Counseling for Choice: Does a consumer-powered approach to counseling lead to better contraceptive outcomes?

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Background: While globally the modern contraceptive prevalence rate is increasing and unmet need decreasing, contraceptive discontinuation remains high. A comprehensive review of contraceptive discontinuation in developing countries, done in 2015, found that half of women who start a modern method will discontinue within two years, half of those due to reasons other than wanting to become pregnant[1]. Method-related concerns, which is primarily fear of side effects, is the most common reason for discontinuation, and is highest among injectable users, though this varies by context.[2] In countries where less effective methods are used, like condoms or traditional methods, method failure is also a large part of discontinuation. In countries where injectable use is more common, health concerns and side effects are increasingly given as reasons for non-use.

The most common side effect of modern methods is changes in bleeding- either heavier bleeding with the IUD or irregular bleeding or amenorrhea with injectables and implants. In the minds of many women, these changes are linked to two major health concerns - loss of future fertility and cancer. Preparing women for bleeding changes during counseling has been shown to increase satisfaction and decrease discontinuation.[3]

Most existing training on counseling gives little guidance on how to discuss bleeding changes with clients. Often, they are listed with other side effects, which are said to go away with time – yet most bleeding changes remain over the entire time the method is used, and with the injectable, even a few months after it is stopped. It is important both to prepare the client for the possibility of bleeding changes and explain why these changes are not harmful to her health or future fertility.

Malawi

Malawi, with a total fertility rate of 4.4 children per woman, has a relatively high modern contraceptive prevalence rate (58% among married women; 43% among sexually active, unmarried women), but contraceptive discontinuation is high. More than a third of Malawian women (37%) discontinue a method within 12 months. The main reason women cite for discontinuing a method is side effects/health concerns, with the highest proportions of women citing this method discontinuing the most effective methods, implants and IUDs.[4]

[1] Castle, S and Ian Askew. Contraceptive Discontinuation: Reasons, Challenges and Solutions. Population Council, 2015.

[2] Ali, M et al. Causes and consequences of contraceptive discontinuation: evidence from 60 Demographic and Health Surveys. WHO 2012.

[3] Backman T et at. Advance information improves user satisfaction with the levonorgestrel intrauterine system. Obstet Gynecol. 2002; 99:608–13.

[4] National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.

Establishing a good interpersonal relationship has been shown to increase method continuation. In particular, higher continuation rates were found when providers establish trust at the beginning of the session and ask about the client's needs.[5]

Counseling for Choice Intervention

To address contraceptive discontinuation, particularly discontinuation due to methods related concerns, PSI, through the Supporting International Family Planning Organizations 2 (SIFPO2) project, has developed the Counseling for Choice (C4C) intervention.

Contraceptive counseling has evolved as options for contraceptives have increased. In order to counsel patients thoroughly on their options, many clinicians utilize the autonomous approach to counseling. This involves provision of information on all available, medically-appropriate methods and the patient subsequently making a decision with minimal provider input. Another commonly utilized approach is directive counseling, in which a clinician has a preferred method in mind for the patient and counsels him or her toward it. One example of this is the "tiered-effectiveness" method. With an effectiveness framework, clinicians present the most effective options first, including long-acting reversible contraception (LARC) methods . Yet, these approaches have not consistently met the goals of reducing unintended pregnancy and increasing contraceptive continuation and satisfaction.

The C4C approach seeks to help clients make better choices about which method is right for them. There are three phases of method choice and PSI has designed a suite of tools for each phase.

During the pre-counseling sessions through interpersonal communication agents (IPCs), the tools are designed to support four key points:

1. Understand key benefits of different methods
2. Understand menstruation and why it is ok not to have regular periods
3. Narrow down to methods that are most appealing to the client
4. Refer for services

During the counseling sessions with providers, tools support five key points:

1. Confirm method choice based on stated needs
2. Check medical eligibility
3. Reinforce menstrual changes if applicable
4. Explain 3Ws (what to do, what to expect, when to come back) for chosen method
5. Help client plan for correct use and side effect management

During the post-counseling follow up, there are tools to support four key points:

1. Reinforce 3Ws and use/side effect management plan
2. Reinforce menstrual changes if applicable
3. Manage side effects as needed
4. Recruit satisfied users for testimonials

[5] Dehlendorf C, et al. Association of the quality of interpersonal care during family planning counseling with contraceptive use. Am J Obstet Gynecol 2016;215:78.e1-9.

The C4C approach has a suite of tools, the foundation of which is the Choice Book. The Choice Book was developed as a job aid and is designed either for IPCs or for providers. For IPCs, it compares benefits of different methods, for each method, gives key messages, the 3Ws (what to do, what to expect, when to come back), and key points for planning, and provides a visual aid and key messages for explaining period changes. The Choice Book for providers includes a pocket reference guide, includes all points from IPC version plus, management for most common side effects, the WHO 2015 medical eligibility criteria (MEC), post-partum and post-abortion eligibility, and a new job aid that tells provider when to use the pregnancy checklist to rule out pregnancy, versus when a pregnancy test is recommended.

Objective: The overall objective of the C4C evaluation is to test the effect of the counseling for continuation approach. To this end, the evaluation seeks to answer the following three main research questions:

1. Does the C4C approach have a measurable impact on continuation of a client's chosen method at six months while she remains in need of contraception, compared to the current approach?
2. Does the C4C approach have a measurable impact on client satisfaction at post-counseling and six-month follow-up, with a chosen method, compared to the current approach?
3. What are providers' perceptions on the C4C approach, including barriers/facilitators to use of the approach?

Methods: This evaluation employs a mixed methods approach for a more complete picture of counseling for continuation, both from the client perspective and the provider perspective. A quasi-experimental matched case-control design is used to evaluate the impact of the C4C approach on contraceptive continuation and client satisfaction. Sixty facilities in the private sector were matched to create 30 matched pairs and each facility of the pair is randomly selected to be the intervention and control facility. The same matching process was done for facilities in the public sector, for a total of 120 facilities, 60 intervention and 60 control. All family planning providers in the intervention facilities were trained in the C4C approach. Qualitative data collection among 20 providers, 10 in the private sectior and 10 in the public sector, is used to understand providers' perceptions of the C4C approach.

Pre-counseling survey (quantitative)

After an informed consent process, a trained data collector administers a short questionnaire to the woman before her visit with the provider. This questionnaire will ask about topics such as pre-counseling method preference and their feelings about the acceptability of specific side effects. See Appendix for full questionnaire. It will be translated into the local language and take about 10-15 minutes to complete. This will be done in a pre-defined area that allows for privacy with only the woman and the trained data collector present.

Post-counseling survey (quantitative)

Following her visit with the provider, the data collector will invite her to participate in the post-counseling survey. A unique identifier code, described in section 3.2.5, will be used to link her pre- and post-counseling survey responses. The questionnaire covers topics such as method chosen, reason for choice, why they are leaving without a method (if no method selected), what they were told during the counseling session, and satisfaction with the counseling experience.

Six-month follow-up survey (quantitative)

Six months following the pre- and post-counseling survey, all women who agreed in the post-counseling survey to be contact again and provided a phone number, will be contacted by phone to participate in a six-month follow-up survey. The follow-up survey will mainly seek to understand whether women are still using their method received at the time of their visit, whether they are satisfied with their method, and whether they have gone back to the provider for any problems.

In-depth interviews (IDIs)

The qualitative in-depth interviews are conducted using a structured interviewed guide developed by PSI with input from FHI 360. The IDIs cover topics such as:

- How has the C4C approach changed your counseling?
- How has this approach changed the types of methods you give?
- How has this approach impacted clients coming back with complaints?
- What parts of the Choice Book do you use most?
- What parts do you use least?

Results: The evaluation study will have three main outcome measures:

1. 6-month contraceptive discontinuation rates (while in need)
2. Satisfaction with contraceptive method experience
3. Barriers and facilitators to using the C4C approach

Outcome measure 1 will be measured through the six-month follow-up survey. Outcome measure 2 will be measured both immediately following uptake of services and during the six-month follow-up survey to investigate both short-term and long-term method satisfaction. Outcome 3 will be measured by the qualitative data collection.

Six-month contraceptive discontinuation rates and satisfaction with contraceptive method experience will be measured in both intervention facilities and control facilities to investigate whether there is a significant difference in the two measures between intervention and control facilities in both the private and public sectors.

Discussion: The C4C counseling approach has been designed to directly address the pervasiveness of contraceptive discontinuation. The results of this evaluation are intended to provide rigorous evidence as to whether taking this kind of client-centered approach and counseling explicitly on side effects of methods so that clients know what to expect and how side effects align with their needs while finally reduce contraceptive discontinuation while a woman is still in need of contraception. Ensuring that women are satisfied with their method and are able to prevent a pregnancy for as long as they intend to fundamentally ensure that we are meeting her sexual reproductive health needs and rights.