






'I haven't heard much about other methods': quality of care and person-centredness in a programme to promote the postpartum intrauterine device in Tanzania

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ABSTRACT

Background Programmes promoting the postpartum intrauterine device (PPIUD) have proliferated throughout South Asia and sub-Saharan Africa in recent years, with proponents touting this long-acting reversible contraceptive (LARC) method's high efficacy and potential to meet contraceptive unmet need. While critiques of LARC-first programming abound in the Global North, there have been few studies of the impact of LARC-centric programmes on patient-centred outcomes in the Global South.

Methods Here, we explore the impact of a PPIUD intervention at five Tanzanian hospitals and their surrounding satellite clinics on quality of contraceptive counselling and person-centred care using 20 qualitative in-depth interviews with pregnant women seeking antenatal care at one of those clinics. Using a modified version of the contraceptive counselling quality framework elaborated by Holt and colleagues, we blend deductive analysis with an inductive approach based on open coding and thematic analysis.

Results Interpersonal aspects of relationship building during counselling were strong, but a mix of PPIUD intervention-related factors and structural issues rendered most other aspects of counselling quality low. The intervention led providers to emphasise the advantages of the IUD through biased counselling, and to de-emphasise the suitability of other contraceptive methods. Respondents reported being counselled only about the IUD and no other methods, while other respondents reported that other methods were mentioned but disparaged by providers in relation to the IUD. A lack of trained providers meant that most counselling took place in large groups, resulting in providers' inability to conduct needs assessments or tailor information to women's individual situations.

Discussion As implemented, LARC-centric programmes like this PPIUD intervention may decrease access to person-centred contraceptive counselling and to accurate information about a broad range of contraceptive methods. A shift away from emphasising LARC methods to more comprehensive, person-centred contraceptive counselling is critical to promote contraceptive autonomy.

Key questions

What is already known?

- ▶ Person-centred contraceptive care is essential for reproductive rights, and includes an emphasis on informed choice from a broad range of methods.
- ▶ Family planning programmes often seek to innovate new methods of service delivery, sometimes with a narrow focus on that method.

What are the new findings?

- ▶ In a Tanzanian postpartum intrauterine device (PPIUD) intervention, a programmatic focus on promoting the PPIUD introduced elements of low quality of contraceptive care.
- ▶ Rather than neutral, evidence-based contraceptive counselling on a wide range of methods, women were told by providers that the PPIUD has no side-effects, is broadly superior to other contraceptive methods, or were counselled on no other methods at all.

What do the new findings imply?

- ▶ Instead of pursuing method uptake, family planning programmes should be designed to exclusively pursue person-centred outcomes and promote contraceptive autonomy.

INTRODUCTION

Long-acting reversible contraceptive (LARC) methods have taken the family planning world by storm in the past two decades, but not without controversy. Both in the Global North and in the Global South, family planning programmes have expressed tremendous optimism about the contraceptive subdermal implants and intrauterine devices (IUDs) that constitute the LARC category, and the ability of these methods to reduce unintended pregnancies.^{1–3} Proponents of

LARC methods tout their high efficacy at preventing pregnancy, their extended duration of protection, their lower levels of user error, and their suitability during the postpartum period.⁴ These perceived advantages over shorter-acting contraceptive methods have led to the rise of the ‘LARC-first’ approach to contraceptive service provision, in which implants and/or IUDs are presented as the first and best options for most users, with shorter-acting methods and fertility awareness-based methods presented last or not at all.¹⁵⁶

The LARC-first model to contraceptive service provision has been implemented both throughout the Global North and Global South. In the USA, for example, LARC-first programmes such as the Contraceptive CHOICE Project in St. Louis encouraged clients to adopt implants and IUDs while less effective methods were de-emphasised.²⁵ The *New York Times* wrote about how Upstream, a contraceptive access programme in Delaware, was promoting LARC methods as a means to reduce poverty, lauding their LARC-first approach for its ‘Set it and Forget It’ ease.⁷ As these programmes emerged in the USA, however, they faced a swift pushback from women of colour and reproductive justice advocates, both in activist circles and in the peer-reviewed literature.⁶⁸ Critics of LARC-first programmes in the USA have called attention to the legacies of scientific racism and to stratified reproduction along racial/ethnic and class lines that had long subjected marginalised groups to fertility control.⁹ In 2016, for example, a group of leading reproductive health scholars wrote in the *American Journal of Public Health* that

Through unquestioned assumptions about whose reproduction is valued and whose is not, they [providers emphasising LARC methods] may be contributing to social inequality. Promotion of LARC methods above all others is particularly disconcerting given the longstanding devaluation of reproduction among a range of socially marginalised groups, including poor people, young people, and people of colour. From their inception, LARC methods have been employed in abusive and unconstitutional ways; our nation’s history of eugenics can be traced through them.¹⁰

A growing body of evidence suggests that these scholars’ concerns about the ways that a LARC-first approach can further stratify reproduction by targeting marginalised groups and through the use of coercion are well founded. Studies in the past 5 years have shown that patients from marginalised groups do indeed perceive racial discrimination in their contraceptive counselling, and that some programmes do use coercive tactics to promote LARC uptake and prevent method discontinuation.^{11–14}

Rather than restricting contraceptive counselling to a few of the most efficacious methods, researchers and advocates of reproductive autonomy have instead demanded that LARC-first programming be replaced by a broader focus on high-quality person-centred reproductive care.⁶⁸ In 2017, a coalition of reproductive rights and justice groups led by the National Women’s

Health Network and the SisterSong Women of Color Reproductive Justice Collective put forth a LARC statement of principles which affirmed that ‘a one-size-fits-all focus on LARCs at the exclusion of full discussion of other methods ignores the needs of each individual ...’ and that it is essential for programmes and providers to provide and receive ‘information that doesn’t privilege LARC over other methods’. As a result of these efforts, several LARC-oriented programmes in the USA have made efforts to broaden their focus on patient-centred care.¹⁵ The Upstream USA programme, for example, now writes that all Upstream programming is designed ‘to provide patient-centered, evidence-based contraceptive counseling and care that respects a patient’s time, goals and decision-making abilities’.¹⁶

At the same time that LARC-first programmes were cropping up in the USA, a spate of similarly conceived LARC-based programmes also sprang up throughout the Global South, with a focus on South Asia and sub-Saharan Africa. In the Global South, these programmes have tended to focus on a single LARC method (such as the implant alone or the IUD alone) and/or a specific time period in the reproductive life course (such as the postpartum period). Like other global family planning programmes, the majority of the LARC-first programmes implemented in the Global South have been funded and/or implemented by donors and non-governmental organisations from the Global North.^{17–20} Yet despite the similarity of these LARC-first programmes in the Global South to those in the Global North, those in the South have faced very little scrutiny over reproductive rights concerns in the global family planning literature. Though local media outlets and civil society groups have expressed concern, these models have been hailed mostly uncritically by the global health community as an important piece of the sustainable development agenda.⁴²¹²² Indeed, the vast majority of literature on LARC-first family planning programmes in the Global South over the last decade has been overwhelmingly positive, focusing on the myriad ways that LARC use could hypothetically improve outcomes ranging from maternal health to the demographic dividend.^{23–2717–19} Scientific studies evaluating these programmes have tended to focus on barriers to implementation, user acceptance and uptake, provider perspectives, and other outcomes of programmatic interest.^{2528–32} The effect of these LARC-first family planning programmes in the Global South on a broad understanding of contraceptive autonomy and reproductive well-being, beyond programmatic goals and method uptake has not yet been examined.

There is, however, a rich body of scholarship examining patient-centred family planning programming in the Global South on which to draw. In the past, this line of inquiry has been most often framed as part of the discourse on ‘quality of care,’ dating back to Judith Bruce’s 1990 well-known framework for quality of care in family planning.³³ Using the Bruce framework as a guide, the global family planning community has seriously engaged

with questions of quality of care, seeking to improve dimensions of interpersonal quality, technical quality and access to a wide range of methods, often focusing on the counselling interaction between provider and patient.^{34 35} Although a major focus of these works has been on rights and well-being, much of the work around family planning quality of care, from Bruce's original framework to contemporary examples, draws explicit links between improved quality and increased contraceptive acceptance and/or continuation.^{33 36–38}

A growing number of researchers and advocates argue, however, that providing all contraceptive clients a high standard of care should be pursued regardless of its eventual impact on contraceptive uptake or continuation.^{39–41} Recent work by Holt and colleagues advances a conceptual framework for person-centred family planning that frames the provision of high-quality counselling as the end goal in and of itself, rather than as a tool to help achieve the goal of higher contraceptive prevalence.⁴² Defining person-centredness as 'a core dimension of quality' focused on the 'necessity of assessing individuals' specific needs, preferences and prior experiences with contraceptive methods,' Holt and colleagues identify three phases of the counselling process: (1) needs assessment; (2) decision-making support and (3) method choice and follow-up, emphasising relationship-building elements such as privacy, respect and trust as foundational to the counselling experience. The Holt framework emphasises the need for neutral, evidence-based and understandable information throughout the counselling process, with the goal of helping people meet their own contraceptive and reproductive goals.⁴²

Under the banner of quality, a growing number of recent studies document the ways that family planning programmes, intent on providing LARC methods, are failing to help clients make free, full and informed contraceptive decisions.^{11 43–45} A recent study by Yirgu *et al*⁴³ from Ethiopia found that 'some women felt manipulated toward using LARCs' and that some providers refused to help women discontinue LARC methods they no longer wished to use. A 2019 South African study from Towriss *et al* found that 'the delivery of injectable contraceptives to women in the hours following birth is a procedure that emerged during apartheid and became so common that healthcare workers referred to it as the 'fourth stage of labour', and that, even today, 'healthcare workers may not always present the procedure as optional'.⁴⁴ Other studies from throughout the Global South show that provider bias, directive counselling, limited method mix, as well as outright coercion have been found in a wide array of programmes.^{11 36 46}

Despite the longstanding focus on quality of care in global family planning and the emerging work on method choice, few studies have assessed the ways that LARC-oriented family planning programmes impact method choice, counselling quality and other patient-centred outcomes in the Global South. We begin to fill this gap by drawing on the Holt framework and in-depth

interviews with Tanzanian women accessing antenatal care in facilities participating in a postpartum family planning programme. Through its local Tanzanian affiliate, the International Federation of Gynecology and Obstetrics (FIGO) led a programme beginning in 2016 to train providers in six tertiary hospitals throughout Tanzania and their accompanying satellite clinics on postpartum family planning counselling for women receiving antepartum, peripartum and postpartum care. The intervention also built capacity for a new postpartum family planning service, immediate postpartum IUD (PPIUD) insertion. Though the programme was intended to increase access to postpartum family planning more broadly, FIGO named it the 'PPIUD Project' due to its emphasis on PPIUD as a newly added service.⁴⁷ PPIUD project implementers have cited 'poverty, gender inequality, lack of access to health services and poor quality services' as contributors to unmet need for contraception that motivate the programme.²⁴ We conducted an independent mixed-methods stepped-wedge cluster randomised evaluation of this intervention, nesting a qualitative component within our larger quantitative study to better understand women's subjective experiences of the PPIUD Project.⁴⁸ Using data from this nested qualitative study, we explore how women describe the contraceptive counselling they received as part of this PPIUD intervention, with a focus on the ways that counselling aligns or fails to align with a high quality, patient-centred approach to family planning counselling.

METHODS

Patient involvement

Patients and the public were not involved in the design, conduct, reporting or dissemination plans of our research.

Description of intervention

The research described here is part of a broader evaluation study of the six-country FIGO PPIUD initiative.²⁰ In the words of the programme's architects,

The aim of the FIGO PPIUD initiative was to address the gap in the continuum of maternal health care and to provide for the postpartum contraceptive needs of women by increasing the capacity of healthcare professionals to offer PPIUDs by training community midwives, health workers, doctors, and delivery unit staff, as appropriate, in counselling and insertion of PPIUD.²⁰

Contraception, including the IUD, is available free of charge in the Tanzanian public health system. Contraceptive counselling is routinely provided as a part of antenatal care, first as part of 'health education' delivered in group settings, followed by individual counselling. Although interval IUDs were already available as part of routine family planning service provision in Tanzania, the postpartum insertion of IUDs was not well-known or widely available at the onset of the intervention. The FIGO designers did not explicitly motivate this project

as a single-method or LARC-first programme, but rather, cited the desire to address contraceptive unmet need and improve postpartum family planning options by adding PPIUD services to the existing contraceptive method offerings, thus expanding contraception choices.²⁰

The initiative aimed to provide prenatal counselling on all aspects of contraception with a focus on postpartum family planning. Within the menu of methods of contraception, there was a special emphasis on the advantages of PPIUD as a safe, effective, and reversible long-acting method.²⁰

The Association of Gynaecologists and Obstetricians of Tanzania (AGOTA, the Tanzanian FIGO affiliate) organised a series of trainings in six referral hospitals and in the surrounding satellite clinics that provide antenatal care and refer patients into the larger hospitals for delivery. The FIGO/AGOTA programme focused on training providers on cadre-appropriate skills and knowledge to support the implementation of PPIUD services. For doctors in the referral hospitals, this included technical training on postpartum insertion and removal of the copper IUD, while for nurses and midwives in satellite clinics, this included training to integrate PPIUD counselling into routine family planning counselling during antenatal, perinatal and postpartum care. The FIGO/AGOTA initiative employed a 'training the trainer' approach for both counselling and insertion training, identifying master trainers who then provided cascade training to other providers in their facilities. Trainers held sessions for counselling on 'postpartum family planning inclusive of PPIUD' for the staff of both referral hospitals and satellite clinics, aimed primarily at nurses and midwives. During these training sessions, 'information on the advantages of PPIUD was presented and opportunities were given for prospective counsellors to openly state their views of the methods and address any prejudices'.²⁰ After training, FIGO and AGOTA monitored providers' work, including their rate of PPIUD insertion and any PPIUD-related complications to improve clinical quality of care. More information about the FIGO intervention can be found in de Caestecker *et al.*²⁰

Data and analysis

We launched a multi-site mixed-methods study (including a cluster-randomised trial) to evaluate this intervention in three countries: Nepal, Sri Lanka and Tanzania. The primary goals of this study were to examine the effect of the intervention on uptake, continuation and institutionalisation of PPIUD, and did not explicitly include any aims to assess person-centredness.⁴⁸ A detailed description of the cluster-randomised trial and evaluation is described by Canning *et al.*⁴⁸ The qualitative portion of this study included in-depth interviews with women after their antenatal counselling, follow-up interviews with women 20 months postpartum, as well as interviews with providers who were trained by the PPIUD Project. Previous qualitative analyses from this study have focused on women's reasons for PPIUD use/non-use,⁴⁹ as well as provider and

patient perspectives broadly on the programmatic implementation.²⁸ Here, we focus specifically on perceptions of quality of care, with an emphasis on the impact of the PPIUD intervention on person-centred contraceptive counselling at the time of antenatal care.

Data collection

Management and Development for Health hired two Tanzanian women research assistants as independent consultants to conduct 20 in-depth interviews with pregnant women who had experienced at least two antenatal visits at one of the satellite clinics affiliated with the PPIUD intervention, but who had not yet given birth. Interviews took place between February and June 2017. The research assistants had extensive training and experience with qualitative interviewing prior to joining our study. Each had a bachelor's degree in sociology and over 10 years experience conducting qualitative interviews for research studies. The study team conducted a training with these interviewers that included modules on the PPIUD intervention and postpartum family planning, research ethics, study protocols, non-directive and non-judgmental interviewing techniques, building rapport and active listening. These training modules included both didactic and interactive components. The interviewers had no prior relationship to study participants, and participants had no prior knowledge of any research team members. The research team translated the semi-structured interview guide from English into Swahili, piloted them in that language, then made necessary changes to language, clarity and content. The interview guide focused on prior knowledge and use of contraception, experiences and perceptions of family planning counselling during maternity care, and postpartum contraceptive decision-making.

The research assistants took a purposive sample of four women from five of the intervention sites (the sixth intervention site was not included in the evaluation due to a preexisting PPIUD intervention there). Since age and education are known to affect experiences of contraceptive counselling,⁵⁰ the assistants attempted to recruit a diverse sample across these sociodemographic axes. Assistants approached women in clinic waiting rooms to invite them to participate in the study. If women agreed to be screened, they were assessed for the following four eligibility criteria: (1) currently residing in Tanzania; (2) between the ages of 18 and 49; (3) willing and able to provide informed consent and (4) received at least two antenatal visits at one of the satellite clinics affiliated with the PPIUD intervention, but had not yet given birth. If they were eligible and provided informed consent, one of the research assistants conducted an interview with them in a private area within the clinic. All respondents provided written informed consent to be interviewed and audio recorded. Women who could not sign their names but wanted to participate provided thumbprints to consent, in addition to the signature of a witness. We did not retain any names or identifiable information, and we

Table 1 Respondent characteristics

Number of women=20	
Age (in years)	
18–23	4
24–29	10
30–42	5
Education	
Primary	4
Secondary	13
More than secondary	2
Marital status	
Married or cohabitating	15
Unmarried	3
Total number of live births	
0	6
1	8
2	2
3 or more	3
Consented to use PPIUD during ANC	
Yes	12
No	8

ANC, Antenatal Care; PPIUD, postpartum intrauterine device.

assigned all participants a pseudonym for the purposes of analysis. Audio recordings were transcribed verbatim in Swahili, then translated into English. We show the background characteristics of the women interviewed in [table 1](#).

Analytic framework and data analysis

The team analysing these data consisted of a multidisciplinary group of both Tanzanian and North American researchers. After an initial reading of the transcripts, we created a preliminary codebook, blending open coding (capturing codes emerging from the data) with a more concept-driven, deductive approach in which we coded for concepts defined by the Holt framework, including elements of relationship-building, needs assessment and decision-making support.⁵¹ After we generated the initial codebook, each interview was independently coded in Atlas.ti by at least two analysts. Our team discussed and incorporated codebook modifications throughout this process, before a final round of coding and analysis. We then applied thematic analysis to generate key themes and identify recurrent patterns related to quality of counselling and other emerging outcomes of interest.^{52 53}

Prior to the final round of coding, we used our data to inform the creation of a modified version of the Holt framework ([figure 1](#)). Since our respondents were pregnant at the time of interview, their conversations with interviewers focused on their experience with the contraceptive counselling that was integrated into their antenatal care. They had not yet reached the stage in the contraceptive service provision process in which the final choice

Relationship building	Counseling was private and confidential
	Counselor treated client with respect and empathy
	Counselor did not discriminate against the client
	Respondent felt she could trust the counselor
Needs assessment	Counselor elicited client needs and preferences related to contraceptive methods
	Counselor elicited client's prior experiences related to contraceptive methods
	Counselor elicited client's preferences for provider involvement in method choice
Decision-making support	Counselor provided information that was neutral, understandable and evidence-based
	Counselor presented the full range of appropriate methods to the client
	Counselor provided accurate information on method effectiveness and side effects
	Counselor provided individualized counseling based on the needs assessment
	Counselor addressed client concerns about specific methods

Figure 1 Modified Holt framework.

was made and method administered, which took place after delivery. As a result, these transcripts do not include data relevant to final method choice and follow-up, and so that pillar of the Holt framework, though important, is not included in our analysis. We show the modified version of the Holt framework, retaining all elements relevant to antenatal family planning counselling in [figure 1](#). We present key themes that emerged related to quality of care, and person-centredness in family planning, and we map them onto the modified Holt framework, retaining key quotes for illustrative purposes.

RESULTS

Respondents reported a general sense of satisfaction with the contraceptive counselling they received, with positive reactions to the integration of maternity care and family planning programming, and an appreciation for the information they received during counselling. Overall, respondents told us of counselling that adhered to the modified Holt framework in some important ways related to the foundational elements of relationship building. However, respondents also reported counselling experiences that diverged dramatically from the person-centred standards set by the Holt framework, particularly in relation to issues of privacy, need assessment and decision-making support with a particular gap surrounding neutral, evidence-based counselling.

Relationship building

Relationship building was the aspect of the counselling encounter about which respondents reported the most positive feedback. Respondents expressed satisfaction with the quality of care they received overall, often with a focus on the interpersonal aspects of counselling as the reason for their satisfaction. Respondents reported feeling that providers were doing their best under difficult working conditions to provide a good standard of care. In particular, respondents reported positive assessments of the interpersonal aspects of their contraceptive counselling, especially with regard to the dimensions of respect, empathy and trust. Andrea, an 18-year-old woman, explained how she felt that the professionalism of the providers was responsible for their high standard of care.

Interviewer: When you look at the service provider or counsellor, does she seem to be willing to answer the questions that people ask her [in the group counselling sessions]? Or does she get annoyed when they ask questions?

Andrea: She is ready ... she doesn't get annoyed ... She can't get annoyed because that is her career ... She answers well, because it is her profession. You may be surprised that you can ask someone a question, and all of a sudden she gets annoyed but this one [this provider], when you ask her questions, she answers them well.

Interviewer: And when people give their views or complain, does she listen to them?

Andrea: She listens to them politely ... she listens to us well.

This view of patience, politeness and respect was echoed by Irene, a 22-year-old woman, who told us how much she appreciated the way her provider counselled her. Irene told us that her provider '... was listening to me and she explained things well. Truly, she valued me a lot'. Similarly, Sarah, a 26-year-old woman, summed up her level of satisfaction succinctly, telling us, 'Honestly, the service was good'.

Despite this overall satisfaction with the interpersonal quality of care, respondents also identified some elements of relationship building that diverged quite significantly from the standards set in the Holt framework. The most notable divergences from the Holt framework come when considering the elements of privacy and confidentiality, as very few respondents reported individual contraceptive counselling sessions during which their personal medical information could be protected. Instead, the vast majority of respondents reported receiving their entire contraceptive counselling experience in the large group 'educational' setting. In these large group settings, any information shared would be available not only to the provider but to the other patients attending that day as well. In theory, each woman should receive an individualised counselling session after the group educational sessions, providing a more private, confidential counselling experience. In practice, however, many respondents indicated that the opportunity for counselling in private

was never offered. Andrea, the 18-year-old woman who expressed appreciation for the professionalism of her counsellor, also shared the following exchange when we asked how she thought counselling could be improved:

Andrea: They should increase materials [like pamphlets], they should show us the materials, and the service providers or counsellors should also be increased so that they can teach well, because you will be surprised to see that the nurse is just alone or they are two. So, she is unable to answer all the questions alone and the time goes on and when it reaches a certain time is when the clinic starts [when counselling stops and antenatal care service provision begins].

Interviewer: ... What do you suggest?

Andrea: There should be a specific person to give counselling because one nurse alone gets tired because she gives counselling as well as goes to the clinic.

Interviewer: She gets tired. Do they provide counseling individually or in a group?

Andrea: No, it is given to all of us as a group.

Interviewer: How many are you in a group?

Andrea: Mmmh, many people, for instance, today we were plenty.

Interviewer: ... Did she tell you that if you want more counseling you should go to see her individually?

Andrea: No

At another point in the interview, the interviewer asks Andrea, 'In all of the times that you've come here, is there any time that you have been given counseling alone?' to which Andrea replies that she has never received individual contraceptive counselling at any of her five visits to that facility. Thus, while Andrea reports a sense of overall satisfaction with her counselling primarily informed by her pleasant perceptions of the provider's demeanour, she nevertheless reports a lack of privacy and confidentiality over the course of all of the contraceptive counselling she has received in association with the PPIUD intervention.

Needs assessment

In addition to the effect of the group education counselling structure on the relationship building elements of privacy and confidentiality, this approach also has profound effects on the ability of providers to integrate Holt's needs assessment pillars into their service provision. By definition, the needs assessment portion of the contraceptive counselling encounter must be individualised and tailored to each person's unique history, preferences and needs. In this context in which the vast majority of contraceptive information was offered in group settings, clients reported very little in the way of the elicitation of client preferences (both related to provider involvement in method choice selection and that selection itself) or exploration of clients' prior experiences with contraceptive methods, as outlined in the Holt framework. Among the few clients who did report

some individual counselling, there is little indication that their preferences were elicited in that format either.

Respondents cited constraints on provider time and availability as the main reasons they did not receive any individual counselling. Like Andrea, 30-year-old Charlotte told us that it was her fifth visit for antenatal care at that clinic, but that she had never received individualised counselling or a needs assessment at any of those encounters. Charlotte did not spontaneously cite this as a problem to the interviewer, but when we prompted her on whether she would prefer to receive individual contraceptive counselling or continue with group counselling, Charlotte responded that individual counselling 'is much better'. Our interview guide did not include any explicit prompts on needs assessment or exploration of client preferences. Several respondents told us that they were able to ask questions during their contraceptive counselling (either during group education, or individualised counselling for those few who received it), and asked questions about how certain methods worked, or what side effects there might be. However, no respondents volunteered that their provider sought to understand their contraceptive histories, explore their preferences for provider involvement in decision-making, or otherwise engage in a needs assessment.

Decision-making support

Decision-making support is another area in which respondent stories reveal a wide deviation from the standards of high quality, person-centred counselling outlined in the Holt framework. Overall, respondents' counselling experiences show that the emphasis on the PPIUD (the method promoted by the intervention) often came at the expense of a broader focus on a wide contraceptive method mix, the neutrality of the counselling content, and the accuracy of the information provided. The PPIUD-centric focus of the education and counselling seems to have manifested in one (or more) of three primary ways: (1) counselling on PPIUD to the exclusion of other methods; (2) broad claims of PPIUD superiority to other methods; and (3) downplaying or neglecting to mention the side effects or other risks of PPIUD.

Counselling on PPIUD to the exclusion of other methods

Several respondents reported that their contraceptive counselling focused on the PPIUD alone, and included no mention of any other contraceptive methods. We asked Laura, a 27-year-old woman, to tell us about her counselling experience, and she replied:

Laura: The nurse called me and counseled me on PPIUD ...

Interviewer: Did she mention to you any other methods apart from IUD?

Laura: No, she didn't.

Other women shared similar experiences. We asked Julie, a 37-year-old woman, about her counselling experience, resulting in the following exchange:

Julie: We were advised that if we use the IUD, it is a nice method which does not have hormones, so it doesn't have any problems.

Interviewer: Do other methods have problems?

Julie: Yes

Interviewer: During today's counseling session, did they talk about the Copper T [IUD] alone or did they also counsel you on other things?

Julie: They only talked about the Copper T [IUD].

In the following exchange, Angel, a 25-year-old woman, described her experience with antenatal counselling:

Angel: They provided us general counseling, [such as] what food you should take, what you should do, that's what she told us.

Interviewer: Did they tell you about postpartum contraceptive methods you could use apart from these IUDs?

Angel: Apart from the IUD?

Interviewer: Yeah.

Angel: They talked more about the IUD ... I haven't heard much about other methods.

One of the most significant stories about the effect of the PPIUD intervention on the range of methods counselled on by providers came from Caroline, a 33-year-old woman pregnant with her third child. Having gone through the antenatal care experience with each of her two previous pregnancies, Caroline contrasts those with her current experience:

Caroline: My doctor used to tell me I can decide to use any of the methods, [but today] he did not tell me anything concerning those other methods. He advised me that I can insert the IUD.

Interviewer: Why?

Caroline: He gave me its advantages.

Interviewer: That is?

Caroline: He told me the IUD is good ...

In this case, Caroline contrasts previous contraceptive counselling experiences (in which her provider offered an array of contraceptive methods) with her experience during the PPIUD Project, when the options presented to her were limited to the IUD. Caroline's response along with several others indicate that many providers did not offer clients information on a range of suitable methods. Instead, these providers seemed to portray PPIUD as either the only method available or promote it as the most suitable for all of these women, despite their diverse life stages, preferences and needs.

Broad claims of PPIUD superiority to other methods

While some women reported being only told about the IUD to the exclusion of others, many others reported that other contraceptive methods in fact were mentioned during their counselling sessions, but that they were

framed negatively in relation to the IUD. For example, Theresa, a 34-year-old woman, told us that,

We were talking about contraceptive methods, so we were asked to mention contraceptive methods, like pills, injections, implants, IUD, sterilisation, and the calendar. So today, they really emphasised the IUD. With regards to the IUD, I tried to ask two or three questions. They said it was the best method.

Charlene, a 25-year-old woman, told us how her provider emphasised the long-acting benefits of the IUD over shorter-acting methods like oral contraceptive pills. In explaining how the counselling changed her mind about contraceptive use and convinced her to use the IUD, Charlene told us:

I have decided I'm going to the IUD instead of the calendar method. Just like I said [the provider told me that] the IUD has no side effects. You can even remove it when you are at home through instructions. But not only that, with the IUD you become more confident. Not like other methods. For example, pills which need someone to have a good memory, that you have to take every day. So the IUD is better.

And Andrea shared:

They [the providers] said it is a nice method after delivery before 48 hours, they said it is good, it has fewer side effects, not like other methods.

Likewise, Nancy told us that:

It [the PPIUD] has no side effects, you won't have headaches, or disturbances in your abdomen but they [the providers] say if you use the injectable you will be having frequent headaches and sometimes you may lose weight ...

In this way, the providers encouraged IUD use by downplaying the suitability of other contraceptive methods. While Charlene and Andrea report being told that the IUD is better than other methods generally, Nancy's provider seems to have specifically disparaged the injectable and Theresa tells us that her counsellor explicitly told her in a group context that the IUD was the best method.

Downplaying side effects and other risks of PPIUD

Women also reported being told by providers that the copper IUD has no side effects at all, or suggested that providers downplayed the disadvantages of the method. Clara, a 22-year-old woman, shared the following exchange:

Interviewer: What have you been told about the new IUD method? How is it inserted and how does it work?

Clara: They told us it works in ten to twelve years' time and it can be inserted just after delivery within 24 hours or 48 hours and you may also remove it at any time that you find convenient. And this method has no side effects unlike other family planning methods. Unlike implants, which may cause long term bleeding or lack of menstrual bleeding at all. But this new method you will still have your menstrual cycle as usual and have no side effects...

Interviewer: Now after you deliver, which method do you want to use?

Clara: I would rather use the IUD.

Interviewer: Why the IUD?

Clara: Because they say it has no side effects!

In this case, Clara recalls a significant amount of information from her counselling session, including the immediate postpartum time frame of PPIUD insertion. A significant part of what she recollects is factually incorrect claims about the side effects profile of the copper IUD on menstrual bleeding. De-emphasizing the side effects of IUD was a recurring theme among respondents, as illustrated in the quotes below:

Laura: The nurse told me that I will be having my normal menstrual periods, she has not told me that there might be side effects!

Nancy: I asked a question, if I use it won't there be any effects? She [the nurse] answered 'there will be no effects'

Irene: I was taught that using this IUD I will get my period just normally and there are not any side effects like headache, or any stomach pains [cramps]. It doesn't have any problems.

This type of misleading counselling can be especially noteworthy when the claims made to patients may go against their explicit health needs. Laura decided to use the IUD after receiving counselling from a nurse, and shared the following:

Laura: The nurse told me that I will be having my normal menstrual periods—she has not told me there might be side effects ...

Interviewer: The counseling you received from the nurse, can you tell me how it has influenced your decision today of using the new IUD method?

Laura: She [the nurse] has opened my mind. If it were in my power, I could stop bleeding totally and I could thank God so much for that. I really hate bleeding because I experience severe abdominal cramps during menstrual bleeding, so this will help me as I will have to experience period bleeding only once in a month ... You can't imagine—I was daily suffering from painful period cramps [with the injectable].

Interviewer: So, the nurse's counseling today changed you?

Laura: Yes, absolutely

Laura implies that she was told the copper IUD would cause normal periods and regularise her cycle (and its attendant cramps, which she says were particularly painful when she used the injectable) to once per month. However, the side effects profile of the IUD includes the possibility of additional cramping, menstrual bleeding and breakthrough bleeding.⁵⁴ If Laura had received counselling that explored her contraceptive history and individual health needs, she might have been steered to a method known to lessen menstrual bleeding and cramps. Yet, with the counselling she received as part of the

	Modified Holt Criteria	Findings
Relationship building	✘ Counseling was private and confidential	Counseling was public and in large groups. Follow-up individual sessions were inconsistently offered
	✓ Counselor treated client with respect and empathy	Participants praised providers' demeanor and professionalism
	✓ Counselor did not discriminate against the client	Participants did not mention any form of perceived discrimination
	✓ Respondent felt she could trust the counselor	Participants reported high levels of trust
Needs assessment	✘ Counselor elicited client needs and preferences related to contraceptive methods	Very few reports of any type of needs assessment. The group counseling setting was not conducive to individualized counseling
	✘ Counselor elicited client's prior experiences related to contraceptive methods	
	✘ Counselor elicited client's preferences for provider involvement in method choice	
Decision-making support	✘ Counselor provided information that was neutral, understandable and evidence-based	Counseling content was often biased toward promoting the PPIUD
	✘ Counselor presented the full range of appropriate methods to the client	Other methods were omitted or disparaged in favor of the PPIUD
	✘ Counselor provided accurate information on method effectiveness and side-effects	Information provided on side-effects profile of the PPIUD was often inaccurate or downplayed
	✘ Counselor provided individualized counseling based on the needs assessment	Group counseling, time constraints, and lack of needs assessment made individualized counseling rare
	✓ Counselor addressed client concerns about specific methods	Ability to ask questions differed by respondent but several reported satisfactory responses to their concerns

Figure 2 Summary of findings. PPIUD, postpartum intrauterine device.

PPIUD Project, Laura ended up consenting to a method that seems ill-suited to her needs. Laura's story shows how this type of PPIUD-centric counselling can fail to adhere to several pillars in the modified Holt framework at once.

Even as the information provided to clients was limited and biased, however, respondents reported being put at ease by the friendly approach that providers took to counselling. Charlene told us:

Charlene: [The providers] talk friendly and so charming ... She even showed us the IUD ... They give you explanations about how it works, how they insert it, almost everything, which makes it easier to understand.

Interviewer: Did it scare you?

Charlene: No, I can't be scared when they use nice language.

Figure 2 summarises how the results from this analysis collectively map onto the modified Holt framework.

DISCUSSION

Using 20 in-depth interviews with pregnant women receiving antenatal care in facilities exposed to the PPIUD Project, we explore these women's experience of quality of care in their family planning counselling, with a focus on the effects of the PPIUD intervention on person-centredness. Although several elements of the interpersonal relationship-building dimensions of quality were strong, very few other criteria for high quality person-centred care were met among the women we interviewed. Overall, elements of quality related to privacy, needs assessment, individualised care and

non-biased information were poor. Most notably, contraceptive counselling seemed to exhibit a stark bias toward the PPIUD, at the expense of a broad contraceptive method mix, accurate information and person-centred service provision.

Certainly not all of these lapses in counselling quality can be attributed to the PPIUD intervention. Indeed, many of the threats to high-quality care reported by our respondents are longstanding structural issues, rather than a product of any given short-term programme. The dearth of qualified health providers in Tanzania has been well documented and is associated with a broad range of health challenges, from late onset of antenatal visits to the difficulty of building a trauma registry.^{55 56} In our study, we find that the shortage of family planning counsellors and providers means that the bulk of family planning counselling happens in large groups so that many women can be seen at the same time by a single provider. While women praised the providers for their interpersonal demeanour, the group setting meant that a private, confidential contraceptive needs assessment was not available to the majority of our respondents. As a result, the tailored contraceptive counselling that results from an in-depth needs assessment was unavailable, and providers instead tended to give blanket advice during counselling to all attendees

This approach to contraceptive counselling was in place before the intervention was implemented, and so these particular horizontal health systems challenges to high-quality contraceptive counselling cannot be attributed to the vertical PPIUD Project. These challenges, however,

do demonstrate the limits of vertical programming to provide high-quality services within a broader environment of scarcity. The longstanding structural nature of these challenges calls for a 'diagonal' approach to health interventions in which 'explicit intervention priorities are used to drive the necessary improvements into the health system'.⁵⁷ Only through addressing structural issues with structural solutions will sustainable, high-quality family planning programming be achievable.

Although our interview guide did not have a dedicated prompt, our interviews provided little evidence that providers were conducting in-depth needs assessments or explorations of client histories, even in instances when contraceptive counselling was provided one-on-one. This suggests that changing the counselling format alone is not enough to ensure patient-centred counselling, but that a holistic shift in the way providers are trained and family planning programmes are conceptualised may be necessary.⁵⁸

In addition to these longstanding structural barriers, however, our findings do suggest that several elements of low-quality care were introduced by the PPIUD intervention itself. Though the intervention aimed to improve postpartum family planning provision broadly, its focus on PPIUD as a newly offered service seems to have led providers to promote this method at the expense of neutral, evidence-based and accurate information to clients about the full range of contraceptive options. In many cases, providers exaggerated the benefits of the IUD, downplayed its disadvantages and disparaged other contraceptive methods in their attempts to promote PPIUD uptake.

This approach to PPIUD promotion generated programmatic gains for the intervention. Our team's difference-in-difference analysis of the programme found that the FIGO/AGOTA intervention increased PPIUD counselling by 19.8 percentage points and choice of PPIUD by 6.3 percentage points.⁵⁹ By promoting the PPIUD at the expense of other methods, however, this intervention may be generating short-term gains in PPIUD uptake but fostering longer-term distrust in family planning more broadly. Other studies on family planning counselling and provider trust have shown that lack of balanced counselling, withholding information about side effects, and the derision towards alternative methods may result in a future erosion of confidence in those providers, the method at hand, alternative methods, or all three.^{12 34 60 61}

In addition to the long-term drawbacks of this approach of promoting PPIUD, there are also important and immediate consequences for contraceptive autonomy and reproductive well-being. Due to this narrow focus on the PPIUD, the women who sought reproductive health services under the PPIUD intervention were exposed to biased counselling and deprived of a choice from a broad contraceptive method mix that is a bedrock principle of reproductive rights. Contraceptive autonomy includes the both right to refuse contraception altogether, as well

as the right to decide on the method of one's choice with full information, access and freedom.⁴¹ Women exposed to this intervention were given misleading information both about the reasons to use an IUD as well as the reasons not to use alternative methods, providing subtle examples of both 'upward' coercion (to use a method without informed choice) and 'downward' coercion (to not use a method due to lack of informed choice).¹¹

Limitations of this analysis include an interview guide that was not explicitly designed to assess patient-centredness or counselling quality. The timing of the interviews during antenatal care enabled us to talk to women immediately after their counselling experience, but prevented us from understanding dimensions of final method choice and follow-up care. Strengths include expert research assistants, a multidisciplinary and multi-national team of analysts, and an independent research approach that separated the programme evaluation team from the programme implementation team.

CONCLUSION

The FIGO PPIUD Project is not unique in its conception—many family planning programmes seek to add new offerings to the method mix, which is an important contribution to reproductive health and rights globally. However, great care should be taken in implementing new family planning programmes to ensure that the training and post-training monitoring and evaluation do not incentivise providers to focus on a new method to the exclusion of others. This study provides clear qualitative evidence that the potential for bias in LARC-first programmes implemented in the Global South as part of the global health agenda can indeed manifest as low quality of care and diminished access for those seeking reproductive health services. Although the FIGO PPIUD Project was intended to broadly increase access to postpartum contraception by adding a new method to the overall method mix, in practice, its focus on PPIUD led to biased counselling at the expense of quality of care and access to person-centred family planning.

LARC-first programmes in the Global South have heretofore not been met with the same scientific scrutiny about their effects on reproductive rights that LARC-first programmes in the Global North have faced. By framing their intervention around meeting an unmet need for postpartum family planning and expanding access to family planning, LARC-centric programmes in the Global South have found mainstream acceptance despite the potential for bias they introduce. Our results here show, however, that these same concerns that reproductive justice advocates have voiced in the Global North are salient to programmes in the Global South. This analysis demonstrates how even a strong commitment to contraceptive access can fall short if those guiding principles are not explicitly integrated at every step of the programme, from initial planning to implementation to evaluation. By shifting the ultimate goal of family planning programmes

from method uptake to a broader conception of contraceptive autonomy that centres free, full and informed choice, we can refocus our programmes on reproductive rights and justice.⁴¹

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