

Confronting Concerns About Family Planning Methods

ideas ⁴²

Increasing Sustained Use of LARCs in Uganda

ideas42, Marie Stopes International, and Marie Stopes Uganda partnered to design and test a behavioral intervention to support sustained use of long-acting reversible contraceptive (LARC) methods. Many women in Uganda decide to remove LARCs due to concerns rooted in fears and misconceptions about these methods. Community-based mobilizers working for health organizations are trusted sources of information and therefore powerful channels for reaching concerned users, especially when clinics are not always available. This project equipped community-based mobilizers and health providers working for mobile clinics with materials to address concerns about LARCs, enable concerned users to consider all of their options, and trigger providers to offer appropriate counseling.

Background

214 million women of reproductive age worldwide have an unmet need for family planning (FP); although they do not want to have children at this time, they are not using contraceptives to prevent pregnancy.¹ Increasing access to, and informed uptake of, FP is the first step to meeting this need. The next is to support continued use of their chosen FP method, or to support switching to an alternative method that would better suit their needs, to enable women to achieve their fertility intentions. Long-acting reversible contraceptives (LARCs), such as IUDs and hormonal implants are in many ways well-suited to the goal of sustained use. In settings where health services are hard to reach or inconsistently available, LARCs are a safe and effective FP option that can prevent pregnancy for 3-10 years with no need for provider support, but also allow a woman to return to fertility upon removal whenever she's ready to get pregnant. However, concerns about these methods often get in the way; **some women for whom LARCs are a suitable option never use them, and others take up a LARC but discontinue before they are ready to get pregnant due to either real or perceived side effects and concerns often rooted in myths and misconceptions.**

We partnered with Marie Stopes International (MSI) and Marie Stopes Uganda (MSUG) to explore the behavioral dimensions of this problem, with the aim of supporting women who wish to delay pregnancy to access and continue using the methods that are best suited for their reproductive needs.

Highlights

- ▶ Fears and misconceptions impede sustained use of long-acting reversible contraceptives in Uganda.
- ▶ Community-based mobilizers are a trusted and powerful channel to address concerns, when they are equipped with resources, skills, and support.

Context and Challenge

MSUG provides sexual and reproductive health services in under-resourced communities throughout Uganda through mobile Outreach clinics staffed by roving teams of providers. Outreach clinics complement the existing capacity of government health facilities, which predominantly provide short-term methods. Often, LARCs are a practical choice for Outreach clients who do not have reliable access to LARCs or other FP methods outside of the Outreach clinic days that occur in their communities once every few months. In 2018 over 75% of Outreach clients chose LARCs. However, nationally representative data in Uganda indicates that 28% of IUD users and 20% of implant users discontinue within 12 months.² Our conversations with clients, Outreach providers, and mobilizers revealed that women frequently remove LARCs early due to concerns about side effects that are exacerbated by prevalent myths and misconceptions about the methods, such as the belief that LARCs can get lost in the body, or are actually unrelated health issues misattributed to LARCs.

The way that services are delivered and promoted in the community can end up channeling clients toward discontinuation of LARCs, but this service delivery context also offers a unique opportunity for intervening to support sustained use of LARCs. In advance of a clinic day, community-based mobilizers speak with current and prospective clients to inform them of the clinic and discuss FP needs and methods. Between clinics, these mobilizers are for many clients the closest and most accessible connection to MSUG. Current users who have concerns about their methods often approach mobilizers for information, guidance, and reassurance. We found that mobilizers, unequipped with sufficient information on how to respond, direct concerned users to the next clinic, which can involve a wait of several months. The long wait to resolve concerns and the hassles of getting to a clinic to receive services can entrench a desire to discontinue FP use, leaving concerned users less open to other service options that might better meet their needs. Given that the mobile clinics only run for a single day in each site, providers work under time pressure to serve a high volume of clients, which makes it easy to miss opportunities to counsel concerned users about myths, side effect management, and alternative FP methods.

Solution Design

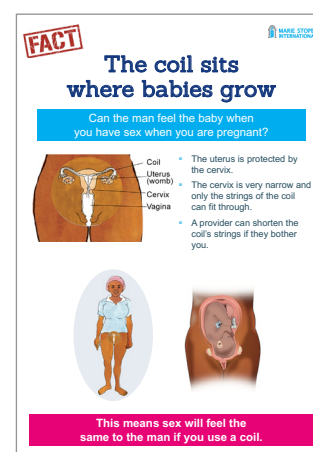
Working with Marie Stopes' Marketing and Behavior Change, Evidence, and Clinical teams, ***we designed a solution set to support Outreach clinic providers and mobilizers to more effectively respond to clients' concerns and allow concerned users to consider their full range of options beyond removal, including side effects management and switching to alternative methods.*** The solution set was refined through user-testing with providers, mobilizers, and clients. It works through multiple touchpoints to equip community-based mobilizers to take an active role in responding to myths and misconceptions about FP and experienced side effects, and referring clients to seek the right care that meets their specific needs. It also aims to ensure that concerned users are offered the appropriate counseling and services when they visit a clinic. The materials included: 1) an FP Facts Flipchart, 2) a Side Effects Response Tool, and 3) referral cards.

TABLE 1. Barriers to LARC continuation addressed by solution set

Barriers to LARC Continuation		Behavioral solutions		
		FP Facts Flipchart	Side Effects Response Tool	Referral Cards
Fears of side effects	Due to pervasive myths and misconceptions about FP, LARC users experiencing normal side effects misinterpret them for symptoms of more serious complications and seek removal.	✓	✓	
Unrelated symptoms	Limited access to other healthcare services and the salience of FP use leads clients to see connections between their method and other unrelated health issues, and to consider removal as the cure.	✓	✓	
Busy, high-volume clinics	For Outreach providers tasked with serving a high volume of clients, quicker service delivery means more needs can be met; thus providers prioritize service provision over in-depth counseling that probes on client concerns.			✓
Removal is the path of least resistance	Mobilizers aren't prepared to respond to clients' questions and concerns, and direct concerned users to the next Outreach visit, which may be weeks away. By the time they see a provider, the time spent waiting and traveling to the clinic may lead them to feel committed to removing.		✓	✓

The FP Facts Flipchart

The FP Facts Flipchart is a client-facing visual tool for providers and mobilizers, which provides accessible information to address concerns and misconceptions related to the side effects of contraceptives using culturally-relevant analogies and accessible images. Each page on the spiral-bound flipchart includes a fact and an illustration. The presenter-facing side offers guidance on what to say as well as a reminder of which specific myths the card is intended to address. The appendix shows pages of the FP Facts Flipchart with the myths and concerns they aim to address.



► Rationale

LARC users often have concerns about their methods that are rooted in fears and misconceptions, and turn to mobilizers for support and answers to their questions. If mobilizers are able to give satisfactory responses that assuage their fears, some users may decide that they no longer need to visit a clinic—avoiding the sunk costs of waiting, worrying, and traveling that could entrench a desire to remove the method and discontinue FP use. Others may still visit the clinic after speaking with a mobilizer, but feel less afraid and more empowered to ask questions about the possible side effects they may be experiencing. The FP Facts Flipchart also assists mobilizers and providers in delivering consistent messages, using culturally-relevant anecdotes and images to help messages better connect with their intended audience.³

The tool uses an evidence-based approach to myth-busting—developing an alternative fact-based narrative to counter a myth. The cards present facts because research shows that repeating myths, even when explicitly countered, can further propagate the belief.⁴ Because people are likely to resist information that contradicts their existing beliefs, presenting an alternative narrative may be more persuasive than framing information as directly combatting a myth. Repetition of consistent messages by providers and mobilizers works to increase trust and belief in the new narrative.⁵

The Side Effects Response Tool

The Side Effects Response Tool is located inside the front and back cover of the referral card booklet (described below) and includes information about side effects that are clinically proven to be connected to LARCs, as well as a list of health concerns that are *not* connected to FP. The purpose is to equip mobilizers with an immediate response to concerns raised by clients, including brief explanations of side effects to expect from the most common methods. The tool reinforces the importance of referring clients to the clinic or a toll-free hotline for information and support in managing side effects, to ensure that clients get the medical care they need.

► Rationale

Conversations revealed LARC users commonly misattribute other health issues to their FP method. Other users are surprised and unsettled by side effects such as changes in bleeding that *are* related to their method, but may not indicate any medical problem. Widespread beliefs that FP methods can undermine future fertility lead women to fear for the worst when they see any change in their bodies after using FP.⁶

The mobilizers approached by concerned users for advice did not previously have materials or training to respond to these concerns directly. While directing clients to a MSUG provider for information may be the best way to avoid giving clients incorrect medical advice, this approach is dissatisfying for clients,

How to Manage Side Effects

Heavy and/or longer periods

COIL: Many women have heavier bleeding when they start a coil. It is usually safe and gets better after 3-4 months. However, women often get their period at unusual times while using a coil.
 IMPLANT: Some women have heavier bleeding when using an implant.
 INJECTION: Many women have longer periods when they start injections. It is usually safe and gets better after 1 year.

Irregular bleeding or spotting

COIL: Some women have irregular bleeding when they start a coil. It is usually safe and gets better after 3-4 months.
 IMPLANT: Many women have irregular bleeding when using an implant and it's safe. If you experience this while using an implant, this is unlikely to change.
 INJECTION: Many women have irregular bleeding when using an injectable and it's safe.

Menstrual cramping

COIL: Some women get more painful menstrual cramping when using a coil and for many it's safe. For some, it improves over time.
 IMPLANT: Cramping is NOT a side effect of the implant.
 INJECTION: Cramping is NOT a side effect of the injection.

OR

No or light periods

COIL: No or light periods is NOT a side effect of the coil.
 IMPLANT: Some women have lighter, less frequent, or no bleeding at all when they use an implant and for many it's safe. If you experience this while using an implant, this is unlikely to change.
 INJECTION: Some women have lighter, less frequent, or no bleeding at all when they use an implant and for many it's safe.

Marie Stopes can provide medication to reduce bleeding, irregularity, and pain when appropriate.

Visit or call +XXX XXX-XXXX Toll Free

Learn more about your method.

Visit or call +XXX XXX-XXXX Toll Free

These are NOT side effects of the COIL or IMPLANT:

Weight change, No interest in sex, Headaches, STIs, Infections, Vaginal dryness

especially in rural areas where it can lead to weeks or months of fear and uncertainty. Outreach teams visit these sites infrequently, and women have limited access to other health services in the interim. Limited phone access means that even the MSUG toll-free hotline is difficult for many clients to access. If mobilizers are able to give simple, clear answers to clients' concerns, they may help to minimize these extended periods of uncertainty and anxiety. By assuaging misplaced fears about LARCs before clients go to a clinic, they may lead clients to be less intent on discontinuing and more receptive to counseling, side effects management, or switching to a different method when they are able to visit the clinic.

"I use the Side Effects Response Tool to encourage clients not to lose hope. I assure them that I am going to give you a referral card or a free toll number which you can call to speak to health workers. There will [also] be an Outreach program in the area you can go and meet the providers." —Community mobilizer

Referral Cards

The referral cards are given to clients by mobilizers in advance of the Outreach clinic. Mobilizers indicate the date, location, and client's desired service on the card and keep a carbon copy in a booklet with the client's contact information, which allows mobilizers to follow up to help the client access services or address any remaining concerns. Clients then show the referral cards to Outreach team providers during FP counseling to indicate their desired service.

► Rationale

The referral cards reframe the choice set of service options available at Outreach clinics for all clients, including concerned users, resetting expectations of what the answer to their concerns might be. Instead of focusing on removing, the referral cards highlight alternative service options such as side effects management, switching methods, or method reviews for concerned users, to reframe their expectations of service options to include continuation. The cards also include the date and location of the Outreach clinic as a reminder for clients to attend, as well as the toll-free number for the informational contact center if they have immediate concerns. The cards were designed to be discrete; they do not include any personally identifying information or overt branding for Marie Stopes, as clients commonly visit clinics without their partner or family's knowledge.

At the clinic, clients give the referral card to providers to signal their needs and direct the provider to give relevant information. This helps streamline service delivery by helping providers to identify a client's needs and reason for visiting, allowing them to easily provide more personalized and effective counseling. The referral cards also offer an easy way for clients to signal to providers that they have concerns, when they may feel intimidated or unsure about raising those concerns during a rushed counseling session. This may help providers to identify instances in which further probing is needed to address clients' needs.

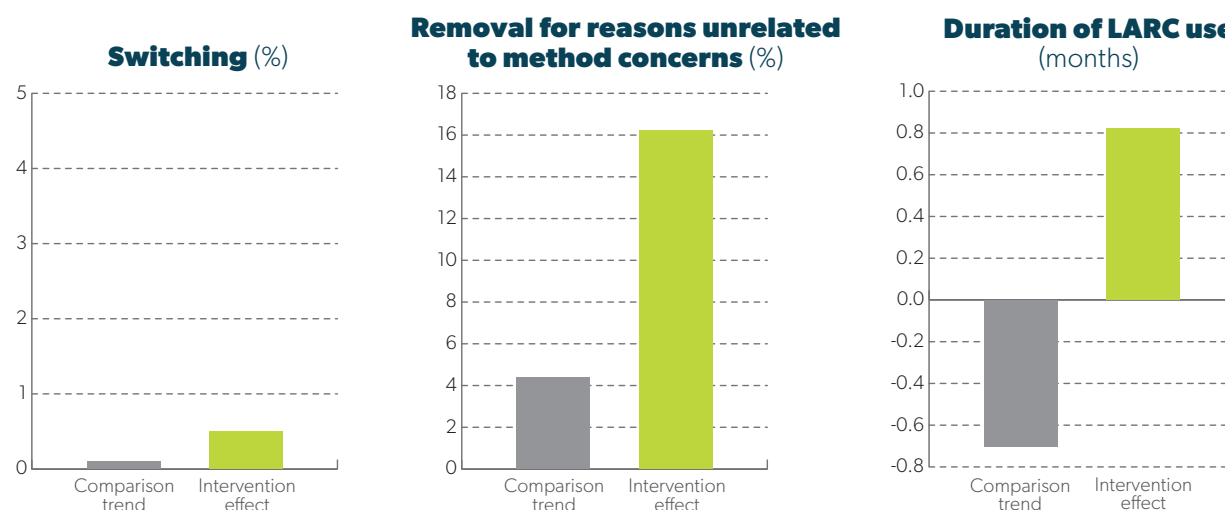
Pilot Test Findings

We conducted a quasi-experimental evaluation of the solution set (August 2019 through January 2020) using a difference-in-difference study design. Eight Outreach teams implemented the solution set (the treatment group), and the remaining 24 teams served as a comparison group.⁷ We then compared trends before and during the intervention period in three outcomes related to LARC continuation: the proportion of removal clients switching from a LARC to any other contraceptive method, the proportion of removals for reasons related to concerns,⁸ and the average duration of use prior to removal. Although the study was limited in both statistical power and in the outcomes we could measure through administrative data, ***the results offer promising evidence suggesting that the solution set can support mobilizers and providers to offer the information, guidance, and services that concerned users need.***

We saw positive trends across all three of these outcome measures, although effects were not statistically significant when measured across all regions. The solution set was well-received by community mobilizers and providers, who reported they helped improve their work with clients by streamlining interactions and equipping teams with messaging to respond to common concerns about LARCs.

In the Central region, we saw statistically significant impacts on two outcomes (Figure 1). We found that fewer clients removed LARCs due to concerns about the method: the proportion of removal clients who cited unrelated reasons increased by 16.2 percentage points⁹ among treatment teams relative to comparison teams. This suggests that the materials helped mobilizers and providers to resolve concerns. Additionally, among Central region clients who removed methods during the study period, the average duration of use for treatment teams increased by 24 days¹⁰ relative to the comparison clinics, from a baseline average of 30 months. This suggests that exposure to the solution set led some users to keep methods when their concerns or fears were addressed or side effects managed. There was also non-significant positive trend in the number of removal clients switching methods in Central region treatment clinics, as compared to comparison clinics.

FIGURE 1. Estimated treatment effects within the Central region, relative to comparison group.



Implementation insight #1:

Higher baseline capacity of mobilizers and their repeat exposure to the materials may lead to more effective implementation and contribute to significant positive effects.

The Central region may have had pre-existing advantages helping to use the materials as intended and experience changes in clients' behavior in the short term, which may have contributed to the significant effects in that region. Higher levels of education among mobilizers and providers and greater comfort reading local languages, as well as closer proximity to the Country Support Office may have meant that staff in the Central region were better prepared and supported to use the materials. Additionally, Central region Outreach teams visit sites more frequently and were more likely to visit the same sites multiple times during the study period, allowing the local community mobilizers repeat opportunities to develop comfort with the materials. These more frequent clinics also mean that there are more opportunities for clients to be exposed to the materials and messaging, including at the time they took up a method, which may have led them to feel more confident in their initial choices. For other mobilizers, a single training and opportunity to employ the intervention materials may not have been sufficient to fully grasp or become comfortable with their messaging, though their comfort may continue to grow with more experience.

Implementation insight #2:

The simple FP Facts are accessible and useful to clients and staff; mobilizers in particular feel better equipped to respond to client's concerns with the Flipchart.

Qualitative interviews conducted as part of a process evaluation with providers, clients, and mobilizers indicate the FP Facts Flipchart was broadly helpful for a range of counseling needs, not only for users with concerns. Mobilizers used the FP Facts Flipchart for a wider range of purposes than was initially intended, such as explaining how LARCs work to prevent pregnancy, and requested that information on other methods beyond LARCs be added. Providers used the tool during group counseling sessions as a visual aid for clients to follow along with detailed explanations of LARCs.

For some mobilizers, the FP Facts Flipchart was the first client-facing informational material they had received to assist with client conversations. The positive response suggests that to some extent, equipping mobilizers with any supporting materials is helpful to their work. However, we found evidence that the simplicity and cultural relevance of the FP Facts Flipchart provided added value due to its accessibility and ease of use. By contrast, the Side Effects Response Tool was less useful to the vast majority of mobilizers, who did not fully understand the clinical information in the material and therefore did not use it when speaking with clients. Further simplifications could make this tool more accessible to mobilizers and elevate its usefulness to the level of the FP Facts Flipchart.

“For the mothers who have side effects, I use the Flipchart to assure them that their method really doesn't cause the side effect or, in case there are side effects they are experiencing, go to the providers to help you. It is helpful in a way that if you are talking to a client, you will have a source of information so it will help the client to know that you are not just [fabricating] what you are saying.” —Community Mobilizer

Implementation insight #3:

The referral cards can help to streamline service delivery, but do not widen a client's sense of service delivery options as intended.

Providers reported the referral cards helped them to more quickly identify clients' reasons for visiting the facility, and clients appreciated receiving them. In the context of clinics with a high volume of demand and limitations on providers' time and bandwidth, the referral cards offered relevant information about clients that helped providers give more personalized advice quickly. However, clients did not seem to perceive a link between the information on the referral card and services available to them in a clinic. As a result, we would recommend employing referral cards when they can serve multiple purposes, such as tracking mobilizer performance or determining pay, beyond simply as a tool to direct clients to consider alternative services.

"As a provider, clients who come with referral cards it helps me take less time because when they come with a referral card I read and it helps me know what they want and I take less time when counseling than the other ones who don't have them." —Provider

Implications and Recommendations

Community-based mobilizers are a trusted and important channel for disseminating information and addressing clients' concerns, especially when access to clinic-based counseling is limited. However, many mobilizers are under-equipped and under-supported; their full potential as a trusted channel to provide relevant and credible information and to combat myths and concerns remains untapped. This solution set filled that gap by helping mobilizers to serve the role that clients expect of them, while recognizing that mobilizers cannot have the medical expertise of a healthcare provider and ensuring that clients also access the services they need in clinics. The pilot intervention's particularly promising results in areas of relatively high mobilizer capacity and support underscores the importance of mobilizer training, practice with materials, supervision, and a baseline level of literacy and comfort with the topic of FP. When adapting to other areas, investment in initial trainings and ongoing support to help mobilizers fully understand the materials is crucial to successful use. When equipped with training and tools tailored to their context and knowledge level, community mobilizers can effectively support women in continuing to use LARCs when those methods meet their reproductive needs and goals.

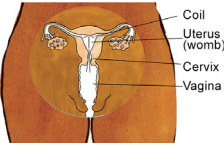
Appendix

The images below show pages of the FP Facts Flipchart facing the mobilizer or provider who uses this tool. Simpler pages with less text face the client.

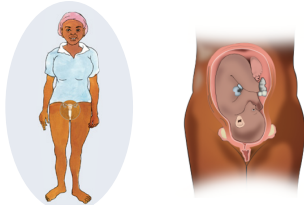
FACT

The coil sits where babies grow

Can the man feel the baby when you have sex when you are pregnant?



- The uterus is protected by the cervix.
- The cervix is very narrow and only the strings of the coil can fit through.
- A provider can shorten the coil's strings if they bother you.



This means sex will feel the same to the man if you use a coil.

➡ **Myth addressed:** IUDs can move around the body and “get lost” or puncture organs, leading to infertility or death.

This fact references the more familiar experience of pregnancy to demonstrate that the uterus is protected from the vagina, without needing to reference female anatomy that is not well-known among clients.

➡ **Myth addressed:** The implant can travel inside through the bloodstream to other parts of the body, leading to infertility or death.

The illustration showed that the implant sits between muscle and skin, not in the blood stream. This replaces the belief that the implant can easily travel around the body.

FACT

The implant sits directly underneath your skin

Do you have an implant?
Can you feel it right now?



- The implant is located away from your veins and muscles.
- Your fat tissue and skin keep the implant in place.

This means the implant will stay in the same place it was inserted.

FACT

Your vagina cleans itself

What can happen if you wash something, like your arm, when it is already clean?



- Washing inside your vagina, or using herbs or potions inside your vagina dries out the vagina's natural moisture.
- Washing inside your vagina does NOT prevent infections.

This means the coil, injectables, or implants do not cause vaginal dryness. Other things can, like vaginal washing or using herbs or potions inside your vagina.

➡ **Myth addressed:** Women need to douche or use other folk remedies to keep the vagina clean when using an IUD.

These practices can in fact cause infections, contributing to another common myth that IUDs often cause infections. This card emphasizes that the vagina is naturally clean, and that cleaning practices are irritating.

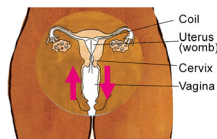
➡ **Myth addressed:** This fact addresses multiple myths, including that IUDs or menstrual blood can travel to other parts of the body.

This image makes a familiar comparison to pregnancy to persuade clients that IUDs, for example, cannot travel to other parts of the body.

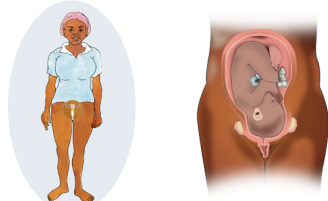
FACT

There is one way in and out of the uterus

Even when the baby is very small in your womb, does it move to other parts of your body?



- Babies and the coil sit in the same place.
- The vagina is the only way for anything to leave the uterus.



This means the coil will stay in the uterus until a provider removes it.

FACT

Your cervix is always slightly open

What happens when you turn over a bucket with water inside?



- If there is blood in your uterus, it will always come out through your cervix.
- Some women have light or no bleeding when they use implants or injectables.
- Menstrual blood cannot build up inside your body.



This means light or no periods means your uterus is producing less or no menstrual blood, so there is less to come out.

Myth addressed: The metal IUDs are made of can rust or degrade inside the body, leading to cervical cancer, infertility or “burned eggs”.

This explanation focuses on the strength of copper, the material that the IUD is made of, and largely avoids terms associated with the myth (e.g. rust). To improve this explanation, compare the IUD to a familiar copper item that is known not to rust. We were not able to find such an example in Uganda.

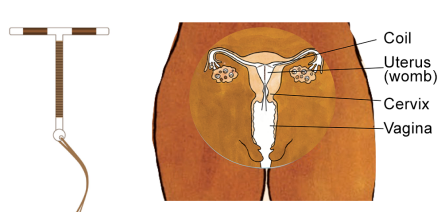
Myth addressed: Menstrual blood can well up inside the body when periods are missed due to hormonal methods.

The simple explanation that the cervix is always open, combined with the previous card, replaces that narrative that missed periods are a result of menstrual blood welling inside the body. The overturned bucket analogy helps to drive home the point.

FACT

The coil is made out of a special material that is very strong

Do things made from strong materials fall apart?



- Coils cannot fall apart or fade over time
- The coil does not put any medicine or hormones in your body

This means when you're ready to have the coil removed, it will look the same as it did when it was inserted

Notes

¹ “Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2017, fact sheet,” Guttmacher Institute, last updated: December 6, 2017, <https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017>.

² Uganda Bureau of Statistics - UBOS and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda: UBOS and ICF. Available at <http://dhsprogram.com/pubs/pdf/FR333/FR333.pdf>.

³ Mayer, R. E. (2008). *Applying the science of learning: Evidence-based principles for the design of multimedia instruction*. American Psychologist, 63, 760–769.

⁴ Skurnik, I., Yoon, C., Park, D. C., & Schwarz, N. (2005). *How Warnings about False Claims Become Recommendations*. Journal of Consumer Research, 31(4), 713–724.

⁵ Schwarz, N., Newman, E., & Leach, W. (2016). Making the truth stick & the myths fade: Lessons from cognitive psychology. Behavioral Science & Policy, 2(1), 85–95.

⁶ Williamson, L. M., Parkes, A., Wight, D., Petticrew, M., & Hart, G. J. (2009). Limits to modern contraceptive use among young women in developing countries: a systematic review of qualitative research. *Reproductive health*, 6(1), 3.

⁷ Teams implementing the solution set were not randomly selected, but were chosen to represent a range of geographies while remaining accessible to the support office in Kampala.

⁸ Reasons related unrelated to concerns were defined as planning for pregnancy and method expiration.

⁹ $p < .01$; 95% CI: 0.034–0.290

¹⁰ $p < .01$; 95% CI: -0.167 –1.845 months