

# **Client-Provider Interactions (CPI) in Family Planning Services: Guidance from Research and Program Experience**

**The role of CPI in program effectiveness.** A growing body of research, and insights from program experience, relate the quality of client-provider interactions (CPI) and contextual factors of clients' lives to the adoption, effective use, and continuation of modern contraception. Greater program effectiveness results from efforts to improve this aspect of quality of care<sup>1-4</sup>. The findings have implications for training of providers, program management, policy and further research. "Client" herein refers to women who receive Family Planning (FP) services from clinics or community-based distributors (CBD). Much of the guidance also applies to reproductive and other health care and to specific client groups--e.g., men, youth, and pregnant, postabortion and postpartum women--and settings such as workplaces or community groups. Although increasing numbers of programs offer information and services focused on these important groups and settings, discussion of their special needs is beyond the scope of this brief document. To emphasize the importance of both the **process** of interacting with clients and the **information** essential for informed choice, the two are dealt with separately below. In reality, they intertwine inseparably.

## **Key Processes in Client-Provider Interactions (CPI)**

**1. Treat the client well.** Clients are more likely to be satisfied with services if **all staff**, not only the counselor, treat them with respect and friendliness. In turn, client satisfaction is associated with improved use-effectiveness, continuation and positive "word-of-mouth" reports<sup>5-7</sup>. Conversely, poor CPI is associated with discontinuation and method failure. For example, research in Egypt found that client-centered (vs. physician-centered) consultations were associated with a three-fold higher level of both client satisfaction and continuation, even though the client-centered sessions lasted only one minute longer<sup>8</sup>. Clients feel more comfortable if assured that information will be kept confidential and if visual and auditory privacy is maintained during counseling and FP procedures. This contributes to an atmosphere of trust in which the client and provider can explore emotional, sexuality or gender-related aspects of method choice. Providers should encourage clients to ask follow-up questions about side effects or to clarify instructions. Both verbal and nonverbal communication skills are important; counselors must listen and observe actively, seeking to understand clients' feelings as well as their medical and personal history. "Body language" that transmits warmth and interest (e.g., giving full attention, smiling and nodding when the client speaks) and a friendly tone of voice are behaviors that enhance CPI<sup>9</sup>.

**2. Provide the client's preferred method.** Informed choice remains the guiding principle: clients who already have a method preference should be given that method after screening and counseling unless it is inappropriate for medical or personal reasons. Research shows that clients who receive the method they came for--and a large number have a preference before they interact with the provider--are significantly more likely to continue using the method than those who do not receive their preferred method<sup>10,11</sup>. However, even clients with a prior preference should be

told that other methods that work in various ways are available and asked if they would like to hear more about any or all of these methods. This is important in case the client asks for a method because it is the only one she is familiar with or she has been pressured to get that method. Programs that respond to a client's appropriate choice recognize that there is no single method good for all clients. There is great variation in what clients and their partners find essential, attractive, inconvenient or intolerable about contraceptive methods. Some clients place highest value on effectiveness in preventing pregnancy, while others weigh effectiveness against a method's potential impact on their sexual relations, personal feelings or health<sup>12,13</sup>. Not surprisingly, continuation is also significantly increased if there is prior couple agreement on the method; couple counseling has been shown to be more effective in general than dealing with the woman or man alone<sup>10,14</sup>. This may not be possible for women who have no steady partner, have multiple partners or whose partners may not be supportive of FP or willing to be counseled. At an international meeting on counseling, participants stressed the point that policies established by governments, donors, country programs and service facilities can either facilitate or hinder sound CPI and informed choice. Clear policies can establish informed choice as the client's right and make counseling a programmatic priority. Biases for and against methods, such as targets at the provider level, method-specific incentives, provider's personal biases, and regulations such as those requiring a level of parity, or spousal approval, limit individual choice and thereby the achievement of programmatic goals<sup>15,16</sup>.

**3. Individualize.** Given that clients' lives and personalities (and their intentions, preferences, knowledge, beliefs, skills, needs and concerns about contraception) vary greatly, effective counseling is tailored to each individual<sup>17</sup>. Discovering individual characteristics, such as a client's difficulty with sticking to a routine, permits the provider to give special help when indicated. For example, one U.S. study which examined dropouts and method failures among oral contraceptive (OC) users found that one-fourth to one-third of the users would have benefited from more counseling on actual use behaviors, such as developing plans to operationalize their intentions and strategies to remember to take the Pill each day<sup>18</sup>. An analysis of data from Demographic and Health Surveys (DHS) found that first-time FP users and those under age 24 have the highest dropout rates; these clients are likely to need extra support<sup>19</sup>. Some clients may also need more information and greater reassurance about the overall safety risks and the personal health impacts of FP methods; they may have deeply held beliefs and perceptions reinforced by family and community attitudes and rumors. Clarification must be respectful. In addition to individual factors, a client may fall into a certain lifecycle stage or life situation that requires special attention from the provider. A provider should "locate" a woman and her fertility intentions on her reproductive life course. She may be a young, single woman who wants to avoid pregnancy, a breastfeeding mother who wants to space the next birth or an older woman who wants no more children. The counselor must also recognize that intentions may change over time and are often accompanied by ambivalence. In addition, the degree to which a woman has control over her sexual encounters bears upon the selection of a FP method. For example, if a woman has a controlling or even violent partner, and/or if her partner opposes FP, she may prefer a non-detectable method and may need to learn skills for discussing and negotiating reproductive matters with her partner. Furthermore, the nature of a woman's sexual activity is relevant--she may be in a mutually monogamous relationship or she may have multiple sexual partners. If her partner works elsewhere, she may have only intermittent, infrequent intercourse<sup>20-22</sup>. In sum, contraceptive counseling must be tailored to the needs of the specific lifestage and lifestyle of each individual client.

**4. Engage the client in dynamic interaction.** Only interactive and dynamic (i.e., responsive) counseling can identify clients' needs, risks, concerns and preferences within their lifestage and life-situation. However, some providers make counseling almost a one-way process. Perhaps they are modeling behavior observed in their own schooling and training; perhaps the social distance between providers and clients makes instruction to a "patient" seem natural. In one study of counseling, for example, providers talked at length about available methods and then asked the client to choose one. There was rarely discussion of reasons for a client to choose a particular method and little checking to see if the clients understood the information given. The study concluded that providers' skills could be strengthened in the areas of eliciting the needs of clients, prioritizing information to make it more relevant to the individual client and empowering the client to make a FP decision<sup>23</sup>. This study and other research have given impetus to training which is focused on counseling as a dynamic interaction, with much less "telling" and much more asking, assessing, listening, encouraging, establishing rapport and clarifying--and letting the client know in advance that such interaction has the goal of helping the client make the best choice<sup>24,25</sup>. Training in counseling yields positive results for provider and client; even radio-based distance education can improve providers' CPI performance<sup>26-29</sup>.

**5. Avoid information overload.** There are limits to the amount of information people can understand and retain--another reason why counseling should not be dominated by a recitation about every method offered in a program. Instead, providers should **focus factual information on the client's selected method** and be brief, non-technical and clear. This approach enhances understanding of the key information on that method (e.g., how to use, side effects) and also leaves time for questions, clarification and checking for comprehension. Earlier in the session, however, all clients should be informed that there are various methods available and that the counselor would be happy to describe any or all if the client so wishes. One major study found that clients who received the most information were more likely to drop the method they received than those who received less information<sup>10</sup>. This could be due to information overload that reduces retention of key points. A session dominated by information may also leave little time to help the client identify the most suitable method(s)--or perhaps the imparting of more information implies that clients' initial preferences were not honored. Affective factors may also be involved: a provider-centered session may lead to client dissatisfaction, a factor inversely associated with remembering and adhering to a regimen. U.S. studies have found that half or more of the information and instructions given during medical visits could not be recalled almost immediately afterwards. These studies also found involvement of the client and tailoring the educational component to the individual's learning style engendered greater client satisfaction, adherence to therapies and improved outcomes<sup>5,6</sup>. In addition, specific information that is organized logically is retained longer and more fully, especially if clients are encouraged to ask questions and repeat the instructions in their own words<sup>30</sup>.

**6. Use and provide memory aids.** During the counseling session, use of posters, flipcharts, illustrated booklets and sample contraceptives help the client remember key information and remind the provider to discuss important points. Use of take-home educational materials--pretested for comprehension and cultural acceptability with client groups--helps both providers and clients focus on key points during counseling and helps clients recall them later. Take-home materials on the method help to disseminate accurate information to others since clients often share the materials with their partners, relatives and friends<sup>31,32</sup>.

## **Key information for clients choosing a contraceptive method**

**1. Effectiveness.** Effectiveness should be explained in easily understood terms. Providers must emphasize that client-controlled methods (e.g., oral contraceptives, barrier methods, natural family planning (NFP), lactational amenorrhea method (LAM)) can effectively prevent pregnancy but only if correctly and consistently used--unlike long-term and permanent methods (sterilization, implants and IUDs) whose effectiveness is close to 100% once properly administered by the provider. Counseling can help each client weigh the trade-offs between effectiveness and other features of various methods and to consider the use of short-term methods in the context of their (and their partners') daily lives. Are clients able and willing, for example, to delay intercourse to insert a spermicide, take a pill every day, or return for the next injection at the time required? For clients choosing short-term methods, counseling should include plans for correct, consistent use. It is also useful for clients to receive information on how to use OCs as emergency contraception (EC) and/or where pre-packaged EC can be obtained.

**2. Side effects and complications.** Clients need information about common side effects and how to manage- or outlast- them. Clients should also be advised about the signs of rare complications and urged to seek immediate help should they occur. Providers should invite clients to return for advice if they have problems and reassure them that they can change methods if dissatisfied. DHS and other research identify side effects and perceived health problems as the major reasons clients give for dropping out of FP use; fear of these effects is also the major reason for not adopting modern methods in the first place<sup>19</sup>. One African study found that women who receive inadequate counseling about side effects are more likely to become FP dropouts when they experience side effects, while those who are fully counseled on side effects are likely to continue contracepting--with the same method or a different, more acceptable method<sup>33</sup>. In China, women who received pre-treatment counseling about DMPA side effects and ongoing support were almost four times more likely to continue with that method than women not so counseled<sup>34</sup>. Women who experience side effects for which they are not adequately prepared may worry that their health is endangered or that the side effect, even if not dangerous, may be permanent and debilitating<sup>35</sup>. They may even blame the method for unrelated ailments. Such worry, followed by discontinuation, is likely to discourage others from using the method, since concerns spread by "word-of-mouth" networks<sup>7</sup>. In addition, respectful clarification is called for if there are misperceptions about the health and/or libido effects of male and female sterilization, the health consequences of menstrual disruption, the IUD traveling outside the uterus or accumulation of pills in the body.

**3. Advantages and disadvantages.** In addition to side effects and health risks and benefits, providers and clients should discuss other important features of the method. These are often called "advantages and disadvantages," but it must be emphasized such perceptions vary widely among individuals and couples. For example, some women may want the highly effective, continual protection offered by the IUD or implant, while others might feel uncomfortable about a "foreign object" in their body or want control over when to stop use. Some want methods with the fewest side effects and others want a method which does not require application at the time of having intercourse. Clients also assess the mode of application differently: some favor or shun injections; some reject implants because they may be seen and recognized by others; some cannot remember to take pills; some want condoms because they offer dual protection, while others find them unpleasant.

**4. How to use.** Clients need brief, practical information on how to use their selected method and an explanation of how the method works, if needed to correct misperceptions (e.g., that the OC need be taken only when intercourse occurs). Clear, specific instructions are associated with better client adherence and outcomes, and are essential for counseling on user-dependent methods such as OCs and barrier methods. Clients may need to develop strategies for using these methods consistently and correctly, and advice on what to do when a method fails or is used incorrectly (e.g., skipping pills). Programs which offer or refer women to reproductive health (RH) education may help them use their methods correctly by increasing their knowledge about the reproductive system, how pregnancy occurs and how contraception works.

**5. When to return.** Clients need advice on when to return for follow-up or resupply. The follow-up counseling session is a good time to reinforce correct and consistent use of client-controlled methods and to ask whether the client is experiencing any unpleasant side effects that need management. The need to change methods may be discovered during follow-up if over time a client has developed medical contraindications to the method or if a change in lifestage (e.g., a desire to get pregnant in six months) or lifestyle (client now has multiple partners) occurs. In addition to scheduling return visits, providers should tell clients that they are welcome to return to the clinic any time they have questions or concerns. Clients choosing implants should be helped to remember when it is time to have them removed--follow-up visits can help--and should be told that they can have them removed at any time before that date as well.

**6. STD/HIV prevention.** As the prevalence of STD/HIV infection spreads, risk-assessment and STD/HIV prevention messages are increasingly being integrated with FP counseling. Programs are also increasingly finding ways to approach treatment and referrals for sexually transmitted diseases (STDs). Clients should be informed whether their FP method protects them against STD/HIV and that abstinence or the consistent use of condoms is the most effective means of protection available<sup>36</sup>. Those who use long-term and permanent methods may be less likely to use condoms for protection, possibly because contraception is a higher priority or because they no longer associate having intercourse with the need for protection. Some--especially young adults or teens--may incorrectly believe that all contraceptives protect against STD/HIV. A study of adolescents in Jamaica found that only about 25% of them knew that OCs did not provide such protection<sup>37</sup>. Providers should help clients assess their level of STD/HIV risk, and explain that the behavior of one's partner can also put a client at risk<sup>38</sup>. This can be done sensitively ("Many women may not be aware..."). Those at high risk need special encouragement, skills and support to use condoms in addition to any other method selected; counseling the couple may be the most effective approach. If this is not possible, helping clients build skills in condom negotiating and in communicating with partners about intercourse would be an effective addition to prevention messages.

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