Discussion

In discussions held by project supervisors with providers after the end of the project, many providers justified their omissions in counseling by pointing to time constraints; none mentioned supply shortages of DMPA or of other methods as reasons for the limited amount of specific information exchanged. Although these results confirm providers’ claims that time constraints affect their performance, one important qualification emerged: Significant improvements in the amount of relevant information exchanged occurred only when sessions were lengthened to up to 14 minutes. When sessions lasted any longer, only trivial improvements occurred in the amount of useful information exchanged.

This finding cannot be attributed to individual clients tending to report specific session lengths. We analyzed the distribution of counseling session lengths to test this possibility. Of the 28 simulated clients, only two reported durations that fell within the same parameters for all of their visits (9–14 minutes in one case and 21–45 minutes in the other). The other 26 clients’ estimated session lengths were distributed throughout all four levels of duration.

Thus, our study shows that a certain amount of provider-client interaction is needed to ensure a minimal level of information exchange: Providers made little progress in sessions lasting 2–8 minutes, while lengthening this duration to 9–14 minutes significantly increased the amount of information covered. However, extending the duration any longer than 14 minutes did not significantly improve the amount of relevant information exchanged. With more time available, providers focused on details that were irrelevant to the needs of their clients.

Our findings strongly suggest that once the client chose her method, providers dedicated little effort to addressing the chosen method again. Providers mostly ignored contraindications and did not use the increased time available to give more detailed information on the chosen method’s side effects and warning signs. For example, providers’ counseling more often included instructions on how to use a method that the client had no interest in (the condom) than on essential facts about the client’s chosen method (such as that the next quarterly injection needed to be given within a two-week window of the scheduled date and that temporary infertility may follow DMPA discontinuation).

A number of simulated clients described the client-provider interaction as a four-step process in which the provider asked a few questions to assess the client’s needs; talked about diverse method options (frequently using a flipchart); instructed the client to choose a method; and, finally, readied a supply of the method and started to discharge the client.

We would like to underscore the problems in this counseling scenario, concentrating on the inherent bias in providers’ executing step 1, and their inefficiency in handling step 2:

*Inadequate assessment of clients’ needs.* The questions that providers asked in step 1 of the counseling process were all medical in nature. For example, they asked about the woman’s age (relevant to pill use), parity (an indicator of reproductive risk), previous contraceptive use (to reveal the client’s physical tolerance to specific methods) and date of last menstrual period (to rule out pregnancy).

Most providers, however, failed to ask the client basic questions about her reproductive intentions—such as whether she wanted to have more children. These women, who were instructed to report that they were relying on rhythm, were also rarely asked how they were using their method. Thus, providers’ tendency to diagnose a client’s contraceptive needs appears to have been influenced by habits from the past, when providers made decisions for the client, taking into account only medical criteria.

*Unnecessary presentation of all available contraceptive options.* Providers behaved as though they had to describe the attributes and instructions of use for nearly all methods offered by the program. Among this full range of methods are condoms, vaginal tablets and other spermicides, the pill, DMPA, the IUD, tubal ligation, vasectomy, the implant, rhythm and lactational amenorrhea. Indeed, sessions were organized around the use of a flipchart that presented all contraceptive options. Sterilization and rhythm were excluded from most discussions, however, because of firmly entrenched preconceptions. To most providers, the calendar rhythm method is ineffective and sterilization is contraindicated for young women with few children.

While such a rigid implementation of step 2 may be part of an international trend, it also may be a specific reaction to scandals that afflicted the Peruvian national family planning program in the late 1990s. In 1997, human rights groups, religious activists and feminists severely criticized providers in the Ministry of Health for coercing clients to accept long-acting methods, such as sterilization. A counseling paradigm based on discussing practically all methods and then letting the client choose one for herself can hardly be regarded as coercive, yet focusing on the process of method choice detracts from focusing on the method the client has chosen.

Policy discussions centered on the need to improve the quality of family planning care stress the importance of having sufficient time for adequate counseling. Yet investing more time in counseling clients does not appear to be a viable solution to improving the quality of care in Peru’s Ministry of Health facilities. In fact, about 50% of professional providers at the ministry’s health centers are now under short-term contracts with the Salud Básica para Todos (Basic Health for Everyone) project, an effort emphasizing quantitative targets that

![Figure 1. Mean number of items on which providers exchanged information with simulated clients, by length of session](image-url)