care in a retrospective chart review

of 1,659 patients. Our study builds on this finding, noting that many health care providers felt that these factors were barriers to teaching and learning self-care, and it is not always clear whether these women are offered self-care in all settings. Half of patients interviewed expressed comfort with having their partner help them with the pessary if needed, which suggests some openness regarding disclosure of their pelvic floor disorder, and the potential for recruitment of other caregivers to aid in pessary care. Undoubtedly, willingness to participate in the current study may confer a certain level of psychological comfort in discussing pessary use, which may not reflect the mindset of nonparticipants. This potential selection bias is an important limitation of the current study.

Autonomy of care was a major sub-theme among 12 of the 14 participants in our study. Storey et al. [9] found that patients were often unable to practice self-care owing to the fear of reinserting the pessary independently. This was not a prominent finding in our study, perhaps because of the timing of interviews in relation to pessary fitting. Although some patients expressed emotional barriers such as fear and apprehension, this was in the context of having overcome the barrier.

Only health care providers expressed the socialization benefit of health care provider-led care as a potential self-care barrier. Frequent follow-ups bring forth a routine and give patients an opportunity to interact with others. Previous literature has noted that older patients describe pessary clinic visits as a social outing and as a significant part of their lives [9]. Given the increased isolation, particularly among the elderly [12, 13] with COVID-19 pandemic restrictions, we expected this theme to emerge in patient interviews. No patients identified concerns around COVID-19 social restrictions as a factor in choosing self-care or provider-care of their pessary. COVID-19 was noted to be a reason for choosing pessary for management owing to delays in operating room access. The support and encouragement from providers were positive factors in learning self-care, but perhaps the effect of pandemic-related restrictions on attitudes to care warrants further study.

Health care provider advice was a major motivation for self-care. The nurses and physicians mentioned that reduced complications were a significant benefit to pessary use and other studies have documented that patients who care for their pessary themselves experience significantly fewer adverse events including vaginal bleeding, discharge, and vaginal erosion [14]. Moreover, it was health care providers in our study who strongly considered current sexual function status in the motivation to teach self-care. Self-care is more common among sexually active patients [11], but many patients who are not sexually active perform self-care. A systematic review found that pessaries significantly improved sexual functioning and provided a better quality of life [15]. In light of this, self-care counseling by providers should focus on potential future sexual function aims rather than current level of activity.

Finally, economic analyses have demonstrated that self-care is more cost-effective [16] and, interestingly, it was our patients (rather than providers) who commented on the burden of recurrent pessary care visits on our health care system. The awareness of allowing access for other patients may be reflective of the significant quality of life impact of pelvic floor disorders. Many patients have been directly impacted by increased wait times for pessary fittings in our region during the pandemic.

One of the strengths of this qualitative analysis is the depth and detail of patient interviews, which allow for rich exploration of patient perspectives around a potentially sensitive topic. Further, individual interviews rather than focus groups may have promoted candid responses by minimizing perceptions of judgment by peers. Finally, our analysis was grounded in established theory to promote best practice in the generation of themes. Limitations of this study include the small sample size of patients, which may affect the generalizability of our findings and limit our ability to analyze subgroups. Unintentionally, 9 of the 10 patients we interviewed practiced self-care, and many had overcome barriers successfully. Self-care is the most common outcome for ongoing pessary care in our clinic among patients who have new pessary fittings. Interviewing a group of patients who preferred health care provider-led care may have revealed differing perspectives.

Conclusion

Overall, our findings suggest that there might be a wide variety of factors that influence desire and ability to learn or teach self-care. When introducing the concept of self-care, health care providers can focus on common motivators and highlight benefits such as reduced adverse complications and improved sexual function. By recognizing barriers to engagement in self-care, providers can tailor their practice to mitigate them. Future work will focus on the development of resources for patient education around pessary self-care.

Appendix

Table 4 Interview framework for patients

Demographic factors	What is your age?
	What is the reason for your pessary? (urinary incontinence, prolapse, more than one problem)
	What is the type of pessary you use?
	How long have you used the pessary?
	How often do you remove the pessary?
	How long do you leave the pessary out when you remove it?
	Do you use local vaginal estrogen?
Interest in learning self-care	If you do self-care, why did you learn to do self-care of your pessary?
	Were you planning to do self-care when you were fitted with your pessary? If not, what encouraged you to learn?
	Are you sexually active? If so, do you remove your pessary for intercourse?
	Do you see any benefits to learning self-care?
Barriers to learning self-care	Any medical or physical conditions that make it difficult for you to reach down to the vaginal area?
	Are there any barriers that have made it more challenging to learn to care for your pessary on your own?
	Do you consider it important to learn to care for your own pessary?
Health care provider interactions/factors	Are there any things that your health care team have done that have encouraged you to learn or not to learn pessary self-care?
	Did your doctor or nurse encourage you to learn to take out and put in the pessary on your own?
	If you prefer to have the doctor/nurse care for your pessary device, why is that?
Challenges with self-care	What are the challenges that you have found with pessary self-care?
Social factors that may impact desire for self-care	Do any other women you know use or have a pessary?
	Do friends or family know that you use a pessary?
	Would you feel comfortable having a family member (i.e., your partner) help you with removing or reinserting the pessary)?
	Are there any other environmental factors that change being able to care for the pessary?
Strategies for encouraging self-care	Do you think there are any things that would help to encourage other patients to learn to care for their pessaries on their own (like peer support groups, drop-in online sessions, a discussion board online, a detailed website)?

Table 5 Interview framework for health care providers

Demographic factors	Are there any patient factors that lead you to encourage pessary self-care?
Motivation for learning self-care	Do you see any benefits to learning/teaching self-care?
Barriers to learning self-care	Are there any barriers you would consider for patients learning self-care? Are some of these patient factors? Environmental factors? Health care provider factors?
	Are there any health care provider barriers to teaching self-care (i.e., lack of time, lack of remuneration)?
	Are there certain times when it is easier to avoid teaching self-care?
Health care provider interactions/factors	Are there any patient–heath care provider interactions that make it easier or more challenging to facilitate pessary self-care?
Challenges with self-care	What are the challenges that you have found with pessary self-care?
Social factors that may impact motivation for self-care	Are there any social factors that impact patient desire to learn self-care?
Strategies for encouraging self-care	Do you think there are any things that would help to encourage other patients to learn to care for their pessaries on their own (like peer support groups, drop-in online sessions, a discussion board online, a detailed website)?

Authors' contributions J.S.: protocol/project development, data analysis, manuscript writing/editing; P.G.: data collection and management, data analysis, manuscript writing; A.E.: data collection and management, manuscript editing; A.v.D.: data collection and management, manuscript editing; A.C.: protocol/project development, data analysis, data management, manuscript writing/editing.

Declarations

Ethics approval The Ottawa Hospital Research Ethics Board approved the study (20210540-01H). Informed consent was obtained in writing from all participants prior to the interviews, and this included consent to audio recording.

Conflicts of interest None.

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