SHOPS PLUS

Understanding Family Planning Counseling in the Private Sector through a Behavioral Economics Lens

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Summary

SHOPS Plus conducted a qualitative study to identify barriers and facilitating factors that influence the provision of family planning counseling by private sector providers in two different country contexts. This brief presents the results of the study using a behavioral economics lens to explore how cognitive and behavioral biases influence the provision of family planning in private sector settings. It provides recommendations to address some of these biases to facilitate appropriate and effective family planning counseling that is tailored to client needs and supports informed choice.

Keywords: behavioral economics, condoms, contraceptives, family planning, family planning counseling, India, Malawi, provider quality, quality improvement

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Cover photo: Jessica Scranton

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SafePlan
General
Eligibility Screening
1. Breast feeding a baby less than six months old?
2. Blood pressure more than 150/100?
3. Skin or eyes appear yellowish?
4. Lump in breast present?
5. Signs of inflammation?
6. Swollen or throbbing varices?
7. Heavy or frequent menses?
8. Difficulty breathing?
9. Frequent Headaches?
10. Signs of pregnancy?
11. Taking the drugs Rifampicine or Grisiofulvin?
12. Unusual vaginal discharge occurring?
13. Tumor present?
Important Notes:
Celebrating
The Malaria Week: 20th - 27th April 2015
Joining hands for
Fight Against Malaria
Hereby do solemnly pledge
To dedicate all my knowledge and strength for the eradication of malaria.
I swear to be loyal to this oath as long as I practice.
LONART
P-Alaxin
In uncomplicated P. falciparum Malaria
LONART
LONART FORTE
LONART DS
P-Alaxin
GENITAL ULCERS DISEASE
ABNORMAL VAGINAL DISCHARGE
URETHRAL DISCHARGE
LOWER ABDOMINAL PAIN IN WOMEN
FAMILY PLANNING CHECKLISTS AND PROTOCOLS
SafePlan
MICROLUTE

Introduction

Over the past decades, family planning advocates have focused on improving the quality of family planning counseling to ensure that clients receive clear and comprehensive information to support an informed choice.[1] Yet, despite a multitude of interventions, the percentage of women who report making an informed choice is highly variable and far short of 100 percent. One United Nations study of 24 countries found that the percentage of individuals provided with information about side effects and alternative methods ranged from 25 percent in Ethiopia to 80 percent in Zambia (Loaiza, Liang, and Snow 2016).

The importance of informed choice is not only one of ethics but of family planning outcomes. A number of studies have demonstrated that a client's satisfaction with family planning services—in terms of informed choice, client engagement, response to client questions—increases the uptake and continuation of contraception (Forrest and Frost 1996; Rosenberg, Waugh, and Burnhill 1998; Abdel-Tawab and Roter 2002; Koenig, Hossain, and Whittaker 1997; RamaRao et al. 2003; Sanogo et al. 2003; Canto de Cetina, Canto, and Luna 2001). The two key components of informed choice, information about side effects and alternative methods, are central to high quality counseling. Clients often do not receive sufficient information from their provider to select the method most appropriate for their needs and desires. This may be due to a lack of knowledge or bias on the part of the provider that may lead him or her to withhold or limit the information shared with clients.

Provider biases arise from socio-cultural norms, observations, and perceptions of a client's personal characteristics (e.g., age, parity, education, economic status). As a result of biases, providers may restrict which methods they offer (Schwandt, Speizer, and Corroon 2017). For example, a provider may not offer IUDs to young women believing it is inappropriate for them to have a long-acting method. In another example, a provider may only offer short-term methods to a newlywed couple with the assumption that they will want to get pregnant quickly. In these examples, eligibility is not based on medical criteria rather perceptions and beliefs of what is most appropriate for those groups of people. Importantly, these biases are often held subconsciously and providers may not even be aware that these biases influence their decision making.

[1] **Informed choice**: a decision based on complete, accurate, unbiased information about all family planning options, including benefits, side effects and risks, and information about the correct use of the method chosen, as well as the risks of nonuse (The RESPOND Project 2014).

Photo: Amos Gumulira

These provider-imposed eligibility restrictions have a negative impact on the quality of family planning counseling and ultimately service provision outcomes (Tumlinson, Okibo, and Speizer 2015; Stanback and Twum-Baah 2011; Hebert et al. 2013). Poor quality or insufficient counseling can result in no offer of a method or a client not receiving information on correct use of the method and common side effects. Non-use, misuse, or discontinuation of a method can result in unintended or mistimed pregnancies and even unsafe abortion (Castle and Askew 2015).

In addition to provider bias, protocols or procedures that require extra effort to complete may interfere with a provider's decision to follow them. An example of this would be a provider who decides not to prescribe a long-acting contraceptive method in an effort to avoid completing required paperwork (Ashton et al. 2015).

Because the private sector plays an important role in may countries' efforts to increase access to modern family planning methods, there is a specific need for improved interventions that better address factors that inhibit effective interactions between private providers and their patients. Although the studies referenced above have helped to define and examine private provider biases that have the most impact on client outcomes, there is still little that is known about the ways in which those biases manifest within a provider's decision-making process to extend family planning counseling or to offer (or restrict) specific methods to clients (Ashton et al. 2015). Behavioral economics offers an approach to understanding the ways in which biases influence decision making.

There is a specific need for improved interventions that ensure effective interactions between private providers and their patients.

Photo: Jessica Scranton

Behavioral economics

Behavioral economics draws from psychological insights in order to examine, codify, and systematize cognitive and behavioral biases that affect decision making. Behavioral economics recognizes that our behavior is shaped by our biases, limits on cognition (complexity of tasks and decision making), and motivations, which may in turn result in suboptimal health choices (Ashraf 2013). Health care providers—like their clients—are subject to biases, limits on cognition, and motivational factors that shape the context in which they make decisions.

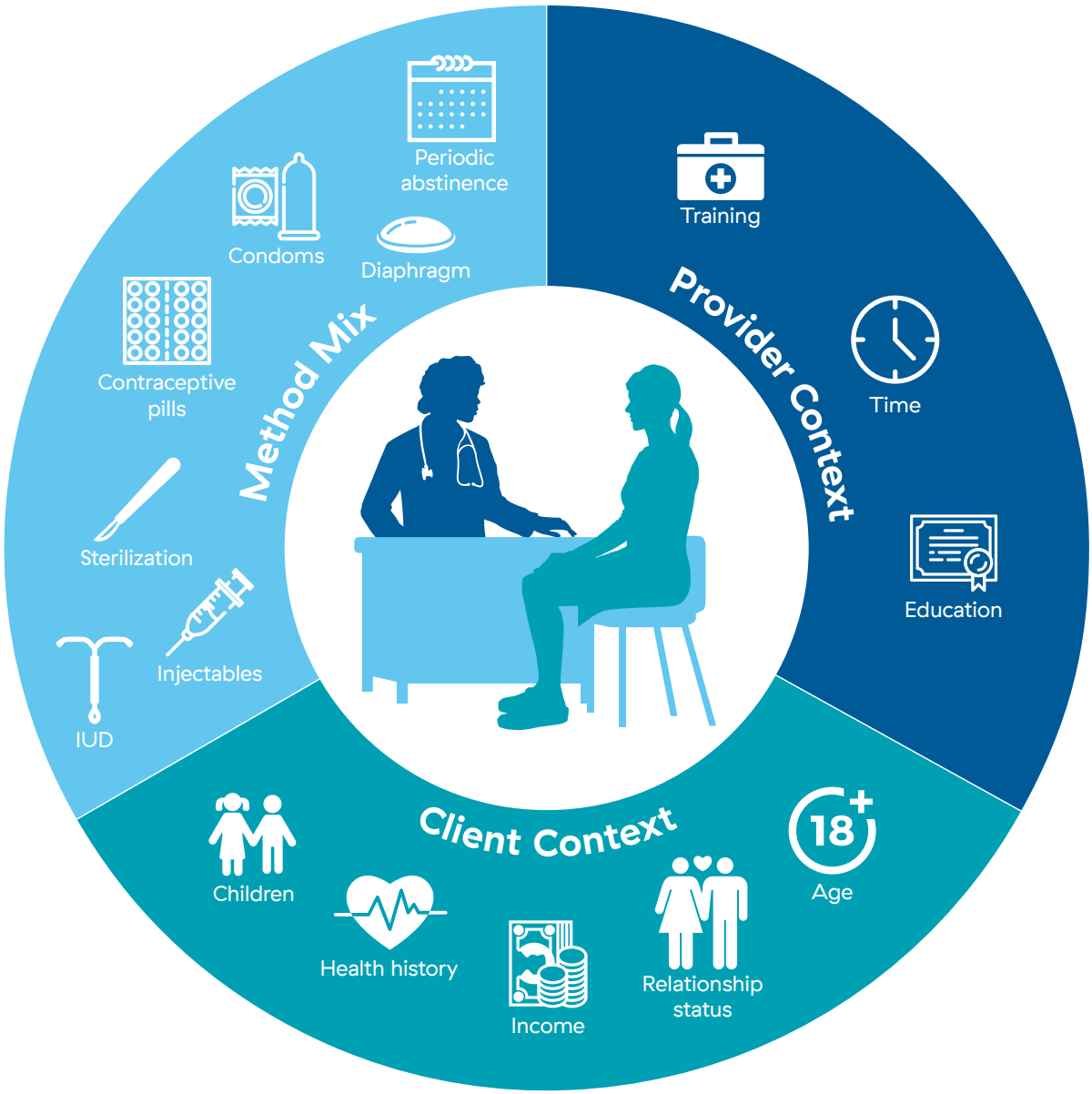
A key construct is *choice architecture*, the layout, sequencing, and range of choices that are available to an individual within a decision-making context (Thaler and Sunstein 2009; World Bank 2015). Simplification is essential to good choice architecture, especially as alternative choices become more numerous and complex (Thaler and Sunstein 2009). Poor choice architecture—or an environment in which decision making is overly complex and unstructured—can lead to cognitive or choice overload within the decision maker, which may result in poor and uninformed choices.

In the context of family planning, two interrelated choice architectures are at play: one in which a provider makes decisions about whether and how to offer various contraceptive methods, and the other in which clients—who may not fully understand the medical information related to their options—make decisions (Hostetter and Klein 2013). Understanding and influencing how providers navigate their own choice architectures during counseling to subsequently frame options for their clients during counseling is a potential area of focus for behavior change interventions. Behavioral economics concepts, which provide a new way to frame barriers and triggers, can provide an array of approaches to help remove or mitigate the impact of biases and facilitate client informed choice.

Why behavioral economics for family planning

- Behavioral economics helps us to understand the influences, biases, and processes of decision making.
- In the context of family planning, behavioral economics helps us to understand how provider biases negatively impact their decision-making process, which ultimately undermines their goal to improve the health and well-being of their clients.
- Behavioral economics helps frame and design interventions that can effectively motivate or incentivize providers.

Improving family planning counseling choice architectures requires an understanding of providers' complex decision–making environments



Study purpose

The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project conducted a study to identify the ways in which private providers could build effective choice architectures to facilitate appropriate and effective family planning counseling that is tailored to client needs and supports informed choice. The project applied a behavioral economics lens to two different country contexts to examine private sector provider biases in the decision to offer family planning counseling and method offerings. By identifying these biases and when they occur during the decision-making processes, it was anticipated that family planning programs could better design targeted provider behavior change interventions at each stage of counseling.

Country context: India and Malawi

India and Malawi have modern contraception prevalence rates (mCPR) that are close to or exceed the average mCPR of their respective regions. India has an mCPR of 48 percent compared to the Southeast Asia regional average of 64 percent (UN DESA 2015). Malawi has an mCPR of 58 percent, which is much higher than the sub-Saharan Africa average of 28 percent. Although both countries have a wide range of method choices at varying price points with most short- and long-acting methods available in the private and public health sector, one method dominates the mix in each country. In India, the method mix has significantly expanded over the past two decades, but female sterilization continues to dominate (36 percent), followed by condoms (6 percent) (IIPS and ICF 2017). In Malawi, injectables comprise 30 percent of all modern methods adopted, followed by implants at a distant second (12 percent) (NSO and ICF 2017). While other market factors should be considered, given the variety of methods available in India and Malawi, the dominance of one method at the exclusion of others could also suggest provider bias, consumer preference, or both (Measure Evaluation, n.d.). When providers—consciously or subconsciously—restrict or withhold certain methods from their clients, they can contribute to a skewed method mix. This study was used to qualitatively explore how biases manifest in the provision of family planning counseling and services among specific cadres of health providers.

In Malawi, injectables dominate the method mix despite the availability of a variety of methods. The dominance of one method at the exclusion of others could suggest provider bias, consumer preference, or both.

Photo: Amos Gumulira

Methods

This qualitative study used semi-structured, in-depth interviews with a purposive sample of health care providers practicing in two different countries—India and Malawi. The interview guides were designed to capture aspects of provider-client interactions through the use of client vignettes to explore approaches to client counseling in a way that can be understood and described using behavioral economics principles. The guides also included a section on the provider's approach to each phase of an interaction with a client seeking family planning services. The questions within the section were informed by family planning decision-making frameworks that have been developed for use by providers and emphasize human rights-based approaches to care and ensuring client choice.

Health care providers were identified and recruited by in-country research teams. Each provider was informed about the study and asked to participate in a one-hour interview. Prior to the interview, each provider's family planning knowledge, training, client loads, and method offerings were assessed in order to better contextualize the findings. The final sample composition for each country is presented in Table 1. In India, the sample consisted of three cadres of providers who work in private clinical settings and were trained to offer family planning services including: medical doctors, ob/gyn specialists, and providers who specialize in ayurveda, unani, and homeopathy (AUH). AUH providers were included in the sample given that they are potentially important providers of family planning services within rural areas in India. In Malawi, the study population included clinical officers and medical assistants working in franchised and non-franchised private clinics. These cadres of providers were chosen because they represent the clinical providers who have undergone training and most interface with clients for family planning counseling.

Table 1. Composition of study sample

	India	Malawi
Number and type of health care providers	AUH providers: 22 Medical doctors and ob/gyn specialists: 13	Clinical officers: 24 Medical assistants: 10
Facility types	Private health clinics: variable Public and private hospitals: variable*	Franchise clinics: 24** Non-franchise clinics: 10
Gender	Males: 16 Females: 19	Males: 33 Females: 1***

* It is difficult to quantify the number of facilities since ob/gyn specialists can provide services in both a health clinic setting and hospital. Unlike Malawi, providers in India were sampled based on cadre and not facility type.

** Franchises included Population Services International's Tunza clinics (n=17) and Marie Stopes International's Banja La Mtsogolo/Blue Star clinics (n=7).

*** According to the Malawi Medical Council, four female clinical officers and medical assistants were in full-time private practice in 2018 (out of a total of 226 providers). As a result, only one female provider was available to interview in the selected study locations.

Photo: Jessica Scranton

Findings

The summary of findings found in Table 2 and the categorizations below begin to demonstrate—using behavioral economics concepts and terminology—how private providers' and clients' family planning choice architectures can contribute to skewed method mixes.

Table 2. Summary of key findings

	India	Malawi
Overall family planning knowledge level among providers	• Low among AUH providers • High among ob/gyn specialists	• High across both clinical officers and medical assistants
Counseling behavior	• Significant differences between ob/gyn specialists and AUH providers both in quality* and consistency	• Both clinical officers and medical assistants counsel according to national service delivery guidelines
Method choice	• Driven by provider comfort and knowledge of the method, provider cognitive biases, and client demand	• Strongly driven by client demand (herd behavior)
Provider cognitive bias toward method or client	• Substantial	• No evidence
Facilitators	• Little evidence of any type of facilitators • No evidence that any service delivery guidelines are used	• Service delivery guidelines consistently cited as helpful for counseling. They include the *National Sexual and Reproductive Health and Rights (SRHR) Policy* 2017–2021 (Government of Malawi 2017) and the *National Reproductive Health Service Delivery Guidelines* (Malawi Ministry of Health 2014)

* Assessed against the Bruce–Jain framework (Bruce 1990).

Analysis of interview responses revealed that two distinct sets of factors—those within a provider's control and those outside of it—influence counseling on all available methods and ultimately impact which method, if any, a client selects.

Provider–controlled factors

When a person has many options to choose from, complexity can be a *hassle factor*, or barrier, to decision making. In the context of family planning counseling, health care providers must consider a client's health history, current health status, medications, and fertility desires before presenting a range of contraception options to the client. While informed choice requires that the client make the final contraceptive decision, the provider plays a very important role in constructing a choice architecture for their client to take action. Constructing a choice architecture for a family planning client is a complex process in which the provider must take into account client-side factors and motivations, while simultaneously describing aspects of each available method. From the provider's perspective, contending with these complexities can make comprehensive counseling and service provision a hassle. In these situations a provider may be perversely incentivized to inadequately counsel or avoid counseling their clients entirely.

Hassle factor is a barrier that is perceived to be too big or complex to overcome in order to carry out a behavior.

One way in which providers may contend with complexity is by *defaulting* to counseling on methods that are the simplest to explain (e.g., condoms) or have a high degree of familiarity to the client, which will limit the range of methods counseled. In other situations, providers with a client who requires too much time, energy, and cognitive resources may curtail their counseling by referring the client to other providers or forgoing counseling altogether. This behavior is especially common among AUH providers in India, who explained that they typically refer to allopathic providers such as ob/gyns.

"My work is to make them understand and, if they don't agree, then I give them another option. Like I told you, I don't deal with such patients, I don't waste time in counseling if they don't agree with me, otherwise I refer [sic]." *—AUH provider*

"If the client is still indecisive or the client is quite headstrong and does not want to adopt a method, then we refer the clients." *—AUH provider*

Default is the option that takes effect when the decision maker makes no choice.

Although referral may seem to be preferential to inadequate counseling, it can result in loss to follow-up if the client cannot or does not want to complete the referral. Further, because the AUH providers in this study had lower patient loads and tended to spend more time with their clients than allopathic providers, referral to busy allopathic providers does not necessarily lessen a client's chances for sub-optimal service delivery.

Another approach providers in India use to manage decision-making complexity is through the use of *representative heuristics* (or *rules of thumb*) to simplify the decision-making process by excluding choices based on a few client attributes. In the context of family planning, the decision on whether to counsel and what methods to offer may be based on a provider's perception of a client's need for comprehensive counseling or their capacity to use a particular method. Across both cadres of Indian providers, these perceptions are rooted in commonly held assumptions about a client's socioeconomic and educational background.

Representative heuristics are mental shortcuts or rules of thumb that are based on assumed client capacities or characteristics.

"Yes, naturally counseling will differ from one [client to] another. As for example, if I advise pills for educated clients, I advise IUD for less-educated clients as they will forget to take pills regularly." —*Ob/gyn*

"Those who are well-educated don't need counseling; they are already knowledgeable." —*AUH provider*

As in India, providers in the Malawi sample offer a wide range of methods and have to negotiate decision-making complexity. In contrast to the Indian providers, however, decision-making complexity was found to be less of a hassle factor for Malawian providers because they have a *facilitator*.

"It takes less time when we use the tools during counseling compared to the amount of time when we don't use the tool." —*Medical assistant, non-franchise*

"We know that there is a difference in interaction with clients when we are not using the tool because we skip most of the important information." —*Medical assistant, franchise*

Facilitators are factors, tools, and approaches that make a behavior easier to perform.

A majority of providers in the Malawi sample noted the *Malawi National Reproductive Health Service Delivery Guidelines* (Malawi Ministry of Health 2014) is a helpful reference for decreasing decision-making complexity. They rely on the guidelines as a tool to systematize and simplify the complex processes of counseling and of determining medical eligibility for each method (presented in a simple checklist and decision tree format).

Importantly, a majority of providers in the Malawi sample explained that the guidelines are helpful because they ensure that providers do not omit important information and provide accurate information on side effects and limitations of the method.

In addition to simplifying their own decision making, the Malawian providers explained how visual aids also facilitate client decision making by helping to dispel misconceptions regarding how a method works.

"When counseling is done using materials, clients are able to see, and it makes it easier for us. For example, this is an IUD, [provider points to a sample IUD] we use during our counseling. We introduce [the IUD] to the client so that she can see and understand the method and see how the method works. There have been negative [client] perceptions about [the IUD]…they think it is a big thing that enters the vagina. So, we discuss it with them and they observe it is a small thing that enters their body, not the whole package." *—Medical assistant, franchise*

Although there are service delivery guidelines and job aids available in India,[2] few providers in this study mentioned using them. When a provider did mention a guideline, it was in general terms and not by name. It was not apparent from the interviews why providers in Malawi relied on service delivery guidelines and providers in India did not.

In addition to guidelines, another facilitator that motivates family planning counseling and service provision among Malawian providers is confidence in their skills. According to the providers in this study, the ability of a client to understand the provider and make an informed choice is a direct reflection of a provider's self-efficacy to deliver comprehensible family planning counseling. The affirmation that providers receive when clients make an informed decision reinforces the motivation to counsel.

"When explaining the methods, I explain with confidence to let the client believe in what I am saying. If I fail to explain with confidence, the client might have doubts in what I am explaining to her. So, I need to be knowledgeable enough so that I can comfortably counsel the client…If a client fails to choose a method it means as a provider you have failed to comprehensively explain the methods to her." *—Clinical officer, franchise*

In India, commonly held assumptions about a client's socioeconomic and educational background could alter the provider's decision on whether to counsel and what methods to offer.

Photo: Sharbendu De

[2] http://www.nhm.gov.in/nhm/nrhm/guidelines/nrhm-guidelines/family-planning-guidelines.html

Client and structural factors

All providers in the study said that strong client demand—for sterilization in India and injectables in Malawi—has a considerable influence on their counseling (or the lack thereof) and method offerings. Although provider bias can stoke client demand for a particular method, other factors play a role, including affordability and accessibility (relative to other methods), client knowledge, and misconceptions. There are also some health system and socioeconomic structural barriers and policies that make it difficult, if not impossible, for clients to consider all medically appropriate options. As a result, provider bias may be inconsequential to client demand in many instances. For example, many long-acting methods are more cost-effective over the long term than short-term methods but many women/couples cannot afford the upfront costs (e.g., IUD insertion). Even when the method is free, travel costs and time off from work to obtain the method are well-established barriers. Individuals are aware of these barriers, which shapes the demand for specific methods.

In India, client demand for female sterilization is strong and has been the default family planning method after child bearing, regardless of the woman's age. This default choice has been reinforced by a long-standing government of India policy to promote sterilization for families with one or two children. Since 1981, the government of India has reimbursed individuals who undergo sterilization for the cost of the medical procedure and for the loss of income during recovery. For tubectomies (and vasectomies) performed in public facilities, compensation is given to the client and to the health worker who refers the client (Family Planning Division 2014). Consequently, both health care workers and clients are responding to decades of intense government promotion and incentives.

Although a majority of providers in this study recommend IUDs for women who have completed child bearing, they cited low client demand due to widely held misconceptions about the method (e.g., the IUD may become dislodged and travel to the heart), availability, and affordability.

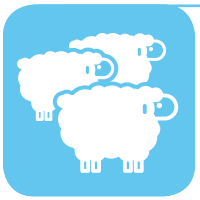
"Patients often say that Copper T won't suit. There is too much of problems [sic]. Patients actually don't know what it is but many times they believe what others are saying."
—Ob/gyn

Many lower-level health care providers (including AUH providers) with IUD training who want to offer the method do not have the facilities or equipment to do so. Instead, they must refer the client to other providers. This may create a hassle factor for the client, who might have to take time off from work or save money for travel to get the IUD. Such women may instead opt for sterilization as a long-term solution. Other women, who want monthly oral contraception but cannot afford the monthly expense, may also see sterilization as their only option.

Ob/gyn specialists state that there is strong client demand for sterilization, but unlike lower-level providers (such as AUHs), they have the ability to push back because they can readily offer an IUD as an alternative. A referral to another facility is not required and an IUD can be obtained by the client in the same health facility immediately after delivery or

during a post-natal check-up, significantly reducing the hassle factor for clients. The government of India has begun to emphasize increasing the counseling and provision of long-acting methods in the post-partum setting, so the behavior of ob/gyns in this setting is of particular importance.

Although Malawi's government has not sponsored programs to promote a specific method, client-side factors contribute substantially to the dominance of the injectable. The majority of providers stated that client demand for a specific method makes it challenging, frustrating, and time consuming to counsel clients on other types of contraception. A majority of clients seek service provision for a particular method—typically the injectable Depo-Provera (Depo). According to providers, the influence of friends and family (*herd behavior*) is a key driver for injectable demand.



Herd behavior occurs when individuals follow the behavior of other people instead of making independent decisions.

Providers expressed frustration that their advice is counteracted by the influence of friends and widely held misconceptions about other methods, particularly implants and IUDs. Providers asserted that many clients come into the clinic already knowing which method they want, often Depo, and are unwilling to be counseled on an alternative. As a result, the client is not informed of all the options available.

"When clients come and tell you that I want a particular method, it means they have heard it from their friends. When women are chatting, they discuss the experiences they have had using different family planning methods. Some clients choose a particular method based on their friends' experiences." —*Clinical officer, franchise*

"The advice is supposed to come from the provider, but mostly it comes from a client's friends and relatives who tell her myths about the method. Because of her low literacy level, the client is influenced to choose a method. They tell the client 'eh, I tried this other method and bled nonstop, eh, I tried this method and I was found with a tumor in the stomach,' things which don't relate with family planning; so, there is this false information which is circulating around the community hence influencing client's decision." —*Medical assistant, non–franchise*

Nearly all providers stated that they attempt to counsel clients on all methods even if the client arrives with a method in mind. A majority of providers counsel with the hope that through increased knowledge of other methods and fewer misconceptions, clients will choose the method that best meets her own family planning needs.

"Even though they [the client] has never done family planning before, they base their choice on the experiences of others. But when they come to this clinic, we also tell them of other methods and sometimes the client changes her mind based on the information gained during counseling." —*Clinical officer, non–franchise*

A small number of providers stated that as long as the method is medically appropriate, they will offer it out of concern of losing the client, even if another method is better suited for the client's needs. Since Depo is widely available throughout Malawi, clients can easily get it from another provider so the concern about losing business is not unfounded. Although only a very few providers voiced this concern, it is likely that other providers share it.

"We still counsel them on all family planning methods but as you know, this is a private clinic; it is always hard for us to lead them or influence them in decision making because we are afraid of losing some clients. So, what we do is that we still counsel them on the method they have already chosen." —*Medical assistant, franchise*

Some clients, despite being told they are medically ineligible for a method, still demand it. All providers were emphatic that under no circumstance would they offer a medically inappropriate method for fear of losing their license and client base if the method were to harm the patient.

"Most clients have an idea already that they will receive Depo (injectable), so we have the chart whereby we provide all the information and at the end they choose injectables. When they come here they have their mind already set that they will receive Depo. You can try to convince them to choose another method according to their health condition, but most of them refuse." —*Clinical officer, non-franchise*

Similar to results from India, method choice in Malawi is also associated with cost. Providers state that one reason clients like Depo is affordability. However, providers were quick to point out that Depo only has a price advantage over pills, and over time Depo and oral contraceptives are less cost-effective than the implant and IUDs. Many providers shared their frustration that clients—including those who can afford IUDs and implants—don't consider the long-term cost savings of long-acting methods and instead focus on the short-term savings of Depo (*present bias*). In this respect, Depo serves as the unofficial comparator against which the prices of all other methods are measured (*anchoring*).

Present bias is the tendency of people to assign more importance to present rather than future pay-offs.

Anchoring is when an individual uses an initial piece of information as a reference point for subsequent judgments of value.

Method choice in Malawi is associated with cost. Many providers shared their frustration that clients don't consider that over time Depo and oral contraceptives are less cost-effective than the implant and IUDs.

Photo: Amos Gumulira

"As you can see charges here, injectable and pills cost MK1,000 each and [the IUD] costs MK1,500 and Implanon costs MK3,000. When it comes to costs, the injectable is expensive as compared to Implanon because a client would just pay MK3,000 for Implanon at once and use the method for five years. For the injectable, you get it every three months; hence it is more costly. We deliberately increased the charge on injectables to discourage them [from choosing] that method and opt for a long-term method like Implanon, but still people go for [the] injectable." *—Clinical officer, franchise*

"Most clients like injectables because they don't have enough money. The immediate cheapest method is [the] injectable, so clients go for this method thinking that they are getting the cheapest method yet in comparison to implants, the injectable is expensive." *—Clinical officer, non-franchise*

A number of providers try to address present bias and anchoring on injectables by reminding clients that any immediate cost savings is negated by the cost of having to receive an injection every three months. Providers also remind clients that they will need to have money saved for the next injection. Several providers shared their frustration that clients do not heed their advice, resulting in unplanned pregnancies.

"We explain she spends much of her time in here every three months getting Depo instead of just getting a long-term method. There are transportation costs as well. Just coming here once for a long-term method is saving a lot. And finally, we also tell them that on the date their Depo injection has arrived she may have no money and cannot buy Depo so it's likely for her to get pregnant." *—Medical assistant, non-franchise*

Despite overwhelming client demand, providers in this study demonstrate significant resiliency and commitment to the well-being of their clients. There is no evidence that providers are relenting blindly in the face of client demand. There are many examples of providers who, client by client, work to mitigate uninformed choice.

"We ask her if it's the first time she is using the method or if she has used the method before. If she says 'yes' then we just remind her about some things, but if she says it's her first time then we ask her why she has chosen a method she has never used before. Then she says my friends told me that this is the right method. Then we say 'yes' the method you have chosen is the right one for you but now let us explain to you further about the method. Then we start explaining to the client the details of the method." —*Medical assistant, franchise*

Photo: Jessica Scranton

Limitations

The generalization of the results of this study is limited in the following ways.

- Only four cadres of providers were included in the study. One of them, ob/gyns, are highly specialized and, unlike the other cadres, are not frontline health care workers. Moreover, the ob/gyns interviewed were practicing in hospitals and thus had a higher number of post-partum clients and clients referred for specialized family planning services (e.g., sterilizations) than did the other cadres of providers.
- The study results do not contextualize provider decision making and behavior; this decreases the reliability and validity of some results. It is important to distinguish when a provider restricts a method due to local health needs (e.g., high anemia rates) and not bias.
- Caution should be exercised when comparing the results between providers in Malawi and India because inclusion criteria are different. Many differences can be partially explained by different screening criteria and rigor of screening. Providers in Malawi had higher levels of knowledge and experience than did Indian providers due to more rigorous screening by design. In India, the study found that many providers had inadequate levels of knowledge and very limited experience with modern methods, and it was more likely that this, rather than bias, confounded their behavior. To mitigate against that confounding factor in the Malawi study, the research team changed the provider selection criteria so that only providers with a sufficiently high level of knowledge and experience were included.
- The interviewers in Malawi were more extensively trained than those in India. This produced better-quality data in Malawi. Moreover, the interview guide was updated after the India study, so that interviews could better capture and explore issues that emerged from the earlier findings in India.
- There is a high likelihood of respondent bias. Since providers are legally and professionally bound to provide services in a specific manner, some providers may have been less than truthful about their actual behavior.
- There was no observation of provider behavior, so it is impossible to determine if the behavior actually occurred as reported.

Conclusions and Recommendations

The increased number and availability of contraception options in India and Malawi attests to each country's commitment to family planning. However, increasing the number of method choices has increased the complexity of the decision making that providers face. Helping providers to deliver family planning counseling and services more easily, while also being respectful of their clients' needs and desires, is key to ensuring clients are satisfied with their family planning method. Two approaches to making family planning counseling and service provision easier are to (1) reduce complexity and (2) make complexity easier to overcome. Providers must also become aware of their own biases and how those biases can have a negative impact on the health outcomes of their clients. The recommendations outlined below were derived from in-country consultative meetings between practitioners and the research team. The purpose of the meetings was to contextualize and interpret the findings in the local context in order to design interventions that are specific to the local needs.

Reduce complexity through checklists and job aids

As the number of method choices increases, so does the amount of knowledge required to determine medical eligibility and effectively convey comprehensible information to the client. Clients are more likely to make an informed and appropriate decision when they do not feel overwhelmed by the number of choices, and it will be easier for providers to present more methods when they aren't overwhelmed as well. Two commonly referenced behavioral economics tools to reduce complexity are checklists and job aids. Uptake of these tools by private sector providers, however, should be further explored. This study identified possible ways to reframe the importance of such tools to encourage consistent and proper use. Some benefits identified by providers who use the tools include shortened time and improved quality of counseling sessions, better alignment of services with Ministry of Health standards, and a feeling of greater contribution to national family planning goals.

1. **Checklists**. Checklists break down behavior into small, discrete, and actionable steps rather than one long complex process, thereby making the behavior feel easier to execute. Service delivery guidelines can be converted to a checklist and actively promoted to providers as a tool that can make their jobs easier (rather than another guideline that acts as a burden). These guidelines mitigate decision fatigue by decreasing the amount of cognitive resources required to determine medical eligibility and side effects.
2. **Job aids**. Job aids make counseling easier and quicker. It is quicker to show someone how and where a method works, rather than explaining it only with words.

Reframe to identify and correct for bias

As stated previously, people, including health care providers, are often not conscious of their own biases. They make decisions without thoughtful consideration and instead rely on heuristics, which are influenced by socio-cultural norms, policies, or health system characteristics. The key point is that biases influence decision making at a subconscious level.

Two types of reframing approaches can help identify and correct health provider biases.

1. **Reframe for perspective**. Biases (and heuristics) must be identified before they can be changed. One way to do this is by *changing perspective*. This exercise teaches people to think reflectively about their own biases and the sources of those biases (e.g., socio-cultural norms). Providers should be trained to consider how clients' negative experiences with family planning or other aspects of health service delivery has negatively impacted their lives. By humanizing the client, a provider can see the negative consequences their biases can have.
2. **Reframe for gain**. Equip providers with the knowledge and communication skills to reframe the way they present methods to clients. They should be able to present methods from the perspective of what exactly a client may gain (*gain frame*) rather what the client may lose (*loss frame*) (e.g., side effects). For example, as described earlier, providers in Malawi stated that one reason Depo is preferred to other methods is that it is less expensive in the immediate term than are IUDs and implants, the cost of which is less over the longer term; providers need a better approach for reframing the cost decision for their clients.

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