

Encouraging Counseling that Promotes Meaningful Choice

Behavioral Design for Provider Behavior Change in Family Planning Services in Malawi

Behavioral design is an approach that leverages insights from behavioral economics, social psychology, human centered design, and other disciplines to develop and test innovative solutions that reshape people's environment to positively influence their behavior.

As part of Breakthrough ACTION, ideas42 employs a four-stage behavioral design methodology which consists of (i) defining a problem in terms of a behavior we seek to encourage, (ii) diagnosing the behavioral drivers of that problem, (iii) designing solutions that address the behavioral drivers, and (iv) testing the effectiveness of solutions and adapting as needed. This approach is one way to design interventions to change health-related behaviors and decision-making, grounded in an understanding of why people choose as they do and what motivates their decision-making and action. This brief will describe the application of this approach to a provider behavior change activity in Malawi.

Provider Behavior and Family Planning Uptake in Malawi

Despite recent gains in usage of modern contraceptive methods, Malawi has a high unmet need for family planning (FP), at 19 percent among married women.¹ Of women using a modern contraceptive method, 60 percent rely on injectables, male condoms, or pills, methods with high discontinuation rates. This suggests that many women of reproductive age who intend to use a modern method are using methods that do not fully satisfy their fertility needs.² Social-cultural norms and biases, large provider caseloads, lack of patient privacy, inadequate provider-client contact time, and inadequate health worker skills in providing FP methods, particularly long-acting reversible contraceptives (LARCs), are just some of the reasons which may lead providers in Malawi to refer women to a limited choice set of FP methods or offer sub-optimal counseling. Breakthrough ACTION used a behavioral design approach to investigate the factors driving provider behavior and to create provider-facing behavioral solutions to challenges of FP use amongst postpartum women in Malawi.

Defining the Problem

The project conducted formative research to systematically define a behavioral problem, drawing from health facility observations, interviews with key stakeholders, and discussions with partners. These insights led Breakthrough ACTION to develop the following behavioral problem statement:

Providers do not counsel postpartum women on the full range of contraceptive methods in a way that women internalize. We want providers to consistently provide comprehensive FP counseling that resonates with their clients.

The formative research found that:

- Providers often fail to offer FP counseling that clearly conveys the advantages and disadvantages of all methods in a way that supports a meaningful, informed choice.
- Women receiving counseling reported feeling uncertain about whether a method is suitable for their unique FP needs.

Diagnosis

The team generated hypotheses about potential behavioral barriers contributing to the problem of incomplete counseling. These hypotheses were then investigated through interviews with providers and clients and through observations of antenatal care (ANC), FP, and immunization counseling sessions to identify the behavioral barriers described below.

DIAGNOSIS #1: Providers use faulty heuristics that result in presenting inconsistent information on the advantages and disadvantages of each FP method.

Throughout a woman's journey from pregnancy through the postpartum period, most of the important health information she receives is shared during health talks, which are conducted at the health facility in a group setting. Providers were observed giving health talks with a limited set of resources to help them present information. Without job aids, providers rely on their memory of methods' advantages and disadvantages. Providers usually start group health talks by asking clients which FP methods they are familiar with or want more information on and then focus the health talk on these methods. Both clients and providers are influenced by the **availability heuristic** during health talks. Clients are most likely to request information on methods they have heard of before, and providers are most likely to discuss methods that they administer often. As a result, certain methods are discussed in more depth than others.



BEHAVIORAL DESIGN CONCEPTS

Availability heuristic: the tendency to more easily recall examples that one has heard recently

Risk aversion: a preference for avoiding uncertainty and favoring options that are more certain, even when their expected result is worse, on average

Ministry of Health protocols dictate that providers must provide health talks at ANC, on immunization days, and by the FP waiting area. However, there are no explicitly stated requirements on what to discuss nor cues to discuss FP in detail. Providers were observed strictly adhering to protocol when discussing topics and many used a handwritten list of topics as a reminder of which topics to discuss. When asked in interviews, providers considered a mere mention of FP as sufficient to comply with the protocol and encourage client choice.

Furthermore, during provider interviews, providers stated that they prefer to focus counseling on FP methods that they know are in stock that day rather than the full suite of methods. This is due to providers' **risk aversion** and desire to reduce the risk that a client may not return to the facility or follow through if she chooses a method that she cannot immediately adopt. Providers focus on an outcome they perceive as achievable (encouraging the client to take up a method immediately, even if it is not the best fit for her needs) rather than using their time to counsel on methods they know are not immediately available.

DIAGNOSIS #2: The provision of FP methods is systematic and automatic.

In most cases, after the health talk clients also receive a short one-on-one FP consultation with providers where clients select and receive their method. Providers rely on protocols to guide the counseling, which do not prompt discussion of options or additional information-sharing. Providers' first question in a FP consultation is, "Which method have you chosen?" However, providers were not observed asking any follow up questions; for example, providers do not consider if or when the client received information on all the methods in her choice set. Providers are also busy and suffer from time **scarcity**. They described a preference for focusing on more immediately urgent tasks; this focus often leads to a failure to thoroughly assess a client's

needs, particularly if she is able to answer the initial question of which method she has chosen. As a result, women are frequently not informed of all FP options.

For returning clients, providers report using the last FP method listed in a client's health passport, a health booklet updated at every health visit, as an indication of what method to provide in the current visit. In this way providers exhibit **status quo bias**. Providers were rarely observed asking a woman about her satisfaction with her current method or her preferences if she is a returning client, even if she expresses some dissatisfaction or has difficulty using the method effectively.



BEHAVIORAL DESIGN CONCEPTS

Scarcity: a context of not having enough of a key resource, including time, which negatively impacts cognition, decision making, and self-control

Status quo bias: a preference for maintaining the current state of affairs

DIAGNOSIS #3: In both health talks and consultations, providers counsel on certain methods based on their assumptions of clients' needs and preferences.

Information provided to clients does not adequately address the factors that clients consider most when adopting a method. Clients report that they consider (i) their return to fertility, (ii) how quickly the method can be adopted after delivery, (iii) what the method requires of the client, and (iv) how it relates to their desired birth spacing. Providers were observed focusing solely on a method's maximum duration of effectiveness without emphasizing reversibility, time to return to fertility, and what a client must remember and do to use the method correctly.

Providers understand that most postpartum women want to have their next child in fewer than 3 years and interpret this preference to mean that LARCs would not be suitable. Providers often discussed LARCs in terms of length of effectiveness (e.g., 3-year implant, 10-year intrauterine contraceptive device (IUCD)) and have a **mental model** that a method's maximum length of effectiveness equates to its recommended duration of use. Some providers even cited that they thought a method was wasted if it was removed prior to the maximum duration. Further, providers incorrectly believe that women are more likely to discontinue IUCDs and lead to further waste. As a result, providers might deter women from adopting an IUCD.

Providers also hold strong beliefs on the number of children a woman should have. This has led to **stereotyping**, whereby a provider recommends a method based on their expectation of how many more children a woman will (or should) want, steering a client with many children towards permanent methods while recommending short-acting reversible contraception (SARCs) for a woman with few children.



BEHAVIORAL DESIGN CONCEPTS

Mental model: cognitive structures of organized prior knowledge that are developed from experience

Stereotyping: an oversimplified view about the characteristics of a group or thing based on past experiences

DIAGNOSIS #4: For returning clients, providers rely on an incomplete *mental model* of client satisfaction to inform which method they administer.

Providers described side effects, especially irregular bleeding, as the primary reason that a woman should consider switching to an alternative FP method. Providers associate a client's lack of side effects with method satisfaction and are unlikely to probe on adherence, ease of use, concerns about return to fertility, or child spacing needs when discussing method selection and satisfaction. Providers were not observed to question a returning client on her satisfaction with the method unless the client explicitly mentions concerns.

DIAGNOSIS #5: Providers perceive method switching—particularly switching to LARCs—to have high costs and risks, so they focus client counseling on SARCs.

Providers often suggested that clients adopting LARCs have a higher chance of being dissatisfied. LARC discontinuation is much more salient to a provider because they must remove the method. In contrast, when a woman discontinues a SARC she can simply stop using the method on her own. **Confirmation bias** leads providers to focus their attention on evidence that confirms their existing beliefs that LARCs are more likely to be discontinued compared to SARCs. Providers tend to notice and remember clients choosing to remove LARCs and interpret those cases as an indication that clients are dissatisfied with the LARC. This scenario is reinforced by providers' concerns that it is wasteful to remove LARCs before the maximum time of effectiveness.



BEHAVIORAL DESIGN CONCEPTS

Confirmation bias: seeking or interpreting evidence in ways that are partial to existing beliefs or expectations

Present bias: tendency to favor immediate rewards at the expense of long-term goals

There is also a perception of risk when a provider refers for a LARC. Providers note that they are concerned that, if a client leaves the health facility without a method, she may not return to receive the LARC. This may lead to an unwanted pregnancy. Instead, providers may provide a SARC, knowing that a woman will at least leave the facility with a method.

Finally, there is a perception of additional cost in providing a LARC since insertion requires more resources and additional time. Providers often make LARC clients wait in the back of the queue to minimize the wait time for other clients, creating an additional hassle for a woman who wants to adopt a LARC. This also triggers **present bias** in both women and providers. SARCs are quicker and easier to administer now, without considering the longer-term consequences of discontinuation or inconsistent use.

DIAGNOSIS #6: When providers mention FP and/or give a referral for FP at ANC, PNC, immunization, or FP consults, they are unable to consistently follow up to ensure FP uptake.

Providers have different assigned responsibilities every day, e.g., ANC, PNC, immunization, or FP. The rotation schedule means clients are not consistently seeing the same provider, and providers are not able to confirm whether referrals are completed. Additionally, facility FP registries do not track referrals, so there is no prompt for a subsequent provider to follow up on previous referrals or counseling discussions. Since referrals are not tracked and are not considered in providers' evaluations, they do not receive much attention.

DIAGNOSIS #7: Providers do not consider offering complete FP counseling until six weeks postpartum because providers see this as the most appropriate time for a postpartum woman to start using FP.

During the immediate postpartum period, providers deprioritize FP counseling, waiting until 6 weeks postpartum to provide information about the benefits of method uptake. Providers describe prioritizing other health information that is more immediately relevant to women during ANC, PNC, and immunization visits, such as information on how to breastfeed, clean post-delivery wounds, and care for the baby's umbilical cord. As a result of the limited information that clients receive during ANC and PNC visits, women are often not aware of all the FP options that may be available to them. Additionally, though women may understand the benefits of FP at 6 weeks postpartum, the counseling is not comprehensive, so they receive little guidance on how to select a method.

Diagnosis to Design

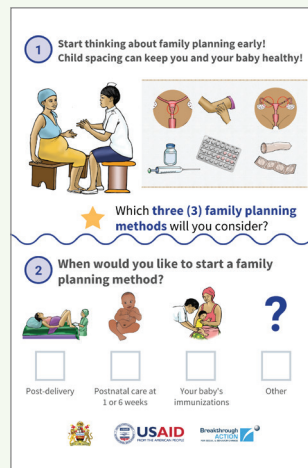
The diagnosis provided insights into how to support providers in offering FP counseling in a way that promotes meaningful client choice. The five solutions outlined below aim to expand the range of interactions in which counseling might occur and to encourage providers to counsel on all methods and account for individual client preferences.

ANC passport inserts

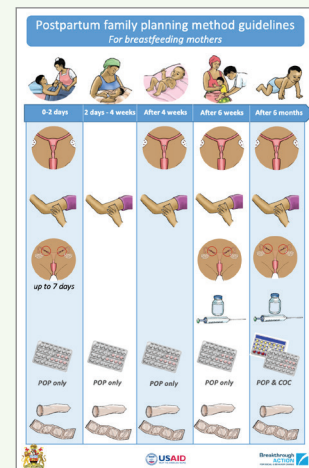
The solution includes a sticker which is affixed to a woman’s health passport during the third or fourth ANC visit, which prompts providers to at least mention FP during these visits. The solution also includes a postpartum FP reference guide for the health worker which shows when a breastfeeding woman can take up each method after delivery.

How does the solution address behavioral barriers?

- Prompts providers to have an early conversation with clients about FP.
- Expands the set of methods that women and providers discuss.
- Supports providers in helping women plan for when to adopt postpartum FP.
- Reminds providers about the medical eligibility criteria for each method for a postpartum, breastfeeding woman.



ANC passport insert



Provider reference guide

Group counseling tool

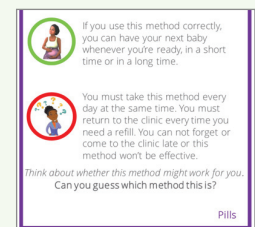
The tool includes a canvas poster that providers use to facilitate group discussion on **all** FP methods during health talks. The poster ensures that providers do not default to discussing methods with which they are most familiar and frames method discussion around factors that are most important to clients. The health talk starts with all methods covered by a colored flap. Clients roll a colored die, then providers read the counseling card of that color and allow women to guess which method it is. Finally, the provider reveals the method, responds to any questions, and the die is rolled again.

How does the solution address behavioral barriers?

- Ensures equal and comparable information is available on all methods.
- De-biases the way and order in which information is provided.
- Expands a woman’s choice set beyond learning about methods with which they are already familiar.
- Corrects misperceptions about particular methods, appropriateness of methods for certain women, duration of use, and reversibility.



Group discussion poster



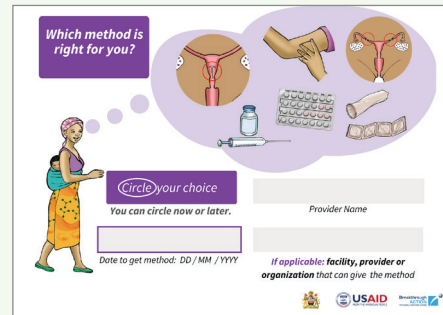
Card detail

Method referral card

The referral card is a card that providers can give to clients as needed. It can be given to women who express interest in other methods, have a need for another method, or when women choose a method that is not available during their FP consultation.

How does the solution address behavioral barriers?

- Prompts providers and clients to discuss method satisfaction.
- Helps providers facilitate a discussion on different methods.
- Gives women a tool to consider alternative methods and prompts providers to help her make a plan to return to the clinic to get the method of her choice.
- Enables providers to refer women for unavailable methods.
- Shows providers whether a woman returns to the clinic after considering her options or to follow through with a referral.



Method referral card

Referral tracking system

The referral tracking system consists of (i) facility-based storage box for method referral cards, (ii) drop box for clients to leave their completed referral cards when they revisit the facility, and (iii) referral tracking form to determine the number of completed referrals.

How does the solution address behavioral barriers?

- Allows providers to see whether a woman follows through on a referral.
- Gives providers visibility into women's desired methods.
- Allows providers to see the effects of and reflect on their FP counseling.

Values clarification workshop

Providers participate in a workshop that introduces the solutions for feedback and serves as an opportunity to discuss FP counseling.

The workshop (i) includes a refresher on the importance of postpartum FP, (ii) discusses options for methods in the postpartum period and introduces immediate postpartum FP, (iii) reviews information on LARCs (e.g., reversibility and long-acting), and (iv) dispels myths on LARCs (e.g., 3-year implants should be used for 3 years).

How does the solution address behavioral barriers?

- Resets providers' beliefs about recommended duration of use and reversibility of LARCs.
- Provides a refresher on clinical components of LARC provision.
- Trains providers on the solution set and allows for discussion of implementation.

The solutions will be tested to determine their feasibility, sustainability, and suggested impact.

Key Takeaways

While the diagnosis phase acknowledged that structural barriers such as client volume, staff capacity, and method stock-out may limit provider behavior, it also highlighted behaviorally-focused opportunities to ensure informed choice and modify the context and processes surrounding FP counseling and method selection.

In particular, the findings highlighted differences in how information was presented to clients and the salience of that information. The diagnosis and design process emphasized the need to consider the client perspective in designing for provider behavior. The behavioral design approach looked beyond a provider's clinical knowledge and focused on how counseling sessions and health talks were conducted.

Cross-Cutting Findings in the Application of Behavioral Design to Provider Behavior Change

This brief is one of a series on the application of behavioral design to provider behavior change programming in Zambia, Malawi, and Nigeria. While the context varies across country programs, Breakthrough ACTION identified several common behavioral barriers when addressing provider behavior.

1. The environment in which providers work and the feelings of **scarcity** and subsequent tunneling generated by that environment have critical implications for providers' decision-making and ability to follow through on intentions. Often these challenging environments can exacerbate the effects of other behavioral barriers.
2. In the three program examples, providers demonstrated **risk aversion**. Rather than adhering to best practices, providers acted in a way that they perceived to minimize the risk of a particularly salient poor health outcome. In Malawi, providers were hesitant to counsel on LARCs if a client could not immediately adopt a LARC during the visit because they were focused on the risk that she might not return at a later date.
3. Understanding a provider's **mental model** is important to understanding a provider's actions. While there is no consistent provider mental model across the 3 countries, faulty mental models contributed to a behavioral barrier in each of the three programs examined. In Malawi, many providers hold a flawed mental model wherein method satisfaction is solely determined by whether a woman experiences any side effects.
4. The programs highlight the need to consider actors other than the provider when addressing provider behavior change. **Clients' behavior** influences that of the providers and vice versa. Other actors' perspectives can be valuable both in diagnosing behavioral barriers and in developing solutions to address them. Understanding a client's FP desires was critical to identify gaps in FP counseling and develop appropriate designs.
5. Providers tend to prioritize actions and outcomes that are **measured** or on which their performance is evaluated. In Malawi, this was considered in the design of the method referral card and the referral tracking system. These solutions allow referrals to be tracked, so providers have a way to assess their performance and understand how women follow up on referrals.

While not an exhaustive list of behavioral barriers or approaches to behavior change, these programs highlight some key areas of exploration in designing and implementing provider behavior change activities.

Endnotes

¹ Malawi National Statistical Office (NSO) and ICF International (2016) Malawi Demographic and Health Survey (DHS) 2015-16. Zomba: NSO; and Calverton, MD, USA: ICF International.

² 4 Malawi NSO and ICF International (2016) Malawi DHS 2015-16. Zomba: NSO; and Calverton, MD, USA: ICF International

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