

Informed Choice and Decision-Making In Family Planning Counseling in Kenya

By Young Mi Kim, Adrienne Kols and Stephen Mucheke

Context: Family planning programs have long endorsed the principle of informed choice as a way of ensuring that clients select a method that best meets their needs. There has been little research, however, that examines how, or whether, family planning clients make informed decisions.

Methods: Interactions between female family planning clients and clinic- and community-based providers at 25 service delivery sites in Kenya were audiotaped over a 9–15 day period. Transcripts of 176 counseling sessions were analyzed to identify key counseling behaviors and assess the completeness of information provided to the clients.

Results: Providers collected information about a new client's marital and reproductive history in 60% of counseling sessions, but asked women about their childbearing intentions in only 7%. In 55% of sessions with continuing clients, providers asked whether the woman was experiencing any problems with her current contraceptive method; providers raised the issue of switching methods in 27% of these sessions, and inquired about a continuing client's reproductive intentions in 17%. Providers discussed an average of four contraceptive methods with new clients, while with continuing clients they typically discussed fewer than two. Providers seldom tailored their discussion of contraceptive methods to the client's reproductive intentions, prior knowledge of family planning, contraceptive preferences, personal circumstances or health risks. In addition, while they emphasized a woman's right to make the final decision as to method choice, they rarely assisted women in fully weighing alternatives or ascertained that they understood completely the personal implications of their choices.

Conclusions: Family planning providers could enhance the quality of women's contraceptive decision-making if they took a more active role in contraceptive counseling—for example, by relating information on specific methods to women's personal circumstances and helping clients weigh the advantages and disadvantages of various methods. *International Family Planning Perspectives*, 1998, 30(1):4–11 & 42

Health care providers usually decide which medical treatment is best for a patient. In family planning counseling, however, the right of clients to receive accurate information and make their own decisions about reproductive health care—their right of informed choice—is considered fundamental.¹ Informed choice emphasizes that clients select the method that best satisfies their personal, reproductive and health needs, based on a thorough understanding of their contraceptive options.

Accordingly, many family planning programs have placed an emphasis on informing clients about all available contraceptive methods, through multimedia communication campaigns as well as during counseling sessions. However, few program managers and researchers have attempted to understand the steps and

processes that constitute informed choice in the context of a client's encounter with a service provider or, indeed, to determine whether clients actually make informed choices about their contraceptive method.

Because clients' values, preferences and priorities are an integral part of the contraceptive decision-making process, focusing providers' attention on informed choice has the potential to improve family planning outcomes. Research in other health care settings, largely in developed countries, suggests that involving clients in decisions about their care may increase their satisfaction with (and thus their use of and continuation with) their treatment. In addition, informed choice may increase clients' confidence in and commitment to their health care decisions.² Since such research is limited, however, it is difficult to generalize these arguments to family plan-

ning settings in developing countries.³

To develop a practical understanding of the concept of informed choice in these settings, we explored the nature of family planning decision-making during client-provider consultations in Kenya. Three critical issues complicate such a study, however. First, any single client-provider encounter is just one moment in a much longer decision-making process and just one episode in an ongoing relationship between the client and the health care system. Family planning decision-making often begins at home, as couples gather information from friends, the media and previous health care encounters and discuss the issue together. Indeed, so many aspects of the decision-making process already have taken place before the client arrives for a family planning consultation that some researchers have questioned whether clients actually make contraceptive decisions during family planning counseling sessions.⁴ Instead, clients may come for services already having chosen a method.

In addition, it has proven remarkably difficult to define what "informed" really means for family planning clients, and it is unclear how much and what kinds of information facilitate contraceptive choice.⁵ For example, providers may be trained to tell clients about every available

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method, regardless of its relevance, in order to give clients the broadest range of choices, both for now and for the future. Yet, informing clients about a great number of methods may not necessarily be in their best interest: Research conducted in Nigeria found that the greater the number of methods mentioned during a counseling session, the less likely the client was to return for another visit.⁶ Likewise, a study of six countries (including Kenya) showed that the amount of method-related information that clients received during counseling was positively associated with the likelihood of method discontinuation.⁷

Finally, the relationship between the needs of continuing clients and those of new clients remains unclear. Both clients and providers often view return family planning visits as simply a means of obtaining supplies or getting a check-up. However, high rates of method discontinuation in Kenya and elsewhere suggest that returning clients should be offered a choice of either continuing their current method or switching methods if they have developed unacceptable side effects, have found a method inconvenient or have changed their reproductive intentions.⁸ If so, then family planning decision-making is a process that continues throughout a client's reproductive years, and informed choice has relevance for continuing clients as well as for new clients.

All of these issues were considered in the design of the study described in this article. After using a number of models⁹ to identify four key steps in the decision-making process, we applied these steps to contraceptive method choice among both new clients and continuing clients (Table 1).

•*Step One: Understanding personal circumstances.* The first step in making an informed choice about a family planning method is for the client to understand his or her own needs, priorities and reproductive intentions. In this step, providers encourage clients to examine these personal issues, and they explain to clients how these issues relate to method choice. Providers help returning clients review their current situation and experience with their method, and also encourage them to think about other options.

•*Step Two: Considering alternatives.* By relating information about contraceptive methods to the client's personal situation, providers help clients narrow their contraceptive options. Providers can discuss—and clients can absorb—only a limited amount of information in a single session. Therefore, providers must be se-

Table 1. Components of and steps in contraceptive decision-making among new and continuing clients

Step	New clients	Continuing clients
Understanding personal circumstances	Discuss client's reproductive goals Review client's medical history Review client's contraceptive experience Discuss client's personal situation	Review client's experience with method Verify client's satisfaction with method Review changes in client's reproductive goals Check that client is using method correctly
Considering alternatives	Offer sufficient information Offer accurate information Personalize information Narrow down options Teach about the preferred methods	Remind client about side effects Discuss client's ability to tolerate side effects Discuss convenience or inconvenience of method Teach about alternative methods
Choosing the best option	Weigh pros and cons of preferred methods for client Explore client's reason for choice Examine provider's influence on the decision	Weigh pros and cons of continuing vs. switching Explore client's reason for choice Examine provider's influence on decision
Implementing the decision	Teach how to use the method Give directions for check-ups or resupply Instruct how to respond to problems	Reinforce instructions about method use Provide additional supplies Schedule future visits or further counseling

lective in the information they offer, focusing on the most important issues for the client and then thoroughly explaining potential side effects or inconveniences. If returning clients are dissatisfied with their current method, providers can alert them to their options: adjusting to side effects, switching to a different method or discontinuing contraceptive use and facing the risk of pregnancy.

•*Step Three: Choosing the best option.* In this step, clients compare the advantages and disadvantages of their different contraceptive options, with the provider's help. To ensure that clients fully understand their options, providers may ask them to explain the reasoning behind their choice. Likewise, providers can encourage returning clients who are considering a change of method to evaluate how another method might better suit their needs or increase their satisfaction.

•*Step Four: Implementing the decision.* Once clients have chosen a contraceptive method, providers offer them the practical information that they need to use the method safely and effectively. They discuss how to use the method, when to return for a check-up or for contraceptive supplies and what to do in case side effects or other problems arise. Providers offer new clients this information, while for clients who are continuing with a method, providers restate and reinforce this material.

We applied this decision-making model to family planning counseling sessions in Kenya, a country with a long-established family planning program and one of the highest rates of contraceptive preva-

lence—33% among married women—in Sub-Saharan Africa.¹⁰ We examined the way in which providers help new clients select a contraceptive method and how they assist returning clients in deciding whether to continue or switch methods.

The family planning providers who participated in this study received no special training on promoting informed choice, and this study was not an attempt to assess their performance. Rather, it was an initial effort to explore the nature of family planning decision-making and to put into practice the concept of informed choice.

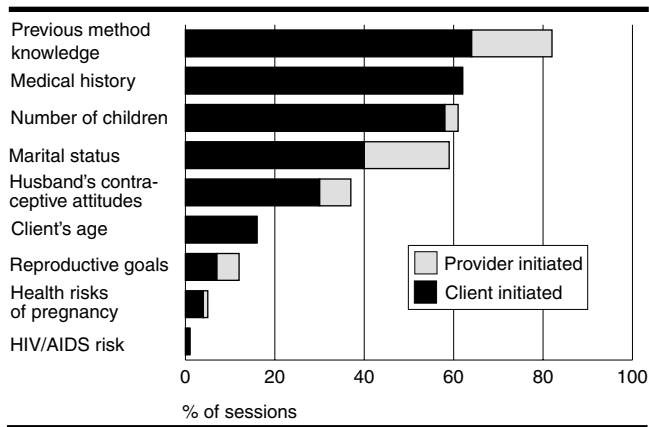
Methods

Data Collection

Structured observations and client interviews are the data collection techniques most commonly employed to gather information on family planning counseling.¹¹ Nevertheless, they may provide far less insight into the complex processes involved in decision-making than does interaction analysis—the analysis of complete recorded conversations between clients and providers. Interaction analysis has been widely used to analyze health care interactions in developed countries¹² and, more recently, in developing countries.¹³

The transcripts analyzed in this study were gathered during November and December 1993 as part of the Kenya Provider and Client Information, Education and Communication Project.¹⁴ Research assistants initially observed 358 family planning counseling sessions at 25 service delivery sites chosen to reflect a wide range of service situations in Kenya. First, urban and

Figure 1. Percentage of sessions with new clients in which topics important to decision-making were discussed, by who initiated discussion, Kenya, 1993 (n=77)



rural locations were proportionally selected in coastal, central, and western Kenya.* Specific sites in these locations were then purposively selected to include both clinic- and community-based service providers among the six leading organizations offering family planning services in Kenya.

Research assistants observed 16 sessions at each site over a 9–15-day period, involving as many different clinic- and community-based providers as possible. Because the number of providers at each site varied widely, some providers were observed with many different clients, while others were observed with only one client. Since new clients were scarce, research assistants observed virtually all new clients who visited a study site. In contrast, continuing clients were plentiful, and their sessions were chosen randomly. The observed sessions were divided equally between new and continuing clients.

Counseling sessions with new clients lasted 10–30 minutes and those with continuing clients lasted 5–10 minutes. With the client's and provider's permission, the research assistants audiotaped each session, filled out an observation guide during the session and interviewed the client privately after the session. Research assistants listened to each tape, translated it from the local language into English and made a written transcript of each session. Transcription was kept as literal as possible, with nothing omitted and no attempts made to interpret what either the provider or the client had said. However, all references to names and places that might identify the client or

*Kenya's fourth major region, the northeast, was omitted because of its long distance from Nairobi and its relatively sparse and nomadic population.

†The condom, the pill, the injectable, foaming tablets, the diaphragm, the IUD, the implant, tubal ligation and vasectomy.

provider were removed.

This article reports on background data from the observations and interviews, but we focus primarily on the audiotapes of the sessions. Unfortunately, problems in taping the consultations (faulty tape recorders, poor sound quality, incomplete recordings and lack of permission to record) limited us to 176 usable transcripts—77 from sessions with new clients and 99 from sessions with continuing clients. Seventeen dif-

ferent service sites are represented. These 176 sessions do not vary significantly from the complete set of 358 sessions in regard to client education, age, contraceptive use and provider type. Thus, our findings probably reflect the typical interaction between provider and client, although they may not represent all service situations in Kenya.

Data Analysis

We used both qualitative and quantitative methods to investigate the decision-making process during counseling sessions. For the qualitative analysis, we identified specific client and provider behaviors associated with each of the four steps in the decision-making model, and examined which of these behaviors occurred during the consultations, how consistently they occurred and in what order. For the quantitative analysis, we identified and tallied key behaviors and then calculated the proportion of counseling sessions in which each behavior occurred. The unit of analysis in all findings presented is the session. This means that the findings do not reflect how many times per session a behavior occurred.

To assess quantitatively the contraceptive information offered by providers during counseling sessions, experts in contraceptive technology developed a comprehensive list of key information points for each of the nine modern methods available in Kenya.[†] Between 20 and 35 information points were listed for each method. Information points covered how the method works, how it is used, the method's advantages and side effects, warning signals that require a provider's attention and what, if any, follow-up is necessary. These lists were drawn up purely for research purposes, and providers were not expected to mention all of the infor-

mation points. After coding the transcripts, we calculated the proportion of counseling sessions that included mention of each information point. This measure does not reflect the accuracy of the information or how often an information point was repeated during a single session.

Findings

Client and Provider Characteristics

All of the clients attending the examined sessions were women; 88% were aged 20–34. Almost half (46%) had at least a secondary education. Eighty-four percent were married, and 99% had children. Fifty-six percent of the women were continuing clients, more than four-fifths of whom had come for contraceptive supplies or a routine checkup.

Sixty-one different service providers (24 community-based distributors and 37 clinic-based providers), with an average of seven years of experience in providing family planning services, participated in the study. All but three providers were women. Seventy-eight percent of the clinic providers were nurses, and the remainder were counselors and doctors. The community-based distributors were community members who had received limited training in family planning and were affiliated with nearby clinics. All data were analyzed by provider type, but we only report these results if significant differences were found.

Data on the method selected during the counseling session were available for 153 clients. Of these, 128 women left the service site with a method—usually the pill (59 clients) or the injectable (41 clients). The 25 women who left without a method were asked to return when they had their menses, to go for further health screening or to come back at a later date for a long-term method. While roughly the same percentage of new and continuing clients left without a method (16% and 18%, respectively), new clients left with condoms or foaming tablets more often than did continuing clients (20% versus 4%). Usually, providers gave women condoms and foam to use for short-term protection until they could return and receive their method of choice.

Understanding Personal Circumstances

Providers collected information about new clients' marital status and number of children in approximately 60% of sessions (Figure 1). Some providers did so at the end of the session, however, only after a method decision had been made (defined simply as the client requesting a specific

method). Providers asked the client's age in 16% of sessions. Providers rarely discussed new clients' reproductive intentions; in only 7% of sessions did they ask if and when the client wanted more children, while in another 5% of sessions, clients brought up this issue themselves.

In 17% of sessions with continuing clients, providers asked whether the woman's reproductive goals had changed since her last visit. In 27% of sessions, providers asked continuing clients if they were ready to switch to a long-term or permanent method. In 55% of sessions with continuing clients, providers asked if the woman had experienced any problems with her current method.

In 62% of sessions with new clients, providers explored medical conditions that might contraindicate a particular contraceptive method; clinic providers did this more consistently than did community-based distributors (71% vs. 47%, $p < .05$). However, sessions with either type of provider rarely included assessments of other health risks faced by new clients, such as the risk of undergoing another pregnancy (5%) or contracting HIV or some other sexually transmitted disease (STD) (1%). In 61% of sessions with continuing clients, providers investigated specific physiological symptoms—for example, they checked blood pressure or inquired about headaches, backaches or changes in menstrual flow.

In 30% of sessions with new clients, providers asked about partners' attitudes toward contraception, and in another 6% of sessions, the client raised this issue themselves. The following exchange is typical:

Provider: So why don't you use this tubal ligation?

Client: My husband and I have talked, but he doesn't seem to want me to be done.

Provider: You can also try to talk to your friends or his friends who can talk to him and he might hear them. But it is very good to get advice from different people, so try to talk to his friends and see if they can change him. If you don't want to give birth again.

Only rarely did sessions entail discussions of other issues not related to health, such as a new client's pattern of sexual activity or her willingness to undergo a medical procedure. Likewise, in only 9% of sessions with continuing clients did providers ask about personal problems associated with method use, such as diminished sexual satisfaction or their husband's attitude toward contraception.

Learning about the Options

•*Method alternatives.* Informing clients, especially new clients, about available contraceptive methods occupied a large amount of the provider's time. Indeed, providers' training emphasizes the importance of educating clients about all nine methods. However, the amount of contraceptive information given by providers varied widely. Some providers described a broad range of contraceptives and systematically furnished a wide array of important information. Here, for example, is one provider's description of implants:

"Another method taking five years is called Norplant. You see that the mother's arm is slightly cut and capsules inserted below the skin and closed in. You do not feel pain. After five years, you come back for them to be removed. If you want re-supply, new ones will be inserted. If you want to conceive, you will return to fertility immediately. If you have a problem with it, you come to the clinic immediately. It is also important for you to come to the clinic for examination for us to find out if you have any infection. We examine every Thursday."

Other providers offered sketchy descriptions of a few methods and asked clients to make a decision based on extremely limited information. For example, this conversation with a new client followed a brief exchange of greetings:

Provider: There are different methods: pills, injection, tubal ligation, coil, foam. For the injection, it needs mature people around 35 years of age, and for the pill, it is from 20 years and above. And for tubal ligation, it requires a married couple, because it is a permanent method. We have the other method of coil, which is inserted into the uterus by the doctor to prevent pregnancy. So, as of now, I don't know which method you would like to adopt.

Client: I would prefer the pills.

From this point on in the consultation, the provider gave the client detailed instructions on obtaining and using the pill.

On average, providers mentioned approximately four contraceptive methods in sessions with new clients. In 48% of these sessions, providers mentioned 1–3 contraceptive methods, in 27% of sessions, they mentioned 4–6 methods, and in 21% they mentioned seven or more. In sessions with continuing clients, providers discussed an average of fewer than two methods per session.*

In 79% of sessions with new clients, providers included at least one information point about the pill. In 65% of ses-

sions, they mentioned one point about the injectable, while in approximately 40%, providers discussed one information point about either the condom, foaming tablets, the IUD, implants or tubal ligation; in fewer than 20% of sessions did they discuss one point about vasectomy and the diaphragm. In sessions with continuing clients, providers also were most likely to mention the pill (34%), although there was less of a disparity between mentions of the pill and mentions of other methods than there was in sessions with new clients: Implants and injectables were covered in 23% and 22% of sessions, respectively.

The emphasis on the pill was especially common among community-based distributors. In sessions with new clients, community-based distributors discussed the pill more often than did clinic providers (88% vs. 69%), although the difference was only marginally significant ($p = .06$); such providers also tended to offer a fuller description of the method. In contrast, clinic-based providers offered new clients more information than did community-based distributors about clinical methods, including the IUD, implants, tubal ligation and vasectomy.

Using oral contraceptives as an example, Table 2 (page 8) shows how providers focused on a few key points about a method in counseling sessions with new clients. In 66% of these sessions, providers mentioned the need to take the pill daily; in 48%, they covered the 28-day cycle for each pill packet; in 29%, they discussed what to do after forgetting to take one pill; in 27%, they mentioned the suitability of progestin-only formulations for breastfeeding mothers; and in 26% of sessions, providers covered the need to return to the clinic for additional supplies, for check-ups or if the woman experienced other problems. Other information points were mentioned in far fewer sessions.

As Table 3 (page 8) indicates, for all non-permanent contraceptives, providers most frequently emphasized information about how methods are used. Providers also often discussed a method's advantages, usually focusing on one important benefit: the suitability of progestin-only pills for breastfeeding mothers; the protection condoms offer against STDs; the long duration of use of the IUD; or the perma-

*Data on the number of methods discussed are somewhat conservative because they include only those sessions in which the provider covered one of the information points listed in the coding guide. If the provider mentioned a method without offering any further information (for example, "We have pills, condoms, foam, injectables, coil, Norplant"), it was not coded, and is therefore not included in the data.

Table 2. Percentage of family planning counseling sessions with new clients in which specific information points about the pill were mentioned

Category and information point	%
Advantages	
Does not interfere with milk production in breastfeeding mothers (progestin-only pill)	27.3
Does not interfere with sexual relations	1.3
Produces more regular, lighter periods with less cramping	2.6
Is highly effective	1.3
Decreases risk of pelvic inflammatory disease, ovarian and uterine cancer, breast tumors and ovarian cysts	3.9
How method works	
Prevents monthly release of egg	6.5
How to use method	
Take one pill daily at the same time each day	66.2
When 28-pill pack is empty, start a new pack; for 21-pill pack, skip one week before starting a new pack	48.1
After forgetting one pill, take two pills the next day	28.6
After forgetting two pills, use another method and return to the clinic	10.4
To get pregnant, do not start a new packet	2.6
Possible side effects	
Mild headaches or dizziness	18.2
Nausea	14.3
Spotting between periods	7.8
Weight gain	1.3
Follow-up	
Return to clinic for new supply of pills	26.0
Return for recommended checkup or if you experience any warning signs or problems	26.0
Warning signs	
Severe chest pain, shortness of breath	1.3
Severe leg pain or swelling in legs	2.6
Yellowing of skin or eyes	1.3

nence of tubal ligation and vasectomy. Compared with other contraceptives, more information was generally offered about the pill and the injectable, the two most commonly used methods in Kenya.

With new clients, providers rarely discussed how a method works, its possible side effects or the warning signals that require a provider’s attention. (The one exception was the frequent mention of the delay in return to fertility after discontinuation of the injectable.) Overall, menstrual changes were the side effect most often mentioned.

During the follow-up interviews with providers, they expressed concern that presenting too much negative information, such as possible side effects, might scare clients and make them reluctant to adopt a method. In 16% of sessions with new clients, providers informed a woman about a method’s side effects before she made her decision; in another 34% of sessions, however, providers discussed a method’s side effects only after a new client had made her decision (frequently as part of the medical screening process).

• *Personalizing information.* Providers typically gave equal weight to all of the methods they discussed with clients; they did not focus more time and attention on those methods that might be most appropriate for, or of most interest to, a specific client. For example, a woman who wanted to delay her next birth for two years listened to lengthy descriptions of implants and tubal ligation, along with descriptions of the short-term methods that better fit her immediate needs.

New clients were asked about their prior knowledge of family planning methods in 64% of sessions and about prior method use in 60% of sessions. At some time during the session, 82% of new clients indicated that they had some preexisting knowledge about family planning. However, providers did not tailor their presentations to the clients’ level of awareness.

At times, providers related specific methods to three factors from a new client’s personal history: her breastfeeding status (12% of sessions), medical contraindications (10% of sessions) and partner’s attitudes (4% of sessions). Providers did not tailor discussions with new clients to the women’s prior knowledge of family planning, contraceptive preferences, reproductive intentions, or risks of contracting HIV or other STDs.

Providers specifically pointed out the advantages of long-term or permanent methods in 27% of sessions with continuing clients (usually older women with many children) and encouraged them to switch methods: Clinic providers promoted switching somewhat more often than did community-based providers (35% vs. 13%, $p=.054$).

In 60% of sessions with continuing clients, providers discussed contraceptives other than the method currently in use; they sometimes reviewed the full range of available methods. Continuing clients who had no problem with their current method tended to resist any suggestion that they might want to consider switching methods. In 69% of sessions with continuing clients who had complaints about

side effects, providers reassured the women that the problem was not dangerous, and in 50% of these sessions, they offered them the option of switching methods. In 14% of these sessions, providers dismissed the client’s concerns as unimportant and simply offered supplies, without providing either reassurance or the option of switching methods.

Weighing the Options

Providers assisted new clients in comparing the strengths and weaknesses of one method to another in 22% of sessions. In the remainder of sessions with new clients, providers did not encourage clients to seriously consider more than one method. For example, the majority of new clients chose either the pill or the injectable, yet providers rarely counseled them to compare the relative advantages and disadvantages of these two hormonal methods. Thus, providers did little to help new clients assess their choice of method, beyond screening clients for medical eligibility.

In 73% of the sessions in which a new client chose a method, the provider did not ask the client to explain her decision, nor did providers explore the reasons why continuing clients in 57% of sessions wanted to switch methods. These omissions, combined with limited discussion of a method’s advantages and disadvantages for the client and little discussion of her preexisting knowledge or personal circumstances, make it difficult to determine how carefully a woman considered the alternatives or whether her decision was based on an accurate understanding of the method.

When new clients gave a reason for choosing a method, regardless of whether they were asked, they usually offered a single, personally compelling reason, one often based on the attitudes and advice of their spouse or their peers, rather than on specific information about the method itself. For example, in 28% of sessions, new clients opted for a method they felt their husbands could accept (or, alternatively, that they could hide from their husbands),

Table 3. Percentage of sessions with new clients in which at least one point in an information category was included in counseling, by method

Category	Con-dom	Foam	Diaphragm	Pill	Inject-able	IUD	Implant	Tubal ligation	Vasec-tomy
Advantages	24.7	18.2	2.6	28.6	20.8	29.9	35.1	35.1	20.8
How method works	10.4	11.7	11.7	7.8	1.3	18.2	3.9	19.5	7.8
How to use method	48.1	41.6	15.6	74.0	61.0	37.7	36.4	26.0	11.7
Side effects	2.6	5.2	0.0	26.0	41.6	14.3	10.4	0.0	0.0
Follow-up	1.3	2.6	0.0	45.5	23.4	13.0	15.6	3.9	0.0
Warning signals	na	na	na	6.5	7.8	7.8	0.0	0.0	0.0

Note: na=not applicable.

in 10% of sessions women chose a method recommended by a friend or neighbor and in 5% of sessions women said they wanted progestin-only pills because they were breastfeeding.

In at least 46% of their counseling sessions, new clients arrived with a strong preference for a specific method.* Providers appeared to both expect and accept this; often they began sessions by asking what method a woman wanted. While providers reviewed other methods with these clients, generally they did not ask the woman to reconsider her initial decision, nor did they explore how well the chosen method might fit her reproductive intentions and lifestyle. During the few sessions in which providers asked new clients to consider an alternative method, the woman generally listened and appeared to appreciate the advice.

Providers consistently respected the central element of informed choice, that the client, not the provider, should decide which method best suits her needs. In fact, this conviction may have discouraged providers from taking a more active role in counseling clients. In 50% of sessions with new clients, providers accepted the client's decision without question or comment; clinic providers accepted the decision somewhat more often than did community-based distributors (59% vs. 33%, $p=.054$). Even when a client tried to defer to the provider, the provider generally insisted that the client take responsibility, as in the following exchange with a new client:

Client: You just examine me and see what is fit for me.

Provider: Yes, we shall examine you, but we must also know what you think is best for you.

These findings do not imply that providers are playing a passive role during counseling sessions, however. A prior analysis of these same transcripts found that providers dominated more than two-thirds of the consultations, controlling both the content and direction of the conversation, while client participation was relatively limited.¹⁵ Although providers may defer to clients when it comes time to select a method, they are nonetheless highly active throughout the session.

Implementing the Decision.

Providers did not always supply the additional, more complete information clients need to use their chosen method properly. Table 4 compares the extent of information covered in sessions with new clients obtaining either the pill or the injectable with the amount of information covered in sessions with women obtaining other methods.

Sessions in which the client adopted the pill or the injectable were only somewhat more likely than sessions in which women adopted other methods to cover proper use of the method. Often, new users of the pill and injectable left the counseling session with limited information about their chosen method.

Also, the instructions offered frequently were incomplete. For example, providers explained that the pill must be taken daily in 72% of sessions with new clients who adopted the pill, but in only 52% did they describe when to begin each new cycle, and in just 32% did they instruct clients what to do after forgetting to take a pill. In addition, providers did not routinely check whether the client understood and remembered the information. Generally, providers were less consistent in reinforcing clients' continuing use of a method than in instructing new clients and clients who switched methods about how to use their new methods.

Table 4 shows that sessions were considerably more likely to focus on appropriate follow-up for the pill and the injectable when the client had adopted that method. Eighty percent of sessions with new pill users and 64% of sessions with new injectable users discussed when to return for resupply, check-ups or problems related to the method. However, in only 20% of sessions with new pill users and 14% of sessions with new injectable users did providers list any of the warning signs that are specific reasons to consult a doctor or nurse.

Discussion

Family planning providers in Kenya do appear to recognize the essential elements of informed choice and understand the importance of offering clients information about a variety of methods and of letting clients make their own decisions. This finding confirms earlier reports that Kenyan providers discuss multiple methods with clients and that, for the most part, clients are involved in the decision about which method to adopt.¹⁶

Nonetheless, informed choice is not fully realized in these sessions. Clients may not understand how the often generic information offered by providers relates to their own needs. They also may need help in weighing the advantages and disadvantages

Table 4. Percentage of sessions with new clients that included at least one information point about either the pill or the injectable, by method client received, according to information category

Category	Information about pill		Information about injectable	
	Client received pill (n=25)	Client received other method (n=52)	Client received injectable (n=14)	Client received other method (n=63)
Advantages	28.0	28.9	28.6	19.1
How method works	0.0	11.5	0.0	1.6
How to use method	80.0	71.2	64.3	60.3
Side effects	32.0	23.1	57.1	38.1
Follow-up	80.0	28.9	64.3*	14.3
Warning signals	20.0	0.0	14.3	6.4

*This may be an underestimate, because the transcripts frequently ended before the client received the injection, which was typically administered in another room.

of different methods or in verifying that their preferred method is suitable.

Providers may not have offered as much help as clients needed, but their determination to leave the decision to the client does mark a meaningful and important step towards informed choice. There is a fine distinction, however, between respecting clients' preferences and allowing them to make impulsive or uninformed decisions. Insufficient information and inadequate advice meant that many of the clients observed in this study did not make fully informed choices, although they undoubtedly had personally compelling reasons for their decisions.

Thus, while Kenya has made great progress in recognizing clients' right to choose, current standards for family planning counseling now need to be reassessed. By analyzing each step of the decision-making process, this study suggests ways in which providers can encourage clients to make better informed and more thoughtful choices.

Focusing on the Client's Needs

A woman's individual needs and preferences determine which contraceptive method is best for her. Personal issues such as discomfort, husband's attitudes and inconvenience may be as important for client satisfaction and method continuation as technical issues such as effectiveness and safety.¹⁷ However, given that most providers receive training that emphasizes technical issues, they may not ask about many other factors that affect a woman's contraceptive choice. If providers do not discuss the client's reproductive intentions and personal situation, many women may not recognize the importance of these issues or understand

*Transcripts indicate that while 46% had a clear preference on arrival, 31% did not know which method they wanted; it is not certain whether the remaining 23% had a preference.

that they should be a decisive factor when they choose a contraceptive method.

Providers and clients rarely treat return visits as an opportunity to review and revise their choice of methods. Yet the ability of continuing clients to change methods is a critical element in their commitment to and satisfaction with family planning.¹⁸ If providers do not probe the client's experience with their current method, they may fail to discover doubts, misgivings and minor sources of dissatisfaction that might eventually cause clients to discontinue a method; nor will providers learn about changes in a woman's reproductive intentions that call for a method switch. Thus, providers need to view every consultation, whether with new or continuing clients, as an educational opportunity and as a decision point.

While providers mentioned alternative methods in 60% of sessions with continuing clients, they explicitly raised the option of switching methods less than half as often. According to a study of quality of care in family planning services in Kenya, women perceive this as a problem: They consider counseling on side effects and alternative methods to be key elements of good quality care, and they are dissatisfied if providers refuse to assist them with selecting a new method when they complain about disagreeable side effects.¹⁹

Managing the Information Flow

Our results confirm earlier studies indicating that providers discuss, on average, 3–4 contraceptive methods with each new client, and they most often mention the pill and the injectable.²⁰ Other recent studies suggest that focusing the discussion on a few appropriate methods may be better than presenting information on all available contraceptives.²¹ Family planning providers have limited time in which to counsel each client, and clients may have difficulty identifying and retaining the key facts from an extensive, unfocused flow of information.²² Clients also may find so much information and choice to be too stressful.²³

However, our findings suggest that personalizing information and narrowing the discussion still further could markedly improve the quality of counseling offered to family planning clients in Kenya. Relating factual information to each client's reproductive goals, values, priorities and lifestyle shifts the provider's role from that of technical expert to that of advisor.

*An attempt to follow up the clients in this study failed because clinic records for more than half of the clients were missing.

Providers might also confine the details of the discussion to the two or three contraceptive methods that best suit an individual client's expressed needs and preferences. In Kenya, this may mean talking more about methods suitable for limiting births and less about the short-term methods that currently dominate the method mix.²⁴ Narrowing the discussion can give providers the time to discuss each method fully and can make it easier for clients to understand the options.

The very idea of limiting discussion to two or three methods may appear to violate basic principles of informed choice, which demand that clients be fully informed about all options. We found that most new clients already knew about some contraceptive methods before seeing a provider, however; indeed, many had already chosen a method. In addition, providers frequently took the opportunity to discuss long-term and permanent methods with continuing clients when they returned for resupply. This indicates that in Kenya, formal counseling sessions with new clients form just a small part of a continuing stream of family planning education and information directed to couples. Thus, it is possible that new clients could be educated about the range of methods that are available before counseling takes place—through mass-media communication campaigns, for example, or group talks and waiting-room materials such as videos and leaflets. This would free providers to focus on each client's immediate needs.

Facilitating a Decision

Most family planning clients have little experience in making health care decisions that require them to match technical information with personal considerations. Providers can help women evaluate and compare their options during the third step in the decision-making process. The provider's help is critical because a client's judgment may be influenced by misinformation and faulty reasoning or be skewed by emotion.²⁵ For example, clients tend to place more weight on a friend's anecdote than on statistical evidence. They also find it difficult not to worry about side effects such as menstrual changes, even though they are not dangerous, they may not occur and they may be easy to adapt to over time. Providers can correct misinformation, reassure clients when their fears are groundless and explain potential side effects.

In Kenya, however, the idea that clients alone must decide on a contraceptive method is deeply rooted in providers' minds—so much so that most providers

relinquish all involvement in the decision, except for medical screenings. Providers generally do not offer advice, do not question the clients' choices and do not validate clients' reasons for their decisions. This problem is not limited to Kenya, or indeed to developing countries. Interaction analysis of family planning consultations in the United States also found that clients lacked experience in making health care decisions, while nurses offered them little support or guidance.²⁶

Types of Providers

There were few significant differences in the sessions conducted by clinic- and community-based providers, and regardless of provider type, the decision-making process largely followed a similar course. However, differences in a provider's training and responsibilities affect certain counseling behaviors. Because of their limited medical training, community-based distributors must refer clients elsewhere for almost all contraceptive methods; they are allowed only to distribute condoms and foaming tablets and to resupply continuing clients with oral contraceptives. Perhaps as a result, community-based distributors tended to emphasize the pill more and explore medical contraindications less than did clinic providers.

In contrast, clinic providers are trained to screen clients for and offer the full range of contraceptive methods. This may explain why clinic providers spoke at greater length about clinical methods of contraception than did community-based distributors, and why they more often encouraged continuing clients to switch to a long-term or permanent contraceptive—all of which are clinical methods. It is more difficult to explain why clinic providers accepted new clients' choice of methods without question more often than did community-based distributors.

Conclusions

We have taken a first step in investigating how informed choice actually operates in family planning sessions. However, our findings are limited to a small sample of counseling sessions in a single country. Even more importantly, we focus on a single interaction between client and provider, to the exclusion of all outside influences on the client's decision, such as information and advice gathered from friends and relatives or previous visits with a provider. In addition, no data were available on the outcomes of these sessions,* making it impossible to link the quality of the decision-making process with client

satisfaction, appropriate method selection, effective contraceptive use or contraceptive continuation rates.

Moreover, the transcripts on which the analysis was based convey only spoken information, and thus cannot give a complete picture of how clients and providers approach the decision-making process. Clients may think through their decisions, including the personal factors affecting their choice, far more thoroughly than they give voice to. Likewise, it is possible that providers make a "silent assessment" of new clients to identify important factors in selecting a contraceptive method. Simply by looking at a new client, for example, a provider may roughly guess her age and, if she is holding an infant, learn about her recent reproductive history. In addition, when counseling continuing clients, providers may rely on clinic records or personal knowledge for this information.

Further research is needed to examine the nature of informed choice in other countries, to trace the course of the decision-making process over a period of months in the home as well as at family planning facilities, and to determine whether better-informed decisions do in fact lead to improved outcomes.

Our findings suggest that family planning providers can enhance the quality of a woman's contraceptive decision-making by playing a more active role in the process. By relating contraceptive information to a woman's personal circumstances, and by assisting women in considering their options, providers can use counseling sessions to help women make informed and thoughtful choices about a critical reproductive health issue.

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Resumen

Contexto: Los programas de planificación familiar han apoyado desde hace mucho tiempo el principio de la elección informada, para asegurarse que los clientes seleccionen el método que mejor se adapta a sus necesidades. Sin embargo, se ha estudiado muy poco cómo se toman dichas decisiones informadas, o si es que lo toman.

Métodos: Se grabaron las interacciones que tuvieron lugar entre las mujeres que acudieron a clínicas de servicios de planificación familiar y a proveedores comunitarios en 25 centros de Kenya, durante un período de 9–15 días. Se analizaron las transcripciones de 176 sesiones de asesoramiento prestado, para identificar los comportamientos clave y evaluar la información suministrada a las clientes para cerciorarse de que estaba completa.

Resultados: Los proveedores recabaron información sobre los antecedentes reproductivos y del estado marital de las nuevas clientes en el 60% de las sesiones, pero formularon preguntas acerca de sus intenciones de fecundidad en únicamente el 7%. En el 55% de las sesiones con las clientes establecidas se les preguntó si experimentaban algún problema con su método actual; en el 27% de estas sesiones los proveedores sugirieron el cambio de método, y en el 17% se les preguntaron acerca de sus intenciones reproductivas. Durante las entrevistas a las nuevas pacientes, los proveedores se refirieron a un promedio de cuatro métodos anticonceptivos, en tanto que con las pacientes establecidas, se refirieron a menos

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de dos métodos. Pocas veces se conformaba la conversación sobre métodos con las intenciones reproductivas de las clientas, con su conocimiento de planificación familiar, con sus preferencias anticonceptivas, con las circunstancias personales o con los riesgos de la salud. Además, si bien destacaron que la decisión final es el derecho de la mujer misma, muy pocas veces la ayudaron a evaluar detenidamente las alternativas o se cercioraron que la cliente comprendía plenamente las consecuencias personales de su selección.

Conclusiones: Los proveedores de la planificación familiar podrían mejorar la calidad del proceso de la toma de la decisión en cuanto a la anticoncepción si adoptan un papel más activo en el asesoramiento—por ejemplo, en suministrar información sobre métodos específicos según las circunstancias personales de la mujer, y en asistir a las clientas a ponderar las ventajas y desventajas de los diferentes métodos.

Résumé

Contexte: Les programmes de planning familial avalisent depuis longtemps le principe du choix informé comme moyen d'assurer que la méthode

sélectionnée est celle qui répond le mieux aux besoins de chaque cliente. Peu de recherches ont été effectuées, toutefois, quant à savoir comment, et si même les décisions individuelles sont prises en connaissance de cause.

Méthodes: Les dialogues intervenus entre les clientas et les prestataires de services de planning familial en 25 endroits de prestation cliniques ou communautaires du Kenya ont été enregistrés sur une période de 9 à 15 jours. Les transcriptions de 176 séances consultatives ont été analysées dans le but d'identifier les comportements consultatifs clés et d'évaluer le caractère complet ou non des informations fournies aux clientas.

Observations: Les prestataires de services se sont informés de la situation matrimoniale et des antécédents procréateurs de leurs nouvelles clientas dans 60% des cas, mais ils ne se sont enquis des intentions de procréation des femmes que dans 7% des cas. Dans 55% des séances avec leurs clientas existantes, les prestataires leur ont demandé si leur méthode actuelle leur posait des problèmes; ils ont soulevé la question d'un changement éventuel de méthode dans 27% des cas, et se sont informés des intentions de procréation de leurs clientas dans 17% des cas. Quatre méthodes

contraceptives ont été discutées, en moyenne, avec les nouvelles clientas, alors qu'avec les clientas existantes, la discussion restait généralement limitée à moins de deux méthodes. Les prestataires ont rarement adapté leur présentation des méthodes contraceptives aux intentions de procréation de leurs clientas, à leur connaissance antérieure du planning familial, à leurs préférences contraceptives, à leurs circonstances particulières ou aux risques pour leur santé. De plus, bien que soulignant le droit des femmes à prendre elles-mêmes la décision finale quant au choix de la méthode à pratiquer, ils les ont rarement aidées à évaluer pleinement les options proposées, pas plus qu'ils ne se sont assurés qu'elles comprenaient bien toutes les implications personnelles de leurs choix.

Conclusion: Les prestataires de services de planning familial pourraient améliorer la qualité des décisions prises par les femmes en matière de contraception en assumant un rôle consultatif plus engagé (en les informant, par exemple, des caractéristiques de certaines méthodes en fonction des circonstances personnelles de leurs clientas, ou en les aidant à évaluer les avantages et les inconvénients des différentes méthodes).