Evaluation Results: Encouraging Family Planning Counseling that Promotes Meaningful Choice in Malawi

Breakthrough ACTION used a behavioral design approach to investigate the challenges of family planning (FP) use specifically amongst postpartum women in Malawi. Through formative research, we found that providers do not counsel postpartum women on the full range of contraceptive methods in a way that women internalize. Specifically, providers often offer FP counseling in a way that does not clearly convey the advantages and disadvantages of all methods; and women receiving counseling often feel uncertain about whether specific methods are suitable for their unique FP needs. Accordingly, Breakthrough ACTION designed a set of behaviorally informed solutions to support providers in offering FP counseling in a way that promotes meaningful client choice. **We evaluated the solutions in a pre/post study and found positive results which suggest that the solutions may be effective tools to help improve the quality of FP counseling in Malawi.**

The Solution Set

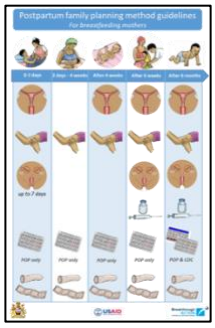
The three solutions outlined below encourage providers to counsel postpartum women on all methods and account for individual client preferences during counseling. These three solutions were adapted from a broader set of solutions to be suitable for the context of COVID-19, for use by trained Health Surveillance Assistants (HSA) who provide community health care provision.

Image 1. Solution Set

FP counseling cards

This solution includes a set of counseling cards which providers use to facilitate a discussion on all FP methods during one-on-one counseling, or during health talks. The cards ensure that providers do not default to discussing methods with which they are most familiar, and frames method discussion around factors that are most important to women.

Postpartum FP reference guide



The deck of counseling cards includes this highly visual postpartum FP reference guide. The guide shows when a breastfeeding woman can take up each FP method after delivery, ensuring that providers can easily discuss when methods can be started throughout the postpartum period.

Method referral card

This solution is a referral card that providers can give to clients who (1) are interested in other methods but don't know which one they'd like, (2) have a need for another method, or (3) choose a method that is not available during their consultation. The card prompts a discussion of method satisfaction and each different FP method, and enables providers in the facility or community to refer women for methods they cannot administer.

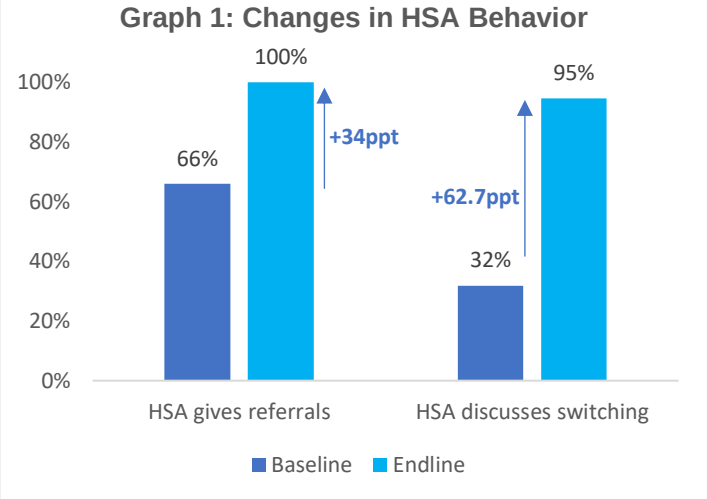
Evaluation Design

In July-August 2020, we ran a two-month evaluation to assess the feasibility of implementing the solutions and to understand the potential impact of the solutions on provider behavior, knowledge, and attitudes. The solutions were implemented in communities in 10 facilities' catchment areas in Lilongwe and Machinga districts. Study sites were chosen based on the following criteria: (i) facilities in the catchment areas had to work with the Organized Network of Services for Everyone's Health (ONSE) our local partner organization and (ii) areas with district hospitals were excluded as these areas were expected to be busy with the COVID-19 response. We included facilities with low, middle, and high contraceptive prevalence rates (CPR).

At the onset of implementation, we trained 48 HSAs to use the solutions. All solutions were meant to be used together during community health provision. Supervision for HSAs was provided by Ministry of Health staff and supervisory staff from ONSE. The study was a pre/post design, and we collected both qualitative and quantitative data at baseline and endline through phone surveys with HSAs. We also collected referral card tracking forms that were filled out by each HSA. Baseline surveys were conducted shortly after the trainings, so the study examines the impact of two months of exposure to the solutions. All 48 HSAs in the study were interviewed at baseline, but only 37 HSAs were interviewed at endline; some HSAs changed their phone numbers, and were thus unreachable, and other HSAs reported being too busy to participate the survey. Nonetheless, we did not see any evidence of differential attrition. To analyze our data, we ran comparison of means analyses using signed-rank significance tests, to test for significant differences in our outcomes of interest between baseline and endline. We also conducted logistic and ordinary least squares regressions on select outcomes. All regression results were consistent with the comparison of means results, and we present means analyses below for ease of understanding.

Key Results

Result 1: The solutions increased the percentage of HSAs who gave referrals to women to take up FP methods. From baseline to endline the percentage of HSAs who reported giving women[1] referrals to take up FP in the past 2 months **increased significantly,[2] by 34 percentage points (ppt).** Additionally, at baseline, only 29% of HSAs who gave referrals said they provided referrals half of the time or more, while at endline, 83.3% of these HSAs said they provided referrals half of the time or more, a significant increase of 54.3 percentage points. See Graph 1.

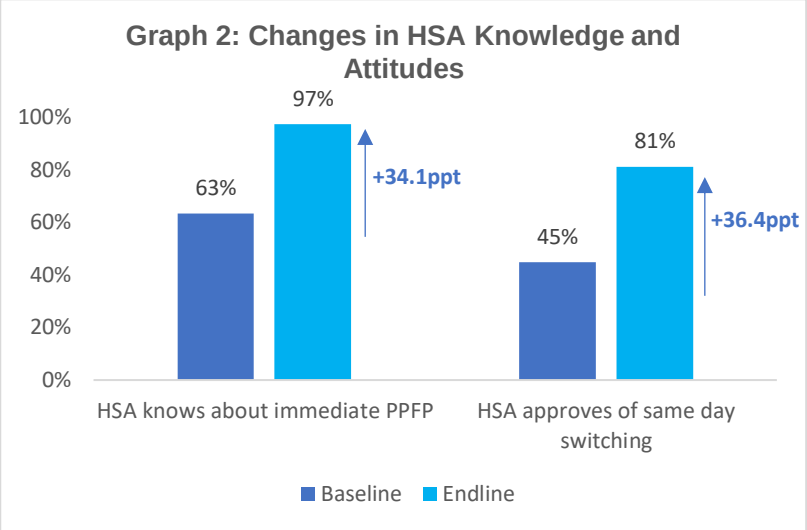


[1] Though the project was focused on postpartum family planning, during data collection we asked providers about their behaviors towards all women. We defined a postpartum woman as one who had delivered her last child less than two years prior; and through data collected from our referral card tracking form, found that 81% of women who received referral cards were postpartum (n=858).

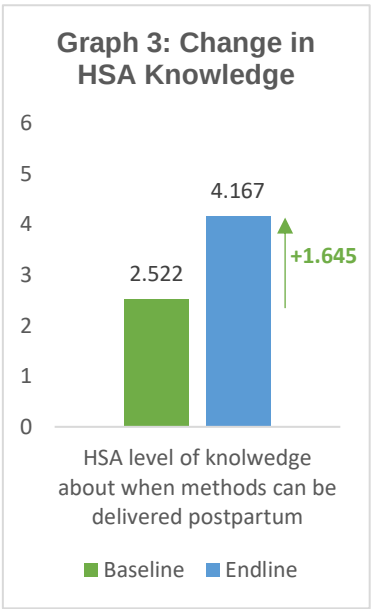
[2] Throughout this brief, significant results refer to statistically significant results with p-values of less than 0.01.

Result 2: The solutions increased the percentage of HSAs who discussed method switching with women. From baseline to endline the percentage of HSAs who reported discussing FP method switching with women in the past 2 months **increased significantly, by 62.7 percentage points**. The percentage of HSAs who reported discussing method switching half of the time or more also increased from baseline to endline, by 12.4 percentage points. See Graph 1.

Result 3: The solutions improved HSAs' attitudes towards same day method switching. From baseline to endline the percentage of HSAs who said that women should always be able to switch their family planning method on the same day of their consultation **increased significantly, by 36.4 percentage points.** See Graph 2.



Result 4: The solutions improved HSAs' knowledge of immediate postpartum FP. When asked *"when can a woman receive family planning after she has delivered"* the percentage of providers who knew that a woman is able to receive a FP method immediately after delivery (48 hours) **increased significantly from baseline to endline, by 34.1 percentage points**. See Graph 2.



Result 5: The solutions improved HSAs' knowledge about when methods can be provided postpartum. We asked HSAs when five[3] different family planning methods could be provided to a woman during her postpartum period, based on the Malawi postpartum FP guidelines. For example, we asked: *"How soon can a woman take up Progestin-only pills after delivery?"* We summed HSAs' correct responses to create an index [0-5] which measures an HSA's knowledge about all methods. From baseline to endline, HSAs' knowledge about when methods can be provided postpartum **improved significantly by 65.2 percent or by 1.645 points on the index.** This means that, on average, at endline, HSAs knew the correct timing of when a method can be taken up for 1.645 more methods than at baseline. See Graph 3.

Result 6: HSAs used the solutions as intended, and generally reported positive experiences with using the solutions. 100% of HSAs reported using the counseling cards with the PPFP reference guide and 100% of HSAs

[3] Methods in the index include: combined oral contraceptives, Progestin-only oral contraceptives, the implant, the intrauterine contraceptive device, and bilateral tubal ligation. We excluded the injection due to conflicting guidelines on PPFP timing across facilities, which did not allow us to appropriately measure knowledge.

reported using the method referral cards. 92% of HSAs who used the counseling cards said the cards were *"very helpful."* Some reasons given by the HSAs included "[women] no longer listen to… myths because FP is being discussed by someone they trust and believe" and "[women] are asking more questions [about FP] than before." Referral cards were primarily used when a woman wanted a method that an HSA was not trained to administer[4] (70%), but cards were also used to refer women when their specific method of choice was currently unavailable (24%) or if they were undecided on their method of choice (6%) (results from the tracking form, n=840).

Recommendations

There were limitations to the rigor of our study compounded by logistical challenges from the COVID-19 pandemic and HSA attrition. Nonetheless, our large, statistically significant results in all of our key outcome indicators are promising and suggest that our solutions may be effective tools to help improve the quality of FP counseling in Malawi. Thus, we recommend that our solution set continues to be rolled out, evaluated, and improved as necessary in Malawi. We also believe that the solution set holds great promise for use in other countries that face similar FP challenges and have similar health systems to Malawi, and could be adapted for use in those contexts.

The original solution set included a group counseling tool and a passport insert for use during facility-based antenatal care (ANC) which were not feasible to implement during this study due to COVID-19. The feasibility of these two solutions were tested in a previous implementation evaluation, in which we implemented the original solution set across seven facilities for three-weeks to test their operational feasibility. For future implementation, we recommend replacing the counseling cards with the group counseling tool, which contains the same messaging and design components as the counseling cards, but is meant for use with women during group health talks. We also recommend reinstating the ANC passport insert – an insert providers place in women's health passports during antenatal care which helps them to discuss FP with women before delivery. During the implementation evaluation, we found that the ANC passport insert showed promise of impact and was desirable by providers. For example, providers noted: *"It is quick, it is really helping begin a conversation about FP"* and *"Women are demanding it…We have even run out of it."* See Image 2 on the following page for more details on the expanded solution set.

The ultimate goal of the solution set is to improve women's postpartum family planning outcomes. Though we were unable to measure these outcomes in our study, we hope that the positive impacts on provider behavior suggested by our results will translate into improvements in women's health outcomes (e.g., immediate PPFP, increased method satisfaction, lower discontinuation). Thus, lastly, we recommend further, more rigorous research into the impacts of the solution set on women's health outcomes in addition to provider behavior.

[4] HSAs can administer oral contraceptives, condoms, and the injection (Depo-provera).

Image 2. Expanded Solution Set

ANC passport insert

A sticker which affixed to a woman's health passport during ANC which prompts providers to discuss FP and supports providers in helping women plan for when to adopt FP postpartum.

Group counseling tool

A poster, which providers use to facilitate discussion on all FP methods during health talks. The tool ensures that providers do not default to discussing methods with which they are most familiar and frames the discussion around factors that are most important to clients.

Acknowledgements

This brief was made possible through the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Breakthrough ACTION and do not necessarily reflect the views of USAID or the United States Government. Breakthrough ACTION gives many thanks to our partners at ONSE and the Reproductive Health Directorate at the Ministry of Health for their support throughout the course of this project and its evaluation, and to our Principal Investigator at the College of Medicine and the USAID Malawi Mission for their strategic guidance. The study was approved by the College of Medicine Research Ethics Committee (COMREC: P/05/118/2404). **If you have questions about this project or the solution set, please contact Breakthrough ACTION staff member Abigail Sellman at asellman@ideas42.org.**