

# MOMENTUM

Private Healthcare Delivery



## ■ Technical Brief

# PERSON-CENTERED FAMILY PLANNING COUNSELING IN THE PRIVATE SECTOR

Counseling for Choice: Experiences implementing and adapting a person-centered FP counseling approach

High quality, person-centered care is essential to improving the health and wellbeing of individuals, families, and communities. MOMENTUM Private Healthcare Delivery – part of a suite of awards funded by the U.S. Agency for International Development (USAID) to holistically improve family planning and maternal, newborn, child, and reproductive health services – supports access to high quality health services and seeks to strengthen the capacity of

private sector health workers to provide respectful, person-centered care. In pursuit of these goals, MOMENTUM uses the Counseling for Choice (C4C) approach. This brief describes MOMENTUM’s experience implementing C4C, focusing primarily on a case study from Uganda and drawing on additional experiences from Niger, Mali, Cote d’Ivoire, and Ghana. The brief shares lessons on how adaptations to C4C’s standard tools and training impacted knowledge transfer to providers and the effectiveness and scalability of the approach. Finally, the recommendations outlined in this brief are intended to reach a wide stakeholder group, including national governments and donors seeking to invest in person-centered approaches like C4C, as well as FP program managers and implementers interested in putting the globally available C4C tools into practice.

## WHAT IS COUNSELING FOR CHOICE?

Counseling for Choice (C4C) is an evidence-based, person-centered approach to contraceptive counseling that helps clients make the best choice about which method is right for them. Developed as a solution to many of the root causes of the unmet need for contraception, the C4C approach addresses gaps in free and informed choice, client surprise by or dissatisfaction with contraceptive-induced bleeding changes, and discontinuation among users who wish to prevent pregnancy. C4C aims to improve how providers and clients participate in family planning counseling discussions to ensure that clients are always at the center and have the power to make the contraceptive choices that meet their needs.

The C4C approach encompasses a set of counseling techniques and principles, and employs a job aid (the Choice Book), that assists providers in fully utilizing the approach. C4C training tools were designed to bring new cohorts of providers together for a three-to-four-day classroom-style training that uses a combination of lecture-based modules, interactive activities, quizzes, scenarios, and practice to instill the approach within the participants. The C4C training tools and job aids are a [globally accessible good](#).

The C4C approach and training tools were designed with support from the USAID-funded SIFPO2 project with private sector providers and private health networks in mind. To further strengthen counseling among private providers, MOMENTUM contributed to the pilot introduction or expansion of the C4C approach. The following presents a deeper dive into Uganda’s experience with C4C followed by highlights from Niger, Mali, Cote d’Ivoire, and Ghana.

## LESSONS FROM UGANDA

### From Classroom to Clinic: Bringing C4C to the Uganda Private Midwives Association through a Mentorship Approach

In Uganda, MOMENTUM partners with a local organization, the Uganda Private Midwives Association (UPMA). UPMA is a national, non-governmental organization of private, reproductive health focused midwives. With a membership of more than 700 private midwives, UPMA supports its members with opportunities for continued professional development to advance clinical excellence, research, advocacy, and improve the standard of care for women in Uganda.

As part of its partnership with UPMA, MOMENTUM provided training on the provision of contraceptive methods, with a focus on postpartum family planning (PPFP), to 76 UPMA midwives located in Kampala’s urban slums. Recognizing quality counseling as a gap among recent UPMA trainings, an orientation to C4C was incorporated into the

### The C4C suite of tools and resources

- **The Choice Book for Providers**, including the NORMAL job aid for discussing contraceptive-induced bleeding changes
- **C4C Trainings: Core Materials**



comprehensive seven-day training on contraception and FP. The C4C orientation provided a rapid, tailored overview of the approach (see Table 1 for a description of this orientation and of the full process of adapting C4C trainings for UPMA midwives). While this didactic C4C orientation gave midwives an initial understanding of the rationale and structure of C4C, it did not fully prepare the cohort to put the approach into practice upon return to their clinics.

During supervision visits following the C4C orientation, UPMA supervisors noted numerous gaps between C4C understanding and practice. Midwives needed further mentorship for the approach to take hold at the clinic level, yet MOMENTUM also recognized that these private clinic owners could not afford to spend more time away from their clinics. For C4C to be adopted and optimized by UPMA, MOMENTUM determined that a new C4C training model was needed: further mentoring must be moved into the clinic setting.

<b>Adapting the In-Classroom C4C Training Program for Use In-Clinic</b>	
<p>MOMENTUM designed and implemented the two-step cascade training and mentorship program for UPMA midwives in Uganda. This was adapted from the standard three-day C4C training guide and tools.</p>	
<p>Hybrid training for C4C mentors</p>	<p>A three-day training session was conducted for six C4C mentors. The curriculum included C4C theory and practice. Two days were spent in-classroom and included in-depth review of C4C principles, activities, scenarios, and time for questions and discussion. One day was spent in a UPMA clinic; mentors practiced C4C with real clients and practiced C4C mentorship of midwives under the observation of C4C master trainers.</p> <p>Mentors were considered proficient in C4C and ready to mentor midwives once completing five high quality C4C sessions with real clients under the supervision of a C4C master trainer.</p>
<p>In-clinic C4C trainings for UPMA midwives</p>	<p>C4C mentors met with assigned midwives, providing in-clinic training and practice on C4C. All midwives had previously participated in the brief C4C orientation provided earlier during the full FP classroom-style training. C4C mentorship visits consisted of:</p> <ul style="list-style-type: none"> <li>- Review and discussion on the principles of C4C (2-3 hours)</li> <li>- Scenario-based sessions to practice C4C (1-1.5 hours)</li> <li>- Supervised practice of C4C with real clients (1/2 day)</li> <li>- Debrief, feedback, and next steps</li> </ul> <p>Mentors were equipped with hardcopy worksheets of C4C information and materials they used side-by-side with midwives during in-clinic sessions. Worksheets were adapted from the <a href="#">standard C4C training slides</a> used during classroom style trainings.</p> <p>All components of the in-clinic C4C mentorship session were typically completed in one day with UPMA midwives; they were designed with the ability to break them into shorter lessons that could be split across multiple mentorship visits. Mentorship sessions were sometimes provided 1 to 1; other times a small group of midwives working at the same facility gathered to be trained together.</p>
<p>Ongoing C4C supervision and mentorship</p>	<p>Following a completed in-clinic C4C mentorship session, mentors continued to visit C4C-trained midwives for routine supervision and support. A standardized counseling checklist that incorporated C4C steps was used as the assessment tool.</p>

## How successful was Uganda's in-clinic mentorship approach?

The in-clinic mentorship model was conducted as a pilot with a smaller cohort: 15 private facilities with high performing midwives who demonstrated interest and enthusiasm for C4C. Following the implementation of the new C4C mentorship approach, MPH Uganda was able to reflect on successes, gaps, and future recommendations for the in-clinic C4C mentorship approach.\*

Following the completion of the in-clinic mentorship, midwives demonstrated improvement in counseling skills. Before the mentorship sessions, midwives scored an average of 62% on a counseling skill-level checklist that included steps related to C4C; following the in-clinic C4C mentorship, average scores rose to 83% using the same checklist.† The mentors themselves were the ones to conduct assessments using the checklist. UPMA felt that for a small private setting such as theirs, the mentor-mentee relationship was most fruitful when a singular person provided UPMA-supported midwives with both mentorship and supervision. In particular, mentors noted that post-C4C mentorship, midwives were offering more comprehensive, person-centered information on potential method-specific side effects, including bleeding changes. One mentor noted that prior to C4C mentorship, routine register reviews indicated large shares of clients who would return to the clinic for method removals due to experiencing unanticipated side effects. Post-C4C mentorship, this mentor noted that *“the [immediate removal] rate is very minimal, which means the acronym NORMAL [a job aid used as part of C4C] is working.”*

*“The C4C-trained providers offered counseling sessions that were more engaging and better tailored to the specific client’s needs than those not trained in C4C. In one session with a non-C4C trained provider, we observed a client fall asleep during a counseling session that took too long and didn’t focus on the client’s stated need! She even left the clinic with a method she didn’t seem fully satisfied with. Meanwhile, C4C sessions were relevant to the unique client, and were person-centered and engaging.”*

– Evaluator during an internal Quality of Care Evaluation of programs MOMENTUM manages in Uganda

Midwives themselves shared positive feedback about their understanding and use of C4C, noting that the approach makes their job easier and equips them with the skills to better determine the unique needs and preferences of each client. When asked about the value of using C4C, midwives often cited that C4C allowed them to provide a shorter, yet more person-centered, counseling session; that the approach encouraged clients to do more sharing about prior method use, preferences, and needs; and that using C4C reminded them to speak about bleeding changes. Midwives shared that, on average, clients were more engaged and better able to follow the counseling session when they were using C4C and the Choice Book.‡

Midwives also had feedback on the in-clinic mentorship approach, with most sharing that it better fit their needs and daily routine than a classroom-style training. One midwife noted that the theory portion of the in-clinic mentorship version was *“more direct and less time consuming [...] I missed concepts during the classroom session because we had many other things to learn.”* Another midwife said that she had not understood the C4C principles well during the

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\* The review of success, gaps, and recommendations are a synthesis of information gathered during 1) an after-action summary report of the original contraceptive technology training and the C4C orientation, 2) a routine quality of care evaluation of all PSI Uganda's FP/RH activities, and 3) a brief survey conducted with C4C mentors and UPMA midwives conducted 4-months post mentorship sessions.

† The baseline averages scores from 9 midwives at C4C mentorship facilities who had been assessed with the counseling checklist prior to the C4C mentorship during a routine supervision visit. The follow-up score averages scores from all 15 facilities included in the intervention.

‡ Prior to C4C, many providers were counseling using comprehensive counseling approaches, citing that FP counseling sessions took 30-40 minutes on average (this was reduced to 15-20 minutes when using C4C). Some providers were also familiar with the [REDI](#) (Rapport Building, Exploring, Decision Making, and Implementing the Decision) framework.

classroom-style orientation, and that it was only after in-clinic mentorship, when her mentor “gave me enough time to support my C4C understanding” that she felt she fully grasped the approach.

### C4C and an increase in PPFp uptake

MOMENTUM’s C4C-related training and support to UPMA was part of a broader effort to increase the capacity of midwives to offer PPFp counseling and services. During the time that UPMA midwives were being supported to use C4C, MOMENTUM also assessed PPFp services, comparing the UPMA facilities who had received MOMENTUM support (including on C4C) to those that had not received support. After one year, at MOMENTUM supported facilities, there was an increase from 3% to 28% of postpartum women who adopted PPFp within 48 hours of delivery, and an increase from 7% to 65% of postpartum women who adopted PPFp within three weeks of delivery.

At the non-intervention sites, there was no observable change, with rates of PPFp adoption resting between 1-3% across the same time period. While these increases in PPFp adoption cannot be directly attributed to the use of C4C at these sites, it may be that introducing a person-centered FP counseling approach like C4C, as well as improved clinical skills and capacity building for immediate PPFp, did contribute to the increased uptake levels at UPMA sites.

Mentors, in addition to midwives, found the in-clinic approach more valuable than classroom style training. Some shared that the in-clinic approach allowed them to identify the strengths and gaps of individual learners, enabling mentors to adapt to the learning speeds and needs of individual midwives. Mentors also remarked that providers appeared more invested in the approach when learning about it within their own clinic: “it improves provider-client confidence and relationships resulting into improved business. This is so because the client [with whom the midwife practices C4C] kept referring to this provider as knowledgeable and a person-centered provider.” For private sector providers in particular, one mentor noted, in-clinic trainings are better: “It is good for private sector because they don’t lose a lot of time from their business; [during mentorship sessions] some time is saved for them to go and complete their other tasks.”

While midwives and mentors largely appreciated the in-clinic mentorship format, they did note some room for improvement. Certain concepts needed more time or focus (such as the 3Ws<sup>5</sup>). Several shared the desire for a “low-dose, high frequency” format as

opposed to mentorship sessions taking place in one long day. One provider also acknowledged that in the clinic, contrary to in a classroom, it can be difficult to find the quiet and calm needed to fully delve into and grasp new or complex topics.

## Spotlight on Niger: Advocating for C4C in the Public Sector

Niger currently has the highest total fertility rate in the world with 6.9 births per woman.<sup>1</sup> Niger’s private sector for FP and other health services and products is underutilized; only 12% of women seek FP through the private sector.<sup>2</sup> From March – December 2022, the MOMENTUM C4C activity in Niger focused on public sector engagement to meet the population’s health needs, collaborating closely with the Niger Ministry of Public Health, Population and Social Affairs. As C4C’s tools and approach were developed with the private sector in mind, training packages and recommendations focus on small- to medium-sized private provider networks. MOMENTUM posited that Niger, with its nascent private sector, could be a context in which to explore scaling C4C trainings in a public sector system.

MOMENTUM originally envisioned working with a small group of private and public sector providers in Niger, providing C4C onboarding using a low-dose, high frequency approach. MOMENTUM began the initial steps to advocate for and introduce C4C by holding regular discussions with the Family Planning Directorate (as well as two other directorates) within the Ministry of Health. After several meetings and information sharing on C4C, the project invited the three

<sup>5</sup> C4C highlights the importance of clients retaining information for their chosen method by using the 3Ws: 1) What to do to use the method correctly, 2) What potential side effects to expect, and 3) When to return to the clinic.

directorates from the Ministry of Health to participate in a C4C training of trainers with MOMENTUM staff in Niamey, Niger. After this training, MOMENTUM held a meeting with the Directorate of Family Planning (including heads of communications and research, monitoring and evaluation divisions) to debrief and develop a roadmap for next steps on scaling C4C. However, despite positive evidence from a [2018 study](#) on the use of C4C in Malawi, the Ministry of Public Health was reluctant to adopt C4C without a Niger-specific research pilot of the approach. Additionally, the Ministry indicated its aim was to adopt one counseling approach, which would combine elements from C4C and from another FP counseling approach, eventually leading to a new, integrated approach, and set of job aids. During discussions, it became clear that such a harmonization exercise would not only require a considerable pivot from original plans but, more significantly, also remove or dilute key attributes that make C4C innovative and person-centered. The project chose to pause discussions until the Ministry had further solidified its plans. Nonetheless, this case offers important learning when advocating for the introduction of a new approach into public sector health curricula and guidelines. Even equipped with an evidence base, it is critical to appreciate that Ministry leadership may require localized evidence of the effectiveness of an approach and may prefer to integrate innovations with other emerging approaches rather than replace existing approaches wholesale.

## Spotlight on Mali: Condensing C4C's Training Curriculum

In Mali the private sector market share of all health visits is significant: 64%.<sup>3</sup> MOMENTUM recognizes the potential of Mali's private sector and works with approximately 350 private sector facilities to improve service quality, with a particular focus on person-centered care. A small cohort of Mali's project staff participated in a global MOMENTUM meeting conducted in Nairobi in 2022 that focused on person-centered care. Using information shared at the global person-centered care meeting, MOMENTUM Mali developed a two-day, in-person training on topics related to person centered care with the intent of cascading the information to private sector providers. As C4C was only one component of the training, just three hours during each of the two days of training were devoted to C4C; yet MPHD Mali retained didactic sessions, role play, videos, and discussions from the standard C4C training curriculum. Rather than cutting entire content areas from the standard C4C training, MOMENTUM in Mali decided to condense each topic so that all aspects of C4C were preserved in the shortened curriculum. Ultimately, Mali trained 1-3 providers at each of the MOMENTUM-supported private sector clinics. Following the training, MOMENTUM provided supportive supervision in C4C and the other clinical and person-centered care topics.

MOMENTUM Mali's pragmatic decision to distill the C4C curriculum and incorporate it into a broader training was innovative and adaptive and demonstrates how C4C training can be combined with other training topics rather than as a standalone full training.

## Spotlight on Cote d'Ivoire: Adapting C4C for use by IPC Agents

The total fertility rate in Cote d'Ivoire is 4.3 but rises to 5.3 in rural areas such as Northern Cote d'Ivoire. Among women in union in need of FP, just 21% across Cote d'Ivoire and 15% in rural zones use a modern method of contraception.<sup>4</sup> With project funding from the High Tide Foundation, Populations Services International (PSI) Cote d'Ivoire adapted C4C for use in a non-clinic, community setting, where FP messages may not be penetrating. Through a small pilot, C4C training and tools were adapted for use, no longer at the clinic level, but by the Interpersonal Communication (IPC) Agents that lead group counseling sessions in rural, Northern Cote d'Ivoire.

Through this pilot, the C4C approach and Choice Book – developed for 1-to-1 use between a facility-based provider and one client – were adapted for a small group setting. The book was converted to larger format cards and a small poster. The C4C script was also adapted; instead of a conversation focusing on the needs of one client, IPC agents were trained to facilitate a small group to select which three, among a wide selection, of method benefits and associated FP methods the entire group wanted to learn about most deeply. The pilot trained 15 IPC agents in March 2022 and was followed

three months later by a brief evaluation to assess how IPC agents had integrated the C4C approach into their group counseling sessions.

The evaluation found that making the shift to C4C counseling was challenging for IPC agents. Agents had been accustomed to a static script: a straightforward, method-by-method introduction of the various modern FP options available. Switching to the C4C approach meant that each group session unfolded slightly differently, with IPC agents tailoring information provision to the specific interests of the group. Moving to the dynamic facilitation required by C4C was a significant and difficult change for IPC agents, particularly for those with lower levels of education. While agents were also trained to use the [NORMAL job aid](#), the evaluation revealed that only female IPC agents covered information on bleeding changes, likely due to cultural hesitancy among men to discuss menstruation.

While the evaluation did reveal significant gaps, this small pilot has indicated that C4C for use in small groups led by IPC agents could be meaningful with some adjustments. IPC agents, or other health workers with lower levels of education, may need more training, practice, and support than originally anticipated in this pilot as they move from traditional group counseling sessions to a dynamic C4C approach.

## Spotlight on Ghana: Adding C4C to A National Protocol

Knowledge of contraceptive methods is almost universal in Ghana, but despite this the mCPR is only 31%.<sup>5</sup> Underutilization of FP may lead to unplanned pregnancies, unsafe abortions, and maternal deaths. The Government of Ghana and the Ghana Health Service (GHS) have committed to increasing rates of modern contraceptive use (including LARCs) by broadening access and availability of services at all levels, capacity building, improving contraceptive method mix, and increasing demand for services. To fully achieve these commitments, private sector LARC provision access must be expanded, and any related barriers addressed.

Through MOMENTUM Private Healthcare Delivery in Ghana, local partner Total Family Health International (TFHO) trained 100 private sector facilities in C4C as part of comprehensive training and support to improve LARC services across the country. During this activity, TFHO worked closely with Ghana Health Services Family Health Division to align training efforts in the private sector with national policies. TFHO took the opportunity to orient Family Health Division officials to the C4C approach and tools. C4C was very well received, and over the last several months, TFHO has worked with GHS to include the C4C suite of approaches and tools in the official National Family Planning Protocol, which includes the National Training Curriculum for Training Health Providers. GHS has requested further support for training of trainers so that it may cascade C4C within the public health system to accompany its addition to official training materials.

## GLOBAL RECOMMENDATIONS

C4C was initially developed for use with private providers at a time when classroom-style trainings were most in demand. PSI has experienced success implementing this C4C training modality within private networks across various contexts and countries. The snapshots in this brief illustrate that through adaptive implementation, the C4C training and counseling tools may be updated and applied to fit a variety of contexts and needs. As global practitioners seek to introduce C4C to government ministries or donors for potential investment, or seek to implement and scale the approach, MOMENTUM has generated the following recommendations.

*When seeking to introduce or advocate to government ministries of health and/or donors on C4C:*

- **Ensure the right stakeholders within Governments are oriented to C4C and the environment enables support from a single stakeholder or stakeholder group that can champion the approach.** In Ghana, C4C's inclusion in

the National Family Planning Protocol was successful due to successful advocacy with the right stakeholders within Ghana Health Services.

- **Plans to scale C4C widely across a mixed or public sector health system require advocacy with a variety of stakeholders and investment at significant inflection points, specific to context; this differs from the steps taken when introducing C4C into a private network.** Though MOMENTUM was unsuccessful introducing C4C in Niger, the experience elevated the need to provide contextually specific proof of concept and to demonstrate the value add of the approach vis-a-vis other approaches introduced to the government. C4C's value add must be demonstrated and shared with stakeholders in a systematic manner.

*When ready to implement the C4C approach with providers:*

- **Across contexts and stakeholders, a low-dose, high frequency approach is in demand.** Stakeholders in Niger and mentors in Uganda have noted that longer training, without opportunities to reinforce learning, results in providers quickly reverting to old habits. Breaking modules into sections that may be spread across days or weeks may enable providers to most fully absorb and retain new information.
- **The tools and job aids needed to immediately implement C4C should be available to the provider or IPC agent the day of, or prior to, their training or mentorship.** Any small delay in equipping providers with the relevant job aids reduces the likelihood that providers will master and implement the C4C approach following training.
- **In-clinic mentorship may be preferable to classroom-style training, particularly in the private sector.** Remaining in the clinic for C4C mentorship in Uganda allowed for an agenda to be adapted to the daily responsibilities of a private midwife. It also enabled midwives to see the practical value of a theoretical approach like C4C by immediately experiencing how their clients respond to the approach in real time.
- **Clustering C4C trainees into groups of 3-5 may provide an ideal number of learners.** When classroom style training was very large, implementers noted it became difficult to ensure all participants absorbed the information and had adequate time to practice C4C.
- **C4C may hold potential for use by IPC agents, but this warrants further testing and understanding.** Moving from a static group counseling script to a dynamic script that changes based on the preferences and interests of a particular group, was a difficult shift for community-level IPC agents in Cote d'Ivoire. Testing new tools or digital approaches – such as tablet or phone apps equipped with digital C4C algorithms so that IPC agents can quickly determine method benefits that match group preferences – is needed before significant investments are made in C4C through this channel.

## CONCLUSION

While the principles and approach of C4C remain consistent across implementation settings, there are several implementation elements that can – and indeed may be best to – adapt when introducing it in a new context. In some instances, training may be more effective when moved from the classroom to the clinic, or to a more flexible, incremental model. In some networks, it may be most efficient to condense the training and combine it with other training topics. And while the adaptation to a community setting requires further examination on the best optimization, it is an adaptation worth exploring. MOMENTUM looks forward to following the private sector adaptations of C4C outlined in this brief and will continue to seek opportunities to apply learnings from the successful, in-clinic training module in Uganda to new contexts.



# REFERENCES

<sup>1</sup> Niger Fertility rate, total (births per woman), World Bank. Retrieved from [data.worldbank.org](https://data.worldbank.org)

<sup>2</sup> *Family Planning Market Analyzer. Niger*. Retrieved from <https://fpmarketanalyzer.org>

<sup>3</sup> Castle, Sarah, Bokar Touré, Françoise Armand, Yann Derriennic and Romana Haider. December 2017. *Mali Private Health Sector Assessment*. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc.

<sup>4</sup> Institut National de la Statistique-INS et ICF 2022. Enquête Démographique et de Santé de Côte d'Ivoire, 2021. Rockville, Maryland, USA. INS/Côte d'Ivoire et ICF.





<sup>5</sup> Track 2020. Ghana. December 2022. "Exploring Opportunities for mCPR Growth in Ghana."

<https://www.track20.org/download/pdf/Opportunity%20Briefs/english/Ghana%20FP%20Opportunity%20Brief.pdf>

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**Photo caption:** UPMA midwives receive in-clinic C4C orientation. **Credit** PSI Uganda 2023.

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