Provider strategies for contraceptive counselling among Swedish midwives

The World Health Organization (WHO) (2007) has determined that the average woman must use some form of effective contraception for at least 20 years if she wants to limit her family size to two children, or for 16 years if the intended number of children is four. Furthermore, WHO proposed that during her fertile years, a woman’s needs differ and that consequently she may need different contraceptive methods at different periods of life. With professional contraceptive counselling, a woman may be assisted in making informed choices (WHO, 2007).

Family planning services take different forms in different countries. In Sweden, 80% of all contraceptive counseling is performed by nurse-midwives and women have easy, free-of-charge access to contraceptive counselling at all primary healthcare centers. Specially trained nurse-midwives prescribe different hormonal contraceptives and insert implants or intrauterine contraceptive devices (IUDs) (Medical Products Agency, 2005). Youth centers provide adolescents with contraceptive counselling, testing for sexually transmitted infections (STIs), treatment, and therapy in the field of sexuality up to the age of 20 or 23 years (Forum for Swedish Youth Centers, 2011).

In a study involving 18 women aged 20–28 years, the core category ‘finding the best fit’ described the process of contraceptive decision-making (Noone, 2004). The result showed that the women chose a contraceptive method based on their knowledge, experience, and evaluation of what would be the best fit within the context of their current life situation (Noone, 2004). Concerns for health and side effects, and the belief that there was no risk of getting pregnant are the most common reasons for why women do not use contraceptives (Blanc et al, 2002; WHO, 2007).

A review of theory-based interventions of contraceptive counselling showed a better result for a theory-based intervention group with repeated sessions in one of ten studies (Lopez et al, 2011). Previous studies from Kenya, Egypt and Turkey have demonstrated that in contraceptive counselling the provider controls the agenda and that by giving more, or less, information, the provider controls the conversation (Kim et al, 1999; Abdelby giving more, or less, information, the provider controls the agenda and that consequently she may need different contraceptive methods at different periods of life. With professional contraceptive counselling, a woman may be assisted in making informed choices (WHO, 2007).

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Could you describe a contraceptive counselling consultation?

If the patient cannot decide a contraceptive method, what do you do?

If the patient is an adolescent, how do you act?

If the patient is a woman born outside Sweden, how do you act?

Further probing explored the kind of questions the midwife uses in counselling. Questions asked included 'How do you ask?' and 'What kind of sentences do you use?'

To test the interview guide, a pilot interview was conducted and showed that no adjustments were necessary. The pilot interview and another interview were excluded owing to technical problems with the tape recorder, leaving 16 interviews in the convenience sample. The first author, a nurse-midwife with 17 years' experience in contraceptive counselling, performed the interviews in a secluded room at the participants' workplace. The length of the interviews varied between 35 and 65 minutes (median = 55 minutes), and all interviews were transcribed verbatim by the interviewer.

Data analysis
The text was analysed using the qualitative content analysis method described by Graneheim and Lundman (2004) which includes several steps. In the first step the interviews were read through several times to gain a sense of the whole and find 'meaning units' corresponding to the aim of the study. In the second step the meaning units were shortened to condense meaning while still preserving its core. In step three the condensed meaning units were coded. The codes were abstracted, compared for differences and similarities, and sorted into subcategories and categories (Table 1).

Ethical considerations
Studies involving interviews with staff are not subject to requirements for ethical approval, but the ethical rules for humanistic-social science research and the Helsinki Declaration were followed (World Medical Association, 1964; CODEX, 2009).

Findings
The midwives had developed their own model for contraceptive counselling, which is reflected in the five categories: exploring the woman's situation; providing information about contraceptive methods; performing medical evaluation; guiding the decision-making process; and following up on the counselling (Table 2).

Exploring the woman's situation
To treat the woman as an individual was crucial to all midwives. For some, this started with the phone call when making an appointment. If there were many questions the midwife booked a longer appointment.

During the contraceptive counselling, the participants considered it important to establish good contact with the woman by greeting her in the waiting area, shaking hands with her, and starting the session with small talk:

‘At first I think it is important to make a good contact … small talk so we make contact’. (Participant 8)

Also during the contraceptive counselling, previous experiences with contraception, positive and negative, were explored to get a broad view of the problem. The midwife made it clear that it was the woman's choice and that the woman had to choose what felt best for her.

Providing information about contraceptive methods
The participants had different models for providing information about contraceptive methods. Some of the midwives said they did not mention different contraceptive methods unless the woman asked. They would merely ask about the current contraceptive method, explore the woman's medical history and heredity, take her blood pressure and then prescribe the contraception. Other participants took the opportunity to inform clients about new or different contraceptive methods.

The participants differed in their opinion about how much information about side effects was necessary. Some midwives believed that if the woman was aware of the problems that could arise, she would be prepared and would take appropriate action, i.e. instead of stopping the pill due to nausea or irregular bleeding, she would instead call the provider for advice:

‘I try to explain side effects and why you get them, so you don't get scared, because you usually get scared and then quit the contraceptive method’. (Participant 1)

Other participants did not talk about side effects if the woman did not ask questions, because they did not consider the side effects to be a problem.

Some participants considered the woman's knowledge about her body, hormones, and ovula-
They described in detail how current methods of contraception affect the female body, and impact on ovulation, bleeding patterns, etc and checked how much the woman knew about this:

‘I check up how much the woman knows about ovulation and menstruation … I think it is important to have a base of knowledge to stand on’. (Participant 8)

Other participants focused their information on how the contraceptive method influences everyday life, such as remembering to take the pill every day or the possibility of irregular bleeding. A few midwives only gave this kind of information if the woman asked.

Some midwives adjusted the information for immigrant women or teenagers. Information to the immigrant women included more detail about the female body and was communicated in simple language or using a more direct form of address. The information also included pictures, showing intrauterine devices, and education on hormonal effects. With teenagers, the midwives tried to talk about the risks of unprotected sex, and testing for STIs:

‘Young girls ... I usually ask how they live, how many sex partners ... If I ask directly, I think I get an answer’. (Participant 9)

Performing medical evaluation
Some midwives found it a problem to include the medical evaluation (taking past history, heredity, blood pressure, and body mass index) naturally in the conversation. Some said they started the consultation by performing a medical evaluation, so as to have a medical base for their counselling. This informed them of the need to exclude some methods for medical reasons:

‘Before we start I perform a medical evaluation ... so we know that oral contraceptives are an option’. (Participant 16)

Guiding the decision-making process
If the woman had difficulties in deciding a contraceptive, the participants had three different strategies for helping her make up her mind.

One strategy was to capture the woman’s feelings about different contraceptive methods. The midwife asked for the woman’s opinion of the contraceptive method, capturing the woman’s reaction when they were talking about it and then asking her for a reaction. The second strategy was to refer to the woman’s contraceptive history and

Table 1. An example of the analysis process from meaning unit to category

<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Condensed meaning</th>
<th>Code</th>
<th>Subcategory</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Initially, I usually try to explore earlier experiences—like, what contraceptive method worked or not. Any side effect or why did she stop using that method?’ (Participant 9)</td>
<td>Try to explore earlier experiences</td>
<td>Exploring experiences</td>
<td>Treating the woman as an individual</td>
<td>Exploring the woman’s situation</td>
</tr>
</tbody>
</table>

Table 2. Providers’ reflections on contraceptive counselling: categories, subcategories and codes

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploring the woman’s situation</td>
<td>Treating the woman as an individual</td>
<td>• Longer appointment if needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Greeting the woman in the waiting area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exploring experiences</td>
</tr>
<tr>
<td>Providing information about contraceptive methods</td>
<td>Giving information</td>
<td>• Current contraceptive method</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Different contraceptive methods</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Other methods if woman asks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Side effects</td>
</tr>
<tr>
<td>Checking the woman’s knowledge</td>
<td></td>
<td>• Effects of contraceptives on female body</td>
</tr>
<tr>
<td>Adjusted information</td>
<td></td>
<td>• Effects of contraceptives on everyday life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Answering questions</td>
</tr>
<tr>
<td>Performing medical evaluation</td>
<td>Strategies for medical evaluation</td>
<td>• Starting with medical evaluation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• After decision about method</td>
</tr>
<tr>
<td>Guiding the decision-making process</td>
<td>Strategies for decision making</td>
<td>• Capturing the woman’s feelings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referring to contraceptive history and daily life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Point out benefits and comparing differences</td>
</tr>
<tr>
<td>Strategies for managing indecision</td>
<td></td>
<td>• Postponing the decision</td>
</tr>
<tr>
<td>Following up on the counselling</td>
<td>Strategies for follow-up</td>
<td>• Encouraging contact in case of problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Booking a second visit</td>
</tr>
</tbody>
</table>

Other interviewees performed the medical evaluation after the woman had chosen a specific contraceptive method.
what the woman had related about her daily life, thus helping her make a decision. A third strategy was to point out the benefits of, and differences between the various contraceptive methods, e.g. the pill, which has to be remembered every day, compared with contraceptive implant, which can be forgotten about for three years:

‘I say, ‘This one you have to remember every day, do you think you will remember? This one you have all the time, you don’t have to think about it’. (Participant 4)

When the woman could not make a decision at the consultation, the participants used one of two strategies. Some midwives just let the woman go home and come back when she had made up her mind:

‘When a woman cannot decide I give her the brochures and say: ‘Maybe you should think about this a little bit more together with your partner and you could decide together what is best for your relationship’. (Participant 14)

Other midwives managed indecision by pushing the woman in one direction or making the decision for her at the consultation.

Following up on the counselling
The contraceptive counselling was sometimes followed up directly by the midwife who asked the woman if she was content and had understood. Other midwives encouraged the woman to contact them if any problems or worries arose:

‘I give the responsibility to the woman to contact me if the contraceptive method does not work’. (Participant 15)

Sometimes a second visit was booked for follow-up, especially when the woman was starting a new contraceptive method or if she was an immigrant.

Discussion
The main findings of this study indicate that the midwives used their own, self-made models for providing counselling and employed a variety of strategies. The categories represent different steps in the contraceptive counselling process, and the number of steps taken depended on the woman and her needs.

Exploring the women’s situation
The category ‘Exploring the woman’s situation’ showed consensus among the midwives on the importance of establishing contact with the woman and treating her as an individual with individual needs. All participants described their efforts to understand the woman’s individual needs and wishes regarding a contraceptive method.

Providing information
The category ‘Providing information about contraceptive methods’ showed a variety of strategies among participants for informing and transferring knowledge about different contraceptive methods. The participants differed in their opinions on what was necessary for the woman to be informed about. Also, the analysis revealed that the participants were at risk of stereotyping immigrant women and giving them more simplified information compared with ethnic Swedish women, which is a common pitfall (Skelton, 1998). It seems that at this stage of contraceptive counselling the midwives dropped their individual focus and resorted to their own, self-made model.

In this regard, it may be useful for midwives to employ the communication methodology known as ‘motivational interviewing’ to help them to stay focused on the individual and explore the woman’s motivation by asking questions about her intentions and desires (Rollnick et al, 2008). In motivational interviewing it is fundamental to provide information only with permission from the patient, as one-way information can go wrong and elicit resistance when the patient is not ready or is unwilling to receive the information. Providing information only with permission reinforces the patient’s autonomy and active involvement in her health care (Rollnick et al, 2008). The women in Noone’s (2004) study illuminate the importance of choosing a contraceptive method based on the woman’s personal knowledge. Only the woman can decide what she needs to know in order to make her choice, and the midwife is only one source of information. Moreover, information about contraceptive methods is easily available on the Internet.
Divergent opinions about how to talk about side effects were also expressed by the midwives. Studies have shown that structured pre-treatment counselling on expected side effects increases continuation of contraceptive use and that providing information on possible symptoms in advance improves user satisfaction with the contraceptive method (Canto de Cetina et al, 2001; Backman et al, 2002).

**Decision-making: Use of theories**
The category ‘Guiding the decision-making process’ shows different strategies for guiding the process and managing indecision. Only a few participants used more than one strategy and strategies were not selected based on the situation; instead, the midwives used their personal strategies. The woman was often ‘abandoned’ in her indecision, perhaps because the midwife did not want to influence what is considered a woman’s personal decision. In this situation different decision-making theories may be useful (Ajzen and Fishbein, 1980; Bandura, 1986). According to the theory of reasoned action, developed by Ajzen and Fishbein (1980), intentions and behaviours are functions of three basic determinants: beliefs about performing the behaviour; beliefs about social referents; and beliefs about factors that serve as barriers or facilitators to the behaviour (Ajzen and Fishbein, 1980). In the context of contraception counselling this theory finds expression in the following questions (Libbus and Kridli, 1997):

- What do you see as the advantages/disadvantages of (avoiding pregnancy/getting and using specific contraceptives)?
- Are there any people or groups of people who would approve/disapprove of you (avoiding pregnancy/getting and using specific contraceptives)?
- Are there any factors that make (avoiding pregnancy/getting and using specific contraceptives) easy/difficult?

These questions may help the woman to decide what kind of contraceptive method she should choose.

**Follow-up**
Only a few midwives had a clear strategy in the category ‘Following up on the counselling’ and the most common strategy was to encourage the woman to contact her provider if any problems arose. According to Blanc et al (2002), within the first year of starting a new contraceptive method, 7–27 % of women stop using the contraceptive for reasons that could be addressed during counselling.

The participants had different models for providing information about contraceptive methods—some did not mention the different options, but instead discussed the current method, explored the woman’s medical history and heredity, took her blood pressure and then prescribed the contraception.

**Summary**
The focus of this study was midwives’ perceptions and practice of providing contraceptive counselling. The use of a broad opening question in the interviews allowed the participants to choose how they defined their way of working during the interview. The participants were asked to discuss their experiences of contraceptive counselling. The judgment of trustworthiness should be based on credibility, dependability and transferability (Lincoln and Guba, 1985). One aspect of credibility was to present data and processes of analysis. To establish dependability, an open dialogue between the researchers was created. The authors discussed the interpretation of the data, so their judgments about similarities and differences of content were consistent (Graneheim and Lundman, 2004). The term ‘transferability’ refers to the extent to which these findings could be transferred to other, non-Swedish contraceptive providers. The present conclusions on contraceptive counselling in practice are arguably transferable to other providers in other contexts.

**Limitations**
This study was limited in that the sample was a convenience sample and that all the participants came from the same county, and analysis of non-response was not undertaken. However, while some participants practised in smaller towns, other worked in larger cities; some worked with largely Swedish-born women in primary health care centres.
Key points

- Midwives need to make an effort to understand the woman’s individual needs and wishes regarding a contraceptive method
- It is important to consider the woman’s individual needs for information and to be aware of the risk of stereotyping needs
- In guiding the decision-making process and for managing indecision, different decision-making theories could be useful
- The option for follow up with a selected contraceptive method needs to be made clear to women

while others were employed in areas with mostly immigrants and also with both adult and teenagers visiting youth centres. The participants also differed in experience, with length of time worked in contraceptive counselling ranging from 2 to 30 years.

Recommendations

This study provides practical examples of how to advise women on contraception and provide information about contraceptive methods. However, in order to achieve the goal of enabling women to make informed decisions on contraception, further intervention studies are needed to find a model for contraceptive counselling built on theory. Interventions with different communication methodologies and decision-making theories could aid understanding of how to develop a theoretical model for contraceptive counselling. Once further research has been undertaken, guidelines and best practice in contraceptive counselling could be developed. Guidelines in contraceptive counselling should contain guidance in medical/physiological issues, communication methodology, the decision-making process and follow-up, as well as take into account the needs of different groups such as adolescents and immigrant women.

Conclusions

This study shows that the providers had developed a self-made model for contraceptive counselling. The model could be analysed under the categories exploring the woman’s situation, providing information about contraceptive methods, performing medical evaluation, guiding the decision-making process and following up on the counselling. In contraceptive counselling the task is to always stay focused on the individual woman and her personal needs and wishes and also to be aware of pitfalls such as stereotyping and generalizing with regard to immigrant women. It is hoped that this study may contribute to personal reflection on contraceptive counselling in practice, both for experienced counsellors and for those who have newly started this task.