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Structured contraceptive counseling provided by the Contraceptive CHOICE Project

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Abstract

Background: We describe the contraceptive counseling provided by the Contraceptive CHOICE Project (CHOICE) and compare contraceptive methods selected between the university research site and community partner clinics.

Study Design: We developed a structured, contraceptive counseling program. All CHOICE participants enrolling at our university research site underwent the counseling, which was evidence-based and included information about all reversible contraception. Participants enrolling at partner clinics underwent "usual" counseling. We trained 54 research team members to provide contraceptive counseling; the majority had no formal health care training. We compared the contraceptive methods chosen by participants enrolling at our university research site to participants enrolling at partner clinics who did not undergo structured contraceptive counseling.

Results: There were 6,530 (86%) women who enrolled into CHOICE at our university site and 1,107 (14%) women who enrolled at partner clinics. Uptake of long-acting reversible contraception was high at both the university site and partner clinics (72% and 78%, respectively, $p<.0001$). However, uptake of the intrauterine device was higher at the university site (58% compared to 43%, $p<.0001$) and uptake of the subdermal implant was higher at partner clinics (35% versus 14%, $p<.0001$). After adjusting for confounders, we found no difference in the uptake of long-acting reversible contraception between women counseled at the university site compared to partner clinics (adjusted relative risk=0.98, 95% confidence interval [0.94, 1.02]).

Conclusion: Structured contraceptive counseling can be effectively provided in a clinical research setting by staff without prior health care experience or clinical training.

Keywords: Contraceptive counseling; Long-acting reversible contraception; Intrauterine device; Subdermal implant

1. Introduction

Contraceptive counseling has the potential to increase the uptake of highly effective methods of contraception, to improve contraceptive use, and to increase continuation and satisfaction. However, prior studies of contraceptive counseling have not demonstrated consistent results. A survey of women after a visit with their primary care providers found that women who received counseling about hormonal contraception were more likely to report use of that method at last intercourse [1]. A recent Cochrane review found that there was no data to support the effectiveness of contraceptive counseling in improving contraceptive adherence [2]. However, in this review, the authors did not evaluate whether contraceptive counseling impacted the choice of contraceptive method. A randomized controlled trial of structured contraceptive counseling among women seeking abortion did not show any increase in the uptake of very effective contraceptive methods compared to typical counseling [3]. A limitation of this study was that the typical counseling was provided by family planning specialists, which may have attenuated the effect of the structured counseling.

Increasing the uptake of highly effective contraceptive methods and improving contraceptive continuation are important strategies to decrease unintended pregnancy. The Contraceptive CHOICE Project (CHOICE) is an ongoing cohort study of 9,256 women with high uptake of long-acting reversible contraception (LARC) which includes the intrauterine device (IUD) and the subdermal implant. In this paper, we provide a description of the structured contraceptive counseling developed as part of CHOICE and

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compare the uptake of LARC between participants enrolled at the university site where they received structured contraceptive counseling and partner clinics where they received "usual" counseling.

2. Methods

We have described the methods of CHOICE in detail elsewhere [4], but will briefly review them here. CHOICE is a prospective cohort study of 9,256 women designed to: 1) promote the use of LARC; 2) remove financial barriers to contraception; 3) evaluate continuation and satisfaction for reversible methods; and 4) reduce unintended pregnancies in the St. Louis region. Women were eligible to participate if they were aged 14–45 years, resided in St. Louis City or County, had been sexually active with a male partner in the past six months or anticipated sexual activity in the next six months, had not had a tubal sterilization or hysterectomy, did not desire pregnancy in the next year, and were interested in starting a new reversible contraceptive method. We provided participants with the reversible contraceptive method of her choice at no cost. Participants completed follow-up surveys by telephone at 3 and 6 months and then every 6 months for 3 years (first 5090 participants) or 2 years (rest of the cohort). The majority of CHOICE enrollments occurred at our university clinical research site. Women at this site were self-referred and had heard about the project from a health care provider, family, friends, or a flyer. We also partnered with 13 community clinic sites where patients could be referred to CHOICE and enrolled on-site by research staff. These partner clinics included 6 federally qualified health centers that provided family planning services, two Planned Parenthood health centers, the outpatient Obstetrics and Gynecology clinic and the inpatient postpartum floor at an academic teaching hospital, a clinic providing no-cost health care services to adolescents and young adults, and two clinics providing abortion services. We obtained approval from the Washington University in St. Louis School of Medicine Human Research Protection Office prior to recruitment of participants.

The first CHOICE participant was enrolled in August 2007. We initially developed the CHOICE protocol with the assumption that health care providers would refer women to CHOICE for reversible contraception after contraceptive counseling had been performed and the woman had chosen a method. During the pilot phase of enrollment, we found that many of the women referred to CHOICE were unfamiliar with the complete range of reversible contraceptive options. In particular, women were not familiar with the most effective methods of contraception, the IUD and implant. They also had limited knowledge about the advantages and disadvantages of specific contraceptive methods.

We subsequently developed 2 strategies to increase contraceptive knowledge among our participants. First, we introduced a short script about LARC which was read to every woman at the time she was screened for study eligibility. This script has been previously described [4]. All participants heard this script regardless of enrollment site. Second, we developed a structured, comprehensive contraceptive counseling program for all participants enrolling in CHOICE at our university research site. Women who enrolled in CHOICE at one of our partner clinics underwent the "usual" contraceptive counseling provided at that site and were not provided with standardized counseling from CHOICE research staff. However, the CHOICE staff would provide additional information about the available contraceptive methods if requested at the time of enrollment. We instituted this contraceptive counseling during the pilot phase of the study.

Our main objective in developing a standardized, comprehensive contraceptive counseling program for our university enrollment site was to ensure that women enrolling into CHOICE were knowledgeable about all reversible contraceptive options including effectiveness, advantages, and disadvantages. The counseling framework for CHOICE was modeled after the GATHER process for counseling [5]. GATHER is a client-centered process focused on the woman, her expressed needs, situation, problems, issues and concerns. The goal of the contraceptive counseling component is to provide accurate, unbiased information about all contraceptive methods to help the woman assess her needs and make an informed decision. GATHER includes these components; GREET each client in a friendly, respectful way; a good connection between provider and client builds trust. ASK clients about their lives with simple open-ended questions, taking the lead from the client. TELL clients about available contraceptive methods and sexually transmitted infection (STI) protection within the context of their lives and preferences. HELP the client decide which contraceptive method works best for her needs. EXPLAIN everything about the client's chosen method, how to use it, possible side effects and when to contact the clinic. RETURN clinic visits or follow–up phone calls are a time to discuss client's use of their chosen method and their concern.

We developed a standardized contraceptive counseling script which was presented to the participant at her enrollment appointment at our university site, regardless of her baseline contraceptive knowledge or her interest in specific contraceptive methods. Participants underwent contraceptive counseling at the beginning of the enrollment process prior to completing informed consent or the baseline questionnaire. The script concisely describes the effectiveness, advantages, and disadvantages of each reversible method in order of effectiveness, including the levonorgestrel intrauterine system (LNG-IUS), the copper IUD, the subdermal implant, depot medroxyprogesterone acetate (DMPA), oral contraceptive pills (OCPs), the transdermal patch, the contraceptive vaginal ring, and condoms. Other methods such as diaphragm, contraceptive sponge, and natural family planning were discussed at the woman's request. We provided participants with physical models of